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Walden University

College of Management and Technology

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Lawrence R. Ford

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Walden University
2016

Abstract

Exploration of Practice Managers' Decision-Making Strategies in a Managed-Care Paradigm

by

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MSM, Troy University, 2005

BS, Southern Illinois University, 2002

AA, Saint Leo University, 2001

AAS, Community College of the Air Force, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Management

Walden University

November 2016

Abstract

Practice managers are facing challenging expectations when deploying a managed-care paradigm. The problem addressed in this study was a gap in knowledge regarding practice managers' decision-making strategies that affect, or could be perceived to affect, a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm. The purpose of the qualitative exploratory study was to explore practice managers' decision-making strategies affecting primary health care, physicians, and patients. Guided by Simon's ideology of decision-making strategies in a management environment, the overarching research question and 3 subquestions centered on how practice managers delineate their decision-making strategies and how those strategies affect primary health care, physicians, and patients. To close the gap in knowledge, the study included (a) a homogeneous purposive sampling of 14 practice managers (n = 2, pilot study; n = 12, main study) as research participants; (b) face-to-face interviews with semistructured, open-ended questions to collect data; and (c) in vivo and pattern coding during data analysis. The study results indicated a need for change agents, interactions, partnerships, and accountability in a managed-care paradigm. Managing health care is complex and practice managers will continue to be challenged. Alliances between practice managers and stakeholders are recommended to meet those challenging expectations. As a result, positive social changes may be observed in improved access to primary health care, better health care treatments, and collaborative interactions in a managed-care paradigm.

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Dedication

I dedicate this dissertation to two of the most influential people in my life, my parents, Mommy and Daddy, as I called them, Louise and Fred Ford, Jr., respectfully known as Hut and Junior to my family and their friends, for instilling in me that your circumstance does not dictate your future. Although Mommy and Daddy only had an elementary school education, they were incredibly full of knowledge and experiences that they acquired in spite of living in the racial oppressed and segregated southern region of the United States where receiving an education was not afforded to everyone. Mommy and Daddy taught me to dream, be confident, never give up on my dreams, always help others, believe in myself, and use my perceived weaknesses to create strengths that can lead to opportunities.

Even though Mommy and Daddy are in heaven now, their spirits live within me and I will never stop dreaming or believing in myself, just as they taught me. Throughout this Ph.D. journey, whenever I was tired and did not think I would make it, I looked into the heavens and I felt Mommy and Daddy in my heart, and that gave me the strength and motivation to keep pushing forward. Mommy and Daddy, thank you for the sacrifices that were made for me and I will pass on your knowledge and experiences to the next generation. I will always appreciate your efforts and I will love you all forever and a day. We will meet again at the King's table with his son.

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Chapter 1: Introduction to the Study

In the United States, establishing and cultivating a climate of excellence with business and client relationships while striving for successful outcomes is a necessary objective in any organization. However, it is particularly challenging for *practice managers* assigned to health care organizations deploying a *managed-care paradigm*. Health care is a complex, evolving business process with physicians and patients as clients, each with shared and diverse interests regarding how they desire to be led and managed to attain quality health care services (Concannon et al., 2014; Cottrell et al., 2015; Herremans, Nazari, & Mahmoudian, 2016).

To promote quality health care services, health care organizations are expected to be empathetic and compassionate to patients' needs and provide physicians with the tools they need to deliver quality health care services (Piña et al., 2015; Zabaleta-del-Olmo et al., 2015). Health care organizations are expected to provide patients with open ease of access to health care services and allow physicians to share scientific research evidence that is beneficial when delivering quality health care treatments to patients served in their health care communities (Piña et al., 2015; Zabaleta-del-Olmo et al., 2015). To meet physicians' and patients' expectations, it is necessary that health care organizations have committed, sustainable, and competent leadership and management teams in place that can direct the delivery of quality health care services (Alhaddi, 2015; Arroliga, Huber, Myers, Dieckert, & Wesson, 2014; Melo, Silva, & Parreira, 2014; Trastek, Hamilton, & Niles, 2014). Practice managers are accountable for meeting physicians' and patients' expectations (Alhaddi, 2015; Arroliga et al., 2014; Melo et al., 2014; Trastek et al.,

2014). In the context of exploring business and client relationships, delineating practice managers' decision-making strategies affecting physicians and patients in a *primary health care* setting would significantly further an understanding of how they establish and cultivate a climate of excellence in a managed-care paradigm.

A managed-care paradigm is a business structure utilized to manage health care services with respect to cost, quality, and value (U.S. Department of Health and Human Services, [HHS] 2015). For practice managers, validating deployment of a managed-care paradigm is vital for meeting physicians' and patients' expectations. To meet those expectations, practice managers work with *managed-care organizations* (MCOs). MCOs manage health care plans in market exchanges that delineate physicians' limitations and patients' necessities for health care services, particularly in primary health care settings (HHS, 2015).

Primary health care in a managed-care paradigm is considered the gatekeeper of health care services for patients seeking health care treatments from their physicians (Godager, Iversen, & Ma, 2015; March et al., 2015; Zabaleta-del-Olmo et al., 2015). It also acts as a platform for physicians to provide consultations and referrals to patients with numerous specialty and subspecialty complaints (Godager et al., 2015; March et al., 2015; Zabaleta-del-Olmo et al., 2015). Physicians consult with practice managers and MCOs to confirm patients' abilities to receive additional consultations and/or referrals in a managed-care paradigm.

Emerging studies regarding aspects of deploying a managed-care paradigm are plentiful. Addicott and Shortell's (2014) examination revealed that effective use of a

managed-care paradigm can elevate health care organizations' significance in their communities by making them more socially accountable. Alden, Friend, Schapira, and Stigglebout's (2014) research focused on investing in physicians' leadership and development training to help them learn how to manage the cost of delivering health care services and collect fees from insurers and payors. Bhattacharjee and Ray's (2014) investigation underscored the value of removing barriers and improving access to health care services. Hung and Jerng's (2014) study underlined the necessity for equality in the delivery of health care services and refining physicians' and patients' interactions.

However, when seeking aspects of practice managers' decision-making strategies affecting physicians and patients in a managed-care paradigm, a gap in knowledge in the health care literature exists, particularly in primary health care settings. As a result of the gap in knowledge, delineating aspects of practice managers' decision-making strategies in a managed-care paradigm is vital for comprehending how they establish and cultivate a climate of excellence to attain business objectives. Closing the gap in knowledge in the health care literature could add to positive social changes, as practice managers' decision-making strategies could improve patients' abilities to access their primary health care services, strengthen physicians' capacity to deliver valuable health care treatments to their patients, and support collaborative physicians' and patients' interactions.

Chapter 1 provides an evidence-based context for studying practice managers' decision-making strategies. The chapter includes the background of the study, problem statement, purpose of the study, research questions, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance of the study. Chapter

1 concludes with a delineation of aspects of the study and transitions to the literature review in Chapter 2.

Background of the Study

Recent debate over the effectiveness of the health care industry in the United States has been the focus of many leadership and management studies. However, a small amount of research has focused on practice managers' decision-making strategies. Health care scholars have not addressed practice managers' decision-making strategies affecting primary health care, physicians, and patients in a managed-care paradigm. Emerging research suggests that the delivery of health care services is an important commodity for every U.S. citizen to possess (Addicott & Shortell, 2014; Hawthorne, Sansoni, Hayes, Marosszeky, & Sansoni, 2014). In particular, scholars noted that primary health care is the gatekeeper for managing health care services (Godager et al., 2015; March et al., 2015; Zabaleta-del-Olmo et al., 2015). Other scholars described primary health care as the linchpin for physicians' and patients' interactions and collaborative communications, and the origination point for decisions on providing patients with the best health care services possible in a managed-care paradigm (Godager et al., 2015; March et al., 2015; Zabaleta-del-Olmo et al., 2015). HHS (2015) described a managed-care paradigm as a business structure that is utilized to manage health care services with respect to cost, quality, and value during the delivery of health care services. HHS also concluded that MCOs assist health care organizations in managing the health care services that are provided to patients in a managed-care paradigm. Addicott and Shortell (2014) stated that

any services offered by MCOs help practice managers shape policies for their organizations.

McManus et al. (2015) wrote that MCOs and managed-care paradigm alliances are required when structuring decisions to control the cost of health care services. Russo, Ciampi, and Esposito (2015) reported that MCOs and managed-care paradigm alliances can expand access to health care services. Shmueli, Stam, Wasem, and Trottmann (2015) acknowledged that MCOs and managed-care paradigm alliances can support health care organizations in maintaining their competitiveness. Russo et al. and Shmueli et al. emphasized that the alliances help health care organizations stay relevant in the health care industry through active engagements in their communities, such as building social and financial capital, particularly when delivering primary health care services.

With the deployment of a managed-care paradigm, Concannon et al. (2014), Cottrell et al. (2015), and Herremans et al. (2016) elaborated that physicians and patients expect practice managers to be held accountable for managing fiscal data and activities in health care organizations that satisfy their interests. Issel (2015) identified that practice managers' leadership and management obligations consist of an awareness of multi-level capital interests for their health care organizations. Russo et al. (2015) said that capital interests, such as social and financial interests, are critical aspects to consider when managing health care organizations. Shmueli et al. (2015) advocated that practice managers are required to have meaningful, persuasive relationships with their physicians and patients, as their decisions have an impact on their organizations' social and financial resources in their communities. Issel suggested that practice managers use their authority

to find methodologies to make the delivery of health care services a profitable enterprise for their organizations, regardless of whether their health care organizations are for-profit or not-for-profit entities. Issel argued that capitalism plays a significant role during decision-making in health care management in a managed-care paradigm.

Sidorov (2015) advocated deploying the *Triple Aim methodology* when managing organizations, physicians, and patients' capital interests. Sidorov concluded that the Triple Aim methodology is advantageous for enriching physicians' and patients' experiences in health care organizations, promoting collaborative decision-making during health care treatments, and minimizing per capita cost when delivering health care services. Rutitis, Batraga, Muizniece, and Ritovs (2012) and Sikka, Morath, and Leape (2015) agreed with Sidorov's implications of the Triple Aim methodology, but they also added that it should be utilized as a tool for creating learning opportunities for practice managers while building their organizations' identity, definition, and dimension that influences structure, strategy, culture, behavior, design, and communication when making decisions.

Integrating aspects of the Triple Aim methodology, coupled with leadership and management obligations, appear to be a frequently exploited methodology for practice managers when attempting to deliver the best experiences for physicians and patients in a managed-care paradigm. Nundy and Oswald (2014) and Trastek et al. (2014) recognized that Triple Aim-modeling leaders must possess distinctive powers required to influence business operations, strategic decision-making, attitudes, and behaviors of physicians and patients under their span of control. Other leadership and management scholars, such as

Lussier and Achua (2015), Mainemelis, Kark, and Epitropaki (2015), Mehrabani and Mohamad (2015), and Northouse (2015), linked aspects of the Triple Aim methodology to practice managers' leadership and decision-making strategies. They rationalized that effective leadership and decision-making strategies are indispensable when attending to capital interests regarding physicians and patients and building positive business relationships while yielding profitable outcomes. Further, the aforementioned scholars emphasized that practice managers have the potential to possess a superior ability to influence attitudes, behaviors, and opinions of physicians and patients, and, whether for good or ill, they could have powers to persuade them to follow a particular course of action. Arroliga et al.'s (2014) investigation reached conclusions similar to Nundy and Oswald's (2014) and Trastek et al.'s (2014) assessments, but the scholars warned that any inducements could manipulate practice managers' decision-making strategies, which could have positive or negative consequences for physicians' and patients' interests in a managed-care paradigm.

Lee (2015), Wai and Bojei (2015), and Yardley, Morrison, Bradbury, and Muller (2015) acknowledged that in human behavior, physicians and patients are susceptible to emulating what they are taught and respond with positive or negative behaviors and actions regarding what they have learned. Addicott and Shortell (2014), Hawthorne et al. (2014), and Minvielle, Waelli, Sicotte, and Kimberly (2014) suggested that patients' responses to health care services are indicators of their life experiences from interactions with their physicians. Lundberg's (2014) survey of physicians' and patients' interactions described that patients' health care experiences are established and cultivated when they

modify their health care needs based on health care treatments from their physicians. Lundberg wrote that physicians provide health care treatments to patients that are grounded on their previous medical school education, specialty training and development, and specific health care policies and strategies as articulated by practice managers.

Additional leadership and management scholars examined aspects of physicians' and patients' interactions. VanVactor (2012) noted that when physicians' and patients' interactions are patient-centered and relationship-centered, based on practice managers' previous decision-making strategies that led to their interactions, physicians and patient's relationships feature open communication, and health care becomes a collaborative effort. Labrie and Schulz (2015) acknowledged that physicians must deploy an enthusiastic, healthy respect for patients' views, values, cultures, experiences, and knowledge that they convey during their interactions. Labrie and Schulz also emphasized that a fundamental obligation of practice managers includes encouraging physicians to participate in *argumentation* with patients, such as open, collaborative communication to reinforce positive effects of health care decision-making during the delivery of health care services.

Nundy and Oswald (2014) and Trastek et al. (2014) noted that argumentation can play a significant role when deploying population health care management in a managed-care paradigm. The scholars concluded that implementing aspects of argumentation are important when practice managers apply valued-based health care services, monitor and verify quality indicators, keep track of health care utilizations and results, and encourage active physicians' and patients' engagements. Gulbrandsen (2014) defined argumentation as shared decision-making agreements between physicians and patients in their

communication exchanges, particularly when patients conceive the delivery of their health care services and experiences as, “Nothing about me without me” (p. 145). Bisbe and Barrube (2012) advised that practice managers utilize balanced scorecards to track, measure, implement, and reevaluate their decision-making strategies during patient-centered and relationship-centered collaborative communications. They implied that balanced scorecards can assist practice managers with staying abreast of fluctuating situations that have the potential to affect physicians’ and patients’ interactions during the delivery of health care services.

Ellen et al.’s (2014) research displayed that several domains of organizational structures prevent effective communication and result in substandard delivery of health care services, unproductive decision-making strategies, and poor physicians’ and patients’ interactions. The scholars posited that deficient organizational structures can construct unsuitable health care relationships between practice managers, physicians, patients, and MCOs that can progress into inappropriate organizational climates in a managed-care paradigm. Further, Ellen et al. noted that any deficient structures can increase health care services barriers that encourage problematic trust situations and promote attitudes and behaviors that hinder rational thinking. Heydenfeldt’s (2013) research revealed that organizational structures are associated with decision science and applied neuroscience. Heydenfeldt specified that communication during decision-making can be characterized as a linear or step-by-step process, and practice managers’ neuro-decision processes should be driven by a comprehensive analysis of all alternatives presented with their consequences weighed in order to ensure that an optimal alternative

is selected. Fargen and Friedman (2013) and Issel (2014) considered neuro-decision processes as acts of persuasion or manipulation that have attitude, behavior, and trust consequences.

Rubinelli (2013) said that acts of persuasion and manipulation play a vital role when managing communication efforts, as physicians and patients in a managed-care paradigm can be influenced to follow practice managers' instructions. Using Fishbein's (1967) model of attitudes, which illustrates that attitudes toward objects are a function of an individual's salient beliefs about the objects, Rubinelli posited that physicians and patients have different beliefs about decisions. Rubinelli also conveyed that at any given time, only some of the beliefs are considered salient and could determine attitudes and behaviors. Rubinelli considered attitudes and behaviors as belief-based approaches that can be the basis for practice managers' strength when persuading and manipulating decision-making concepts and trust alliances. Rubinelli stated that this is needed when convincing physicians and patients to follow a particular course of action.

Leadership and management research on decision-making strategies is evolving. Practice mangers' obligations to their organization are expanding. Integrating effective leadership and management strategies during decision-making are significant tasks for any organization but may be particularly challenging for practice managers assigned to health care organizations utilizing a managed-care paradigm. Concannon et al. (2014) and Mosquera et al. (2014) emphasized that simple decisions usually require a simple decision-making process, but more difficult decisions characteristically involve issues such as uncertainty, complexity, high risk, alternatives, trust, and interpersonal concerns.

Lerner, Li, Valdesolo, and Kassam (2015) concluded that every decision is made within a decision environment, which is delineated as the collection of information, alternatives, values, and preferences accessible at the time of the decision.

In the current health care literature, scholars have not clearly described how practice managers make decisions. A gap in knowledge exists, particularly for primary health care settings. As a result of the gap in knowledge, delineating aspects of practice managers' decision-making strategies in a managed-care paradigm is significant for comprehending how they establish and cultivate a climate of excellence.

Problem Statement

In 2012, the Centers for Disease Control and Prevention's National Ambulatory Medical Care Survey statistics reported that approximately 292 million patients received primary health care services in private physician's practices that utilized a managed-care paradigm. The distributions of managed-care contracts in health care organizations constitute over 80% of the health care market, which attests to how patients receive their health care services (Shmueli et al., 2015). The problem addressed in this qualitative exploratory study was a gap in knowledge regarding practice managers' decision-making strategies that affect, or could be perceived to affect, a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm. With the advent of the managed-care paradigm, there has been a shift in the health care industry in the United States (Alhaddi, 2015; Arroliga et al., 2014; Melo et al., 2014; Trastek et al., 2014). Despite an increased deployment of the managed-care paradigm in health care organizations, not all aspects of practice managers'

perspectives have been explored to identify their decision-making strategies, particularly in primary health care settings (Broqvist & Garpenby, 2015; McDonnell & Graham, 2015; Ramachadran, Banahan, Hardwick, & Clark, 2015).

Other scholars' attempts to address the gap yielded less than effective results. Arroliga et al. (2014) and Bhattacharjee and Ray (2014) examined strategies to increase patients' primary health care access and improve physicians' capability to provide health care treatments to patients. Hung and Jerng (2014) and Lundberg (2014) investigated the significance for enhancing physicians' and patients' experiences. Numerous results from health care case studies and indicators inferred that certain interactions can manipulate physicians' and patients' perspectives regarding the value of health care services provided and received (McManus et al., 2015; Manary, Boulding, Staelin, & Glickman, 2013; Piña et al., 2015; Russo et al., 2015; Shmueli et al., 2015). Because the nature of quality health care treatments is subjective, the Agency for Healthcare Research and Quality ([AHRQ], 2015) emphasized a continuous requirement for vigilant investigations when deploying a managed-care paradigm. AHRQ reported that constant analyses are necessary to uncover if there are any aspects of the decision-making process that have the capacity to manipulate how health care organizations are led and managed. After assessing the value of deploying a managed-care paradigm, health care scholars have not adequately explored underlying aspects of how practice managers conceive and implement decision-making strategies (Alhaddi, 2015; Arroliga et al., 2014; Melo et al., 2014; Trastek et al., 2014).

Purpose of the Study

The purpose of the qualitative exploratory study was to explore practice managers' decision-making strategies as they establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm. Specifically, the purpose of the study was to explore aspects of practice managers' underlying decision-making strategies affecting primary health care, physicians, and patients in a managed-care paradigm. I queried practice managers assigned to primary health care departments in Hampton Roads, Virginia. The objective of the queries was to gain deep, rich knowledge that could lead to what aspects influence practice managers' decision-making strategies and delineate how they conceive and implement their strategic processes in a managed-care paradigm.

Key research concepts of interest for the study that emerged were aspects of physicians' and patients' expectations, leadership and management attributes, and decision-making attributes in a managed-care paradigm. Data connecting the key research concepts of interest and the available research are lacking in the health care literature, and current research inquiries are deficient. To explore and delineate practice managers' perspectives of their decision-making strategies, I conducted 14 face-to-face interviews (n = 2, pilot study; n = 12, main study) utilizing semistructured, open-ended questions during the data collection process to bridge the gap in knowledge.

Research Questions

Qualitative research questions were deployed to conduct an in-depth exploration of practice managers' decision-making strategies. I created qualitative research questions

to elicit practice managers' responses and link their responses to the research problem while aligning the research design to the phenomenon of the study (Denzin & Lincoln, 2011; Maxwell, 2013; Paulus, Lester, & Dempster, 2014; Punch, 2014). I applied the following overarching research question to elicit practice managers' responses to the research problem:

> Research Question: How do practice managers delineate aspects of their decision-making strategies to establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm?

I used the following subquestions to further probe practice managers' perspectives:

> Subquestion 1: How do practice managers delineate aspects of their decision-making strategies affecting primary health care delivery in a managed-care paradigm?
>
> Subquestion 2: How do practice managers delineate aspects of their decision-making strategies affecting physicians in a managed-care paradigm?
>
> Subquestion 3: How do practice managers delineate aspects of their decision-making strategies affecting patients in a managed-care paradigm?

Conceptual Framework

I sought to close the gap in knowledge regarding practice managers' decision-making strategies that affect, or can be perceived to affect, a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm. The conceptual framework for the study followed Simon's (1960) ideology of decision-making strategies in a management environment. Key

research concepts of interest for the study that emerged were aspects of physicians' and patients' expectations, leadership and management attributes, and decision-making attributes in a managed-care paradigm. Simon stated that decision-making strategies are constructed on a succession of exchanges, such as intelligence, design, and choice processes, with respect to bounded rationality/rational choice and exchange processes. Palfy (2015) termed intelligence process as investigating the environment and identifying the need to make a decision. Elf, Fröst, Lindahl, and Wijk (2015) defined design process as scrutinizing and developing a problem or situation to create plausible options for a solution. Lepora and Pezzulo (2015) labelled choice process as selecting an appropriate course of actions to solve a problem or situation from the plausible list of options.

When exploring intelligence, design, and choice, the processes connect decision-making strategies as a descriptive method, and the decisions are constructed on practice managers' assessments of actual actions or past actions. Simon's (1960) ideology exhibits a bounded rationality/rational choice process and advocates that all decision-making is behavioral-centered and motivated by practice managers' interpretations of their desires or goals that are expressed as preferences. Likewise, Simon's ideology deploys exchange processes. Elf et al. (2015), Lepora and Pezzulo (2015), and Palfy (2015) reasoned that exchange processes are decisions that are structured on aspects of actions, relationships, communications, and/or behaviors, and these are necessary for negotiating exchanges between physicians and patients. Brophy's (2014) and Kidholm et al.'s (2015) research highlighted that decision-making strategies deploying aspects of intelligence, design, and choice processes have been utilized extensively in health care research. Brophy and

Kidholm el al. used Simon's ideology as a management paradigm for medical decision-making and to explain the rationality for interpreting actions, behaviors, and processes, which is explored further in Chapter 2.

I used Simon's (1960) ideology as a platform to explore and delineate aspects of practice managers' perspectives that are centered on exchanges between their health care organizations' guiding principles and their physicians' and patients' interactions in a managed-care paradigm. Simon described the decision-making sequences of intelligence, design, and choice as complex processes because decision-making is a repetitive series of making decisions. Simon said that decision-making demands that practice managers constantly reevaluate problems or situations to comply with their strategic objectives. Aspects of interactions, relationships, communications, actions, and behaviors are subjective in nature. As a result, exploring and delineating how practice managers' exchange processes are considered and executed in a managed-care paradigm are notably related to the research problem. In particular, it is noteworthy when practice managers' decision-making strategies must be addressed continuously to solve fluctuating problems or situations, which is explored in more details in Chapter 2.

Nature of the Study

The research design for the study was qualitative in nature with an exploratory research strategy of inquiry. I used a qualitative exploratory research design to facilitate an in-depth, rich, detailed methodology to seek understanding of the research phenomenon, as I explored and delineated practice managers' responses during the data collection process (Denzin & Lincoln, 2011; Maxwell, 2013; Paulus et al., 2014; Punch,

2014). Qualitative exploratory research was appropriate for the study because I conducted 14 face-to-face interviews ($n = 2$, pilot study; $n = 12$, main study) using semistructured, open-ended questions with practice managers to elicit their responses regarding how they make decisions. The interviewing process gave practice managers opportunities to describe aspects of their decision-making strategies. Practice managers also were able to communicate how aspects of their decision-making strategies could be perceived to affect a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm (Irvine, Drew, & Sainsbury, 2013; Roulston, 2014).

Establishing a data saturation prior to conducting the study was expected to be challenging to determine. Therefore, I initially identified 30 practice managers assigned to primary health care departments in Hampton Roads, Virginia with the intent to interview 10-15 practice managers for balance and depth of inquiry. I recorded all data collected via the 14 interviews in high definition audio using a Samsung Note 5 recorder to assist with data clarity and for accuracy of audio replay when transcribing the data. After I transcribed the data, I coded, created memos, managed, and stored the data using QSR NVivo 11 computer assisted qualitative data analysis software (CASQDAS).

Key research concepts of interest for the study that emerged were aspects of physicians' and patients' expectations, leadership and management attributes, and decision-making attributes in a managed-care paradigm. Data connecting the key research concepts of interest and the research phenomenon are lacking in the health care literature and current research inquiries are deficient. I deployed a qualitative exploratory

research design because it is noted as a practical methodology consistently and reliably used for exploring, comprehending, and interpreting research participants in their real-life context (Andres, 2012; Fowler, 2014), such as practice managers assigned to primary health care departments in a managed-care paradigm.

Definitions

Accountable care organizations: Aligning incentives across a variety of health care providers and/or organizations with the intent to achieve practical integration driven by outcomes (Liddell & Welbourn, 2012). Health care providers and/or health care organizations have full responsibility to their patients and managed-care organizations for an agreed set of health care requirements based on a predetermined population for a fixed budget (Liddell & Welbourn, 2012).

Argumentation: Open communication during the delivery of health care services, particularly between physicians and patients in a managed-care paradigm, with the intent to improve the outcome of health care services rendered (Labrie & Schulz, 2015).

Integrated funding: A systematic approach for health care organizations to invest and disperse financial capital with the intent to improve business operations, specifically in the delivery of primary health care services, in a managed-care paradigm (Birch, Murphy, MacKenzie, & Cumming, 2015; Lee, 2015; Mason, Goddard, Weatherly, & Chalkley, 2015).

Integrated home care: Process of moving health care services from health care organizations to locations that meets physicians' and patients' needs (Russo et al., 2015).

Managed-care organizations: Business organizations that manage health care plans in market exchanges that delineate physicians' limitations and patients' necessities for health care services, particularly in primary health care settings (HHS, 2015).

Managed-care paradigm: A health care delivery system for managing cost, utilization, and quality of health care services in health care organizations (HHS, 2015).

Managed network: A group of physicians and/or health care organizations that are contractually obligated to provide health care services to patients at a predetermined rate or a capitation limit (Damberg, Elliott, & Ewing, 2015; Godager et al., 2015).

Practice managers: Leaders and/or managers in health care organizations, such as CEOs, business managers, administrative managers, or clinical managers (U.S. Bureau of Labor Statistic [BLS], 2014). The BLS registered practice managers' duties as strategic planning, review, and implementation of processes that increase efficiency and contribute to the overall excellence of their organization's strategic objectives. The BLS recorded strategic objectives as financial management, human resource management, planning and marketing, information management, risk management, business and clinical operations, governance and organization dynamics, and professional responsibilities.

Primary care provider: A physician, nurse practitioner, or physician assistant that is responsible for navigating patients' primary health care services. In a managed-care paradigm, they regulate when, and/or if any, other health care services are necessary or referred to other specialists (Damberg et al., 2015; Godager et al., 2015).

Primary health care: A systematic model of health care that includes applications of multiple health care policies and health care system reforms (Barbazza & Tello, 2014;

Greer & Lillvis, 2014; Mosquera et al., 2014). Health care practitioners address patients' principal health care needs, develop physician-patient alliances for treatment plans, and construct a framework of family and community health care interventions (Kooienga & Carryer, 2015; Meier & Onzivu, 2014; Zabaleta-del-Olmo et al., 2015).

Triple Aim methodology: A business process to optimize health care services through implementation of improved procedures with population health management, enhanced health care experiences, and reduced per capita cost of health care services rendered (Sadovykh, Sundaram, & Piramuthu, 2015; Sidorov, 2015).

Value-based: Any actions or behaviors that lead to how health care organizations and health care leadership teams implement quality measures to strengthen the effects of health care services with the intent to include physicians' and patients' perspectives (Piña et al., 2015; Zabaleta-del-Olmo et al., 2015).

Assumptions

To address the necessity to explore and delineate aspects of practice managers' decision-making strategies and describe how aspects of their decision-making strategies can be perceived to affect a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm, several assumptions were relevant for the study. The primary assumption was that practice managers' decisions-making could improve the operation of their health care organization's strategic objectives. Practice managers were assumed to have professional, respectful partnerships with MCOs, physicians, and patients in primary health care as they establish and cultivate a climate of excellence with business and client relationships

in a managed-care paradigm. The partnerships were assumed to develop quality health care experiences for physicians and patients that were constructed on practice managers' decisions. The assumptions were necessary, as practice managers were assumed to be superior leaders and managers with the expectancy to navigate the delivery of quality health care services (Arroliga et al., 2014; Melo et al., 2014; Trastek et al., 2014). Furthermore, the aforementioned assumptions were necessary because delineating aspects of practice managers' decision-making strategies could have significant indicators for determining the outcome of physicians' and patients' interactions.

Another assumption was that deploying qualitative exploratory research could provide suitable boundaries for collecting and analyzing the projected data. There was a rational expectation that qualitative exploratory research could address the research questions and provide an in-depth, rich, detailed exploration of practice managers' decision-making strategies. It was assumed that practice managers could be a contextual lens for delineating leadership and management obligations. There was a reasonable expectation that practice managers had leadership and management skills and could straightforwardly articulate their decision-making strategies in a managed-care paradigm. The assumptions were necessary as the results of practice managers' responses provided clarity for delineating how aspects of their decision-making strategies affect physicians' and patients' interactions in a managed-care paradigm.

Scope and Delimitations

What was not known were the strategies that practice managers deployed when they make decisions. The scope of the study was restricted to collecting data only from

practice managers assigned to primary health care departments in Hampton Roads, Virginia. Deploying a focused methodology toward practice managers' activities allowed data to emerge when exploring aspects of their decision-making strategies. To collect data and increase knowledge, I used qualitative exploratory research. I applied Simon's (1960) ideology of decision-making strategies in a management environment to assist with exploring and delineating the experiences and processes of practice managers' decision-making strategies. The exploration focused on intelligence, design, and choice processes with respect to bounded rationality/rational choice and exchanges processes. Decision-making is a cognitive process and practice managers were assumed to be superior leaders and managers. Accordingly, I selected only practice managers for inclusion in the study that possessed a college degree. Practice managers that did not have a college degree were disqualified from the study. I initially identified 30 practice managers with the intent to interview 10-15 practice managers for an applicable balance and depth of inquiry. However, I conducted 14 face-to-face interviews ($n = 2$, pilot study; $n = 12$, main study) utilizing semi-structured, open-ended questions with practice managers to elicit their responses regarding how they make decisions. All data were collected by means of interviewing practice managers over a 15-day time frame in private locations. Each interview lasted about 60 minutes and the interview protocol (see Appendix A) consisted of 19 interview questions.

Key research concepts of interest for the study that emerged were aspects of physicians' and patients' expectations, leadership and management attributes, and decision-making attributes in a managed-care paradigm. Data connecting the key

research concepts of interest and the research phenomenon are deficient in the health care literature and current research inquiries are insufficient. Exploring, comprehending, and delineating underlying aspects of practice managers' decision-making strategies in the health care industry could be transferable if other scholars adhere to the study's methodology, with some flexibility as applicable for diverse settings.

Limitations

The gap in the health care literature was a lack of knowledge regarding practice managers' decision-making strategies that affect, or can be perceived to affect, a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm. Several limitations were relevant for the study, such as the research design, practice managers' perspectives regarding the research phenomenon, and the unpremeditated biases that I have toward aspects of leadership and management, decision-making strategies, and deploying a managed-care paradigm in primary health care. The primary health care system in the U.S. care industry is very large. For the study, I deployed a homogeneous purposive sampling technique. I only recruited and interviewed practice managers assigned to primary health care departments in Hampton Roads, Virginia. The data were collected from a limited amount of practice managers participating in the study and their responses were centered on their personal, subjective experiences. Additionally, I was the sole researcher, data collector, data analyst, and data transcriber during the pilot study and the main study.

By the nature of qualitative exploratory research, it is consistent with exploring, comprehending, and interpreting research participants in their real-life context (Andres,

2012; Fowler, 2014) through exhaustive descriptions of meanings (Denzin & Lincoln, 2011; Maxwell, 2013; Paulus et al., 2014; Punch, 2014). Data collected for the study was not secured from an all-inclusive list of practice managers assigned to primary health care departments across the United States. The research location was positioned in a metropolitan area and the results had limitations based on practice managers' decision-making strategies significant to that area, as compared to rural areas in the United States.

Maxwell (2013) emphasized that the credibility of a qualitative research design hinges on the skills, competence, and rigor of the person doing the fieldwork. Qualitative research design introduces a wide-range of strategic, ethical, and personal issues into the research process (Miles, Huberman, & Saldaña, 2014). As the research analyst, I have over 30 years of health care administration experience, including over 20 years in senior-level positions, both military and civilian sectors, while previously working at six large health care organizations and collectively providing oversight supervision for over 40 thousand health care employees. Due to my previous experience with formulating and implementing organizational change and leadership and management protocols in the health care industry, certain biases were brought into the study. I separated my personal experiences from the practice managers' responses and was cognizant to withhold judgement of the data collected and reported. I informed all practice managers of my past extensive experience in the health care industry.

Although the biases were recognized as limitations, reasonable measures to mitigate the limitations for the study included managing interview techniques, deploying computer assisted data management tools, and participating in continuous dialogue with

the practice managers to discuss any concerns they had during the study. The limitations were challenging, but did not undermine or weaken the value of the study. The limitations did not impede any aspects of exploring, interpreting, and delineating practice managers' underlying decision-making strategies.

Significance of the Study

The focus of the study was to fill the gap in knowledge regarding how practice managers conceive and implement leadership and management obligations. The study was centered on how practice managers make decisions that affect, or could be perceived to affect, a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm. Currently, an awareness of how practice managers make decisions is an underresearched topic and requires more vigilant investigations (AHRQ, 2015). The results of the study could contribute to the limited data found in the health care literature.

Significance to Practice

Health care is a complex, evolving business process that must be appropriately led and managed to deliver quality, cost effective health care services (Concannon et al., 2014; Cottrell et al., 2015; Herremans et al., 2016). Access to health care services is one of the most significant social and economic occurrence facing U.S. citizens today, thus, the phenomenon affects the livelihood of many of those citizens in one way or another (Boak, 2014; Gulbrandsen, 2014; Issel, 2014). When primary health care departments implement a managed-care paradigm, patients' health care experiences are the results of their abilities to access health care treatments (Söllner, Bröder, Glöckner, & Betsch,

2014). Patients initiate decisions for their health care necessity grounded on all accessible treatment options presented to them by their physicians (Söllner et al., 2014). Physicians communicate health care options to their patients based on how practice managers lead and managed their primary health care departments (Söllner et al., 2014). Physicians' and patients' interactions could influence their perspectives of primary health care, and could persuade and manipulate their attitudes, behaviors, and relationships in a managed-care paradigm (Addicott & Shortell, 2014; Hawthorne et al., 2014; Minvielle et al., 2014; Piña et al., 2015; Zabaleta-del-Olmo et al., 2015).

Significance to Theory

A managed-care paradigm is an entity of management that bestows authority to practice managers to conceive and implement diverse health care strategies that stipulate how patients receive health care treatments, and how physicians deliver the health care treatments (Rissi et al., 2015; Russo et al., 2015). The study was an instrument for exploring and delineating practice managers' decision-making strategies in primary health care departments during the deployment of a managed-care paradigm. Insight from the study makes available additional knowledge for inclusion in the health care literature via practice managers' boundaries of their organization's objectives. Centered on aspects of practice managers' decision-making strategies, how practice managers establish their intelligence, design, and choice processes are significant to comprehend, as patients are pursuing health care treatments from their physicians to achieve optimal health and wellness. Comprehending how health care services are led and managed in primary

health care settings could delineate how practice managers make decisions that affect how health care treatments are sought and rendered.

Significance to Social Change

In the current health care literature, scholars have not clearly delineated how practice managers make decisions. As a result of the gap in knowledge, delineating aspects of practice managers' decision-making strategies in a managed-care paradigm is significant for comprehending how they establish and cultivate a climate of excellence. Closing the gap in knowledge in the health care literature could add to positive social changes, as practice managers' decision-making strategies have the potential to improve patients' ability to access primary health care services, strengthen physicians' capacity to deliver effective health care treatments, and support collaborative physicians' and patients' interactions.

Summary and Transition

Establishing and cultivating a climate of excellence with business and client relationships while striving for successful outcomes are necessary objectives in any organization, but may be particularly challenging for practice managers assigned to health care organizations deploying a managed-care paradigm. Practice managers are described as leaders and managers of health care organizations tasked with protecting physicians' and patients' interests using various decision-making strategies. What was not known were the strategies practice managers deployed when they make decisions. In the current health care literature, from the lens of practice managers, scholars have not clearly delineated how practice managers make decisions. A gap in knowledge exists,

particularly in primary health care settings. As a result of the gap in knowledge, delineating aspects of practice managers' decision-making strategies in a managed-care paradigm is significant for comprehending how they can establish and cultivate a climate of excellence. Key research concepts of interest are recognized for exploring and delineating practice managers' decision-making strategies and are reviewed in more details in the literature review in Chapter 2.

Chapter 2: Literature Review

In the health care industry, leaders and managers make decisions to ensure that their health care organizations can operate effectively. When health care organizations deploy a managed-care paradigm, there is a requirement for practice managers to make decisions that can strategically establish and cultivate a climate of excellence with their business and client relationships (Alhaddi, 2015; Arroliga et al., 2014; Melo et al., 2014; Trastek et al., 2014). The problem addressed in this qualitative exploratory study was a gap in knowledge regarding practice managers' decision-making strategies that affect, or can be perceived to affect, a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm. The purpose of the qualitative exploratory study was to explore practice managers' decision-making strategies as they establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm. Specifically, the purpose of the study was to explore aspects of practice managers' underlying decision-making strategies affecting primary health care, physicians, and patients in a managed-care paradigm.

The advent of a managed-care paradigm has created a shift in the U.S. health care industry (Alhaddi, 2015; Arroliga et al., 2014; Melo et al., 2014; Trastek et al., 2014). When health care organizations deploy a managed-care paradigm, the data suggest that there are some underlying aspects regarding how practice managers conceive and implement their decision-making strategies (Alhaddi, 2015; Arroliga et al., 2014; Melo et al., 2014; Trastek et al., 2014). Bhattacharjee and Ray's (2014) investigation focused on the value of removing barriers and improving access to health care services. Hung and

Jerng's (2014) study underlined the necessity for equality in the delivery of health care services and refining physicians' and patients' interactions. Sidorov (2015) recommended deploying the Triple Aim methodology when managing organizations, physicians, and patients' capital interests. Despite increased deployment of a managed-care paradigm in health care organizations, not all aspects of practice managers' perspectives have been explored to delineate their decision-making strategies, particularly in primary health care settings (Broqvist & Garpenby, 2015; McDonnell & Graham, 2015; Ramachadran, Banahan, Hardwick, & Clark, 2015).

Chapter 2 is guided by Simon's (1960) ideology of decision-making strategies in a management environment and is the nucleus of the literature review. Chapter 2 contains an exhaustive inquiry of research data in current health care literature to delineate what aspects, if any, could determine how practice managers conceive and implement their decision-making strategies in a managed-care paradigm. I reviewed data pertaining to how MCOs function and how practice managers integrate MCOs with physicians and patients in health care organizations. I investigated key research concepts of interest for the study, such as delineating aspects of physicians' and patients' expectations, leadership and management attributes, and decision-making attributes in a managed-care paradigm. Chapter 2 includes a description of the literature search strategy, conceptual framework, review of the literature, and concludes with a summation of the findings in the literature review.

Literature Search Strategy

The majority of literature reviewed for the study was comprised of data collected from peer-reviewed, scholarly articles located in professional business and health care journals dated within the past five years. I discovered, assessed, and managed the articles via online databases in libraries at Walden University, Eastern Virginia Medical School, and Riverside College of Health Careers. Online databases such as ScienceDirect, CINAHL, PubMed, MEDLINE, EBSCO, ProQuest Central, and Business Source Complete existed as points of reference to locate journal articles. Other data that were utilized for the study were discovered, assessed, and managed via the U.S. Government's public, open-access online databases, such as www.DATA.gov, www.USA.gov, and www.HealthCare.gov.

Significant topics for the study included managed-care, health care management, leadership and management, primary health care, and decision-making. The topics were further developed into key search terms, which included *primary health care management, health care decision-making strategies, accountable care organizations, managed-care organizations, health care leadership and management processes, managed-care paradigm, practice management, health care risk management tools, health care values, shared decision-making strategies, collaborative teamwork, population health care management, relationships in health care, cultures and valued-based care, health care diversity,* and *health care access and barriers*.

Health care is an evolving, progressive research topic in the field of management, specifically in the leadership and organizational change specialty, and a copious number

of journals with potentially useful articles were located in the databases mentioned above. To narrow the list of relevant articles found in the databases to review for suitability, the process consisted of inserting the key search terms into each database, then drilling down the search by linking the key search terms to articles within the last five years. Data-drilling assisted with eliminating unsuitable articles and statistics that did not add value to the study, and it contributed to effective time management, as I did not read unsuitable articles.

Conceptual Framework

There was a gap in knowledge regarding practice managers' decision-making strategies that affect, or can be perceived to affect, a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm. The conceptual framework for the study followed Simon's (1960) ideology of decision-making strategies in a management environment. Simon's ideology referenced deploying three actions necessary for effective decision-making that consist of intelligence, design, and choice processes, with respect to bounded rationality/rational choice and exchanges processes, in a managed-care paradigm. Aljaaf et al. (2015), Lee (2015); Martin, McKee, and Dixon-Woods (2015), and Weiszbrod (2015) specified that intelligence, design, and choice processes are widely recognized terms associated with applying decision-making strategies and the terms are applicable for practical use in the health care industry. The scholars also emphasized that health care organizations termed bounded rationality/rational choice and exchange processes as critical aspects to consider during the decision-making process.

Historically, Simon’s (1960) ideology of decision-making strategies has been investigated, compared, and utilized repetitively in the management of the military, business, information technology (IT), economics, psychology, and humanity fields of study to explore and delineate how decision-making strategies are implemented during personal and organizational activities (Campitelli, 2010; Fiori, 2011; Kalantan, 2010; Kerr, 2011). As with the fields of study above, the health care industry could benefit from utilizing Simon’s ideology. Health care is a highly scrutinized, complex industry that collectively incorporates all aspects of the aforementioned fields of study simultaneously, particularly when practice managers have to balance their organizations’ objectives with physicians’ and patients’ interests and interactions (Struijs, Drewes, Heijink, & Baan, 2015). Brophy’s (2014) and Kidholm et al.’s (2015) research reported that decision-making strategies deploying aspects of intelligence, design, and choice processes, with respect to bounded rationality/rational choice and exchanges processes, have been used extensively in health care research as an instrument for medical decision-making. Brophy and Kidholm el al. incorporated Simon’s ideology into their research as a management paradigm for medical decision-making and to explain the rationale for interpreting actions, behaviors, and processes.

Intelligence process means investigating the environment and identifying the need to make an effective decision (Palfy, 2015). Design process represents scrutinizing and developing the problem or situation for plausible options for a solution (Elf et al., 2015). Choice process refers to selecting a suitable course of actions to solve a problem or situation from the plausible list of options (Lepora & Pezzulo, 2015). Practice managers

influence and persuade health care activities under their purview and they make key decisions grounded on their organizations' objectives and physicians' and patients' interests and interactions. Simon's ideology is a suitable framework to engage in an in-depth, rich exploration to delineate aspects of practice managers' decision-making strategies. In particular, Simon's ideology is significant when concentrating on how physicians and patients are affected in a managed-care paradigm during the delivery of primary health care.

Decision-making in health care services is a changing, subjective process based on situational activities that require situational management (Broqvist & Garpenby, 2015; Rissi et al., 2015). Simon (1960) argued that the decision-making cycle of intelligence, design, and choice processes is a complex process because it is a repetitive activity due to the changing complexity of continuous sequences of decision-making situations required to maintain strategic objectives. Health care scholars such as Angstman and Briggs (2014), Cleven, Winter, Wortmann, and Metter (2014), and Elwyn et. al. (2014) asserted that due to the complexity and uniqueness of the human body's functions, health care treatments are also subjective in nature that form situational interactions between practice managers, MCOs, physicians, and patients. Situational interactions require practice managers to engage in regular intelligence, design, and choice analyses to uphold their organization's strategic objectives while establishing and cultivating a climate of excellence (Angstman & Briggs, 2014; Cleven et al., 2014; Elwyn et. al., 2014).

Sannentag and Starzyk (2015) characterized situational interactions as situational appraisals and asserted that situational appraisals set the priorities to identify, define, and,

resolve a situation. Guth et al. (2015) likened Simon’s (1960) ideology to Kepner and Tregoe’s (1965) situational analysis framework. The scholars conceived that intelligence, design, and choice processes contain aspects of problem analysis, decision analysis, and potential problem analysis. When practice managers conduct a problem analysis, they can define the situation, as data are continuously collected to determine if a problem actually exists (Guth et al., 2015). Using a decision analysis, practice managers can identify alternatives and risks, as best options are presented before deciding on a course of actions (Guth et al., 2015). When practice managers use a potential problem analysis, they can scrutinize numerous alternatives against potential problems and negative consequences while taking actions to minimize risks for their organizations when a decision is implemented (Guth et al., 2015).

While Simon’s (1960) and Kepner and Tregoe’s (1965) ideologies are similar, Guth et al.’s (2015) investigation held Simon’s as more suitable for decision-making and Kepner and Tregoe’s as more appropriate for problem solving. In the literature, the terms problem and situation are sometime used in a similar manner. However, Brodbeck and Guillaume (2014) cautioned that they should not be used as interchangeable terms when solving a problem or making a decision. Brodbeck and Guillaume delineated a problem and a situation as a gap between a present position and a future desired position. Problem solving identifies possible solutions (Brodbeck & Guillaume, 2014). Decision-making is a process that selects the best solution from the identified possible solutions (Brodbeck & Guillaume, 2014). In this study, I sought to delineate what activities or processes practice managers undertake to make strategic decisions and the significance of practice

managers' decision-making strategies that affect, or could be perceived to affect, a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm.

Barbazza and Tello (2014) and Minvielle et al. (2014) argued that scrutinizing information as it is collected is an essential component for assessing if a problem or situation exists. The scholars posited that scrutinizing information can be accomplished by asking key questions or observing the environment to identify the signs and symptoms leading to the problem or situation. For example, health care workers conduct triage procedures and fact finding investigations with patients to determine what is the best methodology to provide health care treatments by asking questions such as, "where are you having pain?," "what causes the pain?," or "when did the pain begin?" (Jarvis, 2016, p. 212). Comparably, Arroliga et al. (2014), Concannon et al. (2014), and Trastek et al. (2014) proposed that intelligence, design, and choice processes in health care decision-making are grounded on signs and symptoms within their organization's climate, such as client satisfaction, employee satisfaction, quality of health care services, impact of cost and benefits, and implementation of policies and procedures.

Perera and Peiró (2012) regarded signs and symptoms as business data that rigorously focus on constructing strategies or designs that could lead to fulfilling an organization's mission, vision, and values. Delineating aspects of an organization's mission, vision, and values afford practice managers opportunities to categorize alternate options during the decision-making process before actually making a decision that affects their physicians', patients', and/or organization's interests. Perera and Peiró specified that

actions of intelligence, design, and choice processes are transformational procedures and the end goal is to create a practical decision statement. Decision statements must provide precise characteristics of the problem, a clear vision of future goals, and an unambiguous action plan that moves the current problem or situation to the future desired goal. Perera and Peiró stated that the end description or choice process of the decision statement must include a strategic formula. The scholars designated the strategic formula as a design that combines external climate analyses, internal climate analyses, and risk assessments with aspects of strengths, weaknesses, opportunities, and threat analyses.

Simon's (1960) ideology is cognitive in nature and infers that decision-making strategies can be associated with behavioral and interactive processes, such as bounded rationality/rational choice process and exchange process. Achtziger, Alós-Ferrer, Hügelschäfer, and Steinhauser (2014) and Li, Ashkanasy, and Ahlstrom (2014) suggested that bounded rationality/rational choice process can be behavioral-centered actions that are substantially motivated by wants or goals, and communicated as practice managers' preferences through participation in the exchange of information. Watson and Foster-Fishman (2013) and Stiegler and Gaba (2015) concluded that the exchange process consists of decisions that are corroborated on relationships and interactions with negotiations between individuals to achieve the best outcome for all involved. The aforementioned scholars underscored that decisions are characteristically made based on a logical, rational process that considers aspects of resources, cost, and norms.

Achtziger et al. (2014) and Li et al. (2014) depicted bounded rationality as having limited actions that can be taken based on certain guidelines or boundaries when making

decisions utilizing aspects of the rational process. Bendor's (2015) and Radner's (2015) analyses insinuated that practice managers' cognitive processes during decision-making are restricted by the availability of data, the manageability of the problem or situation, the deficiencies in their problem solving and decision-making skills, and the time available to make the best decision from available alternatives. Achtziger et al. and Li et al. warned that even though all decisions are social actions, exchanges of information, and regarded as rationally motivated, sometimes decisions can appear to be irrational or without merit.

Based on previous vetting of the aforementioned fields of study, Simon's (1960) ideology is deployed to explore and delineate practice managers' cognitive processes of decision-making strategies linked to the key research concepts of interest. The key research concepts of interest for the study are delineating aspects of physicians' and patients' expectations, leadership and management attributes, and decision-making attributes in a managed-care paradigm.

Literature Review

Delineating a Managed-Care Paradigm

Managing the delivery of health care services is significant in the United States and the advent of a managed-care paradigm is industrialized as a mechanism to fortify patients' capacity to receive quality health care services (Peterson, Bernstein, & Spahlinger, 2016). The rise of a managed-care paradigm is due to the increasing necessity to control cost and distribution of health care services while enhancing physicians and patients interactions during the delivery of health care treatments (Shmueli et al., 2015). When practice managers are assigned to health care organizations that utilize a managed-

care paradigm, the expectation is that they make strategic decisions that are in the best interests of their health care organizations, physicians, and patients. Not all scholars share the same views regarding decision-making strategies in a managed-care paradigm. Discussions regarding a managed-care paradigm continue to be a prevailing topic in leadership and management curricula, particularly relating to the philosophy of controlling cost for the sake of greater health care services and benefits. The ongoing debates have given cause to explore and delineate aspects of practice managers' strategic decision-making that affect physicians and patients in a managed-care paradigm.

Managed-care alignment. Birch et al. (2015), Lee (2015), and Mason et al. (2015) argued that when health care organizations implement a managed-care paradigm into their business operations, they have the potential to deliver greater benefits to patients, such as increase access to health care services, reduce unplanned hospital admissions, promote cost savings, and improve patients' overall health care service experiences. The aforesaid scholars endorsed that decisions affecting patients are based on how health care organizations invest in funding programs that benefits patients' health care services. Mason et al. designated investing in health care services as *integrated funding*. Utilizing an integrated funding approach details the level of health care organizations' wiliness to allocate substantial resources to improve how health care services are delivered and how they connect physicians and patients to their health care services (Mason et al., 2015).

Lee's (2015) analysis of managed-care linked integrated funding to aspects of universal health care, noting that patients' ability to receive health care services should be

a right, not a privilege based on socioeconomic factors, and health care organizations should make reasonable efforts to bridge the gap between cost and services. Birch et al. (2015) disagreed with deploying universal health care, and they called it a mechanism to deplete financial capital. However, their study did contribute to aspects of supporting integrated funding. Birch et al. reinforced the necessity for health care organizations to attain financial sustainability to connect patients and physicians with timely, quality health care services in a managed-care paradigm. The outcomes of Birch et al., Lee, and Mason et al.'s studies indicated that integrating funding is contingent on how practice managers conceive, design, implement, and reevaluate decision strategies that can affect the allocation of fixed budgets that fund programs in their health care organization.

Mason et al. (2015) did a cross-referencing study to explore and delineate how practice managers consider aspects of integrated funding in their organizations. Aspects of Mason et al.'s vision for integrated funding comprised of how practice managers should execute transfer payments, cross charging, aligned budgets, lead commissioning, pooled funds, integrated management, structural integration, and lead commissioning with aligned incentives (see Table 1).

Table 1

Delineating Aspects of Integrated Funding

Aspects of Integrated Funding	Expectations of Integrated Funding
Transfer Payment	Allocating funding to support specific segments of health care services in the health care organization
Aligned Budget	Combining financial funding that can target effective spending and performances in the health care organization
Lead Commissioning	Funding of health care services that are grounded on the health care organization's strategic objectives
Pooled Funds	Overall funding of health care services that are placed in a central account and utilized to fund other health care services as needed
Integrated Management	Utilizing funding to combine all resources (financial and human) in multiple segments in the health care organization to ensure that each segment can function regardless how the funding was initially allocated
Structure Integration	Funding health care services that are delegated as a function of the health care organization's management team
Lead Commissioning with Aligned Incentives	Reinvesting funding that can improve quality of health care services and reduce other health care cost

Note. Conceived implications of integrated funding, as applicable to practice managers in a managed-care paradigm. Adapted from "Integrating funds for health and social care: An evidence review," by A. Mason, M. Goddard, H. Weatherly, and M. Chalkley, 2015, *Journal of Health Services Research & Policy*, p. 1-12.

Mason et al. (2015) reviewed and cross-referenced 3,281 surveys with integrating funding concepts via patients' observations of health care effects, health care services use and cost, quality of care and use experiences, unintended consequences, and barriers to integrating care. The results yield that financial factors are major barriers for attaining successful delivery of health care services. Although financial assets influenced how health care services could be delivered, patients that were surveyed expect their health

care organizations to find ways to support their health care necessity. Further, patients articulated that practice managers' financial decisions are based on corporate greed, and greed regulated how health care organizations provide the health care services to targeted populations.

Lewis and Pflum's (2015) research defended aspects of integrated funding. They maintained that integrated funding creates bargaining powers that can manipulate how practice managers disseminate financial capital in a managed-care paradigm. Lewis and Pflum believed that practice managers should negotiate with MCOs and secure higher reimbursements for health care services rendered, then, utilize the higher reimbursements to fund patients' health care services. Glied and Janus (2015) and Bobbitt and Rockswold (2016) furthered Lewis and Pflum's assessment. They emphasized that, although MCOs' objectives include methods to control cost and enhance quality of health care services, practice managers should reject MCOs' terms that are not beneficial for patients, then, renegotiate with them, or negotiate with other MCOs for better terms and conditions that are advantageous for patients.

McWilliams, Chernew, Landon, and Schwartz (2015) suggested that other terms and conditions imply that health care organizations should function as *accountable care organizations* (ACOs) in a managed-care paradigm. They deemed that ACOs can have a sizable impact toward patients' health care treatments. ACOs link financial incentives to health care services via measured quality indicators. McWilliams et al. explained that when health care organizations meet certain goals and performance standards established by MCOs, such as Medicare and Medicaid Services (CMS), they are reimbursed for their

efforts. McWilliams et al. noted that in 2014, CMS awarded approximately 147 million dollars in bonuses to health care organizations functioning as ACOs. Similar to Mason et al.'s (2015) investigation on distributing integrated funding, McWilliams et al. stressed that all bonuses should be utilized to strengthen patients' capacity to attain quality health care treatments. Further, McWilliams et al.'s investigation likened to Glied and Janus's (2015), Lewis's (2015), and Bobbitt and Rockswold's (2016) assessments, agreeing that practice managers' implementation of their decision-making strategies can illustrate the future of patients' health care services in a managed-care paradigm.

Hung and Jerng (2014) offered an altered approach for aligning decision-making strategies to a managed-care paradigm. They suggested that health care services should focus on aspects of equality in the delivery of health care services and refine physicians' and patients' interactions through measurements of quality indicators. Similar to ACOs' methodologies with linking financial incentives to health care services through measured quality indicators, the same indicators could be utilized to strengthen practice managers' ability to increase equality, collaborative efforts, and quality when deploying a managed-care paradigm. Hung and Jerng focused on practice managers' intelligence process to make changes in their organizations' design while managing measured quality indicators, such as structures, processes, and outcomes. Delineating aspects of structures, processes, and outcomes imply certain conditions or situations must be attained while engaging in a decision-making strategy. Quality indicators could be measured with instruments such as surveys, questionnaires, or interviewing physicians and patients to aid practice managers when aligning their organizations' objectives with to ACOs' expectations.

Structures are expressed as a clear approach for assessing how well all decisions meet practice manager's objectives during the management of health care services (Hung & Jerng, 2014). Processes are articulated as evaluating how well all health care services are delivered (Hung & Jerng, 2014). Outcomes are conveyed as valuing the effects of all health care services provided, including the validity of the processes and adequacy of the structures (Hung & Jerng, 2014). Hung and Jerng suggested that conditions or situations give practice managers different options when selecting and prioritizing how they could manage and measure quality indicators. Hung and Jerng deduced conditions or situations as preparing for, actions before, and actions after incorporating intelligence, design and choice process throughout the decision-making process, with respect to aspects of bounded rationality/rational choice and exchange processes, in a managed-care paradigm (see Figure 1).

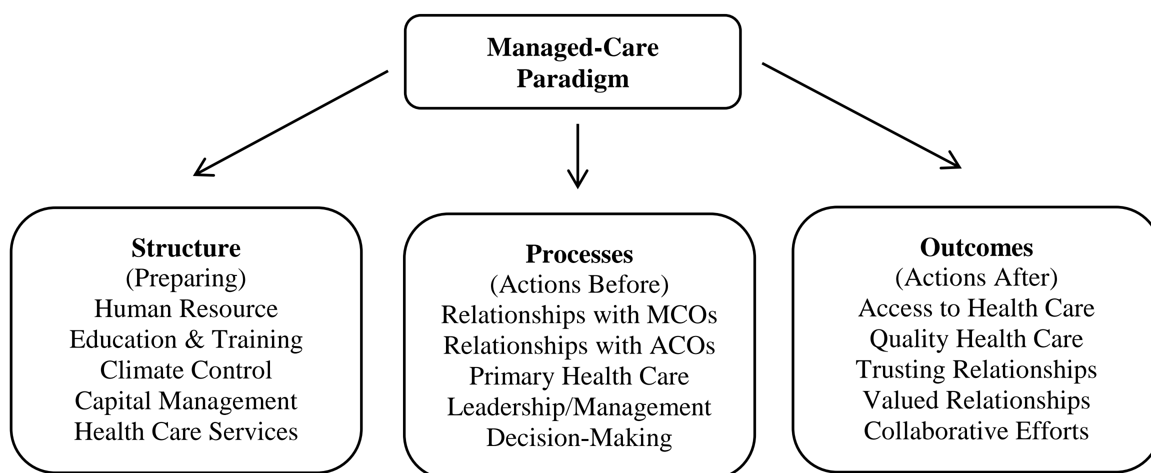

Figure 1. Conceived implications of quality indicators, as applicable to practice managers in a managed-care paradigm. Adapted from "Time to have a paradigm shift in health care quality measurement," by K. Y. Hung and J. S. Jerng, 2014, *Journal of the Fomosan Medical Association,113*(10), p. 673-679.

Cochran, Kaplan, and Ness's (2014) and Grace, Rich, Chin, and Rodriguez's (2014) studies concurred with Hung and Jerng's (2014) perspectives of quality indicators, but they focused on physicians, rather than patients, in a managed-care paradigm. Cochran et al. and Grace et al. acknowledged that patients interpret their physicians as their health care organization, and they often use the terms interchangeably. They recommended that practice managers should meet with physicians regularly to assess their effectiveness as viable representatives of their health care organizations. Cochran et al. suggested that practice managers get physicians to support their organizations' mission, purpose, and values that could lead to effective delivery of health care services, and in turn, generate additional revenue. Grace et al. reminded that physicians' buy-in to their organizations' objectives strengthens practice managers' abilities to negotiate with MCOs and could further advance how they create cost savings measures, such as integrated funding, that could lead to effective delivery of health care services.

Bisbe and Barrube's (2012) earlier research on incorporating balanced scorecards as a quality indicator to track, measure, implement, and reevaluate decisions is relevant for assessing physician's commitment to a managed-care paradigm. For example, The Physicians Foundations' 2014 Survey of America's Physicians used a balanced scorecard to quantified physicians' perspective regarding the delivery of health care services. The following summarizes The Physicians Foundations' results:

1. 81% of physicians are described as overextended or at full capacity.
2. 44% of physicians will take actions to limit their practice and reduce patients' access to the health care services they offer.

3. 44% of physicians feel positive about the current state of affairs in health care services.
4. 69% of physicians believe that they have limited autonomy with the health care services they offer and their decisions are compromised by MCOs.
5. 26% of physicians are assigned to ACOs, but only 13% believe it will decrease cost and enhance quality health care services.
6. 39% of physicians indicate that they will accelerate their retirement plans due to the managed-care paradigm shift in the health care industry.

Nielsen and Nielsen (2015) and Valmohammadi and Ahmadi (2015) warned that due to the complexity of operating in a managed-care paradigm, physicians are frequently liable for their organizations' successes or failures. They asserted that decision-making, and any decision conceived and implemented by practice managers, is a critical aspect for determining the successes or failures of health care organizations' objectives. Measuring the significance of cost and health care services utilizing quality indicators implicates an obligation for practice managers to develop strategies to cultivate a climate of excellence with business and client relationships in a managed-care paradigm.

Managed-care organizations. Over four decades ago, patients seeking health care services had some type of indemnity insurance coverage, managed either privately or government assisted. At that time, indemnity insurance, or Fee-for-Service (FFS), suggested that patients could see any physician of their choice for health care services, then share a portion of the health care cost with their insurance company (Damberg et al., 2015). Although FFS still exists, the delivery of health care services has evolved from a

simple process of providing patients with rudimentary health care services to deploying a more complex, comprehensive health care delivery system led and managed by practice managers in a managed-care paradigm (Christianson, 2014).

In 1970, Dr. Paul Ellwood worked with President Richard Nixon's administrative team to modernize national health care policies. Motivated by the works of Dr. Ellwood, the creation of a managed-care paradigm was conceived from the Health Maintenance Organization Act (HMOA) of 1973 (Marcinki & Hetico, 2011). The principal aspect of the HMOA of 1973 delineated how organizations that offered health care plans for patients seeking health care services must compete with other organizations to provide the best price and quality for services rendered. Marcinki and Hetico (2011) labelled competition as health care plans in market exchanges that offer patients viable options when choosing how the delivery of their health care services, particularly primary health care, is managed by select groups of physicians and/or health care organizations. Organizations that manage health care plans in market exchanges are called MCOs.

When physicians and/or heath care organizations agree to accept health care plans managed by MCOs, they are functioning in a managed-care paradigm. Within practice managers' span of control, physicians and/or health care organizations must function in the boundaries of specific guidelines during the delivery of health care services. With the advent of a managed-care paradigm, Marcinki and Hetico (2011) emphasized that MCOs have changed how health care organizations are managed, how patients can receive their health care services, how physicians should provide health care services to their patients to meet their needs, and how health care organizations can recapture health care cost.

MCOs, although not insurance companies, operate as gatekeepers of financial assets and assist with distributing funds to physicians and/or health care organizations for health care services rendered to patients (Christianson, 2014). Glied and Janus (2015) and Bobbitt and Rockswold (2016) characterized MCOs in a managed-care paradigm as a management tool. MCOs' objectives, as they monitor patients' health care services, are to curtail unnecessary health care services offered by physicians and reduce health care cost, with the intent to strengthen patients' abilities to attain quality of health care services (Christianson, 2014). Practice managers work with MCOs in a managed-care paradigm and make decisions that affect physicians and patients during the delivery of health care services in a managed-care paradigm (Christianson, 2014).

Piña et al. (2015) and Sharan, Schroeder, West, and Vaccaro (2015) asserted that MCOs have contractual agreements with physicians and/or health care organizations to deliver health care services to select groups of patients. Contractual obligations between MCOs, physicians, and/or health care organizations establish a payment arrangement for health care services rendered (see Figure 2). Piña et al.'s and Sharan et al's investigations reported that MCOs manage three categories of patient health care plans, such as Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and Point-of-Service (POS). Although FFS can be considered as a health care plan because of their payment arrangement, they do meet MCOs' specific parameters during the delivery of health care services (Piña et al., 2015; Sharan et al., 2015). Cohen et al. (2015) and Holtrop, Luo, and Alexanders (2015) articulated that MCOs do not commission physicians and/or health care organizations for FFS health care services or arrangements,

as physicians and/or health care organizations are not bounded by contractual agreements. Additionally, Piña et al. and Sharan et al. identified that each health care plan has equivalent objectives for delivering quality health care services with cost control as a priority, and they differ with their payor mode, selection of physicians, and discounts accessible to patients. Glied and Janus (2015) and Bobbitt and Rockswold (2016) proclaimed that practice managers must monitor how MCOs manage payment arrangements to patients and physicians that are assigned to their organizations to minimize any discrepancies with ethical standards, federal and local laws, and organizational policies.

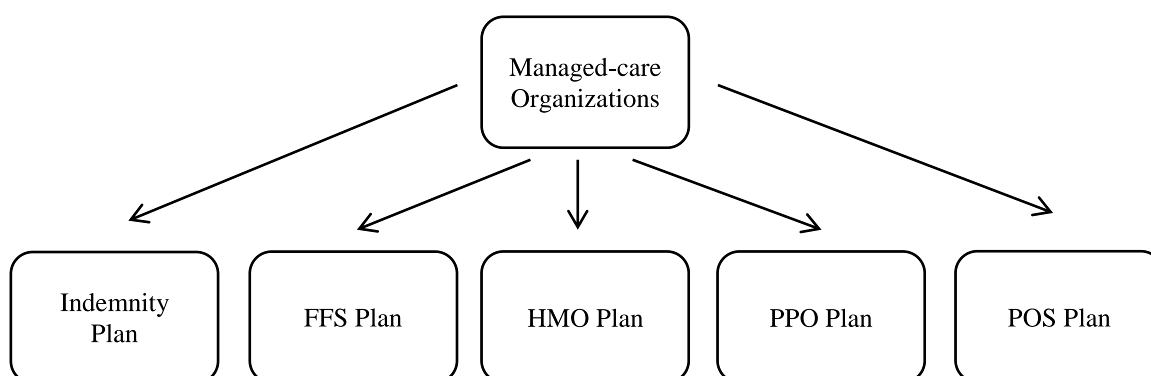

Figure 2. Visualization of managed-care organizations' payor mode, as applicable to practice managers in a managed-care paradigm.

HMO plans allocate funds for select health care services delivered by specific groups of physicians and/or health care organizations assigned to a *managed network* (Damberg et al., 2015; Godager et al., 2015). A managed network of physicians and/or health care organizations are contractually obligated to provide health care services to patients at a pre-determined rate, or a capitation limit (Damberg et al., 2015; Godager et al., 2015). Patients select a *primary care provider* (PCP) to navigate the delivery of their

health care services and they must receive health care services and advice from their PCP before receiving additional health care services in their managed network. PCPs serve as the gatekeeper of health care services, as they regulate when, and/or if any, other health care services are necessary or referred to specialists (Damberg et al., 2015; Godager et al., 2015).

Per contractually agreement, PCPs only refer to specialists if they cannot solve the patient's health care problem (Damberg et al., 2015; Godager et al., 2015). HMO plans are well-liked among physicians and patients. Physicians can benefit when they maintain patients' health care needs and receive referrals from other physicians in their managed network. They receive financial incentives for assisting with cost-reduction procedures that reduce any unnecessary health care services, as deemed by the MCOs (Christianson, 2014). Patients can benefit from receiving health care services in their managed network. They receive discounts or reduced fees when participating in health care services in the boundaries of their HMO plan (Christianson, 2014).

PPO plans are similar to HMO plans, but are less restrictive. PPO plans allocate funds for health care services delivered by physicians and/or health care organizations, regardless if the health care services are provided in or out of the boundaries of their managed network (Damberg et al., 2015; Godager et al., 2015). The patient selects a PCP, regardless if the PCP is in or out of the boundaries of their managed network, and referrals are not required when seeking additional health care services or to see specialists (Damberg et al., 2015; Godager et al., 2015). PPO plans are popular among physicians and patients due to the flexibility of the plan. Patients can receive financial incentives if

they receive health care services in the boundaries of their managed network, such as lower deductibles and reduced co-pays (Christianson, 2014). Physicians, with practice managers' assistance, could negotiate higher fees with MCOs for health care services rendered (Christianson, 2014). Patients have a slight disadvantage when participating in PPO plans. Patients pay higher physicians' fees, as much as 50% higher, due to the flexibility when health care services are delivered out of the boundaries of their managed network (Christianson, 2014).

Proponents of MCOs agree that when health care organizations incorporate a managed-care paradigm into their business strategy, it could provide patients with the flexibility to best decide how to participate in the delivery of their health care services (Damberg et al., 2015; Godager et al., 2015). Opponents of MCOs believe that the integration places too many restrictions on health care services, as practice managers and physicians ambitious to reduce cost, could lead to poor quality of health care treatments (Damberg et al., 2015; Godager et al., 2015). However, Cohen et al. (2015), Glied and Janus (2015), and Bobbitt and Rockswold (2016) favored MCOs and argued that the availability of multiple health care plans could increase opportunities for lower income patients to receive health care services. Since MCOs have contractual obligations with select groups of physicians and/or health care organizations to partner in patients' health care treatments, fees for services have an established price, such as co-pays, and patients pay the same price regardless of the frequency and/or type of health care services they receive (Bobbitt & Rockswold, 2016; Christianson, 2014; Cohen et al., 2015; Glied & Janus, 2015).

Bhattacharjee and Ray (2014) reasoned that when patients have increased opportunities to receive health care services, the likelihood of preventing other illness could increase while enhancing their overall experiences during the delivery of health care services. Feldman (2015) added that positive health care experiences could create effective collaborative relationships between physicians and patients that result in better communication, trust, respect, and rational health care decision-making. Because MCOs have contractual obligations to reduce health care cost, they encourage patients to seek health care services in the boundaries of a managed network, such as primary health care (Christianson, 2014).

Primary health care. The 1978 Declaration of Alma-Ata was created at the International Conference on Primary Health Care in Kazakh, U.S.S.R. At the conference, international leaders and decision makers of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) addressed the need to improve open access to public health care for global citizens (Labonté, Sanders, Packer, & Schaay, 2014). Members of WHO and UNICEF determined that primary health care is an indispensable component for all individuals seeking health and wellness care (Labonté et al., 2014). The contents of the 1978 Declaration of Alma-Ata included a pledge from international leaders to make humane decisions to improve the social justice of those seeking adequate health care by means of primary health care initiatives by 2000 (Labonté et al., 2014).

In 2001, WHO and UNICEF proposed a health care enterprise to attain universal primary health care for all global citizens based on six components toward health care

intervention that include first contact, longitudinality, comprehensiveness, coordination, community coordination, and person and/or family-centeredness (Gostin, Sridhar, & Hougendobler, 2015; Roa & Pilot, 2014). Although WHO and UNICEF failed to attain their goal of attainment by 2000, a substantial portion of their 2001 proposal came from Dr. Barbara Starfield's (1991; 1992; 1994) visualization of primary health care modeling (Bodenheimer, Ghorob, Willard-Grace, & Grumbach, 2014; Caley, 2013; Grumbach, 2015). Starfield's views presently shape the current approach for the delivery of primary health care in the United States, particularly in a managed-care paradigm (Bodenheimer et al., 2014; Caley, 2013; Grumbach, 2015).

Starfield's (1991; 1992; 1994) earlier literature regarding effective utilization of primary health care modeling are accepted as the foundation for health care decision-making, health care promotion, preventive health care, and rehabilitative health care (Bodenheimer et al., 2014; Grumbach, 2015; Caley, 2013). Roa and Pilot (2014) and Gostin et al. (2015) concluded that Starfield's perspective on primary health care is the foundation for a rational health care system. They argued that Starfield's data consist of four pillars required for humane decision-making that include initial contact for health care services, continuity of health care treatments, point of health care referrals, and the overall management of health care services.

Other scholars agree with Starfield's ideology regarding health care operations and decision-making strategies in a managed-care paradigm. Barbazza and Tello (2014) underscored primary health care as the linchpin for health care interventions. Greer and Lillvis (2014) and Mosquera et al. (2014) noted that leadership and management teams in

primary health care are responsible for implementing health care policies, shaping health care system reforms, and improving the comprehensiveness and effective operations of health care services. March et al. (2015), Godager et al. (2015), and Zabaleta-del-Olmo et al. (2015) coined primary health care as the gatekeeper of all health care interventions that influences physicians and patients interactions, collaborative communication, and it is the origin of decision-making strategies that can establish quality health care in a managed-care paradigm.

Porter, Pabo, and Lee (2013) shared the views of the aforementioned scholars, but varied slightly, and declared that health care cost modeling and health care reform could motivate practice managers' operational and decision-making strategies in primary health care. Porter et al. advised that health care transformation is based on assessing physicians' and patients' value pertaining to their needs. Value is described as enabling necessary actions to attain health care organizations' Triple Aim outcomes that could deliver better health care experiences, improve population health care, and establish lower health care cost (Porter el al., 2013; Sidorov, 2015). Actions that build the foundation for transforming health care services are described as integrating visionary leadership while promoting a climate of excellence, constructing improvements through experiences, sharing evidence-based best practices, and assembling an effective IT platform (Greer & Lillvis, 2014; Mosquera et al., 2014). The Triple Aim methodology deduces that practice managers' actions could build relationships, manage population health care, and add value to health care services by delineating aspects of physicians' and patients' expectations, leadership and management attributes, and decision-making

strategies attributes. Greer and Lillvis's and Mosquera et al.'s research connect aspects of the Triple Aim methodology to the succession of exchanges, such as intelligence, design, and choice processes, with respect to aspects of bounded rationality/rational choice and exchange processes, in a managed-care paradigm.

Physicians' and Patients' Expectations

Primary health care is considered to be the most repeatedly utilized health care services provided to patients by physicians (Misra-Hebert, Rabovsky, Yan,, Hu, & Rothberg, 2015; Zabaleta-del-Olmo et al., 2015). Primary health care is considered as a platform that can give individuals, groups, and communities a model venue to encourage health care promotion and disease prevention (Misra-Heber et al., 2015; Zabaleta-del-Olmo et al, 2015). Yet, emerging scholars (Concannon et al., 2014; Cottrell et al., 2015; Herremans et. al., 2015) continue to emphasize that attaining primary health care is a challenging endeavor for U.S. citizens. In 2015, the National Health Expenditure Accounts (NHEA) agency reported that the U.S. health care spending in 2014 reached approximately $3 trillion, and approximately $604 billion were distributed to physicians and other clinical services in primary health care. The NHEA data included an increase in health care spending by 5.3% in 2014 and 2.9% in 2013 to cover aspects of medical expansions under the 2010 ratification of the Patient Protection and Affordable Care Act (ACA) (NHEA, 2015).

The creation of the ACA was envisioned as a pathway to increase patients' health care coverage and affordability, primarily via CMS' mandates (Holtrop et al., 2015; Issel, 2015). The updated 2014 reformed version of the ACA was instituted to assists patients

with selecting how they could receive access to health care services utilizing state and/or federal financial assistance (Holtrop et al., 2015; Issel, 2015). Cunningham's (2015) and Marshall's (2015) investigations illustrated the significance of the ACA as an instrument that can offer patients ease of access to health care, but they warned that the ACA did not give practice managers directives for executing health care services. The ratification of the ACA only underscores a need to deliver equitable, quality health care services while reducing cost. The ACA does not dictate the actions or behaviors of practice managers when delivering health care services (Cunningham, 2015; Marshall, 2015). However, when practice managers implement decision-making strategies, they are expected to be empathetic and compassionate to patients' needs and provide physicians with the tools they need to deliver quality health care services (Piña et al., 2015; Zabaleta-del-Olmo et al., 2015).

Physicians and patients as stakeholders. Physicians and patients are in every health care organization in the United States, and they are often characterized as stakeholders (Felipe-Lucia et al., 2015; Fetterman, Rodriguez-Campos, Wandersman, & O'Sullivan, 2014; Mishra & Mishra, 2013). Stakeholders have been defined as any entity that is involved in, affected by, or have the power to influence a course of actions or activities that can enrich or impede any desired actions or activities (Felipe-Lucia et al., 2015; Fetterman et al., 2014; Mishra & Mishra, 2013). Stakeholders have a vested interest in the performance of their health care organizations, in particular how practice managers' decision-making have a cumulative effect, such as physicians' and patients' interactions and expectations (Felipe-Lucia et al., 2015; Fetterman et al., 2014; Mishra &

Mishra, 2013). Interactions and expectations are influenced by health care policies that provide directions for how health care organizations will function (Arroliga et al., 2014).

Physicians provide health care services to patients based on health care policies and procedures that are conceived, implemented, and monitored by practice managers. Patients receive health care services from physicians based on practice managers' ability to effectively manage the process of conceiving, implementing, and monitoring health care policies and procedures in their health care organization. Derry (2012), Hasnas (2013), and Eskerod, Huemann, and Rignhofer (2015) posited that practice managers' decisions-making requirements are connected to R. E. Freeman's (1984) stakeholder theory. Freeman suggested that decisions are related to aspects of organizational management and business ethics that accentuate morals and values when managing an organization. Practice managers' decisions are envisioned to establish and cultivate a climate of excellence with business and client relationships (Alhaddi, 2015; Arroliga et al., 2014; Melo et al., 2014; Trastek et al., 2014). Collectively, Derry, Hasnas, and Eskerod et al.'s investigations articulated that practice managers must satisfy the needs of their stakeholders and be seen as well-informed, compassionate leaders that can balance both organizational and stakeholders' interests that can sustain and manage their capital when making decisions.

Managing stakeholders' capital. According to Xie et al.'s (2015) research on the dynamics of multi-stakeholders in health care organizations, effective health care sustainment is determined by an effective health care delivery system in place, and it can also be driven by other key issues that are not health care related, such as social factors,

economic factors, and environmental factors. Rauscher and Wheeler (2012) and Grossmeier et al.'s (2016) analyses on stakeholders' capital concurred with Xie et al.'s research, but additionally, they noted that health care organizations, such as hospitals, research centers, medical practices, and social services, are created as business organizations with goals of creating profits that can make their organizations viable. The aforementioned scholars described profit-seeking stakeholders as shareholders that have powers to influence how health care organizations' resources are managed. The scholars regarded financial and social capital as two vital resources in health care management, as both resources can be deployed with the intent to create revenue and project social, moral, and ethical awareness for the benefit of health care organizations when practice managers make decisions. Coleman (1988) and Putnam (1995) explained social capital as any resource that has value in relationships that can construct collective actions, such as trust, norms, and networks of association, and could represent any entity that assembles consistently for a common purpose. Barton and Gordon (1987) and Robb and Robinson (2012) outlined financial capital as any resource that has value and represents wealth, such as money, gold, and stocks, with the intent to purchase goods or services

Lega, Prenestini, and Spurgeon (2014) and Lee and Kam (2015) cautioned that financial and social capital could influence the complexity and dynamics of health care organizations' environment. Each has the ability to alter how practice managers make decisions, conduct business relationships, and thrive during uncertainty. Stroetmann's (2013) and Tulchinsky's (2014) research concluded that health care organizations cannot thrive without financial capital, and without financial capital, practice managers have the

potential to default on their pledges to delivery applicable health care services to patients in their communities. Participating in community engagements could create social capital by attaching financial capital to social awareness issues, and as a result, health care organizations are viewed as being invested and devoted to the needs of their communities (Stroetmann, 2013; Tulchinsky, 2014).

Lega et al.'s (2014) and Lee and Kam's (2015) research endorsed Stroetmann's (2013) and Tulchinsky's (2014) views, but they also highlighted the significance of delineating the dissimilarity between how health care organizations function in their communities. Lega et al. and Lee and Kam acknowledged that health care organizations providing primary health care must be classified into three groups: for-profit, not-for-profit, and state and local government. How they function can determine what decision-making strategies should be deployed to create capital. Each classification incorporates the managed-care paradigm, but with very diverse agendas that delineate how health care organizations manage their capital, per their stakeholders' interests. Puyvelde, Caers, Bois, and Jegers's (2012), Stein's (2015), and Woodring's (2015) investigations conveyed that fluctuating fiscal situations could influence how practice managers' decision-making strategies determine how their health care organizations expands. For-profit health care organizations have better access to capital than not-for-profit health care organizations. Puyvelde et al., Stein, and Woodring wrote that not-for-profit health care organizations could expand by distributing debt through tax-exempt bonds, rather than expanding by creating additional financial capital, such as specialty or customized health care services. State and local government health care organizations depend on

capital exclusively from distributions provided by their state and local governments (Puyvelde et al., 2012; Stein, 2015; Woodring, 2015).

In 2015, the American Hospital Association (AHA) reported that 4,974 hospitals that provide primary health care exist in the United States. The AHA noted that 1,060 are for-profit hospitals (21%), 2,904 are not-for profit hospitals (58%), and 1,080 are state and local government hospitals (21%). A for-profit hospital is investor-owned, either private or public, by shareholders with their practice managers' intent to issue publicly traded stock shares to generate revenue to expand their hospital's capital or increase profits (Bai & Anderson, 2015; Turner, Broom, Elliott, & Lee, 2015). A not-for-profit status does not mean a hospital cannot expand their capital or increase profits, nonetheless, it does mean any surplus financial capital must be reinvested back in the hospital, such as facility upgrades, medical equipment, IT infrastructures, education, training, employees' salaries, and community involvement (Bai & Anderson, 2015; Turner et al., 2015). Similar to not-for-profits hospitals, state and local government hospitals reinvest back into the operation of their organizations, and they have a strong emphasis on being liable to shareholders (tax payers) that support their hospitals' operational budget (Bai & Anderson, 2015; Turner et al., 2015).

Each hospital classification has obligations to its community with strict rules and governing processes. Stroetmann (2013), Lega et al. (2014), Tulchinsky (2014), and Lee and Kam (2015) collectively recognized that when practice managers write policies that govern their health care organization's operations, their decisions-making strategies are critical for delineating how patients' health care needs should be met, how patients'

health care charges should be calculated, and how their hospital should protect their local community's interests. The AHA (2015) documented that it is advantageous for practice managers to assist their hospitals develop outreach and education programs, offer health and wellness screenings, and support preventive and collaborative health care activities in their communities. The AHA's suggestions indicated that any health care promotion by practice managers in their communities could deliver both social and financial capital that could further advance stakeholders' interests. Stroetmann's, Lega et al.'s, Tulchinsky's, and Lee and Kam 's (2015) research proposed that community engagement denotes aspects of Freeman's (1984) stakeholder theory with underlying themes that include how practice managers can build value, balance, and loyalty with their organization's brand.

Aspects of Freeman's (1984) stakeholder theory implicate that practice managers' decision-making strategies should have an authoritarian-focus on stakeholders' interests and be motivated to create wealth and/or strengthen market shares for their health care organizations. Comparable, Bakan's (2004), Bazen and Moyes's (2012), and Cockshott et al.'s (2012) studies suggested that aspects of the stakeholder theory rationalize practice managers' responsibilities for generating activities. They noted that without exceptions, Freeman's theory demanded that practice managers must appease shareholder's interests to attain profits at all cost, regardless of harmful effects it causes others. Their studies connect to Friedman's (1970) assertion that shareholders are within their legal rights to create capital and practice managers' actions should comply with their expectations.

In 1991, Carroll reported that shareholders have narcissistic attitudes and hold managers accountable for creating profits at all cost. Karnieli-Miller, Frankel, and Inui's

(2013) and Fisman, Jakiela, Karive, and Markovits' (2015) investigations centered on Carroll's report and associated aspects of narcissistic attitudes to elitism. Bakan's (2004) earlier study on elitism described that elitist attitudes lead to a relentless and pathological pursuit of profits and power. Bakan advised that profit and power can have both positive and negative influences on organizations. Positive influences allude to profits and power that can create revenue for organizations. Revenue can support positive social change initiatives in communities, such as health promotion and reducing barriers to health care assess (Stroetmann, 2013; Tulchinsky, 2014). Negative influences allude to profits and power that can create segregation among stakeholders in their communities. Segregation supports inequalities and creates disadvantaged social classes that can impede progress among stakeholders in their communities (Stroetmann, 2013; Tulchinsky, 2014).

Other scholars, such as de Paula Rodriguez and Peiro (2012), Jacobs (2013), and Torugsa, O'Donohue, and Hecker (2013), held opposing interpretations regarding how practice managers are portrayed when utilizing profits and power for generating capital during decision-making. They agreed that profits and power should play a critical role in management, but should be deployed to endorse a corporate social responsibility (CSR) strategy for sustaining stakeholders' interests. Organizations can deploy CSR strategies as their self-regulatory process for being aggressively engaged and compliant with legal, ethical, social, and environmental concerns in their communities (de Paula Rodriguez & Peiro; 2012; Jacobs, 2013; Torugsa et al., 2013). Health care organizations can promote themselves as having acceptable business, social, and ethical standards while being loyal to their communities' interests to gain the trust and respect of those they serve (de Paula

Rodriguez & Peiro; 2012; Jacobs, 2013; Torugsa et al., 2013). However, opponents of CSR maintained that it is a marketing tool that detracts from exposing organizations' greedy ambitions and generating profits at all cost (Bazen & Moyes, 2012; Kadlubek, 2015; Shamir, 2011).

Deploying CSR strategies involve the triple bottom line (TBL) framework, noted as social, environment, and financial capital to measure how performances and profits of organizations affects stakeholders (Alhaddi, 2015; Tullberg, 2012). The TBL framework evaluates the consequences between practice managers' decision-making processes and the outcomes of their organization's performance from a profit-based representation of shareholders' interests (Alhaddi, 2015; Tullberg, 2012). When organizations engage in a TBL framework, it suggests that practice managers have better control for monitoring the financial impact of their organization's business objectives, improving how stakeholders are managed, increasing awareness with social issues, and reducing antagonistic effects on the environment while enhancing the delivery of health care services. Alhaddi and Tullberg asserted that if practice managers deploy CSR strategies, they can create capital by being socially responsibility to their communities and the environment, while creating considerable economic growth for their organizations.

Managing stakeholders' value-based interests. Piña et al. (2015) and Zabaleta-del-Olmo et al. (2015) reported that the delivery of health care services is stakeholder-focused and stakeholders' interests merge with *value-based* activities throughout the decision-making process. They designated valued-based activities as any actions or behaviors that could lead to how practice managers implement quality health care

services. Piña et al. and Zabaleta-del-Olmo et al. proposed that value-based activities are contingent on stakeholders' analyses regarding how they are listened to, informed about health care services, respected by their health care organizations, and their level of control and/or involvement when health care services are offered.

Studies have connected values and stakeholders' interests to decision-making strategies in health care organizations. Epstein and Street (2011) and Porter (2013) argued that decisions are conceived and implemented based on values that are patient-centered. Lundberg (2014) and Sims, Tsai, Koopmann-Holm, Thomas, and Goldstein (2014) declared that decisions are based on physicians' values and their expert health care advice that influences health care services. Barello, Graffigna, Vegni, and Bosio (2014) and Wen & Tucker (2015) agreed that physicians and patients are stakeholders and acknowledged that they should be the focus of health care services. Barello et al. and Wen and Tucker also recognized that practice managers are responsible for instituting a climate of excellence and their decisions should create values in their health care organizations, regardless of the physicians' status in their organizations.

Epstein and Street's (2011) investigations on the influence of values and the value of patient-centered health care acknowledged that practice managers should refocus their efforts regarding how they deliver health care services. They emphasized that value is related to quality actions or activities that could improve a situation. Patient-centeredness implies directing quality to patients, as they are the stakeholders. Value insinuates being attentive to patients' health care needs, their interests, and ensuring that they can benefit from future health care services necessities. Epstein and Street noted that values include

openness, and patients should be encouraged to be active participates in their health care services. They recommend that practice managers assist physicians with strategies that build trust, respect, positive engagements, and collaborative efforts in physicians' and patients' interactions.

Epstein and Street's (2011) investigation suggested that value-based strategies include focusing on behaviors, outcomes, and comprehension. They stated that strategies for behaviors, regardless of the health care outcomes, should be perceived as making the right decisions or performance of actions that benefit the patient, such as respecting the patient's preferences during the delivery of health care services. Strategies for outcomes must be connected to behaviors, as behaviors or actions during the delivery of health care services dictate what measures are taken to resolve an illness (Epstein and Street, 2011). Strategies for comprehension are indispensable, as there should be a reciprocal-level of understanding between all stakeholders involved that could encourage behaviors that can produce a desired outcome (Epstein and Street, 2011).

Porter (2013) asserted that patients' values in health care services are dependent on the results of the health care services rendered, and the results are measured by the outcomes of quality health care services achieved, not the amount of health care services rendered. Porter stated that patients' values for effective health care outcomes are also measured by per dollar spent, and patients connect the expected cost of their health care services to the expected quality of health care services they will receive. In 2015, the Kaiser Family Foundation (KKF) reported that patients in the United States spent approximately $563 billion in 2012, $576 billion in 2013, and $603 billion in 2014 for

primary health care services in their physicians' offices. Further, the KKF asserted that 95% of patients assessed in 2014 noted that they associate the value of quality and cost to safety, person-centered care, effective health care treatments, and health care promotion. As noted each year, the total expenditure increased and it suggests that patients are willing to pay more for quality health care services.

Hussey, Wertheimer, and Mehrotra (2013) conducted a health care record analysis and reviewed 61 health care studies (studies published between 1990 and 2012) to assess the association between cost and quality. Contrary to Porters' (2013) interpretation of cost to quality, Hussey et al.'s analysis yield neutral results. Hussey et al. reported the following results: 34% reported a positive or mixed-positive association; 18% reported a negative or mixed-negative association; and 36% reported no difference, an imprecise or indeterminate association, or a mixed association. Also, Hussey et al. acknowledged that patients have different interpretations of quality and value, and recommended that further studies are vital to assist practice managers with comprehending patients' perspectives of quality and cost when they make decisions regarding stakeholder's values.

Roski, Bo-Linn, and Andrews's (2014) and Lakdawalla et al.'s (2015) assessment regarding value, cost, and quality contradicted Hussey et al.'s (2013) health care record analysis. Roski et al. and Lakdawalla et al. communicated that patients do not always distinguish the return on their investments (ROIs) with the cost of value. They noted that practice managers make cost and quality improvements in their health care organizations by upgrading infrastructures that support patient-centered health care services, such as pharmaceutical advancements, improved medical devices, state-of-the-art IT systems,

modernizing their health care facilities, and competitively employing competent health care staff members. Also, Roski et al. and Lakdawalla et al. connected patients' ROIs with the cost and value of constructing social and financial capital that allows their health care organizations to meet social obligations through profit seeking methodologies.

Lundberg (2014) underscored that physicians are essential for creating values. Lundberg's investigation of physicians' and patients' interactions proposed that patients' experiences are developed when they adapt their health care needs based on health care advice from physicians. Physicians render health care advice supported by their prior medical knowledge, education and training, and their organizations' strategic business objectives, as articulated by practice managers (Labrie & Schulz, 2015; VanVactor, 2012). The outcome of Lundberg's investigation was similar to Epstein and Street's (2011) prior investigation, as mentioned above, suggesting that value-based strategies focused on behaviors, outcomes, and comprehension. Lundberg reported that physicians' health care advice drives about 75% of health care expenditures and about 20% of all health care charges are physicians' fees. Lundberg identified that physicians' actions control valued-based strategies because they render health care advice that determines quality to patients, such as what laboratory tests to order, what medications to prescribe, how to render health care treatments, and/or if additional referrals or consultations are necessary.

Sims et al.'s (2014) research on valued-based strategies included aspects of how patients trust the actions and behaviors of their physicians that lead to quality health care services using the Affect Valuation Theory (AVT). They concentrated the research on

two areas of quality preferences in the delivery of health care services: actual affect, how physicians and patients actually feel; and ideal affect, how physicians and patients want to feel. Based on the AVT, Sims et al. concluded that patients trust and value physicians' health care advice when their actual affects are consistent with the ideal affects of their physicians. The AVT details how physicians and patients can transform from an actual affect to an ideal affect by means of three propositions: actual affect differs from ideal affect; personality traits can influence actual affects, while cultural factors can influence ideal affect; and ideal affect can predict behaviors similar or better than actual affect (Sims et al., 2014). VanVactor (2012) and Labrie and Schulz (2015) emphasized that physicians use their education and training credentials to project an image of being a health care expert. The image of being a health care expert assumes power over patients that can influence how they define value, quality, and cost required to transform from their actual affects to their desired ideal affects (Ducios and Carty, 2011; Ellner et al., 2015; Reineck and Kahn, 2013; Sims et al., 2014).

Although power can influence valued-based activities, Russo et al.'s (2015) study reminded that the delivery of health care services is client-focused. Practice managers' decision-making strategies are expected to merge stakeholders' interests with value-based activities without offending other stakeholders (Russo et al., 2015). Physicians and patients, as stakeholders with the most to gain or lose, rely on practice managers' power and influence to attain their desired objectives (Addicott & Shortell, 2014; Hawthorne et al., 2014; Minvielle et al., 2014). Russo et al. suggested that practice managers should adopt an *integrated home care* (IHC) process that allows health care services to move

from health care organizations to any location that meets physicians' and patients' needs. The IHC process has the power to influence and it conveys flexibility.

Russo et al. (2015) discussed five criteria pertaining to merging physicians' and patients' values to IHC and decision strategies: actors involved and their roles played in the different activities; specific actions and the sequences; important decision points; interactions between activities and actors involved in the process; and management teams' systems, tools, and methods used for the coordination of activities. Russo et al. acknowledged that the IHC process is effective for improving business strategies and implementations, enhancing information distribution and exchanges between physicians and patients, getting people/resources involved at the right place and right time, and distinguishing practice managers' roles and responsibilities during the decision-making process. The common assessments of the aforementioned scholars shared the same perspectives: value-based activities in health care organizations, with leadership and management involvement, are expected to create economic growth grounded on how practice managers implement policies that decrease cost and increase quality (Addicott & Shortell, 2014; Barello et al., 2014; Ellner, 2015; Hawthorne et al., 2014; Hussey et al., 2013; Labrie & Schulz, 2015; Lakdawalla et al., 2015; Lundberg, 2014; Minvielle et al., 2014; Piña et al., 2015; Reineck & Kahn, 2013; Roski et al., 2014; Russo et al., 2015; Sims et al., 2014;Wen & Tucker, 2015; Zabaleta-del-Olmo et al., 2015).

Leadership and Management Attributes

Kotter (1999) proposed that aspects of leadership and management are different, nonetheless, they supplement each other and both require decision-making competencies.

In a managed-care paradigm, the term management relates to how practice managers should cope with the complexities of their health care organization's processes, such as conceiving and implementing decision-making strategies to achieve their business objectives (Kotter, 1999). The term leadership relates to how practice managers should cope and influence the variabilities within their health care organizations' processes, such as developing strategies that motivate stakeholders and influence how business objectives are achieved (Kotter, 1999). Alike, Hogan and Kaiser's (2005), Bacha and Walker's (2013), and Elf et al.'s (2015) investigations proposed that aspects of leadership and management competencies are real and valuable, have a focus on tangible performances and behaviors during the delivery of health care services, and how practice managers should envision their organizations' needs. Domnica's (2012), Epstein's (2013), and Elwyn et al.'s (2014) research propositioned that the alignment of leadership and management competencies is associated with motivation, communication, group work, and delegation that centers on the innovation and continuous decision-making strategies that are significant for creating a sustainable organization. Although Kotter stated that a discrepancy exists between the terms leadership and management, other scholars (Chreim & MacNaughton, 2015; Issel, 2015; Singer, Hayes, Gray, & King, 2015) argued that the terms are synonymous in the delivery of health care services when decisions-making strategies are conceived and implemented pertaining to leadership and management attributes.

Leadership and management expectations. Past scholars (Avolio, 2007; Chin & Sanchez-Hucles, 2007; Vroom & Jago, 2007; Zaccaro, 2007) acknowledged that

aspects of leadership and management characteristics are complex with unconventional behaviors that could lead to power and influence with the skills to motivate subordinates. Intrinsically, Lee's (2015), Wai and Bojei's (2015) and Yardley et al.'s (2015) investigations reported that practice managers' behaviors could play a critical role when persuading and motivating physicians and patients under their span of control to act, perform, and behave within acceptable boundaries of their influence. They conveyed that practice managers' behaviors construct principle organizational tone/climate that influence interactions, collaborations, communications, and efficiencies in their health care organizations.

Management ideologies concluded that leadership behaviors are communicated as competing with their peers and imposing demands on their subordinates and stakeholders while behaving assertively to ensure that all required tasks are accomplished in a timely manner (Ayman & Korabik, 2010; Concannon et al., 2014; Cottrell et al., 2015; Herremans et al., 2016). Therefore, the above scholars deduced that practice managers' behaviors are believed to be prototypical of management responsibilities during the decision-making process. Terrell and Rosenbusch's (2013) research advocated that when practice managers anticipate attaining effective decision-making strategies in their health care organizations, they should integrate the following in their leadership and management processes:

1. cultivate first-hand, cross-cultural leadership and management experiences;
2. learn the importance/value of cultural sensitivity, associations, and networks while yearning to learn as a result of evolving practices;

3. obtain a unique set of leadership competencies to prepare for increased leadership roles/opportunities; and
4. develop/learn intuitively and employ ad hoc learning approaches to resolve problematic situations.

Carter (2013) and Labrie and Schulz (2015) pointed toward how practice managers' leadership and management decision-making competencies should include using their communicative skills and past experiences to motivate and persuade diverse groups of physicians and patients to follow their directives. Further, Carter and Labrie and Schulz denoted that those in leadership positions should be active and engaged communicators, rather than being perceived as commanders or scorekeepers trying to get those under their authority involved in the health care process. Gulbrandsen's (2014), Nundy and Oswald's (2014), and Trastek et al.'s (2014) investigations were similar to Carter and Labrie's and Schulz's perspectives, but they maintained that practice managers should give timely feedback and advice to physicians and patients. They noted that feedback and advice can inform and reinforce what decision-making strategies are doing well, or not, during the delivery of health care services. The aforementioned scholars' views implied that balanced communication and group work could offer unique opportunities for practice managers, physicians, and patients. They concluded that practice managers, physicians, and patients' collaborative efforts can create open communication forums that stimulate suggestions/ideas that could improve decision-making processes, collaborative health care engagements, and group interactions in a managed-care paradigm. Caligiuri (2006), Whetzel and Wheaton (2012), and Dusi,

Messetti, and Steinbach (2014), opined that practice managers should have considerable knowledge, skills, abilities, and other personality characteristics (KSAOs) to transform into subject matter experts regarding how health care is delivered and strike a balance with physicians' and patients' interests when making decisions.

Knowledge, skills, abilities, and other personality characteristics. Landry, Stowe, and Haefner (2012) and Wang and Zatzick (2015) emphasized that leaders and managers will emerge as the right people are given the right developmental opportunities, and they can be effective performers that deliver outstanding leadership tasks, activities, and decisions. Landry et al. and Wang and Zatzick asserted that KSAOs are individual-level attributes based on practice managers' level of mutability, such as their knowledge-base and personality traits. They emphasized that aspects of practice managers' KSAOs attributes can be designated as a set of facts/elements of information related to a given content-domain and they can be general- or topic-specific with basic context or advanced context. Landry et al. and Wang and Zatzick noted the significance of the competency domain, such as:

1. general knowledge of diverse cultures, including social-level values and norms such as perceptions, language, thought processes;
2. specific knowledge of diverse cultures, including an in-depth understanding of different individuals or demographical vales, norms, beliefs, rites, rituals, behaviors; and
3. business knowledge, including topic-specific knowledge related to conducting patient care within the health care services setting.

Further, Landry et al.'s research highlighted that practice managers' competency domains are essential for making effective decisions and their KSAOs attributes are transferable to any industry (see Table 2).

Table 2

Delineating Competency Domains

Competency Domains	Definitions
Broad Focus	
Governance and Organizational Structure	Understands the structure/function of health care organization
Health Care	Understands the health care industry environment
General Management Principles	Understands principles that lead to positive organizational stewardship
Business	Understands knowledge functional areas, such as marketing, planning, and strategy
Professionalism and Ethics	Aligns personnel behaviors with professional and ethical standards of behaviors
Narrow Focus	
Human Resource	Understands and applies human resource practices that are ethically and legally appropriate
Finance	Understands financial information and applies financial skills in health care management
Health Care Information and Technology	Understands current and potential use of clinical, administrative, and decision support systems
Quality and Performance Improvement	Able to use information to improve quality and organizational performances
Laws and Regulations	Understands applicable laws and regulations pertaining to the health care environment

Note. Conceived implications of competency domains, as applicable to practice managers in a managed-care paradigm. Adapted from "Competency assessment and development among health-care leaders: Results of cross-sectional survey." By A. Y. Landry, M. Stowe, M., & J. Haefner, 2012, *Health Services Research & Policy 25*(2), p. 78-86.

Landy and Conte's (2004), Markaki, Sakas, and Chadjipantelis's (2013), and Fulmer and Ployhart's (2014) analyses of KSAOs were similar, but they comprehend

practice manager’s skills and abilities for decision-making as practical aspects of human capital. They advised that skills and abilities are mutable, possibly increasing or decreasing over time, and those mutable skills and abilities are within their natural limitations. Additional aspects of Landy and Conte’s, Markaki et al.’s, and Fulmer and Ployhart’s analyses included illustrating how practice managers must interact with physicians and patients with diverse background before they execute decisions. They indicated that practice managers should embrace KSAOs, such as their communication capacity to rely key information, conflict resolution skills that create an effective organizational climate, and cognitive and rational aptitude that could persuade individuals to attain their organizations’ strategic objectives.

Caligiuri’s (2006) and Sanchez and Levine’s (2012) perceptions of KSAOs were described more as personality traits that could influence decision-making. Whetzel and Wheaton’s (2012) and Dusi, Messetti, and Steinbach’s (2014) investigations further the discussion and insinuated that practice managers’ personalities allow them to behave in a certain manner, and in a particular situation, their behaviors are likely to define how they classify goals and complete projects. Additional emerging scholars, such Byrne, Silasi-Mansat, and Worthy (2015), Letzring and Adamcik (2015), and Sirois and Hirsch (2015), wrote about the significance of comprehending the “Big Five” personality traits found in leadership and management teams throughout diverse organizations. They noted how personality traits could affect business services that are rendered to stakeholders, and how those stakeholders could perceive their leadership and management teams’ behaviors. In particular, Sirois and Hirsch’s examination of the “Big Five” personality traits provided a

concise delineation of personality traits that infer aspects of practice managers' behaviors and decision-making strategies, such as conscientiousness, agreeableness, emotionally stability, and openness to experiences, and extraversion (see Table 3).

Table 3.

Delineating the "Big Five" Personality Traits

Personality Traits	Personality Expectancies	Personality Affects
Conscientiousness	High: Persistent, driven Low: Flexible, spontaneous	High: Stubborn, obsessive Low: Careless, unreliable
Agreeable	High: Compassionate, empathic Low: Competitive, challenging	High: Naïve, submissive Low: Argumentative, dishonest
Emotionally stable	High: Resilient, calm Low: Reactive, excitable	High: Unconcerned, uninspiring Low: Unstable, insecure
Openness to experiences	High: Creative, receptive Low: Pragmatic, data-driven	High: Unpredictable, unfocused Low: Closed-minded, dogmatic
Extraversion	High: Sociable, assertive Low: Reserve, reflective	High: Narcissist, dominant Low: Detached, self-absorbed

Note. Conceived implications of the "Big Five" personality traits, as applicable to practice managers in a managed-care paradigm. Adapted from "Big five traits, affect, balance and health behaviors: A self-regulation resource perspective." By F. M. Sirois and J. K. Hirsch, 2015, *Personality and Individual Differences,* 87, p. 59-64.

Sirois and Hirsch's (2015) analysis revealed that when personality traits are high, stakeholders accept decisions and they tend to be more favorable toward organizational objectives, and when personality traits are low, they begin to question decisions and how those decisions affect their interests. Comparable, Caligiuri's (2006) and Sanchez and Levine's (2012) perspectives of leaders and managers' personality traits were interpreted as:

1. Conscientiousness traits have greater efforts and task commitments toward how decisions affect individuals.

2. Agreeableness traits are reciprocal to social capital and alliances, and able to make adjustments with decisions that affect individuals.
3. Emotional stability traits have increase abilities to cope in ambiguity or unfamiliar environments during the decision-making process.
4. Openness to experiences traits are better suited to assess social environment with less rigid views of diversity among individuals during the decision-making process.
5. Extraversion traits tend to have greater natural ease with social demands and more likely to put an effort to interact with different cultures when making decisions.

The aforementioned scholars' (Landry et al., 2012; Wang and Zatzick, 2015) reviews concluded that leaders and managers will emerge and they can be effective performers that deliver outstanding leadership tasks, activities, and decisions. Landry et al and Wang and Zatzick also noted that practice managers' personality traits could determine their leadership styles and relationships with physicians and patients in a managed-care paradigm.

Leadership styles and relationships in leader-member exchanges. A review of diverse research suggested complex levels of dimensions within the relationship between practice managers, physicians. and patients, and labelled as of leader-member exchanges (LMX) in a managed-care paradigm. Kim, Liu, and Diefendorff (2015) and Leroy, Anseel, and Gardner (2015) wrote that aspects of LMX signify that different groups of individuals support different beliefs and practices toward leadership and management.

Practice managers should apply appropriate leadership styles for physicians and patients to maintain positive, productive working relationships. Zhang, Wang, and Shi's (2012) and Gong, Kim, and Lee's (2013) investigations regarding proactive personalities and work outcomes conceded that effective working relationships can build trustful, respectful health care climates whiling creating value, purpose-driven partnerships. Sharma and Kirkman (2015) and Hearld, Alexander, and Shi (2015) described aspects of trustful and respectful climate control as valued dimensions that include individualism vs. collectivism, people-orientation vs. task-orientation, and high power distance vs. low power distance that could be applied during decision-making. Sharma and Kirkman's and Hearld et al.'s research outlined how those dimensions could dictate applicable leadership styles and relationship connections that establish LMX.

Practice managers with individualism leadership styles were illustrated as leaders that perceived themselves as independent of others situations during the decision-making process (Sharma & Kirkman, 2015; Hearld et al., 2015). They were more affected about the significance of their own behaviors and prioritized their agendas over physicians and patients under their span of control to achieve their organization's objectives (Sharma & Kirkman, 2015; Hearld et al., 2015). Collectivism leadership styles were described as a set decision-making strategies that take into account the values, beliefs, behaviors, and expectancies of the group, such as physicians and patients, when determining how to achieve their organization's objectives (Sharma & Kirkman, 2015; Hearld et al., 2015).

Zhang et al.'s (2012) and Gong et al.'s (2013) analyses emphasized that people-orientated practice managers should maintain an inclusive, friendly and supportive

relationships with physicians and patients, therefore, receiving a sense of trust and respect from those under their span of control. Task-oriented practice managers were depicted as having a focus on attaining goals, creating value and productivity of their organizations, and ensuring that physicians and patients follow organizational procedures and instructions (Zhang et al., 2012; Gong et al., 2013). Sharma and Kirkman's (2015) and Hearld et al's (2015) assessments concluded that practice managers should define the roles of the health care organizations, such as how they should function, establish well-defined patterns of organizational channels of communication, and create an appropriate collaborative, team-building climate.

Alike, Kim et al. (2015) and Leroy et al. (2015) assessed dimensions of power relationship as having an association with communication style. They indicated that power distance is considered as the degree of inequality in power between a less powerful individual and a more powerful other. Practice managers with high power distance can be seen as having traditional hierarchy and authority. Earlier scholars, such as Milliman, Taylor, and Czaplewski (2002), Tjosvold (2002), and Wong, Wong, and Heng (2007), compared this to the Confucian cultural values that assumed organizations should be led and managed by the same principles as the family. Milliman et al., Tjosvold, and Wong et al. described the father (practice manager) as the head of the health care organization and those under the father's control (physicians and patients) are the children and they are affected by the outcomes of the father's decisions. Further, Kim et al. and Leroy et al. evaluated low distance power as practice manager sharing the autonomy, preferences, and/or partaking in collaborative efforts with physicians and patients that could influence

how decisions are conceived and implemented. Milliman et al., Tjosvold, and Wong et al. believe this could foster equal distributions of power while embracing practice managers as change agents in management while shaping their decision-making attributes.

Decision-Making Attributes

Since the 1800s, decision-making critically impacted health care processes and how it affected physicians, patients, and communities during the delivery of health care services (Sheingold & Hahn, 2014). In the 1900s, political factors such as global wars, workforce progression, socioeconomic environments, elitism, capitalism, racism, and demographical locations were causations for implementing decision-making strategies (Lee, 2015). Within the last decade, emerging U.S. political leaders vowed to reform the health care system to improve the quality of health care execution, but their proposals failed to yield effective outcomes and advance the development of health care services (Kim, Tanner, Foster, & Kim, 2015). In 2005, results of the National Health Interview Survey (NHIS) revealed that 48% of adults under the age of 65 that was uninsured did not have a usual place of health care (Pleis & Lethbridge-Cejku, 2006). The outcome of the survey exposed that 45% of those adults had not seen a physician or other health care professional in the past 12 months (Pleis & Lethbridge-Cejku, 2006). In 2006, the final report of the NHIS illustrated that 50% of adults under the age of 65 stated that health care cost was the reason for not seeing a physician or other health care professional in the past 12 months (Adams, Lucas, & Barnes, 2008). During 2007, Himmelstein, Thorne, Warren, and Woolhandler (2009) conducted a national survey and discovered that 62% of

all bankruptcy filings in the U.S were due to citizens having an illness or large medical bills.

In 2008, presidential candidate Barack Obama acknowledged that there was a problem with the health care system in the United States and declared to create health care reform that could make it possible for every citizen to attain health care (Maruthappu, Ologunde, and Gunarajasingam, 2015). In 2010, now President Obama, through a succession of decisions based on the failure of U.S. citizens having access to quality health care, signed into law the ACA and initiated a paradigm shift regarding decision-making strategies in health care management that affect physicians and patients in a managed-care paradigm (Maruthappu et al., 2015).

Decision-making assessment. Before health care organizations can start to make a decision, Sainfort et al.'s (2013) and Stallinga, Roodbol, Annema, Jansen, and Wynia's (2014) analyses implicated that practice managers should be absolutely clear that a problem or situation exists, then uncover how it should be solved. Watson and Foster-Fishman (2013) and Stiegler and Gaba (2015) wrote that the first steps in decision-making should include clarifying the nature of the problem or situation before executing any actions, such as the purpose of the decision, the achievable outcome, and any key priorities to consider. Sydney and Purnell's (2012) and Söllner et al.'s (2014) studies indicated that practice managers should demand that there is significant evidence to support emerging data with rational cause and effect before implementing any process, and have common sense evaluations situated to support their strategies.

Additionally, Watson and Foster-Fishman (2013) and Stiegler and Gaba (2015) advised that using charts, graphs, or matrices could determine if decisions are required, and if they are utilized, they have the potential to be valuable assets. Goeree and Diaby (2013) and Ritrovato, Faggiano, Tedesco, and Derrico (2015) proposed that all decision-making strategies are situational and they can set the priorities for collecting intelligence, designing a decision-making process, and selecting between alternative options that can lead to pathways for attaining objectives. Ellen et al. (2014) described those pathways as validating attitudes and behaviors that could lead to successful domains of organizational structures, such as communication, trust, respect, values, and reducing barriers affecting relationships that have the potential to impede the decision-making process. Heydenfeldt (2013) believed that validating attitudes and behaviors can be characterized as linear or step-by-step in nature, and should consist of a thorough analysis of all alternatives, with their consequences weighed, to ensure that the optimal alternative is selected for attaining objectives.

In 1967, Peter Drucker recognized that to define a problem or situation, it is critical that leaders and managers must know what they are dealing with. Goeree and Diaby’s (2013) and Ritrovato et al.’s (2015) analyses followed Drucker’s ideology, and conceded that many leaders and managers already do this informally. They argued that formal situational assessments should get the right individuals involved at the correct level, as it can strengthen the domains of organizational structures during their decision-making process. Goeree and Diaby and Ritrovato et al. stressed that when leaders and managers accept cognitive and issue resolution processes, it has the potential to increase

quality, improve efficiency, and lower cost while prompting which problem or situation has the highest priority. Other emerging scholars, such as Ehrlinger, Readinger, and Kim (2016), Jarvis (2016), and Praveen et al. (2016), further designated aspects of how leaders and managers could evaluate problems or situations when incorporating priorities. They suggested that practice managers should consider the following:

1. Timing: What is the urgency? Is a deadline involved? What will happen if nothing is done?
2. Trend: Will the problem get worse? What is the problem or situation's potential for growth?
3. Impact: How serious is the problem or situation? What are the effects on people, services, and organization?
4. Causal factors: What conditions of events led to the problem or situation? What conditions allow the problem or situation to persist? What other problems or situations surround the existence of the central problem or situation?

Ehrlinger et al. and Praveen et al. noted that each priority can be extended and evaluated for a specific degree of concern, such as high, medium, or low; and if necessary, multiple problems can be aggregated to abridge decision options while assessing risk factors.

Risk and benefit assessments. Risk and benefit assessments play a critical role for evaluating how organizations make business decisions while maintaining operational compliance to meet their strategic objectives (Chemweno, Pintelon, Van Horenbeek, & Muchin, 2015; Talarico & Reniers, 2016). Pintelon and Van Puyvelde (2013) and

Merkova and Drábek (2015) equated risks assessment to risk management. Risk assessment in a managed-care paradigm involves making decisions while applying a framework for identifying, analyzing, evaluating, and mitigating risks during the delivery of health care services. Card and Clarkson (2014) wrote that the managerial landscape in health care is often defined by situations of risk and uncertainty. Antunes and Gonzalez's (2015) and Grace, Leverty, Phillips, and Shimpi's (2015) investigations labeled risk as any threat or vulnerability that could impose harm to an organization. Risk is the likelihood that a loss will occur and a loss occurs when a threat exposes any vulnerability (Bunting, Klein, & Miller, 2014; Johansen & Rausand, 2014). Card and Clarkson added that health care organizations use risk management techniques to identify and differentiate severe risks from minor risks, and when done properly, practice managers can intelligently decide what to do about any type of risk. The end result is a decision to avoid, transfer, mitigate, or accept a risk (Bunting, Klein, & Miller, 2014; Johansen & Rausand, 2014).

Risks affecting organizations can have significant impact in terms of economic performance and professional reputation, as well as environment, safety, and societal impact (Grace et al., 2015; Merkova & Drábek, 2015; Pintelon & Van Puyvelde, 2013). Organizations that manage risks successfully are more likely to defend themselves and thrive in developing their business objectives. Card and Clarkson (2014) and Leung, Noble, Gunn, and Jaeger (2015) connected risk management to other forms of decision-making strategies, such as impact assessment (IA). Card and Clarkson and Leung et al. reported that IA is frequently linked to environmental issues. They also advised that it has

applicability toward other health, financial, social, and community undertakings when confronting uncertainties and when formulating decision-making strategies.

Card and Clarkson's (2014), Leung et al.'s (2015), and Fehr, Mekel, Hurley, and Mackenbach's (2016) research inferred that practice managers deploying IA strategies can recognizes future consequences of an existing or projected decision-making actions. The impact is the difference between what can occur with the action and what can occur without it, and all decision-making actions must be practical, flexible, accountable, and credible (Card & Clarkson, 2014). Leung et al. further implied that practice managers' usage of IA strategies could assist with delineating social, economic, and institutional consequences of projected actions, such as health care equality, quality, and cost control, but they must do so with transparency to their stakeholders. Fehr et al. noted that any IA actions should be utilized as a systematic, rational tool for analyzing the consequences of how health care services are implemented due to legal and institutional restrictions, such as public law boundaries, discriminatory and equality concerns, access barriers, and/or human right violations.

From a global perspective, Wernham's (2011), Kemm's (2013), and MacNaughton's, (2015) studies informed that WHO depicts IA as a health care risk management strategy, and termed it as health impact assessment (HIA). Additionally, Wernham, Kemm, and MacNaughton advised that conducting HIA is imperative for promoting population health care, managing health care initiatives, and mitigating risks associated with the delivery of health care services. Boele and Crispin (2013), Harrison (2013), and Kemp and Vanclay (2013) specifically redefined HIA as a human rights

health care issue and deemed it as a critical decision-making factor for promoting health care across all sectors of managing health care initiatives and mitigating human risks. Although WHO participates in HIA in areas such as agriculture, culture, housing, mining, water, and waste, Wernham, Kemm, and MacNaughton expressed that one of their critical objectives is to reassess the impact of previous decision strategies that affect their active policies, programs, or projects that support global citizens' health care necessities, in particularly concerning vulnerable or disadvantaged group of citizens. Boele and Crispin's, Harrison's, and Kemp and Vanclay's analyses on human rights detailed that any HIA violations linked with previous decision strategies are redesigned to capitalize on attaining positive health care outcomes for those vulnerable or disadvantaged group of citizens, while reducing risk and negative impact.

In the United States, when delineating HIA, and comparable to how IA is deployed during decision-making, key terms are underscored, such as control, prevent, reduce, and protect health care organizations and stakeholders' interests (Ross, Orenstein, & Botchwey, 2014; Schuchter, Bhatia, Corburn, & Seto, 2014). Bourcier, Charbonneau, Cahill, and Dannenberg's (2015) and Milat, Bauman, and Redman's (2015) investigations expanded on HIA's practicality, and they advised that it should be applied as controlling liability, preventing loss, and protecting financial assets and property when managing health care services in a managed-care paradigm. Similar to the aforesaid scholars, such as Hung and Jerng's (2014) study that validated structures, processes, and outcomes and Mason et al.'s (2015) analysis based on integrated funding utilizing quality indicators and measurement, Schuchter and Jutte (2014) advocated that aspects of HIA

are strategic for measuring organizational-wide performance improvement processes. Schuchter and Jutte declared that HIA can provide an effective platform to help reduce patients' health care problems, strengthen physicians' and patients' collaboration, expand the delivery of quality in health care treatments, close any gaps in knowledge between stakeholders and organizational policies, maximize safety initiatives, and construct methodologies to manage revenue. Collectively, Hung and Jerng, Mason et al., and Schuchter and Jutte agreed that aspects of performance improvement processes and quality management strategies can be evaluated by reviewing data, such as patient satisfaction surveys, health care services incident reports, employees' performances and compensation records, MCOs' contracts and/or insurance arrangements, and other logistical resources. Schuchter and Jutte argued that HIA can offer an effective platform in a managed-care paradigm, but the platform is only effective as the leadership and management team conducting the HIA.

Summary and Conclusions

In the health care industry, leaders and managers make decisions and ensure that their health care organizations can operate effectively. When health care organizations deploy a managed-care paradigm, there is a requirement for practice managers to make decisions that can strategically establish and cultivate a climate of excellence with their business and client relationships (Alhaddi, 2015; Arroliga et al., 2014; Melo et al., 2014; Trastek et al., 2014). A review of the health care literature was explored to delineate what, if any, aspects determine how practice managers conceive and implement their decision-making strategies. The nucleus of the literature review focused on ascertaining

data that delineate aspects of practice managers' perspectives of their decision-making strategies that affect physicians and patients in a managed-care paradigm, particular in a primary health care setting.

In Chapter 2, data regarding a managed-care paradigm were plentiful. Data regarding practice managers' perspectives on decision-making strategies in a managed-care paradigm were deficient. The literature review revealed aspects of a managed-care paradigm and exposed the necessity for practice managers to grasp the significance for establishing and cultivating a climate of excellence regarding their business and client relationships. When deploying Simon's (1960) ideology of decision-making strategies in a management environment, key research concepts of interests emerged. Simon stated that decision-making strategies should be constructed on a succession of exchanges, such as intelligence, design, and choice processes, with respects to bounded rationality/rational choice and exchange process. The key research concepts of interest for the study included delineating aspects of physicians' and patients' expectations, leadership and management attributes, and decision-making attributes in a managed-care paradigm.

The literature review contained scholars' efforts to delineate aspects to consider when making decisions or how health care organizations should manage decision-making strategies. The scholars also suggested how those strategies could be utilized by leaders and managers, but failed to integrate practice managers' perspectives applicable to those strategies or strategies they deploy in a managed-care paradigm, particular in a primary health care setting. The literature review disclosed the scholars' analyses regarding the relationship between decision-making strategies and managed-care alignments, MCOs

functions, primary health care positions, physicians' and patient's interests, leadership styles and LMX, and risk and benefit assessments. As a result of the gap in knowledge, delineating aspects of practice managers' decision-making strategies in a managed-care paradigm is significant for comprehending how they can establish and cultivate a climate of excellence and can add to the health care literature. In Chapter 3, I present the research design and methodology, research description, my role as the researcher, selection of research participants, how I collect, analyze, and report the data, and the data's value.

Chapter 3: Research Method

The purpose of the qualitative exploratory study was to explore practice managers' decision-making strategies as they establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm. Specifically, the purpose of the study was to explore aspects of practice managers' underlying decision-making strategies affecting primary health care, physicians, and patients in a managed-care paradigm. In Chapter 3, I present the research methodology for the study that explores and delineates what, if any, aspects determine how practice managers conceive and implement their decision-making strategies. Guided by Simon's (1960) ideology of decision-making strategies in a management environment, Chapter 3 includes the research design and rationale, role of the researcher, detailed methodology to conduct the study, and issues of trustworthiness. Additionally, I explore and delineate in greater details the research questions, selection of the research participants involved, data collection and analysis procedures, data credibility and reliability, ethical procedures to protect the research participants of the study, and conclude with a summation of overall research methodology utilized during the study.

Research Design and Rationale

Decision-making in health care services is a changing, subjective process based on situational activities that require situational management (Broqvist & Garpenby, 2015; Rissi et al., 2015). The problem addressed in this qualitative exploratory study was a gap in knowledge regarding practice managers' decision-making strategies that affect, or could be perceived to affect, a climate of excellence with business and client

relationships, primary health care, physicians, and patients in a managed-care paradigm. Key research concepts of interest for the study that emerged were aspects of physicians' and patients' expectations, leadership and management attributes, and decision-making attributes in a managed-care paradigm, as detailed in Chapter 2. Data connecting the key research concepts of interest and the research phenomenon are lacking in the health care literature, and current research inquiries are deficient.

The research design for the study was qualitative in nature with an exploratory research strategy of inquiry. I used a qualitative exploratory research design to facilitate an in-depth, rich, detailed methodology to seek understanding of the research phenomenon (Denzin & Lincoln, 2011; Maxwell, 2013; Paulus et al., 2014; Punch, 2014). I created qualitative research questions to elicit practice managers' responses and link their responses to the research problem and purpose of the study, thereby aligning the research design to the phenomenon of the study (Denzin & Lincoln, 2011; Maxwell, 2013; Paulus, Lester, & Dempster, 2014; Punch, 2014). I applied the following overarching research question to elicit practice managers' responses to the research problem:

> Research Question: How do practice managers delineate aspects of their decision-making strategies to establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm?

I used the following subquestions to further probe practice managers' perspectives:

Subquestion 1: How do practice managers delineate aspects of their decision-making strategies affecting primary health care delivery in a managed-care paradigm?

Subquestion 2: How do practice managers delineate aspects of their decision-making strategies affecting physicians in a managed-care paradigm?

Subquestion 3: How do practice managers delineate aspects of their decision-making strategies affecting patients in a managed-care paradigm?

Qualitative exploratory research was appropriate for the study because I conducted 14 face-to-face interviews (n = 2, pilot study; n = 12, main study) utilizing semistructured, open-ended questions with practice managers to elicit their responses regarding how they make decisions. The interviewing process gave practice managers opportunities to describe aspects of their decision-making strategies and describe how aspects of their decision-making strategies can be perceived to affect a climate of excellence with business and client relationships, physicians, and patients in a managed-care paradigm (Irvine et al., 2013; Roulston, 2014). Further, qualitative exploratory research was a rational choice, as it is a practical methodology that is consistently and reliably used for exploring, comprehending, and interpreting research participants in their real-life context (Andres, 2012; Fowler, 2014).

No other research design was plausible to acquire practice managers’ perspectives of decision-making strategies. If I had used a quantitative research design, it would not have delivered the required data. A quantitative research design is considered more appropriate for measuring and delivering statistics or numeric values that could report the

impact of practice managers' decision-making strategies (Maxwell, 2013). I did not manipulate any variables during the study; therefore, quantitative research was not a feasible research design. Executing a qualitative research design provided practice managers opportunities to articulate their thoughts and provide feedback on the research process while elaborating on their perspectives of the research phenomenon (Maxwell, 2013).

Although other qualitative strategies of inquiry could allow practice managers to articulate their thoughts, such as ethnography, grounded theory, case study, narrative, or phenomenological, other factors restricted their usage during the study that included the following:

1. ethnography, for which the research time frame prevented prolonged time in the field setting with practice managers;
2. grounded theory, not appropriate since I was not trying to generate theory or process based on practice managers' perspective;
3. case study, not useful because I did not utilize more than one data collection process;
4. narrative, inappropriate as the desired data did not constitute chronologically ordered stories of practice manager's decision-making strategies; and
5. phenomenological, which was not useful due to the restricted view of the essence of practice managers' experiences in an effort to develop patterns or relationships of decision-making (Maxwell, 2013).

Lerner, Li, and Kassam (2015) emphasized that every decision is made within a decision environment, which is delineated as the collection of information, alternatives, values, and preferences accessible at the time of the decision. In this study, I sought to delineate what activities or processes practice managers undertake to make strategic decisions, and the significance of their decision-making strategies. Deploying qualitative exploratory research was appropriate for the study because aspects of practice mangers' perspectives were revealed and provided a potential bridge for closing the gap in knowledge in the health care literature.

Role of the Researcher

Maxwell (2013) emphasized that the credibility of a qualitative research design hinges on the skills, competence, and rigor of the person doing the fieldwork. Qualitative research design introduces a wide-range of strategic, ethical, and personal issues into the research process (Miles et al. 2014). My role as the researcher for the study included recruiting participates, creating a data collection protocol, collecting the data, coding and analyzing the data, reporting the data, strictly adhering to ethical standards to protect the participates that participated in the study, and managing biases within the study. Foremost, my role consisted of conducting investigative work to identify what aspects were required to complete the study, then, completing the actual fieldwork. Lastly, my role shifted from an investigator to acting as an informer that was required to clearly articulate and report the results of the study while protecting the integrity of the study.

Due to my previous experience with formulating and implementing organizational change, leadership, and management protocols in the health care industry, certain biases

and knowledge were brought into the study and had the potential to threaten the how the fieldwork was conducted and how the data was reported. I remained objective while mitigating biases and did not over compensate with the way data were collected, analyzed, and reported. I did not have any personal or professional affiliations with the practice managers or primary care departments that participated in the study. I informed all research participants involved in the study of my past KSAOs in the health care industry to ensure transparency of my health care leadership and management experience. Although potential biases for the study were acknowledged, as previously mentioned in Chapter 1, I took practical measures to mitigate any bias actions during the study. Practical measures included managing interview techniques, deploying computer assisted data management tools, and vigorously engaging in continuous dialogue with the research participants to assess any concerns during the study.

Methodology

Participant Selection Logic

Due to the nature of a managed-care paradigm and the necessity for strategic decision-making to meet certain expectations, I identified 30 practice managers assigned to primary health care departments in Hampton Roads, Virginia via WebMD’s (2016) public, open-access database as the research participants. I selected practice managers assigned to primary health care departments because they are accountable for interconnecting their organizations’ strategic objectives and physicians’ and patients’ expectations as they lead and manage a managed-care paradigm (Alhaddi, 2015; Arroliga et al., 2014; Melo et al., 2014; Trastek et al., 2014). Strategic decision-making is

considered a cognitive process and practice managers are assumed to be superior leaders and managers in primary health care departments. As a result, practice managers included in the study possess a college degree. All 30 practice managers were prescreened as a condition of hire with their health organizations, therefore meeting the stipulations to be leaders and managers in their primary health care departments and meeting the criteria to be included in the study.

At the designated research locations, I contacted all 30 practice managers via mailed recruitment letters (see Appendix B) and telephone calls to explain the intent of the study and to gage their interests for participation. I obtained all 30 practice managers' office addresses and office phone numbers via their health care organizations' public, open-access websites. Of the 30 practice managers identified, I initially anticipated that 10 to 15 practice managers would be included in the study and the remaining practice managers would be utilized as the reserve. I recruited all 30 practice mangers, and all 30 accepted, as participants in the study. However, due to data saturation, I interviewed 14 practice managers ($n = 2$, pilot study; $n = 12$, main study) that led to an applicable balance and depth of inquiry during data collection. I deployed a homogeneous purposive sampling technique and only recruited and interviewed practice managers assigned to primary health care departments in Hampton Roads, Virginia to be included in the study (Denzin & Lincoln, 2011; Maxwell, 2013; Paulus et al., 2014; Punch, 2014).

Instrumentation

The data collection methodology consisted of deploying an interviewing process that utilized an interview protocol (see Appendix A) as the data collection instrument.

Utilizing the interview protocol, I gained deep, rich knowledge that lead to what aspects influenced practice managers' decision-making strategies and delineated how they conceive and implement their strategic processes in a managed-care paradigm. Also the interview protocol served as a detailed guide that connected the research questions to the research phenomenon and made it possible to explore and delineate practice managers' responses during the data collection process (Denzin & Lincoln, 2011; Maxwell, 2013; Paulus et al., 2014; Punch, 2014). When using a qualitative exploratory research design that involves interviewing situations, the data collection instrument functioned as a series of related activities focused on gathering significant information to answer emerging research questions for purposeful engagements of organizing how research participants could interpret and describe the research phenomenon (Andres, 2012; Fowler, 2014).

In the health care literature, there is no data collection instrument identified that can address the research phenomenon. Therefore, I developed a data collection instrument. Accordingly, when I deployed Simon's (1960) ideology of decision-making strategies in a management environment, key research concepts of interests emerged and proved to be valuable with developing the data collection instrument for the study. Simon believed that decision-making strategies in management are constructed on a succession of exchanges, such as intelligence, design, and choice processes, with respect to bounded rationality/rational choice and exchange processes in a managed-care paradigm. When applying intelligence, design, choice, bounded rationality/rational choice, and exchange processes with aspects of how MCOs function, key concepts emerged. The key research concepts of interest for the study that emerged were aspects of physicians' and patients'

expectations, leadership and management attributes, and decision-making attributes, as detailed in the Literature Review section in Chapter 2.

Using the key research concepts of interest, research questions, and research phenomenon, I framed the interview protocol to be a practical instrument to elicit practice managers' perspectives of the research phenomenon, in particular, when I constructed the interview questions. To address content validity and reliability for the data collection instrument, I conducted a pilot test to verify if the interview protocol could connect the research questions to the research phenomenon and make it possible to explore and delineate practice managers' responses during the data collection process (Denzin & Lincoln, 2011; Maxwell, 2013; Paulus et al., 2014; Punch, 2014). As the interviewer conducting the interviews, I followed the instructions listed on the interview protocol with some flexibility. Incorporating aspects of flexibility with the interview protocol, I offered practice managers additionally opportunities to expound on their perspectives regarding the research questions and other emerging decision-making perspectives in a managed-care paradigm (Denzin & Lincoln, 2011; Maxwell, 2013; Paulus et al., 2014; Punch, 2014). When following the instructions in the interview protocol, I conducted face-to-face interviews utilizing semi-structured, open-ended questions with practice managers. I audio recorded all data collected via the interviews in high definition using a Samsung Note 5 for clarity and accuracy.

Pilot Study

I conducted a pilot study to determine the validity and reliability of the data collection instrument to be used with the main study, which consisted of implementing an

interview protocol (see Appendix A) to collect data. To ethically conduct the pilot study, I obtained IRB approval from Walden University (IRB approval # 06-15-16-0371173). The intent of the pilot study was to verify if practice managers assigned to primary health care departments had the necessary KSAOs to meet certain expectations to attain committed, sustainable, and competent leadership and management attributes that could direct the delivery of quality health care services when making strategic decisions in a managed-care paradigm (Alhaddi, 2015; Arroliga et al., 2014; Melo et al., 2014; Trastek et al., 2014). I used the pilot study to validate if the interview protocol could connect the research questions to the research phenomenon, and if the interview protocol could make it possible to explore and delineate practice managers' responses during the data collection process (Denzin & Lincoln, 2011; Maxwell, 2013; Paulus et al., 2014; Punch, 2014).

To begin the pilot study and collect data from practice managers, I recruited practice managers as described in the Participant Selection Logic section as potential participants for the pilot study. I randomly selected two practice managers from WebMD's (2016) public, open-access database and contacted them via mailed recruitment letters (see Appendix B). I followed up the mail recruitment letters with telephone calls to the practice managers to evaluate their willingness to participate in the pilot study. I obtained both practice managers' office addresses and office phone numbers via their health care organizations' public, open-access websites.

Information included in the mailed recruitment letters comprised the intent of the pilot study, how I would conduct the pilot study, how I would collect and analyze the

data used in the pilot study, how I would report the data included in the main study, the potential for the usage of the data in future publications, and copies of the informed consent forms. Attaching the informed consent forms with the mailed recruitment letters gave the practice managers opportunities to review the pilot study information beforehand. Advance review of the informed consent forms gave the practice managers adequate time to formulate and ask any questions before giving their consent to participate in the pilot study and before conducting their interviews. During the follow up telephone calls, I outlined the same information presented in the mailed recruitment letters and asked both practice managers if they had any questions or concerns regarding the pilot study. This process was used to promote consistency of the recruitment process and to safeguard ethical considerations toward the practice managers during the data collection process. No questions or concerns were reported from the practice managers regarding the pilot study before giving informed consent to participate.

Both practice managers agreed to participate in the pilot study and were assigned pseudonyms PSPM 1 and PSPM 2 as unique identifiers for their data and identity confidentiality considerations. The pseudonym PSPM signified *pilot study practice manager*. PSPM 1, PSPM 2, and I agreed on convenient dates, times, and locations to conduct their interviews that were conducive to their schedules and to provide privacy. Per their requests, PSPM 1 and PSPM 2 were interviewed in their personal offices at their work locations.

I provided PSPM 1 and PSPM 2 copies of the IRB approval letter from Walden University as reassurance that the protection of human subjects was paramount for the

pilot study. Before conducting their interviews, PSPM 1 and PSPM 2 acknowledged that they had adequate time to review their informed consent forms that were attached to the mailed recruitment letters. PSPM 1 and PSPM 2 again reviewed and then signed copies of their informed consent forms that signified their agreements to participate in the pilot study. I reiterated the intent of the pilot study and how I would use the data from the interview questions regarding their decision-making strategies. I was the sole researcher, data collector, data analyst, and data transcriber during the pilot study.

Using the interview protocol, I conducted face-to-face interviews utilizing semi-structured, open-ended questions. Each interview lasted about 60 minutes and was recorded in high definition audio using a Samsung Note 5 recorder for clarity and accuracy. I conducted both interviews on the same day. PSPM 1 and PSPM 2 answered all 19 questions listed on the interview protocol without any concerns. At the end of their interviews, I gave PSPM 1 and PSPM 2 opportunities to provide feedback on the content of the interview protocol, particularly, how I approached them, how I asked the interview questions, the practicality of the interview questions, and how I respected their participation when I collected data.

Additionally, I debriefed the practice managers on the purpose and process of the pilot study and how I would use the data collected. I explained the confidentiality of their participation and how their names would not be attached to any data that were collected, as I assigned pseudonyms to both practice managers as unique identifiers. I transcribed PSPM 1’s and PSPM 2’s responses and provided them with copies of their transcripts to verify the accuracy of their data. I used QSR NVivo 11 CASQDAS to manage PSPM 1’s

and PSPM 2's transcripts. The pilot study yielded effective results without having the need to modify the interview protocol or conduct another pilot study, and the results are further detailed in Chapter 4. I thanked PSPM 1 and PSPM 2 for their time and effort and moved forward with the data collection instrument for use in the main study.

Procedures for Recruitment, Participation, and Data Collection

For the main study, as described in the Participant Selection Logic section, I recruited practice managers via mailed letters and telephone calls. After the practice managers agreed to participate in the main study, I corroborated dates, times, and locations with the practice managers to conduct their interviews and collect data. Per the practice managers' preferences, I scheduled and conducted the interviews in their offices at private locations to assist with establishing confidentiality and providing convenience. I conducted face-to-face interviews utilizing semi-structured, open-ended questions. Each interviewing event lasted about 60 minutes and was audio recorded in high definition using a Samsung Note 5 for clarity and accuracy. I afforded the practice managers as much time as they needed to answer the interview questions or if they sought to expound on their decision-making strategies. Each practice manager was assigned a pseudonym as PM 1 to PM 12 for their data and identity confidentiality considerations. The pseudonym PM signified *practice manager*. I was the sole data collector using the interview protocol (see Appendix A).

The interview protocol was the only data collection instrument used during the study to assist with interviewing practice managers. Once the interviews were completed, and complying with the interview protocol, I debriefed the practice managers on the

purpose and process of the study. I explained how their participation was confidential and that their names would not be attached to any data that were collected. I communicated how I would utilize the data collected and I gave the practice managers additional opportunities to supplement their responses to the interview questions. After their interviews, I followed up with all practice managers to ascertain if they had any additional concerns regarding the data that they provided. No practice manager reported any concerns.

Data Analysis Plan

According to Miles et al. (2014) and Saldaña (2015), qualitative exploratory research should be conducted through intense contact with the research participants to collect the required data and execute content analysis to interpret the data. I used content analysis facilitate an in-depth, rich detailed methodology to delineate and explore the research phenomenon. I followed Miles et al.'s and Saldaña's qualitative content analysis methodologies and connected all data collected via the interview protocol (see Appendix A), based on and linked to the interview questions, to identify, describe, analyze, and interpret any themes and patterns as they emerged. Using Simon's (1960) ideology of decision-making strategies in a management environment (intelligence, design, choice, bounded rationality/rational choice, and exchange processes), emerging data arrived from naturally occurring, ordinary events in a natural setting (Miles et al, 2014). Using Miles et al.'s and Saldaña's methodologies, I was able to inductively yield meaningful results, and their methodologies are detailed further in Chapter 4.

Coding strategy. Miles et al. (2014) considered coding as "prompts or triggers that allows deeper reflection on the data's meaning" (p. 73). I focused on aspects of practice managers' perspectives that were linked to the interview questions during the code assignments. Saldaña's (2015) described content analysis codes as single words or phrases with summative, salient, essence-capturing, and/or suggestive attributes for a portion of language-based data. Utilizing Miles et al.'s and Saldaña's methodologies, I assigned the codes in two coding cycles: in vivo coding and pattern coding. Throughout in vivo coding, the first cycle, I evaluated and coded the data that corresponded to how practice managers consistently articulated similar words or short phrases during the data collection process. This process was resourceful for signifying regularities or patterns from the data (Miles et al.; 2014; Saldaña, 2015). I used in vivo coding to assist with initially summarizing large segments of the data, and the second cycle, pattern coding, to group those summaries into a smaller number of emerging categories and themes (Miles et al.; 2014; Saldaña, 2015). I used the pattern codes as explanatory or inferential codes, and the codes helped when I linked the units of analysis (Miles et al.; 2014; Saldaña, 2015).

Coding software. I deployed QSR NVivo 11, a CASQDAS product, to assist with content analysis. I used QSR NVivo 11 as a data management tool because it has the capability to assist with organizing copious amounts of qualitative information, such as data assembly, data storage, data recording of field notes, interview transcripts, audio recordings of interviews, and other pertinent documents related to content analysis (Paulus et al., 2014). Miles et al. (2014) and Saldaña (2015) argued that the use of any

CAQDAS product is vital to qualitative research, as it can provide the researcher with insight into qualitative data sets, such as categorizing, emerging patterns and themes, and when assigning codes for data interpretation, without assigning meaning to any data that are integrated into the software. QSR International (2016), creator of QSR NVivo 11, asserted that their CAQDAS product can help researchers manage, shape, share, and make sense of any unstructured data through smarter insights, better decisions, and effective outcomes. However, they acknowledged that QSR NVivo 11 does not do the thinking for the researcher, but it does provide a workspace and tools for researchers to easily work with data integrated into the software. The CAQDAS provided support when I moved large segments of data into smaller segments of categories and themes.

Issues of Trustworthiness

Credibility

Maxwell (2013) and Patton (2015) noted that the credibility of qualitative research hinges on three distinct, but related aspects: rigorous methodologies for doing the fieldwork that yields high-quality data, credibility of the researcher, and philosophical belief in the value of the qualitative research. To establish credibility and value for the study, I meticulously managed all aspects of conducting qualitative exploratory research by thoroughly collecting, analyzing, interpreting, and reporting the data with the research phenomenon, per Miles et al.'s (2014) and Saldaña's (2015) qualitative content analysis methodologies. Before I collected any data for the study, I conducted a pilot study, as described in the Pilot Study section, to authenticate if the data collection instrument was applicable for yielding credibility data relating to the research questions. After validating

the suitability of the data collection instrument, I devoted a significant amount of time with the practice managers when I conducted their interviews to ensure that I could competently capture their perspectives of the research phenomenon. Once I attained informed consent from the practice managers, I recorded their interviews in high definition audio to assist with clarity of the raw data collected and for accuracy when I transcribed and coded their data. I conducted enough interviews to reach a saturation level. After each interview, I transcribed the data and provided all practice managers with copies of their transcripts for their reviews and approvals to ensure that I accurately documented their perspectives. The practice managers' reviews and approvals processes served a mechanism of transparency for the data collected.

To further transparency and credibility, as the data collector and data coder, I strictly adhered to the data collection protocol for gathering data during interviewing to assist with precise coding assignments and data interpretations. I expounded on the data collection and coding processes to the practice managers. Lastly, as a matter of including reflexivity when recognizing my own biases, as highlighted in the Role of the Researcher section, I acknowledged my professional experiences and KSAOs in the health care industry, and I conveyed this information to the practice managers before I collected data.

Transferability

Maxwell (2013) and Patton (2015) asserted that external validity, referred as transferability, for qualitative research can be demonstrated by effectively providing complete data sets and rich, thick descriptions that can allow other researchers to apply the same research design to different settings or other contexts. I sought to explore and

delineate practice managers' decision-making strategies that affect, or can be perceived to affect, a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm. In the United States, establishing and cultivating a climate of excellence with business and client relationships while striving for successful outcomes are necessary objectives in any organization. In all business entities, organizations strategically deploy leadership and management teams to attain their business objectives.

As rationalized in the Research Design and Rationale section, transferability to other studies is possible if other scholars adhered to the research methodology, with some flexibility as applicable for diverse settings, such as having comprehensive research participant selection logic, utilizing an effective data collection instrument, and applying a suitable data analysis plan. Additionally, my research methodology could serve as a roadmap for other scholars to mimic when conducting similar qualitative exploratory research in any industry regarding exploring and delineating decision-making strategies. I produced complete data sets and provided rich, thick descriptions that could allow other scholars to apply the same research design to different settings or other contexts. I expect that my study could serve as a paradigm for other researcher to follow, and it could transfer and lend decision-making strategies to other industries with a leadership and management emphasis.

Dependability

Maxwell (2013) and Patton (2015) described dependability in qualitative research as establishing the reliability and consistency of the study process. Additionally, their

studies highlighted that the primary methodology for establishing dependability is through audit trails of the research processes and findings. As mentioned in the Pilot Study section, I initially assessed dependability when I deployed the pilot study to determine the validity and reliability of the data collection instrument. The need to gain practice managers' perspectives of their decision-making strategies constituted the validity of the pilot study, as their perspectives were grounded on the feedback received with regards to the interview protocol. Dependability of the practice managers' feedback verified the reliability of the pilot study and confirmed how to move forward with the main study. To increase reliability, I created an audit trail of all data provided from the practice managers and other notes and reflexivity journal data that I used during the pilot study.

Additionally, I integrated member checking and reviewed how I coded the data throughout the data collection and content analysis process, in particular during the main study. Implementing member checking assisted with providing transparency and it gave practice managers further opportunities to articulate their thoughts and elaborate on their perspectives regarding decision-making strategies (Maxwell, 2013). Continuous review of data coding also supported transparency by means of identifying and eliminating any discrepancies during the data collection and content analysis process. Again, to increase reliability in the main study, I created an audit trail of all data provided from the practice managers and corrected all discrepancies discovered during the coding review.

Confirmability

Maxwell (2013) and Patton (2015) posited that when scholars conduct research in an interpretive paradigm, confirmability of data results, noted as objectivity, should be grounded on trustworthiness and authenticity that focuses on neutrality. The scholars also emphasized that the confirmability of the data results should be able to be confirmed by other scholars that read or review the research results. I have confidence that my study achieved confirmability because I remained neutral of the data collection process and I did not place any judgements on the practice managers' perspectives that they provided. I also recognized my past experiences in the health care industry. I ensured that I did not let aspects of my personal values, beliefs, or interests influence the outcome of the study.

Ethical Procedures

Paulus et al. (2014) and Punch (2014) emphasized the importance of gaining access to the research site and research participants. Additionally, the scholars underlined the significance of protecting human subjects involved in the study and adhering to all ethical considerations essential for conducting respectable, trustworthy research. I obtained IRB approval from Walden University (IRB approval # 06-15-16-0371173) to ensure that I complied with all ethical considerations indispensable for completing my study. As explained in the Participant Selection Logic and the Procedures for Recruitment, Participant, and Data Collection sections, I identified primary health care departments in Hampton Roads, Virginia as the research locations, and I identified and recruited practice managers assigned to those primary health care departments as the research participants. I provided the practice managers copies of the IRB approval letter

from Walden University for their review, as it assisted with reassuring that the protection of human subjects was paramount for the study.

I upheld the ethical principles of the National Institutes of Health's Office of Extramural Research (2016) to protect the practice managers' human rights that included respect for persons, beneficence, and justice. I contacted all practice managers via mailed recruitment letters (see Appendix B) and telephone calls to explain the intent of the research and to gage their interests for participation in the study. The mailed recruitment letters consisted of the intent of the study, how I would conduct the study, how I would collect and analyze the data, how I would report the data in the study, and the potential for the data usage in future publications. As a follow up to the mailed recruitment letters, I contacted the practice managers via telephone calls and outlined the same data presented in the mail recruitment letters and to inquiry if they have any questions or concerns regarding the intent of the study.

Practice managers who agreed to participate in the pilot study and the main study gave informed consent that allowed me authorization to audio record and transcribe their interviews. In the informed consent, I outlined the intent of the study, how I would conduct the study, how I would collect and analyze the data, how I would report the data in the study, and the potential for the data usage in future publications. In the informed consent, I also included a statement that explained under no circumstances, the practice managers were not obligated to participate in the study, not obligated to have their data used in the study, and/or they have the right to withdraw from the study at any time. No practice managers refused or withdrew from the study.

I assigned a pseudonym to each practice manager as a unique identifier to assist with data and participant confidentiality. I secured all data collected via locked and encrypted computer hard drive storage in a private location. All data was backed-up via locked and encrypted commercial cloud storage maintained by a private vendor. As the researcher and transcriber of the data, I was the only individual who had access to the data collected. I will store all data for 5 years, as described in the informed consent, and then destroy all data collected. The practice managers was instructed, at any time during the 5-year storage time frame, they can request copies of the data that they provided.

Summary

Through alignment of the research problem, the purpose of the study, and the research questions, I determined that utilizing a qualitative exploratory research design was the most advantageous methodology to acquire the practice managers' perspectives and to analyze all emerging data. The core of the research methodology centered on designing a meticulous process to ascertain applicable data for exploring and delineating practice managers' responses regarding their decision-making strategies that affect, or can be perceived to affect, a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm. In the health care industry, particularly in primary health care departments, practice managers make strategic decisions to ensure that their health care organizations can operate effectively. I took those aspects into consideration when I designed the research methodology.

In Chapter 3, guided by Simon's (1960) ideology of decision-making strategies in a management environment, I described the research design and rationale for the research

design, role of the researcher, methodology for conducting the study, and issues of trustworthiness and how it was addressed. Additionally, I explored and delineated how the research problem, the purpose of the study, and the research questions were utilized as the foundation for how I selected the research participants, how I collected and analyzed the data, and how I attained data credibility and reliability. Finally, I addressed the ethical procedures for protecting the practice managers and their data used for the study. In Chapter 4, I report the results from executing the research methodology in greater details.

Chapter 4: Results

The study consisted of two phases, a pilot study and a main study. The purpose of the qualitative exploratory study was to explore practice managers' decision-making strategies as they establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm. Specifically, the purpose of the study was to explore aspects of practice managers' underlying decision-making strategies affecting primary health care, physicians, and patients in a managed-care paradigm. Chapter 4 includes aspects of the pilot study, research setting, demographics of the research participants, data collection, data analysis, evidence of trustworthiness, final study results, and concludes with a summation of how the research questions related to the emerging themes.

The problem addressed in this study was a gap in knowledge regarding practice managers' decision-making strategies that affect, or could be perceived to affect, a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm. To address the gap in knowledge, I used aspects of Simon's (1960) ideology of decision-making strategies in a management environment to develop research questions, guide the study, and deliver results structured on the practice managers' perspectives. I applied the following overarching research question to elicit practice managers' responses to the research problem:

> Research Question: How do practice managers delineate aspects of their decision-making strategies to establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm?

I used the following subquestions to further probe practice managers' perspectives:

Subquestion 1: How do practice managers delineate aspects of their decision-making strategies affecting primary health care delivery in a managed-care paradigm?

Subquestion 2: How do practice managers delineate aspects of their decision-making strategies affecting physicians in a managed-care paradigm?

Subquestion 3: How do practice managers delineate aspects of their decision-making strategies affecting patients in a managed-care paradigm?

Pilot Study

Before moving forward with the study, I conducted a pilot study to determine the validity and reliability of the data collection instrument to be used with the main study, which consisted of implementing an interview protocol (see Appendix A) to collect data. I used the pilot study to validate if the interview protocol could connect the research questions to the research phenomenon, and if the interview protocol could make it possible to explore and delineate practice managers' responses, labelled as PSPM 1 and PSPM 2, during the data collection process (Denzin & Lincoln, 2011; Maxwell, 2013; Paulus et al., 2014; Punch, 2014). At the conclusion of PSPM 1's and PSPM 2's interviews, I debriefed them on the purpose and process of the pilot study, how I would use the data collected, transcribed their responses to the interview questions, provided them with copies of their transcripts to verify the accuracy of the data that they provided, and gave them opportunities to provide feedback on the interview protocol.

PSPM 1 and PSPM 2 reviewed their transcripts and confirmed that the data I collected were accurate accounts of their responses. They agreed that the content of interview protocol appeared logical and acknowledged that the interview questions were clear, easy to understand, and practical for eliciting responses for the research phenomenon. PSPM 1 disclosed that the interview questions were “comprehensive and thought-provoking,” “precisely-focused on managed-care issues,” and “assessed my ability as a leader.” PSPM 2 articulated that the interview questions were “practice manager-focused,” “decision-making-oriented,” and “straight to the point.”

Based on the results of the pilot study, I moved forward with the data collection instrument to be used in the main study, as the feedback from the pilot study confirmed that the data collection instrument was appropriate for the study. The need to gain PSPM 1’s and PSPM 2’s perspectives of their decision-making strategies constituted the validity of the pilot study based on their feedback regarding the interview protocol. Dependability of PSPM 1’s and PSPM 2’s feedback verified the reliability of the pilot study. No changes to the data collection instrument were necessary.

Research Setting

The research setting for the pilot study and main study was situated in a metropolitan area in the United States called Hampton Roads, Virginia. The practice managers for the study were professional leaders and managers whose names were acquired from a professional medical website. I strictly adhered to the interview protocol and offered to schedule the practice managers’ interviews in private locations, both on campus at their health care organizations or off campus in the local area, to assist with

establishing confidentiality and providing convenience. All practice managers were interviewed and appeared comfortable while being interviewed at their work locations. In fact, eight of the practice managers acknowledged appreciation for having opportunities to give their perspectives regarding decision-making strategies in a managed-care paradigm. All practice managers were very engaging during their interviews and no personal or organizational conditions were perceived to have an influence on how they responded to the interview questions. As a result, the conditions for collecting the practice managers' data were not impaired and were well received.

Demographics

I deployed a homogeneous purposive sampling technique and only recruited and interviewed practice managers assigned to primary health care departments in Hampton Roads, Virginia (Denzin & Lincoln, 2011; Maxwell, 2013; Paulus et al., 2014; Punch, 2014). As noted in the Pilot Study section, 30 practice managers were assigned to primary health care departments in Hampton Roads, Virginia. However, the research participants for the main study consisted of 12 practice managers, labelled as PM 1 to PM 12. I proposed to interview 10 to 15 practice managers for the main study. I selected 15 practice managers as research participants on a first-come, first-selected basis, as they replied to the recruitment invitations. However, data saturation was achieved after interviewing 10 practice managers. I conducted two additional interviews as a safeguard to ensure consistency of the data collection process

Based on data indicated on the practice managers' organizational websites, all 12 practice managers had extensive education, training, and work experience in primary

health care departments (see Table 4). The practice managers had substantial, practical collaborations with physicians, patients, and MCOs when they led and managed primary health services in a managed-care paradigm. Each practice manager had at least 15 years working in the specialty. All 12 practice managers were college educated and had at least a bachelor's degree in management or business administration with a specialization or additional training in health care management. Four practice managers had bachelor's degrees only and they were enrolled in master's degree programs. Seven practice managers received their master's degrees and two of them were enrolled in doctoral degree programs. One practice manager had a doctoral degree. All 12 practice managers were board certified as practice managers. Six practice managers were Lean Six Sigma certified, two of them Black Belts and four Green Belts.

Table 4

Practice Managers' Demographics for the Main Study

Qualifications	Practice Managers
Education, Training, & Experience	Research Participants (*n*)
College degree	12
Bachelor's degree only	4
Master's degree	7
Doctoral degree	1
Enrolled in master's degree program	4
Enrolled in doctoral program	2
Board certified practice manager	12
Lean Six Sigma certified	6
Black Belt	2
Green Belt	4
15 years of work experience	12
15+ years of work experience	7
20+ years of work experience	5

Note. Research participants for the main study were $n = 12$.

Although specific gender selection was not a requirement for the study, six practice managers were females and six practice mangers were males. Practice mangers were selected by the order that they responded to the study's recruitment letters (see Appendix B). The gender equilibrium did afford an equitable gender perspective of the research phenomenon and unintentionally reduced the effects of gender bias.

Data Collection

I conducted data collection for the main study utilizing the same approach as the pilot study, such as providing copies of the informed consent forms, providing copies of the IRB approval letter from Walden University, giving adequate time to review the consent forms, explaining the intent of the main study, and explaining how the data would be used. I collected data using the interview protocol's interview questions, based on and linked to, the research questions (see Table 5). Each interview lasted about 60 minutes and was recorded in high definition audio using a Samsung Note 5 recorder for clarity and accuracy. PM 1 to PM 12 answered all 19 questions listed on the interview protocol without any concerns. All 12 interviews were conducted within a 15-day time frame. I was the sole researcher, data collector, data analyst, and data transcriber during the main study.

Table 5

Linking Research Questions to Interview Questions

Research Questions	Interview Questions
Overarching Research Question	
How do practice managers delineate aspects of their decision-making strategies to establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm?	Section 1: What does it mean to establish and cultivate climate of excellence in health care organizations? Items: 1a, 1b. Section 2: What does it mean to deploy a managed-care paradigm at your health care organization? Item: 2a, 2b.
Subquestions	
1. How do practice managers delineate aspects of their decision-making strategies affecting primary health care delivery in a managed-care paradigm?	Section 3: Why is primary health care important when deploying a managed paradigm at your health care organization? Items: 3a, 3b, 3c, 3d.
2. How do practice managers delineate aspects of their decision-making strategies affecting physicians in a managed-care paradigm?	Section 4: Why are physicians important to primary health care departments at your health care organization when deploying a managed-care paradigm? Items: 4a, 4b, 4c.
3. How do practice managers delineate aspects of their decision-making strategies affecting patients in a managed-care paradigm?	Section 5: Why are patients important to primary health care departments at your health care organization when deploying a managed-care paradigm? Items: 5a, 5b, 5c.

Note. Sections of the interview questions that links directly to the interview protocol.

At the conclusion of the main study's interviews, I strictly adhered to the same standards utilized during the pilot study. The standards include debriefing practice managers on the purpose and process of the main study, how I would use their data collected, transcribing their responses to the interview questions, providing them with copies of their transcripts to verify the accuracy of the data that they provided, and giving them additional opportunities to supplement their responses to the interview questions. I reminded each practice manager that I would follow up with them if other information was needed, which was not necessary. I used QSR NVivo 11 CASQDAS as a data

management tool for PM 1 to PM 12's transcripts and other field notes and reflexivity journal data. Lastly, I thanked PM 1 to PM 12 for their time and efforts for participating in the main study, as they completed the data collection process without incident. The data collection process did not vary nor have any unusual circumstances from the planned research methodology presented in Chapter 3.

Data Analysis

To analyze the main study's data, I strictly adhered to Miles et al.'s (2014) and Saldaña's (2015) qualitative content analysis methodologies. Miles et al.'s and Saldaña's qualitative content analysis methodologies assisted with inductively yielding meaningful results from raw data that emerged from natural/ordinary occurring events in a natural setting, such as those found in a managed-care paradigm, as described by the practice managers. Merging their methodologies with a data management tool, in particular QSR NVivo 11 CASQDAS, I organized copious amounts of qualitative raw data based on practice managers' responses to the interview questions. I identified, described, analyzed, and interpreted codes, categories, patterns, and themes as they emerged. Based on the practice managers' responses to the interview questions, I used a two cycle coding strategy that included in vivo coding and pattern coding to assist with analyzing the data. Miles et al. and Saldaña noted in vivo coding and pattern coding as well-known coding strategies used in qualitative research and they are primarily used by novice researchers.

In vivo Coding

Throughout the in vivo coding strategy, the initial coding assignments were a continuous heuristic process (see Figure 3). After transcribing the practice managers' data

and completing their review process for accuracy of data collected, I reevaluated the transcripts to develop an appreciation of their perspectives before I assigned codes. Miles et al. (2014) and Saldaña (2015) recommended this process, as it can assist with close examinations of data and compare for relationships, similarities, and dissimilarities. To build the initial data sets, the code assignments were symbolic of how practice managers consistently articulated similar words or short phrases during the data collection process. I assigned NVivo codes after sorting and linking segments of practice managers' own language extracted from their interview transcripts to form nodes into broad categories of nodes. I uploading the practice managers' transcripts into QSR NVivo 11 CASQDAS and initially performed a word frequency query. This was used to detect repetitively stated words or phrases in the data that were associated with the interview questions and the research questions. Finally, I re-examined the transcripts for concepts, not repetition.

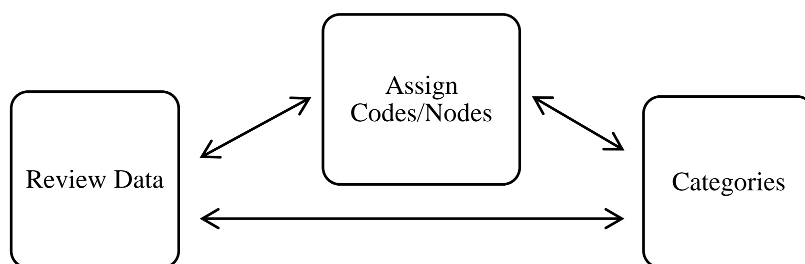

Figure 3. In vivo coding strategy using a heuristic process for initial assignments of codes and nodes.

To begin the word-frequency query and obtain results, I initially established the boundaries for frequent words or phrases collected as the top 20 repetitive words or phrases associated with the research questions. This process was used to counteract capturing any irrelevant data sets in the initial query. The initial query (see Table 6 to

Table 9) established the first round of NVivo codes. The NVivo codes indicated that practice managers held high regards toward attributes of leadership and management expectations, attitudes and behaviors, and rendering effective outcomes in a managed-care paradigm. Aspects of those attributes were frequently cited and coded when the practice managers noted how they establish and cultivate a climate of excellence with business and client relationships, such as “positive thinker” (3.7%), “role model” (3.5%), “team building” (3.2%), and “trusted” (3.1%). The query report specified that practice managers frequently articulated that “initial contact” (5.2%), “collaboration” (5.1%) and “communication” (5.0%) were paramount for effective delivery of primary health care in a managed-care paradigm. When it came to leading and managing physicians, the query report identified that practice managers’ relationships with physicians under their span of control appeared mixed, as frequent responses were itemized as having “professionalism” (4.4%), using “power and authority” (4.3%), being “territorial” (4.2%), engaging in “collaborative partnership” (4.2%), and being “tactful and respectful” (4.2%). Lastly, the report calculated that aspects of patients’ health care were significant in a managed-care paradigm, as practice managers frequently verbalized the importance of “continuity of care” (6.0%), “providing excellent care” (5.9%), and rendering “community services” (5.5%).

Table 6

Overarching Research Question: Initial Data Nodes from Frequency Words or Phrases

Overarching Research Question			
Word Frequency	% of Responses	Word Frequency	% of Responses
"Positive thinker"	3.7	"Loyal to organization"	2.5
"Role model"	3.5	"Loyal to employees"	2.5
"Team building"	3.2	"Loyal to employees"	2.5
"Sets the example"	3.2	"Make things happen"	2.3
"Trusted"	3.1	"Ensuing fairness"	2.2
"Interpersonal relationships"	3.0	"Being supportive"	2.2
"Well versed on diversity"	2.9	"Goal alignment"	2.0
"Knowledgeable"	2.8	"Reduces barriers"	1.8
"Being respectful"	2.8	"Access to care"	1.5
"Set goals"	2.7	"Flexibility"	1.2

Note: Overarching research question: How do practice managers delineate aspects of their decision-making strategies to establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm? Percentage of responses is calculated from the total word count of the all practice managers' responses.

Table 7

Subquestion 1: Initial Data Nodes from Frequency Words or Phrases Query

Subquestion 1			
Word Frequency	% of Responses	Word Frequency	% of Responses
"Initial contact"	5.2	"Providing consultations"	2.9
"Collaboration"	5.1	"Competent staff members"	2.8
"Communication"	5.0	"Sick calls"	2.5
"Keeps order"	4.7	"Ask-a-Nurse"	2.5
"Minimizes risks"	4.5	"Same-day-appointments"	2.5
"Establishes control"	4.5	"Payment schedules"	2.2
"Being cost effective"	4.4	"Customer service"	2.1
"Putting patients first"	4.3	"Health care experiences"	2.1
"Partnerships w/stakeholders"	3.5	"Competent care"	1.9
"Seeing the big picture"	3.0	"Feeling welcome"	1.7

Note. Subquestion 1: How do practice managers delineate aspects of their decision-making strategies affecting primary health care delivery in a managed-care paradigm? Percentage of responses is calculated from the total word count of the all practice managers' responses.

Table 8

Subquestion 2: Initial Data Nodes from Frequency Words or Phrases Query

Subquestion 2			
Word Frequency	% of Responses	Word Frequency	% of Responses
"Health care professionalism"	4.4	"Subject matter experts"	3.0
"Power and authority"	4.3	"Set boundaries"	2.7
"Collaborative partnership"	4.2	"Role restrictions"	2.7
"Territorial"	4.2	"Tasks and responsibilities"	2.6
"Tactful and respectful"	4.2	"Policy focused"	2.4
"Learning opportunities"	3.5	"Procedural focused"	2.4
"Aligns with mission/vision"	3.5	"Climate and culture"	2.0
"Private and confidentiality"	3.3	"Having constant contact"	1.8
"Position of obligations"	3.3	"Mentorship"	1.7
"Special sensitive needs"	3.1	"Aggressive"	1.5

Note. Subquestion 2: How do practice managers delineate aspects of their decision-making strategies affecting physicians in a managed-care paradigm? Percentage of responses is calculated from the total word count of the all practice managers' responses.

Table 9

Subquestion 3: Initial Data Nodes from Frequency Words or Phrases Query

Subquestion 3			
Word Frequency	% of Responses	Word Frequency	% of Responses
"Continuity of care"	6.0	"Greatest good and amount"	3.9
"Providing excellent care"	5.9	"Productivity"	3.8
"Community services"	5.5	"Financial planning"	3.7
"Social involvement"	4.9	"Social responsible"	3.7
"Cost effectiveness"	4.7	"Managing cost"	3.5
"Patient-focused"	4.6	"Supportive"	3.2
"Encouraging"	4.5	"Partnership"	3.1
"Communication"	4.5	"Collaboration"	3.1
"Managing behaviors"	4.0	"Persuasion"	3.0
"Situational assessment"	4.0	"Building trust"	2.5

Note. Subquestion 3: How do practice managers delineate aspects of their decision-making strategies affecting patients in a managed-care paradigm? Percentage of responses is calculated from the total word count of the all practice managers' responses.

Next, I used a more focused process and established the second round of in vivo codes by re-reading passages of the practice managers' responses for additional analysis. Based on the practice managers' own words, I examined the passages for similarities of concepts from practice managers' thoughts and ideals that did not necessary denote any

particular repetition of words or phrases. I created memos that centered on distinctive stories, events, and experiences, as articulated by the practice managers, when they delineated their perspectives of the research phenomenon. Although some new codes were formed as nodes and some codes overlapped from the initial data presented in the above word frequency query, the second round of in vivo coding did provide further insight to the data. Other similarities of concepts in the passages were cited and coded in QSR NVivo 11 CASQDAS as follows:

1. establish and cultivate a climate of excellence: “experience,” “approachable,” “communication,” “caring,” “trustworthy,” “openness,” “honesty,” “takes ownership” “sincere,” and “dedicated;”
2. decision-making strategies affecting primary health care delivery: “cost containment,” “organization,” “adaptability,” “supportive,” “working with others,” “instills value,” “sharing,” and “guidance;”
3. decision-making strategies affecting physicians: “teamwork,” “mutual respect.” “leadership and management,” “professional interaction,” “logical thinking,” “continuous contact,” “mentorship,” “micro-managing;” and
4. decision-making strategies affecting patients: “quality of care,” “continuity of care,” “collaboration,” “empowerment,” “social accountability,” and “value.”

Coding assignments from the initial word frequency query and focused process assisted with identifying the initial data nodes by summarizing large segments of data. Using this process, I was able to move forward to the next coding cycle, pattern coding.

Pattern Coding

Throughout the pattern coding strategy, building categories and themes was a continuous heuristic process (see Figure 4). Integrating pattern coding was used as a way of grouping those summaries of large segments of data into smaller groups of categories and themes based on their common properties (Miles et al., 2014; Saldaña, 2015). Using QSR NVivo 11 CASQDAS to create meta-codes of categories and themes, I captured practice managers' perspective that detailed causes/explanations, relationships, and potential theoretical constructs of the research variables to the research phenomenon.

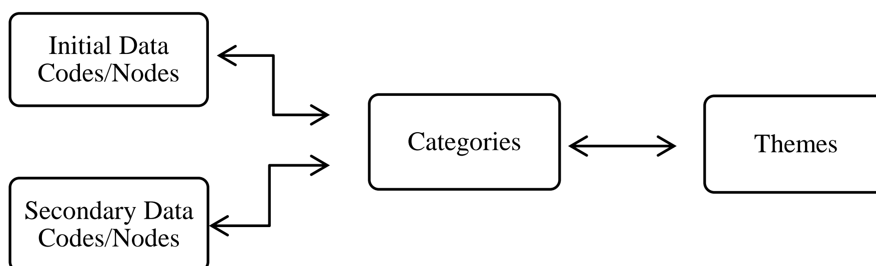

Figure 4. Pattern coding strategy using a heuristic process for building categories and themes.

After I repeatedly examined the codes, I moved the similar codes into categories of nodes. As revealed during the In vivo Strategy section, concepts such as attributes of leadership and management expectations, attitudes and behaviors, and rendering effective outcomes in a managed-care paradigm were visualized, then emerged as categories in the initial round of coding. When incorporating the second round of coding with aspects of the first round of coding, additional categories emerged as attributes of communication, teamwork, respect, strategic alignment, diversity, and social and capital responsibilities.

Next, I reviewed Simon's (1960) ideology of decision-making strategies in a management environment, the conceptual framework that guided the study, to explore

and connect the emerging categories to aspects of the research questions and research phenomenon. This strategy was advantageous for continuously identifying and expanding categories while unifying other data for further analysis (Maxwell, 2013; Patton, 2015). After several additional analyses of the data nodes, no other categories emerged from a review of the practice managers' perspectives and I identified four themes related to the research questions and the research phenomenon guided by the conceptual framework (see Table 10).

Table 10

Emerged Categories and Themes from Analyses of Data Nodes

Conceptual Framework	Categories	Themes
Intelligence	Leadership and management	Change agent
Design	Attitudes and behaviors	Interactions
Choice	Results oriented	Partnerships
Bound Rationality	Communication	Accountability
Rational Choice	Team work	
Exchanges	Respect	
	Strategic alignment	
	Diversity	
	Social responsibility	
	Capital responsibility	

Note. Results after two cycle coding: in vivo coding and pattern coding

No discrepant issues were noted during the data analysis process. QSR NVivo 11 as a data management tool proved valuable because it assisted with organizing copious amounts of qualitative information, such as data assembly, data storage, data recording of field notes, interview transcripts, audio recordings of interviews, and other pertinent documents related to content analysis (Paulus et al., 2014). I concluded that the data collected represented an accurate account of all 12 practice managers' perspectives that were used during the data analysis process.

Evidence of Trustworthiness

Credibility

Respecting Maxwell's (2013) and Patton's (2015) strategies for credibility qualitative research as described in Chapter 3, such as rigorous fieldwork, researcher's credibility, and generating valuable data, I meticulously managed all aspects of the study. Initially, I conducted a pilot study and verified that the data collection instrument (see Appendix A) was appropriate for generating credibility data relating to the research questions and the research phenomenon when I interviewed the practice managers. During the pilot study and the main study, I devoted a substantial amount of time with all practice managers during the interviewing process to capture their perspectives of the research phenomenon, as I recorded their responses to the interview questions for accuracy. I conducted an extensive amount of interviews to gain deep, rich knowledge and to attain data saturation. All practice managers were provided copies of their transcripts for their review and approval. This process was used to ensure that I accurately documented their perspectives and to enhance aspects of transparency during data collection and data analysis.

To further enhance transparency, I strictly adhered to the data collection protocol for gathering data during interviewing and followed Miles et al.'s (2014) and Saldaña's (2015) methodologies for coding to assist with precise assignments of data codes. Since I was the sole researcher, data collector, data analyst, and data transcriber, I explained the data collection and coding processes to the practice managers to confirm that they understood the process. Lastly, as a matter of reflection and recognizing my own biases, I

emphasized my professional experiences and KSAOs in the health care industry to the practice managers to mitigate any influences on the conclusion of the study. No adjustments were necessary to the credibility strategies as described in Chapter 3.

Transferability

Preserving Maxwell's (2013) and Patton's (2015) assertion that external validity, referred as transferability, can be demonstrated by effectively providing complete data sets, I applied transferability methodologies by assigning rich, thick descriptions of the data collected, analyzed, and reported. The transferability methodologies included integrating a qualitative research design by conduct face-to-face interviews utilizing semi-structured, open-ended questions with practice managers. Organizations in the United States strategically deploy leadership and management teams to attain their business objectives. Gaining practice managers' perspectives of their decision-making strategies could allow other researchers to apply the same research design to different settings or other contexts. I debriefed practice managers after their interviews, provided them with copies of their transcripts for review of accuracy of data collected, and gave them opportunities to provide feedback of the data collection process to assist with building complete, descriptive data sets during data analysis. With some flexibility for diverse settings, such as participant selection logic, data collection instrument used, and applying a suitable data analysis plan, the research methodology that I incorporated in the study can serve as a roadmap for other scholars to mimic in other industries with a leadership and management emphasis. No adjustments were necessary to the transferability strategies as described in Chapter 3.

Dependability

Maxwell (2013) and Patton (2015) described dependability in qualitative research as establishing the reliability and consistency of the study process. I confirmed dependability by conducting a pilot study and verified the validity and reliability of the data collection instrument (see Appendix A). Practice managers' perspectives of their decision-making strategies validated the pilot study by means of their feedback regarding the interview protocol. Dependability of the practice managers' feedback authenticated the reliability of the pilot study and allowed the main study to move forward. I created an audit trail of all data provided from the practice managers and documented other notes and reflexivity journal data that I used during the pilot study. With the main study, I integrated member checking and a review of the data to give practice managers opportunities to articulate their thoughts and elaborate on their decision-making strategies. These methodologies were used to demonstrate the reliability and consistency of the data collection and data analysis process. I continuously reviewed how I coded data. I created an audit trail of practice managers' perspectives and discrepancies noted during the coding review. No adjustments were necessary to the dependability strategies as described in Chapter 3.

Confirmability

Maxwell (2013) and Patton (2015) emphasized that confirmability in research should be interpreted as the researcher remaining objective and the study should be grounded on trustworthiness and authenticity that focuses on neutrality. To strengthen confirmability, I recognized my past experiences in the health care industry and I did not

let my personal values, beliefs, or interests influence the outcome of the study. I remained neutral of the data collection process and I did not place any judgements on the practice managers' perspectives that they provided. Practice managers had opportunities to review the data collection and data analysis process and provide feedback. The dissertation review committee members assessed the neutral content of my final dissertation product and how I objectively presented the study. No adjustments were necessary to the confirmability strategies as described in Chapter 3.

Study Results

The problem addressed in this study was a gap in knowledge regarding practice managers' decision-making strategies that affect, or can be perceived to affect, a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm. The purpose of the qualitative exploratory study was to explore practice managers' decision-making strategies as they establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm. Specifically, the purpose of the study was to explore aspects of practice managers' underlying decision-making strategies affecting primary health care, physicians, and patients in a managed-care paradigm.

To deliver the study results, the discoveries are organized by the emerged themes as they align to the research questions (see Figure 5) that developed from the data analysis. Excerpts from the practice managers' transcripts are presented under the associated themes that link the research questions to the research phenomenon. The study

results are reported to bridge the gap in knowledge regarding practice managers' decision-making strategies.

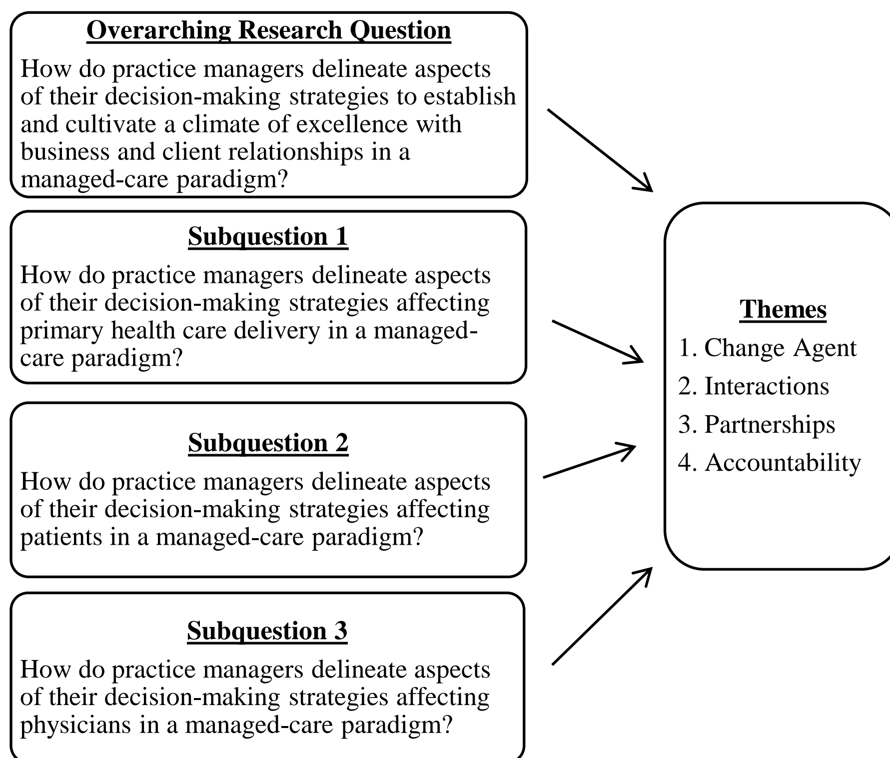

Figure 5. Emerged themes as they align to the research questions and the research phenomenon.

Overarching Research Question

The overarching research question was: How do practice managers delineate their decision-making strategies to establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm? Utilizing qualitative content analysis, I report the four emerged themes to the overarching research question: change agent, interactions, partnerships, and accountability. The results explore practice managers' perspectives of decision-making strategies by means of intelligence, design,

and choice processes, with respect to bounded rationality/rational choice and exchange processes in a management environment, in particular a managed-care paradigm.

Theme 1: Change agent. This theme incorporates how practice managers viewed the need to improve their organizational structure to gain a competitive edge in the health care industry. All 12 practice managers agreed that having the best health care system in place was a very important aspect of their business goals and operations by providing the highest quality health care services possible. They emphasized that having a competitive edge involves knowing when and how to make changes to their organizations' mission statements and value codes that can enhance productivity in business operations. Having a marketable health care organization necessitates that practice managers

> continuously introduce aggressive and effective methodologies that can take care of all stakeholders' requirements that are necessary to sustain an effective health care system and to be the cornerstone of delivering excellence health care services to patients. Also it is important to keep those that provide the services to patients motivated and enthusiastic about changes. To make that happen in primary health care requires constantly changes to cultivate a climate of excellence. (PM 5)

PM 1 articulated that "making constant changes are [sic] required to stay abreast of what the patients and employees want and can build positive relationships with the management teams." "Management involvement with changes in their organizations is paramount for influencing how individuals, subordinates and patients, act and behave" (PM 3).

Three practice managers emphasized that before their organizations can begin to establish and cultivate any climate or relationships within their span of control, they must "have a commitment to their organizations' goals and make changes when needed, but must have absolute buy-in of any changes" (PM 9), "have an understanding of why the change is needed and what it takes to make the change" (PM 7), and "have appropriate, suitable skill sets to stimulate positive attitudes and behaviors of those members that they are seeking to change and make their organizations perform better" (PM 2). Two practice managers believed that successful change management involves "leaders understanding that sometimes they need to make changes within themselves before requesting others to change" (PM 4) and "have the willingness to listen to others, communicate with others, and act on the best interest of those that the change will affect" (PM 6). All 12 practice managers believed that being a change agent within their organizations can establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm that creates a competitive edge in the health care industry.

Theme 2: Interactions. This theme integrates how practice managers saw the need to have inclusive relationships among the stakeholders in their organizations. All 12 practice managers acknowledged that prosperous business operations are predicated on encouraging constructive relationships among those working, receiving care, delivering resources, and advancing from the activities of their health care organizations. Quality health care delivery originates with a "total integration of getting everyone on the same page" (PM 12), "respectful and considerate collaborations among 'givers and a receivers' to create unity" (PM 10), and "valuing what people feel, think, say, and how they react to

certain actions" (PM 11). Practice managers bring their stakeholders together by "taking charge of situations and getting everyone to the table to discuss important issues" (PM 8), "have the managerial wherewithal to set aside their 'management egos' and position their stakeholders' needs first" (PM 3), and "working with all units in the health care industry to ensure that the services they provide include the highest quality, sensible cost, and timely access to care" (PM 2).

Six practice managers highlighted that "effective communication" (PM 1; PM 3; PM 5; PM 8; PM 9; PM 11) is the linchpin for bringing stakeholders together when they implement the Triple Aim methodology in a managed-care paradigm. The Triple Aim methodology is used to generate positive health care experiences, promote and improve collaborative population health, and reduce per capital cost in health care services. Three practice managers emphasized that successful communication involves "active listening" (PM 5), "active actions, not just listening or talking, but acting on what is being said, and then responding in the greatest interests of those you represent" (PM 3), and "knowing when to not talk and knowing when to talk" (PM 1). PM 7 asserted that

> a climate of excellence requires intermingling of stakeholders, working together, and respecting everyone's needs. This requires positive interactions starting with those working in the basement room leading to the patient's room, to the board room, and ultimately to the community that we serve. Practice managers must walk the floor, see their people, talk to them to find out their needs, and listen to them. These components are needed to build positive, cohesive relationships and they are vital when building business and client relationships. This is especially

needed for executing the Triple Aim methodology in a manage-care paradigm and building unity.

All 12 practice managers recognized that being active participants when engaging in stakeholder interactions can strengthen business productivity and establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm.

Theme 3: Partnerships. This theme assimilates how practice managers assessed the necessity to give all stakeholders a prominent role in the decision-making process to build inclusive relationships between their health care organizations, the community, and those with a financial interest regarding how patients' health care needs are met. All 12 practice managers recognized that successful outcomes in any decision-making strategy require an agreement among those making the decisions. "Having a shared, compatible goal and consistently working toward that goal obligates practice managers to have constant contact with their stakeholders (PM 11). PM 6, PM 8, and PM 9 stated that they "have impromptu meetings," "habitually meet weekly." and "sometimes meet daily," respectively, with staff members, physicians, financial intuitions, and community leaders. This was a strategy "to keep stakeholders in the loop" (PM 4) of occurring situations and to obtain their "feedback on health care delivery and how to make delivering high quality health care more accessible to those that need it" (PM 2).

Two practice managers cited that when they meet with their stakeholders, they bring "statistical data" (PM 1) and evidence of "achievements and deficiencies" (PM 10) in their organizations' performance as a measure of quality for developing a climate of excellence. "Once stakeholders see how things 'measure up,' they become more open to

discussing how to making improvements and this facilitates open conversation and it is a hallmark of collaborative partnerships" (PM 10). Collaborative partnerships were a goal that most practice managers suggested. "I have instituted a nurse-patient telephone call system to keep up with patients' needs and make them a part of the team" (PM 4). "I instruct my administrative teams to constantly call managed-care organizations and other insurance organizations in order to stay up-to-date on their new policies and processes to help patients get the care they need" (PM 12). "I conduct town hall meetings with my community partners to ensure that they are included in the way my organization conduct business" (PM 11).

> I introduced the concept of having team huddles first thing in the morning. I used this to ensure that my immediate staff having important information regarding the plan of the day for managing business operations. This gives them an opportunity to include their input regarding my business operation plan. During most morning huddles, my initial plans are always adjusted because my staff members always make excellent suggestions to improve what I have initially presented. (PM 3)

All 12 practice managers conceded that having active partnerships with their stakeholders are significant aspects in their organizations. They also stated that those partnerships have a positive impact with how they establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm.

Theme 4: Accountability. This theme interprets how practice managers grasped their obligations for activities occurring under their management teams' span of control. All 12 practice managers acknowledged that they are the leader of their departments.

Four practice managers was exceptionally proud of what they have accomplished and enthusiastically asserted that “I run the show and what happens is on me” (PM 2), “what happens on my watch is my responsibility” (PM 4), “if my team members don’t follow my orders, something bad could happen and I always expect good things to happen under my management” (PM 7), and “it is my responsibility to take care of my stakeholders and nothing occurs without my approval” (PM 11). Two practice managers declared that their organizations cannot deliver quality health care services if they do not “properly manage their financial resources” (PM 6) or “procure equipment or medicine needed to take care of the patients” (PM 12). PM 10 concluded that “patients count on coming to their health care facilities for quality health care.” “If I misuse how the fiscal assets are distributed or misuse how I my staff members take care of my patients, everyone loses and I have failed with executing my duties” (PM 12). All 12 practice managers spoke highly of fulfilling their leadership and management obligations and they expected to be held accountability for all activities under their charge. The practice managers were also critical of those that did not follow their orders.

Subquestion 1

Subquestion 1 was: How do practice managers delineate aspects of their decision-making strategies affecting primary health care delivery in a managed-care paradigm? Utilizing qualitative content analysis, I report the four emerged themes to sub question 1: change agent, interactions, partnerships, and accountability. The following results are presented from practice managers’ perspectives of decision-making strategies by means of intelligence, design, and choice processes, with respect to bound rationality/rational

choice and exchanges processes in a management environment, in particular a managed-care paradigm.

Theme 1: Change agent. This theme identifies how practice managers viewed the specific strategies required for the efficient operations and applied business structures of their primary health care departments and what changes must occur. All 12 practice managers agreed that having an efficiently ran primary health department was based on measurements of cost, quality, and values structures that is essential to all stakeholders in their health care organizations. Three practice managers noted that is it important to “take a survey” (PM 1), “take an external view ” (PM 4), or “step outside the boundaries” (PM 7) of their business processes to determine what changes are appropriate to improve the structures of their primary health care departments. “Changes should only take place if they will benefit everyone, not just for the benefit of the organization” (PM 5). Four practice managers recounted that they “look within themselves” (PM 3), “take a seat in their in their lobbies” (PM 8), “interview patients and staff members” (PM 10) and “hire outside agencies” (PM 12) to investigate what, and how to make, internal changes in their organizations. When practice managers “intelligently manage their internal resources and implement justifiable, rational internal changes, it contributes to physicians’ abilities to provide quality health care treatments in primary health departments” (PM 11).

Other practice managers explained that being a change agent in primary health care means “taking actions to keep patients’ health care cost as low as possible, such as working with drug companies to provide free medication samples” (PM 5), “find ways to promote quality primary care at a sensible price and greatly improve access to that care

by using telephone consultations rather than using in-person appointment consultations" (PM 9), and "cutting cost and maintaining quality by using telemedicine techniques with video streaming or chatting consultations, such as Teleport or Skype or Face Time, for video face-to-face appointments" (PM 12). Two practice managers indicated that they constantly evaluate how they can make effective changes by examining "what I can do within my own perceptions of quality and cost that could affect the value of my primary health care department" (PM 1) and "putting myself in the patients, physicians, and staff members place to understand what it takes to give them compassionate, quality, and respected primary health care" (PM 6). All 12 practice managers regarded primary health care as a gateway to meeting other specific health care needs and changes should occur when they fail to meet their stakeholders' needs.

Theme 2: Interactions. This theme includes how practice managers regarded their need to have wide-ranging collaborations among stakeholders that they do business with and those stakeholders that are direct recipients of the services provided in their primary health care departments. All 12 practice managers conceded that networking with external stakeholders and those that will benefit from the services that they provide is critical to the success of their primary health care departments. PM 3 expressed that

> keeping close contact with businesses, such as managed-care organizations, goes a long way when it comes to helping patients navigate the complicated channels of paying for their health care. It also benefits physicians because knowing what managed-care organizations expect helps them direct appropriate care within the limits of what their insurance will pay for. I take the time to get to know those

> managed-care organizations' managers so that I can get a feel of what I must do to fight for my patient's care.

Other practice managers offered translations for their interactions. "I go to managed-care organizations to meet with their managers to get 'face time' with them and learn lessons to take back to my department that will give physicians practical options when treating patients" (PM 10). "I invite managers of managed-care organizations and pharmaceutical organizations to round table discussions to put together viable solutions to manage health care cost that seems to be an impediment to patients' access to care" (PM 11), and ultimately to the "deferment of the quality of primary care that they receive, such as ER (emergency room) visits versus primary care visits" (PM 12).

Other practice managers underscored the need to build good relationships with vendors that supply medical equipment/devices to their patients and/or departments.

> My budget includes a line item regarding how much I will spend on equipment and devices. I assess my department's situation, what patients need, and how much I will spend. I negotiate with my vendors and with my past relationships and spending patterns, they usually give me a good deal. I know that having long, positive relationships with my vendors require continuous contact with them and letting them know what my needs are. My vendors understand that building long, lasting relationships with me can increase their bottom line in sells and brand their product in the health care market. I take advantage of this and use it as a selling point during negotiations. (PM 2)

"I keep my vendors on speed dial to ensure that I can reach them ASAP [as soon as possible] when I need something. We converse constantly and we are in sync with the products that I need for my department" (PM 5).

> Each day one of my vendors brings my staff members a reasonable dollar amount and size lunch and we all sit down and discuss how their products can benefit my patients. Talking with them, sitting through their presentations, and engaging in stimulating conversations strengthen our relationships and increase my understanding of their product before I buy it. (PM 8)

"I frequently hold conferences calls and presentations with my vendors, my physicians, and my patients so that everyone will know what they are getting and getting into. This keeps everyone focused on the prize, the best end results" (PM 10).

All 12 practice managers' responses also coincided with pursuing internal communication with other stakeholders within their organizations that are involved in patients' primary health care needs. "Talking directly to specialists in my organization can get my patients seen faster" (PM 1). "Calling a health care peer about a patient can alleviate the need for the patient to call for an appointment" (PM 5). "I can do a telephone consultation regarding a patient and get the patient seen the same day" (PM 9). All 12 practice managers concurred that respectful interactions with stakeholders is an effective strategy to manage business operations.

Theme 3: Partnerships. This theme embraces how practice managers evaluated their obligations working with physicians and patients to build a more efficient primary health care department under their span of control. All 12 practice managers noted that

bringing their physicians and patient together to reinforce quality primary health care is significant for sustaining Dr. Barbara Starfield's (1991; 1992; 1994) visualization of primary health care modeling. They recognized Starfield's four pillars of primary health care: initial contact for health care services, continuity of health care treatments, point of health care referrals, and the overall management of health care services.

One practice manager addressed the four pillars as "getting them together as soon as possible is best technique to begin the healing process and creating collaborative efforts of decision-making regarding how to conduct and receive care" (PM 3). Two other practice managers said that collaboration begins with "partnering patients with their physicians give them ownership of the decision-making process of how they want to receive care" (PM 6) and "allowing patients to bring in their family members when making decisions can help physicians balance the scales of respect, communication, control, values, health promotion, and wellness when they provide primary health care treatments" (PM 7). When balancing the scales of primary health care, two practice managers revealed that physicians' and patients' partnerships are strengthened when "they understand what is expected of each other" (PM 2) and when "physicians and patients talk to each other and not at each other" (PM 9). Two other practice managers disclosed that they bring the physicians and patients together when "patients are asked to complete customer service and health care questionnaires to give their perspectives of the care that they received" (PM 4) and "if a questionnaire or survey indicate that something is wrong, the physician have an opportunity to address the issue with the patient and I mediate the meeting" (PM 6). All 12 practice managers accentuated that a significant

strategy for partnering physicians and patients is generating a forum for open communication that let them express themselves in an honest, but, respectful manner. They noted that physicians and patients expect honest relationships during care management.

Theme 4: Accountability. This theme emphasizes how practice managers led and took responsibility for the activities in their primary health care departments. All 12 practice managers defined that the core of their leadership style rests solely on how they behave and respond to activities in their departments. Two practice managers recognized that in their positions, they “set the tone” (PM 1) and “provide direct solutions” (PM 10) for how business is conducted to fortify operations in primary health care. One practice manager stated that “being visible during patient care lets everyone know things are being taken care of” (PM 4). Another called it “talking-the- talk and walking- the-walk” leadership and management when acting and responding to situations (PM 11).

Three practice managers specified that they act and respond to situations by “assessing the issues” (PM 5), “weighing all aspects of the problems” (PM 6), and “talk to those that the problem is impacting” (PM 11) before making any decisions that will influence their organizations. Three other practice managers gave examples of how they took responsibility, such as “making it a point to communicate with stakeholders with a driven purpose and persuasion” (PM 2), “being a role model for physicians, patients, and staff members to emulate” (PM 4) and “taking the lead on initiating meaningful policies that will create advantages for patients seeking care and minimize impediments in access to primary health care” (PM 7). All 12 practice managers signified that their guidance for

orderly primary health care management is contingent on how they are willing to take full accountability of their departments' actions, specifically with "what goes right and what goes wrong" (PM 1). PM 3 declared that "accountability is how I create an appropriate climate and tone within my department to ensure that everyone is taking care of."

Subquestion 2

Subquestion 2 was: How do practice managers delineate aspects of their decision-making strategies affecting physicians in a managed-care paradigm? Utilizing qualitative content analysis, I report the four emerged themes to subquestion 2: change agent, interactions, partnerships, and accountability. The following results are presented from practice managers' perspectives of decision-making strategies by means of intelligence, design, and choice processes, with respect to bounded rationality/rational choice and exchanges processes in a management environment, in particular a managed-care paradigm.

Theme 1: Change agent. This theme includes how practice managers regarded managing changes in their primary health care departments associated with physicians' behaviors and expectations. All 12 practice managers acknowledged some degree of dissonance with their physicians involves how their practices function. They noted that they are willing to make necessary changes in their management processes to help ease their physicians' concerns. The 12 practice managers concluded that they are determined to provide clarity of policies to their physicians regarding their organizations' objectives.

Two practice managers voiced that most patients perceive that "physicians are department leaders" (PM 4) and "physicians make the decisions that affect how they are

taken care of" (PM 9) without understanding the organizational structure. PM 3 stated that "when I first started here, my physicians believed that they had leadership authority by virtue of their job titles and they wanted to make changes in protocol without understanding any organizational goals." PM 6 said that "my physicians frequently try to go over my head to get things that they want and try to discredit any changes I make in the department." PM 12 disclosed that "my physicians are held with high esteem among my patients and some other stakeholders, and with that logic, they think that they are my boss and can do as they please." "There appears to be many misconceptions in leadership authority and how the organization operates. This creates many problems within my organization" (PM 1).

Misconceptions of the physicians' understanding of organizational authority require "changing their thought process" (PM 2) and "having a sit down with my docs and reviewing our organization's mission statement and value objectives" (PM 8) to define how the organization functions. Two other practice managers replied that their process to get physicians on board with their objectives includes "bringing physicians to team management meetings as guests so that they can see the big picture of what the organization is trying to accomplish" (PM 5) and "taking my physicians to town hall meetings and asking them to listen to the questions and concerns that I have to address with the community stakeholders" (PM 11). Four practice managers likened the change process as a "reorientation" (PM 1), "reprograming intervention" (PM 9), "providing an educational adventure" (PM 10), or "providing a gentle reminder of their responsibilities" (PM 12) to get their physicians to adapt to their organizational objectives.

Other practice managers assumed a more aggressive approach toward changing physicians' behaviors and expectations of their roles. PM 3 said that "I put my physicians on notice and document their inappropriate behaviors toward me and patients." PM 5 said that "I counsel my physicians with a representative from the human resource department and this helps to bring a financial component into the discussion." PM 8 asserted that "I have recommended termination for two of my physicians due to their insubordination and once they learned that the organization was ready to proceed, they changed their negative attitudes and behaviors in the department. PM 10 expressed that

> things in health care in the health care industry have changed. Physicians are still recognized as integral members of the health care team and leaders of providing direct health care, but unless they are designated as the leader of primary care, they are just regular employees and they are expected to comply with the rules, just like everyone else. My department works with a mixture of health care providers, such as physicians, NPs [nurse practitioners], and PAs [physician assistants]. When I started this job, I was told that my new department needed to be restructured. I met with my physicians and I gave them copies of their job descriptions and my expectations. They never saw a copy of their job description before and they thought it was a joke. I bluntly told them how it was and how it was going to be. I politely referred them to HR [human resource] if they had any concerns. A few went to HR and HR supported my decisions. One physician quit, the others complied. My department is now one of the best in the organization.

Regardless of incorporating a conservative or an aggressive approach when managing and changing behaviors and expectations in their primary health care departments, all 12 practice managers detailed the need to maintain order and respect under their guidance.

Theme 2: Interactions. This theme features how practice managers considered the need to build professional relationships with physicians. All 12 practice managers identified that their physicians are the medical experts in their departments, but being a medical expert does not equate to being a leader or having the capacity to make rational business decisions. Three practice managers confirmed that they pay close attention to what their physicians have to say because “the physicians provide the care and I give them the tools to provide that care” (PM 7), “they have closer relationships with patients than I have and they can tell me what the patients need” (PM 10), and “my physicians are the medical experts and I expect them to show me some professional courtesy and let me know what equipment or medicines they need to take care of patients” (PM 12).

PM 1 maintained that “extending courteous, respectful interactions toward my physicians keeps a professional balance, atmosphere within my department.” PM 3 informed that “although I am the boss and can call my employees by their first names, I always address my physicians as doctor to let them know that I respect their medical educational achievement. I appreciate their value in my department.” PM 5 urged that “recognizing what my physicians offer is a fundamental component that promotes effective two-way communication and alleviates some of the tension in the department.”

> I make it a point to make frequent rounds on each of my physicians’ hallways to give them a visual that I am accessible to answer any questions they have or to let

them know that I care about them and the significance of their obligations to deliver quality patient health care (PM 8).

All 12 practice managers conceded that they meet with their physicians often, either formal or impromptu. One practice manager called it "to discuss issues of the day or to just have friendly conversations about our families, sports, or whatever is the current topic in the news cycle" (PM 2). PM 7 confessed that "frequent meetings are the best way to promote teambuilding activities and to assess others rational thought processes."

Theme 3: Partnerships. This theme involves how practice managers evaluated their methodologies for getting their physicians familiar with their policies and strategies during the delivery of primary health care. All 12 practice managers attested that working with physicians consists of continuous evaluations of standard of care protocol because how health care is applied and because the nature of quality health care is subjective. "I have quarterly policies meetings with my physicians to address if they have observed any discrepancies with my leadership that prevent them from adhering to standard operating directives or impede their abilities to provide quality primary health care"(PM 1).

> I created satisfaction surveys for my physicians to complete when they have concerns, issues, or satisfied with the way I manage the department. Their comments are completely anonymous and I address them as a line item on the agenda during the standing monthly meetings. (PM 5)

PM 11 explained that

> partnering with physicians is a team effort. I use a commercial vendor to audit how my physicians document patients' health care records to maintain standard of

> care functions or required documentations for appropriate billing purposes. After the audit, I show them their results, and then we all meet to correct or justify any deficiencies found during the audit. Their input usually reveals some adjustments are required in the standard operating directives. These serve as correcting issues and getting the physicians to understand what is required to adhere to policies.

All 12 practice managers admitted that partnering with their physicians is necessary. Eight of the practice managers voiced concerns that partnering, similar to being a change agent, could lead to physicians' misplaced conceptions of their leadership authority in primary health care.

Theme 4: Accountability. This theme contains how practice managers viewed the need to prepare their physicians for the demanding duties in their primary health care departments. All 12 practice managers admitted that being a physician assigned to a large primary health care department is a challenging endeavor. PM 5 asserted that their physicians "occasionally find it is rewarding, occasionally find it is frustrating, and most times find it is confusing when providing care." PM 11 declared that

> my physicians find it problematic to navigate certain aspects of the managed-care structure and they find it incomprehensible, or they do not take the time, to identify what they can do, or cannot do, within the limits of their patients' managed-care plans.

Practice managers reduced physicians' lack of knowledge of the managed-care structure by "educating them with how each tier of the managed-care plans applies to patients' health care (PM 7), "making arrangements for my physicians to have direct contact with

managed-care organizations' directors and peer/care plan reviewers" (PM 10), or "during physicians' retreats, I present seminars on managing patients' care in a managed-care paradigm" (PM 12).

Recognizing what physicians need to navigate a managed-care paradigm and their flaws in the process, some practice managers considered other alterative options.

> I create 'cheat sheets' for my physicians to utilize when they come to a 'crossroad of uncertainty,' or if they are not sure how to make applicable referrals, or what their patients' insurance will cover, or if other specialists will agree to take their managed-care plan. (PM 3)

PM 9 rationalized that some "physicians need help ASAP. I ensure that my NPs or PAs are up-to-date on the managed-care process. They can step in and execute the contractual obligations for their physicians when their physicians are unable." PM 10 explained that "I require my new physicians to complete an orientation program on the fundamentals of working in a managed-care paradigm. I ensure that my 'seasoned' physicians complete a refresher orientation to maintain their knowledge or to receive updates." PM 11 expressed that

> I hire referral agencies or coaches to work with specific physicians to mentor them and 'bring them up-to-speed' with my organization's expectations of how they should managed their patients in a managed-care paradigm. Because health care cost and quality health care delivery are at the forefront of operations in my primary health care department, I expect my physicians to learn the process. I do not want to lose the confidence of my patients or board of directors when it comes

> to patient care issues because my physicians are unable to perform. I give them the tools to thrive and I expect them to thrive. I am accountable for their actions and I expect excellence.

All 12 practice managers disclosed that managing their physicians can be a difficult task because some physicians do not value the concept of a managed-care paradigm, but they recognize that they are accountable for them. Some practice mangers called physicians "vain and arrogant" (PM 2), "stubborn and inflexible to change" (PM 10), "self-centered and narcissistic" (PM 12), and "self-serving and divisive with hopes of using their job position to create personal gains." They also verbalized that some of their physicians are angry because they are losing control and power regarding how their patients' health care needs are met and how those needs are being manipulated by MCOs.

Subquestion 3

Subquestion 3 was: How do practice managers delineate aspects of their decision-making strategies affecting patients in a managed-care paradigm? Utilizing qualitative content analysis, I report the four emerged themes to subquestion 3: change agent, interactions, partnerships, and accountability. The following results are presented from practice managers' perspectives of decision-making strategies by means of intelligence, design, and choice processes, with respect to bounded rationality/rational choice and exchanges processes in a management environment, in particular a managed-care paradigm.

Theme 1: Change agent. This theme includes how practice managers viewed managing changes in their primary health care departments associated with patients'

behaviors and expectations. All 12 practice managers acknowledged that patients are the principal component in the delivery of primary health care in a managed-care paradigm. In particular, four practice managers specified that managing patients' behaviors and expectations demand that they preserve and revere patients' "trust" (PM 1), "attitudes" (PM 6), "culture" (PM 7), and "values" (PM 12) in their departments. The 12 practice managers stipulated that being an agent of change when delivering primary health care mandates that they have the prudence to put patients' ability to access health care at the forefront of all activities in their departments.

Six practice managers repeatedly replied that patients want "affordable health care," "timely access to health care," and the ability to have "control over their health care needs" (PM 2; PM 5; PM 7; PM 8; PM 10; PM 11). Three other practice managers verbalized that patients want "high quality and reasonably priced health care" (PM 1), "experienced, expert health care providers" (PM 3), and "someone that understands their health care needs and how to effectively provide it to them" (PM 9). To provide for patients' primary health care needs, one practice manager declared that "it is necessary to evaluate what services my patients need and what services my department can offer, then bundling those two services into two consultations utilizing one appointment time slot" (PM 6). PM 7 called being a change agent as "managing and balancing risk" for positive results. Another practice manager said that to be an agent of change,

> it is necessary to replace the old business model of integrating patients into the health care services. Instead, I integrate the health care services with the patients' needs. This means to bring the services to the patients, not the patients to the

> services. I established a home health approach that provides a more resourceful management process. I regularly send out my nurses, NPs, and PAs to patients' homes to assess their needs that do not necessarily require an office visit, such as BP [blood pressure] checks, wound care, medication checks, or diet consultations. This lets my patients know that we care about every aspect of their primary health care needs, constructively shapes their attitudes toward us while providing them with quality health care services, and progressively encourages brand loyalty to our organization rather than to other health care organizations. (PM 4)

PM 12 added that "I help my patients with income challenges by working with drug reps to get them medications without cost or at a steep discount, otherwise, they would not get their meds." PM 2 conveyed that

> I worked with my board of directors to establish two free primary health care clinics in low income areas where families cannot afford to see a provider. Having free clinics help my patients get needed care and reduce some of their frustrations of the inequitable distribution of health care in the United States.

PM 5 noted that "I set aside 10 to 15 appointments each day as same day appointments to prevent patients from using the ER as their PCPs. This process 'gets patients in and gets them out timely' while improving their access to care concerns." All 12 practice managers voiced that any changes that they make in their departments must improve their patients' well-being.

Theme 2: Interactions. This theme features how practice managers reflected on the need to build professional relationships with their patients. All 12 practice managers

replied that quality primary health care begins with the relationships they build with their patients and how they are prepared to position their patients' interests at the forefront of business operations. Three practice managers elaborated that they "respect what their patients say." (PM 1; PM 6; PM 9). Two practice manager said that they "respond appropriately" (PM 5; PM 12) to their concerns because their "feedback can improve" (PM 5; PM 12) how they provide primary health care. Five practice managers expounded that they use a "patient call-back system" (PM1; PM 3; PM7; PM 8; PM 10) to converse with patients and document their experiences in the departments to make improvements. "Talking to patients gives me an opportunity to probe their inner thoughts about what is 'going right' in their health care management and what is 'not going right' in their health care management" (PM 2). PM 11 answered that

> patients assume that I know they want, and that is true to an extent, because I know that they want quality, efficient, and affordable health care. I assign case managers to patients and they call them to evaluate what I can do to make their health care need more accessible or what other needs they may have. I follow up those phone calls with personal calls to let them know that their health care leader is interested in their well-being. This also gives me a huge opportunity to let my patients know how I am investing in their communities to make their lives better.

All 12 practice managers did not waiver from specifying communication as the fundamental element required to build effective interactions with their patients. Likewise, some practice managers noted that effective interactions can "get patients on board when I introduce new policies that could affect some aspects of their health care needs" (PM 2),

"to continuously seek their primary health care needs at my organization" (PM 6), "make myself as visible as possible to have constant interactions" (PM 8) and/or "spread the word about the great services we provide and to let their family members or friends know that we are committed to being their advocate for promoting population health care in their communities" (PM 9).

Theme 3: Partnerships. This theme involves how practice managers assessed their methodologies for getting their patients cognizant of their policies and strategies during the delivery of primary health care. All 12 practice managers agreed that with the advent of a managed-care paradigm, it has presented some challenges for their patients seeking to access primary health care and to comprehend how it works. PM 8 shared that

> I developed a monthly newsletter that details how my department functions. It includes information such as office phone numbers, practice hours, scheduling appointments, practice procedures, insurance and managed-care organizations updates, and health care tips of the month. The newsletter is mailed electronically and each patient has an individual account linking their health care data. The newsletter is specifically tailored to each patient's particular needs. I include in the newsletter a link that directly connects to my team—like having a personal banker at a bank. This gives my patients more control, ownership of their primary health care needs, and how to move forward with their care.

PM 3 disclosed that

> I conduct health care workshops and invite my patient population to open-house style events to 'walk-thru' the process of being a patient in my department. This

> gives me an opportunity to answer any questions they may have regarding their care based on policies and procedures set forth in my practice. I use this as all-inclusive approach that builds trust and unity between the patients, physicians, my department, and my organization. Questions always arise about our processes and with engaged discussions, everyone needs are understood and met.

Three practice managers said that they use resources from government agencies, such as “Meaningful Use concepts” (PM 5; PM 7; PM 11), to foster inclusion in their organizations while giving patients opportunities to learning their policies. Meaningful Use requires that “I give each patient a clinical summary sheet so that they understand what occurred during their visit, and why it occurred. This gives them a sense of being included in their health care management” (PM 5). PM 7 asserted that

> I utilize Meaningful Use questionnaires to query patients about their health care history and to list any concerns they have about their health care. This gives me a chance to explain what services I can offer using the policies that I have in place and gage their satisfaction with the services that I can provide, while including them in the process.

PM 11 recounted that

> I include Meaningful Use concepts on my organization’s website to display my mission statement and objectives, visions, policies, make appointments, pay bills or billing questions, and show my financial statements. My patients value having a ‘one-stop-shop’ for getting information and it makes them feel empowered.

Theme 4: Accountability. This theme comprises how practice managers saw the need to support their patients' efforts to receive the best primary health care possible while working with them in their communities. All 12 practice managers repetitively described that their patients are yearning for the best "quality," "value," and "cost" attributes related to their overall health care needs. Some practice managers linked the attributes to gaining social acceptance in their communities. PM 1 said that "investing in my community is investing in my practice by letting the community populace know that I will do everything possible to give them the best care." PM 3 revealed that

> I hold health fairs in our communities that give my patients free BP checks, mammograms, physicals, or counseling. This lets my patients know that we care about their health care needs, and by keeping them healthy, it helps them to be productive citizens in our communities.

PM 7 reported that "I use the '7-11 or Wal-Mart' method by flooding the health care market with as many primary health care practices as possible. This gives my patients numerous options and encourages variety while building loyalty and trust in the community."

PM 4 emphasized that "I opened community health care centers in urban neighborhoods to provide patients, especially elderly patients, access to see a provider without having difficulty getting to the provider. Transportation is always a problem for my patients" PM 9 underscored that "I created a partnership with my organization's transportation department to provide my patients with subsidized transportation to their appointments. If patients are assured that they have reliable transportation to their

appointments, they are more likely to repeat coming back." PM 5 shared that "I work in an accountable care organization and I utilize agencies such as Medicare and Medicaid to offer transportation services for my patients. I jointly coordinate with their managed-care organizations to get them to their appointments." Practice managers find it critical to "put their patients first" (PM 2), "take care of the community" (PM 7), or "build collaborative efforts with their community" (PM 12) to achieve accountability for their organizations' strategic objective. Likewise, all 12 practice managers were quick to remind that social objectives cannot be achieved without achieving capital objectives.

Summary

The results of this qualitative exploratory study revealed aspects of practice managers' decision-making strategies in a managed-care paradigm. By means of eliciting practice managers' responses to an overarching research question and three subquestions, four themes emerged when I linked the research questions to the interview protocol (see Table 5 and Figure 5): change agent, interactions, partnerships, and accountability. The overarching research question concentrated on how practice managers establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm. The results to the overarching research question identified aspects of practice managers' methodologies for gaining a competitive edge, having inclusive relationships among stakeholders, giving stakeholders prominent roles, and grasping their obligations under their span of control. The overarching research questions was the foundation for the three subquestions that explored and delineated aspects of practice managers'

underlying decision-making strategies affecting primary health care, physicians, and patients in a managed-care paradigm.

Subquestion 1 focused on how practice managers delineate aspects of their decision-making strategies affecting primary health care delivery in a managed-care paradigm. The results of subquestion 1 exposed aspects of practice managers' approaches for efficient operations and business structures, wide-ranging collaborations among stakeholders, evaluating obligations with physicians and patients, and managing leadership responsibilities. Subquestion 2 centered on how practice managers delineate aspects of their decision-making strategies affecting physicians in a managed-care paradigm. The results of subquestion 2 revealed aspects of practice managers' processes for managing changes associated with their physicians' behaviors and expectations, building professional relationships with their physicians, getting their physicians familiar with their policies and strategies, and preparing their physicians for duties in their primary health care. Subquestion 3 concentrated on how practice managers delineate aspects of their decision-making strategies affecting patients in a managed-care paradigm. The results of subquestion 3 discovered aspects of practice managers' procedures for managing changes associated with patients' behaviors and expectations, building professional relationships with their patients, getting their patients cognizant of their policies and strategies, and supporting their patients' efforts to receive the best primary health care possible. In Chapter 5, I present a discussion of the study that incorporates an interpretation of the research findings, limitations, recommendations for future explorations, implications for positive social change, and the study conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of the study was to conduct qualitative exploratory research and engage in an in-depth exploration to delineate aspects of practice managers' decision-making strategies, as they establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm. Specifically, the purpose of the study was to explore aspects of practice managers' underlying decision-making strategies affecting primary health care, physicians, and patients in a managed-care paradigm. What was not known were the strategies that practice managers deployed when they make decisions. In the current health care literature, from the lens of practice managers, scholars have not clearly delineated how practice managers make decisions. A gap in knowledge exists, particularly in primary health care settings. As a result of the gap in knowledge, delineating aspects of practice managers' decision-making strategies in a managed-care paradigm is significant for comprehending how they establish and cultivate a climate of excellence, which could potentially create positive social changes.

I queried 12 practice managers assigned to primary health care departments via interviews during the main study. The research design was qualitative in nature with an exploratory research strategy of inquiry that allowed me to seek an understanding of the research phenomenon. This methodology proved effective, as I explored and gained deep, rich knowledge that led to aspects of practice managers' decision-making strategies and delineated how they conceive and implement their strategic processes in a managed-care paradigm. The interviewing exposed key findings of practice managers' decision-making strategies, such as being change agents, having significant interactions, establishing

partnerships, and being accountable in their primary health care departments with their physicians and patients in a managed-care paradigm. Kassam (2015) emphasized that every decision is made within a decision environment, which is delineated as the collection of information, alternatives, values, and preferences accessible at the time of the decision. In Chapter 5, I offer an interpretation of the research findings, limitations, recommendations for future explorations, implications for positive social change, and the study conclusion.

Interpretation of Findings

The problem addressed in this study was the gap in knowledge regarding practice managers' decision-making strategies that affect, or could be perceived to affect, a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm. I used Simon's (1960) ideology of decision-making strategies in a management environment as the conceptual framework to guide the study, assist with eliciting practice managers' responses to the research questions regarding the research phenomenon, discern emerged themes in Chapter 4's Results section, and facilitate the interpretation of findings. Simon's ideology denotes three actions necessary for effective decision-making, which includes a succession of exchanges, such as intelligence, design, and choice processes, with respect to aspects of bounded rationality/rational choice and exchange processes.

The Interpretation of Findings section is organized by the emerged themes from practice managers' responses grounded on the research phenomenon and purpose of the study, with respect to the conceptual framework: change agent, interactions, partnerships,

and accountability. The interpretation of findings is also presented with considerations to the data located in Chapter 2's literature review. As a final point, the interpretation of findings is grounded on the practice managers' perspectives reported in the Results section in Chapter 4.

Theme 1: Change Agent

Centered on the practice managers' responses to the overarching research question and the three subquestions, being a change agent alludes to practice managers' willingness to make adjustments within their primary health care departments. Health care is a complex, evolving business process with physicians and patients as clients, each with shared and diverse interests regarding how they desire to be led and managed to attain quality health care services, particularly in a managed-care paradigm (Concannon et al., 2014; Cottrell et al., 2015; Herremans et al. 2016). A managed-care paradigm is a business structure utilized to manage health care services with respect to cost, quality, and value (HHS, 2015). There seems to be an essential aspect that practice managers conceive and implement strategies necessary for sustaining and propelling their organizations' business objectives through continuous analyses and making key changes when required.

The health care literature has well documented that practice managers are accountable for meeting their organizations, physicians, and patients' expectations, and these expectations are used as a foundation for conceiving and implementing their strategic processes. Nundy and Oswald (2014) and Trastek et al. (2014) recognized that practice managers influence business operations, strategic decision-making, attitudes, and

behaviors of physicians and patients under their span of control. Arroliga et al. (2014) and Lee (2015) concluded that aspects of practice managers' decision-making strategies could have positive or negative consequences for physicians' and patients' values in a managed-care paradigm. The results of practice managers' responses described that practice managers envision a change agent as someone who can make improvements to their organizational structures to gain a competitive edge in the health care industry. The practice managers advocate that health care is a business and gaining a competitive edge is paramount. They also promote that certain processes must be in place to ensure that their organizations are at the top of the health care industry and implementing specific primary health care processes are needed to be competitive.

This translates as a necessity for practice managers having a 360˚ view of what is occurring in their respective departments, at all times, as necessary for establishing and cultivating a climate of excellence with business and client relationships. It appears that they are ready to progress forward by adopting methodologies to get their stakeholders to share the same vision needed to create a harmonious organizational climate that leads to being competitive. The results of the interviewing data reveal that practice managers continuously review their policies and procedures to assess if their strategies in place are effective. The health care literature supports the interviewing data results. McWilliams et al. (2015) emphasized establishing performance standards and quality indicators. Glied and Janus (2015) and Bobbitt and Rockswold (2016) underscored managing cost, quality, and value. Hung and Jerng (2014) asserted that practice managers must make changes via applicable choices, such as structures, processes, and outcomes. This submits that change

agent practice managers must have 360˚ view of their organization. When using Simon's (1960) ideology, a 360˚ view proposes that practice managers must survey themselves to ascertain if changes are necessary, intermingle with their stakeholders to scrutinize their perspectives of current situations, use stakeholders/group relationships to obtain a competitive advantage, and finally, make frequent assessments of their overall primary health care departments to sustain and propel their business and client relationships.

Scholars acknowledge that decision-making during leadership and management undertakings is an embryonic process, and decision-making strategies in a managed-care paradigm is a demanding challenge for practice managers assigned to primary health care departments (Piña et al., 2015; Zabaleta-del-Olmo et al., 2015). Concannon et al. (2014) and Mosquera et al. (2014) emphasized that simple decisions characteristically require a simple decision-making process. They also noted that more difficult decisions typically necessitate issues that include uncertainty, complexity, high risk, alternatives, trust, and interpersonal concerns. The outcomes of practice managers' responses indicate that practice managers visualize a change agent as someone who can create well-organized business operations and apply applicable organizational structures in their primary health care departments by means of executing effective decision-making strategies. The practice managers regard primary health care as the gateway for access to other health care services, and they are aware that changes must occur when required. This suggests that when practice managers make decisions, they must weigh all the risks associated with the desired outcomes, and then they must heavily invest their resources, such as financial and social capital, to produce long-term, high-level ROIs.

The health care literature is clear about patients being the most important aspect of the health care industry. Starfield's (1991; 1992; 1994) earlier literature advocated that patients' success in primary health care demands that they have timely access to care that includes initial contact for health care services, continuity of health care treatments, point of health care referrals, and efficient overall management of their health care necessities. The results of practice managers' responses summarize that practice managers describe a change agent as someone who is willing to make essential changes in management processes to help facilitate patients' concerns. The practice managers appear to accept that patients want more substance and value with their health care experiences, specifically with cost containment and the quality associated with how their health care treatments are delivered. The interviewing data expose that practice managers construct programs that contribute to pathways for receiving primary health care, such as home health care, free health care clinics, subsidized health care, free transportation, or better access to health care. This also reveals that practice managers' goals are to give patients positive experiences that can shape positive expectations and positive outcomes.

Further, this signifies an obligation for practice managers being empathetic and compassionate toward their patients' struggles to gain applicable primary health care services. It advances the notion that successful primary health care services must move from antiquated business practices to more progressive business practices. This translates as merging financial and social capital for the enrichment of the patients' welfare in a managed-care paradigm. Enrichments entail bringing the organization to the patients, working with disadvantaged/disenfranchised patients, involving medical vendors to assist

with patients' financial burdens, and being active in their communities. When applying Simon's (1960) ideology to Lega et al.'s (2014) and Lee and Kam's (2015) positions, change management has financial and social implications that influence the complexity and dynamics of health care organizations' environment. Each has the ability to alter how practice managers make decisions, conduct business relationships, and thrive during uncertainty.

Theme 2: Interactions

Substantiated on practice managers' responses to the overarching research question and the three subquestions, interactions in a managed-care paradigm implicate that practice managers must engage in collaborative relationships with their stakeholders within their primary health care departments. Practice managers' behaviors are expected to construct a principle organizational tone/climate that should influence interactions, collaborations, communications, and efficiencies in their health care organizations (Lee, 2015; Wai & Bojei, 2015; Yardley et al., 2015). Carter (2013) and Labrie and Schulz (2015) asserted that practice managers' leadership and management decision-making proficiencies must incorporate using their communicative skills and previous experiences to motivate and persuade diverse groups of physicians and patients to follow their directives. This seems to be obligatory that practice managers conceive and implement strategies vital for building a climate of excellence with business and client relationships in managed-care paradigm.

This also infers that practice managers are obligated to have committed, long term structures in places that can sustain effective performances of their organizations during

fluctuating circumstances. It appears that practice managers must seek ways to promote quality primary health care in their departments during exasperating times by engaging in collaborative interactions with their stakeholders. The results insinuate a necessity for shaping meaningful rapports that can create better opportunities to garner stakeholders' perspectives and advance practice managers' overall business objectives. When applying Simon's (1960) ideology, practice mangers must undertake key assessments of current situations to achieve desired outcomes by means of linking those meaningful rapports to emerging opportunities, such as conducting community town hall meetings, presenting seminars with MCOs, seeking feedback from stakeholders, and promoting population health care management. This suggests meaningful rapports embrace open, collaborative communication among stakeholder, termed as argumentation. Labrie and Schulz (2015) noted that argumentation reinforces positive effects of decision-making in primary health care, particularly when communicating with physicians.

Numerous scholars, such as Cochran et al. (2014), Grace et al. (2014), Nielsen and Nielsen (2015) and Valmohammadi and Ahmadi (2015), recognized that physicians are the medical experts for patients' health care treatments and that their behaviors can influence how primary health care is delivered. The results concede that the practice managers relationships with their physicians are, to some degree, fractured due to the implementation of a managed-care paradigm. The Physicians Foundations' 2014 Survey of America's Physicians disclosed that 69% of physicians believe that they have limited autonomy with the health care services they offer to their patients and their decisions are compromised by how MCOs functions. The interviewing data illustrate that practice

managers take inclusive efforts to address physicians' concerns and explain the managed-care process, such as regular and timely meetings, taking them to internal and external high-level meetings, and being visible and accessible to them. This deduces that practice managers' objectives are to give physicians positive experiences that can shape positive expectations and positive outcomes. This also infers that practice managers' interactions with their physicians as someone that make concerted efforts to help ease their concerns regarding how MCOs impact a managed-care paradigm and their roles as physicians.

This indicates that practice managers' willingness for inclusion is based on physicians' values, expert health care advice, and willingness to adhere to the managed-care process. The practice managers appear to have unyielding tolerance toward their physicians' attitudes regarding their leadership charge within their primary health care departments. They expect their physicians to conform to their leadership authority or face the consequences. When applying Simon's (1960) ideology, I interpret this as the practice managers having willingness for inclusion in the decision-making process, but they also expect their physicians to conform policies and procedures, as physicians can influence how patients' perceive the overall effectiveness their health care system. Comparable to Epstein's (2013)and Elwyn et al.'s (2014) observations, change must be guided by aspects of motivation, communication, group work, and delegation that can create a sustainable organization.

Theme 3: Partnerships

Via practice managers' responses to the overarching research question and the three subquestions, creating partnerships in primary health care departments is critical for

the overall success of business operations. Practice managers should apply appropriate leadership styles for physicians and patients to maintain positive, productive working relationships. Zhang et al.'s (2012) and Gong et al.'s (2013) reviews regarding proactive personalities and work outcomes documented that good working relationships can build trustful, respectful health care climates whiling creating value, purpose-driven partnerships. It appears to be a necessary strategy that practice managers build alliances with their stakeholders and work together as a team to produce positive outcomes that are considered synonymous to cultivating a climate of excellence with business and client relationships in managed-care paradigm.

Scholars underscored that to build effective partnerships, leaders must have general knowledge of diverse cultures, including social-level values and norms such as perceptions, language, beliefs, and cognitive processes (Landry et al., 2012; Wang & Zatzick, 2015). The results of practice managers' responses illustrate that practice managers find it vital to give all stakeholders a prominent role in the decision-making process to build inclusive relationships between their health care organizations, the community, and those with a financial interest regarding how patients' health care needs are met. Markaki et al. (2013) and Fulmer and Ployhart (2014) asserted that effective partnerships cannot be established without practice managers' capabilities to effectively utilized aspects of their human capital. This appears to be parallel to how practice managers lead and how they understand their stakeholders' interests and diverse cultures.

Collaborative partnerships are goals that most practice managers encourage. Other scholars, such as McManus et al. (2015) and Shmuel et al. (2015), have characterized

practice managers' willingness to work with their stakeholders to build cohesive partnerships throughout the decision-making process as indispensable. Partnerships include: the actors involved in decision-making and their roles played in the different activities; specific actions, behaviors, and the sequences during the activities; importance of decision points; interactions between activities and actors involved in the process; and management teams' systems, tools, and methods used for the coordination of activities (Russo et al., 2015). The practice managers attempt to keep their stakeholders well-informed about all activities involving their interests, such as quality health care, cost containments, and value-based community services. This appears to be a good selling point to all involved, as inclusiveness among those with the most to gain from how decision-making occurs can promote positive partnerships that cultivate and strengthen business and client relationships in a managed-care paradigm. When applying Simon's (1960) ideology, it appears mandatory for practice managers to explore various opportunities to include their stakeholders with their business decisions. This includes weighing the risks, benefits, and alternate choices that meet the needs of everyone involved. This approach is likely to merge partnership efforts with practice managers' leadership and management attributes.

Scholars emphasized practice managers' leadership and management attributes as causation for effective or failed decision-making strategies (Chreim & MacNaughton, 2015; Issel, 2015; Singer et al., 2015). Bach and Walker (2013) and Elf et al.(2015) advised that aspects of leadership and management competencies are real and valuable, have a focus on tangible performances and behaviors during the delivery of health care

services, and how practice managers should envision their organization's needs. The results of practice managers' responses allude to practice managers making the most of partnering with their stakeholders to find common ground with them during the decision-making process. This evokes a demand to maximize practice managers' endeavors that embrace inclusion and display how their stakeholders are integral components within their primary care team's decision-making processes.

Practice managers' efforts for inclusion appear congruent with Dr. Barbara Starfield's (1991; 1992; 1994) structure of the primary health care model: initial contact for health care services, continuity of health care treatments, point of health care referrals, and the overall management of health care services. This illustrates that practice managers are adamant regarding approaches to let their stakeholders known what they can offer in their primary health care departments to meet their patients' necessities while providing them with alternative choices and options. Using Simon's (1960) ideology, this manifests as practice managers allowing their stakeholders to guide the managed-care paradigm by giving them choices or alternatives and letting them decide what is suitable to them. This approach acts as a resourceful strategy to get stakeholders to accept their primary health care departments' use of a managed-care paradigm, as it appears to give them viable options when they work with practice managers that leads to enhanced health care management. Terrell and Rosenbusch (2013) and Lundberg (2014) advised that this methodology supports practice managers with developing/learning intuitively leadership and management techniques, as they deploy ad hoc approaches to partnering via inclusive decision-making strategies.

Theme 4: Accountability

Centered on practice managers' responses to the overarching research question and the three subquestions, accountability in a managed-care paradigm connects how practice managers take responsibilities for what arises under their span of control. By virtue of practice managers' roles, they are the decision makers in their primary health care departments. They navigate how their departments function, and they influence the outcomes of activities under their command by means of their behaviors. Data in the health care literature established that practice managers' behaviors are anticipated to construct a principle organizational tone/climate that can impact collaborative activities in their health care organizations (Lee, 2015; Wai & Bojei, 2015; Yardley et al., 2015). Scholars noted that those in leadership positions, such as practice managers, should be positive, active, and engaged communicators that can persuade and influence, rather than being seen as commanders or scorekeepers forcing those under their leadership authority to participate in a managed-care paradigm (Carter, 2013; Labrie and Schulz, 2015). This symbolizes that accountability connects practice managers' collaborative activities with their stakeholders to their primary health care departments' ability to sustain and propel their organizational objectives. Further, Gulbrandsen (2014), Nundy and Oswald (2014), Trastek et al. (2014) concluded that practice managers' collaborative efforts can create open communication forums that stimulate suggestions/ideas that could transform decision-making processes, collaborative health care engagements, and health care groups' participation and interactions in a managed-care paradigm. This signifies that practice managers take accountable actions to ensure that they establish appropriate

boundaries that leads to effective working relationships, build trustful health care advice, project respectful health care climates, and create value, purpose-driven management approaches in a managed-care paradigm.

How practice managers communicate with their physicians and patients is significant for setting the climate in their primary health care departments. This asserts that how practice managers ensue appropriate climate control is indicative on how they behave, and how they administer policies and procedures under their leadership authority. Scholars have submitted that leaders and managers take accountable actions based on how they interact with and respond to their stakeholders, therefore, contributing to their decision-making climate (Byrne et al., 2015; Dusi et al., 2014; Sirois & Hirsch, 2015). There seems to be aspects of accountability that are parallel to managing LMX, applying leadership styles, displaying varies leadership traits, and implementing team building tasks during the decision-making process. Aspects of LMX, leadership styles, leadership traits, and team building tasks appear to designate what, how, when, and where practice managers will perform and project the likely outcome of organizational climate. This describes the value of practice managers' actions via collaborative activities with their stakeholders, and their willingness to be accountable for the exchanges of activities between them and their stakeholders.

Aspects of accountability also interpret as ensuring physicians and patients are in the right place, at the right time, and have the right resources to acquire effective primary health care services at all times. Scholars have emphasized the value of removing barriers and improving access to health care services (Addicott & Shortell, 2014; Bhattacharjee &

Ray, 2014) and the commitment for pursuing equality in the health care services (Alden, 2014; Hung & Jerng, 2014) as fundamental responsibilities of the organizations' leaders. The practice managers recognize that networking with external stakeholders and those that will benefit from their services can satisfy those fundamental responsibilities, as well as allowing them to reposition their resources in their primary health care departments to deliver successful outcomes.

The results of practice managers' responses propose that practice managers work diligently to build lasting relationships with vendors that can affect how they deliver and manage access to primary health care. The health care literature and interviewing data uncovered that practice managers build alliances with MCOs to control the cost of health care services (McManus et al., 2015; Russo et al., 2015). Having positive alliances can assist the practice managers with being accountable for their capital expenses, as they negotiate for health care services that are subcontracted to managed network specialists.

These positive alliances are regarded as being accountable because the practice managers devote a substantial amount of time with their external vendors, such as during site visits and meetings, conference calls, presentations, and peer-to-peer retreats. The objective appears to be a need to construct mutual knowledge and structures between all stakeholders so that everyone can present their analyses regarding what it would take to conceive and implement effective decision-making strategies affecting primary health care delivery in a managed-care paradigm. Ellen et al. (2014) noted that any deficient structures increase barriers that encourage problematic trust situations and fuse attitudes and behaviors issues, therefore, affecting practical decisions and rational thinking.

Further, practice managers are accountable to ensure that deficient structures do not impede their relationships with physicians and patients. The health care literature has shown that physicians are not satisfied with their new roles in a managed-care paradigm (Birch et al., 2015; Lee, 2015; Mason et al, 2015). Physicians perceive that because of their job position or stature in the health care profession, they are entitled to the respect and advantages that comes with the providing patient care. Nielsen and Nielsen (2015) and Valmohammadi and Ahmadi (2015) warned that due to the complexity of operating in a managed-care paradigm, physicians are frequently associated with the successes or failures of their organizations. The results of practice managers' response indicate that strife does exist between them and their physicians. I construe this as one of the practice managers most critical challenges when accepting accountability for creating climate of excellence. The results of practice managers' responses highlight that practice managers are eager to develop professional relationships with their physicians and maintain accountability by way of resolving existing conflicts.

The interviewing data disclosed that practice managers try to maintain their accountability with their physicians by having open, honest encounters so that they do not send mixed messages to them regarding what is required to function in a managed-care paradigm. Practice managers strive to keep the interactions sociable, but with a professional tone. If physicians do not agree with the practice managers decisions, the practice mangers have processes in place to resolve their issues, such as surveys, open door policies, regular monthly meetings, and being accessible. Practice managers are not intimidated by the physicians' job positions and they are not afraid to utilize their HR

department to restore order within their primary health care departments and to provide quality and cost effective care to their patients.

Patients are demanding timely and common sense health care management with respect to quality, care, and value-based health care (Alhaddi, 2015; Arroliga et al., 2014; Melo et al., 2014; Trastek et al., 2014). In 2014, 95% of patients assessed in the AHA survey, associated the value of quality and cost to safety, person-centered care, effective health care treatments, and health care promotion (KKF, 2015). The results of practice managers' responses depict practice managers' accountability as being eager to foster professional interactions with their patients. The health care literature and interviewing data exposed that practice managers consider that accountability with their patients is by means of effective communication (Chreim & MacNaughton, 2015; Issel, 2015; Singer et al., 2015). Practice managers connect communication as a two-way process, and that it can be non-verbal as well as verbal. Practice managers' accountability also appears to have aspects of building respectful interactions when communicating with their patients via positive engagements, such as expanding open, equal-access to health care, providing forums to distribute health care information, being attentive when patients express their concerns, providing feedback, and being active in their local communities to build social capital. When applying Simon's (1960) ideology, accountability appears as encouraging a balance between power and authority, and offering a rational approach to ensure that all stakeholders' need are being met without being disrespectful. When practice managers are accountable in their departments, it appears that they are able to create economic growth via progressive negotiations and policies that decrease cost and increase quality.

Limitations of the Study

Several limitations were relevant for the study, such as the research design, practice managers' perspectives regarding the research phenomenon, and any unpremeditated biases toward aspects of leadership and management, decision-making strategies, and deploying a managed-care paradigm in primary health care. To collect purposeful data, selecting a suitable research design was paramount for achieving meaningful results. Since I sought to gain practice managers' perspectives of the research phenomenon, a specific research methodology was required to capture data from a categorical group of research participants. To effectively capture the data, I had to set aside my knowledge and past experiences of leadership and management in the health care industry and remain objective throughout the study.

The most practicable research design was qualitative in nature with an exploratory strategy of inquiry. Although this approach had limitations, this research design was applicable for asking direct questions to elicit the research participants' responses to the research phenomenon. To query the right group of participants exposed to the research phenomenon, my research participants were recruited via homogeneous purposive sampling technique that only sought to interview practice managers assigned to primary health care departments with a college degree and had extensive experience in the specialty. Due to cost, travel, and time constraints, only practice managers located in Hampton Roads, VA were recruited. This limited the number of eligible practice managers for participation to 30, and the research participants did not represent all demographical areas in the United States, such as all rural areas or metropolitan areas. As

the practice managers met the educational and experience requirements for participation, I expected all practice mangers to respond with open, honest answers to the interview questions to increase the value of the study. Although the number of eligible practice manager was small, only 14 practice managers (n = 2, pilot study; n = 12, main study) were needed to complete the study.

As the sole researcher, data collector, data analyst, and data transcriber during the pilot study and the main study, this presented a limitation. I came into the study with over 30 years of health care administration experience, which was disclosed to the practice managers, as I had opinions regarding the research phenomenon. It was imperative that I remained objective and not direct my biases toward the practice managers, how they responded to the interview questions, and have an influence on the results of the study. My past experience posed a risk to the study, as I possess the necessary KSAOs for formulating and implementing organizational change methodologies that can influence leadership and management protocols. By the nature of the research design and disclosing my experience, this could have coerced the practice managers' answers to the interviews questions.

As described in Chapter 4, to minimize the effects of the limitations and to enhance the trustworthiness of the study, I meticulously managed all aspects of the study. Per Maxwell (2013) and Patton (2015), qualitative research requires rigorous fieldwork, the researcher's credibility, and generating valuable data sets. I acknowledged my professional experiences and KSAOs in the health care industry, and I conveyed this information to the practice managers before I collected data. I conducted a pilot study to

authenticate if the data collection instrument was applicable for yielding credibility data relating to the research questions. I strictly adhered to the interview protocol (see Appendix A) for gathering data and to assist with transparency during coding assignments and data interpretations. I expounded on the data collection and coding processes to the practice managers. I integrated member checking and reviewed how I coded the data throughout the data collection and content analysis process. I remained neutral of the data collection process, and I did not place any judgements on the practice managers' perspectives that they provided. I produced complete data sets and provided rich, thick descriptions that could allow other scholars to apply the same research design to different settings or other contexts. I created an audit trail of all data provided from the practice managers with all notes and reflexivity journal data included.

Recommendations

This qualitative exploration study sought to gain practice managers' perspectives regarding their decision-making strategies. Their perspective was sought to explore how their decision-making strategies affect, or perceived to affect, primary health care, physicians, and patients in a managed-care paradigm. It was well documented in the health care literature that health care is an emergent business with complex challenges facing those tasked to lead and manage their organizations' business objectives in the 21st century (Arroliga et al., 2014; Concannon et al., 2014; Cottrell et al., 2015; Herremans et al., 2016). The health care literature also emphasized that all leadership and management tasks are situational endeavors (Broqvist & Garpenby, 2015; Elf et al., 2015; Lepora & Pezzulo, 2015; Rissi et al., 2015). Complex situations necessitate active

engagements when leading and managing multiple aspects of health care organizations to achieve a climate of excellence with business and client relationships (Arroliga et al., 2014; Ellen et al., 2014; Palfy, 2015). The strength of this study is displayed by means of engaging in meaningful dialogue with practice managers to elicit their perspectives on the research phenomenon. This is also supplemented with limitations, such as restricting the study only to collecting practice managers' perspectives without considering or merging other aspects of primary health care's, physicians', and patients' challenges into the decision-making process. Since leading and managing assets in the health care industry are interpreted as complex and challenging business processes, and substantiated on practice managers' responses during the interviewing, further research is recommended to explore those strengthens and limitations.

Scholars, such as Godager et al. (2015), March et al. (2015), and Zabaleta-del-Olmo et al. (2015), noted that primary health care is the linchpin for accessing the health care system and acquiring additional specialty and sub-specialty health care. Although the scholars methodically addressed aspects of the primary health care system and what physicians and patients expected in a managed-care paradigm, they failed to address, from the lens of practice managers, the practice managers' perspectives of their decision-making strategies. Accordingly, this study explored and delineated aspects of practice managers' perspectives regarding their decision-making strategies in a limited capacity. Further research would be noteworthy to address the practice managers' perspectives in a broader format, such as the impact of primary health care in both rural areas and metropolitan areas. Making decisions in rural areas and metropolitan areas also can be

explored from their geographically locations, such as the impact of primary health care in the north, south, east, and west coasts of the United States.

Wide-ranging primary health care research is recommended for exploring and comparing the variabilities in geographical areas to uncover if locations of the primary health care departments could influence practice managers' decision-making strategies. Broader geographical research that are centered on the relationships between practice managers in primary health care and MCOs' locations; their alliances with physicians, patients, and MCOs; their objectives during health care delivery; the variances of social and financial capital within diverse areas; and the health care cost amalgamated with specific regional areas, could reveal other aspects of practice managers' behaviors in a managed-care paradigm. Exploring an all-inclusive demographic is recommended to comprehend practice managers' power and influence over diverse stakeholders in primary health care. This data could provide further in-depth, rich detailed data sets for delineating practice managers' decision-making strategies in a managed-care paradigm.

Lastly, I recommend further research that quantifies the impact of physicians', patients', and MCOs' perspectives of practice managers' decisions. Other scholars, such as Alhaddi, (2015), Arroliga et al. (2014), Melo et al. (2014), and Trastek et al. (2014) reported that practice managers respect the values/opinions of their stakeholders. They noted that seeking and meeting their stakeholders' needs are significant aspects required for creating a climate of excellence in a managed-care paradigm. Measurable data, such as surveys or questionnaires, have the ability to display statistical data that could provide meaningful correlations regarding how MCOs, physicians, and patients appraise practice

managers' attitudes, behaviors, opinions, or other defined variables with the totality of leading and managing primary health care in a managed-care paradigm. This data could have value when generalizing the results from a larger sample, such as a broad-range of research participants from geographically locations in the north, south, east, and west coasts of the United States. This data could provide further in-depth, rich detailed data sets for delineating practice managers' decision-making strategies in a managed-care paradigm.

Implications

The study was centered on how practice managers made decisions that affect, or could be perceived to affect, a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm. The focus of the study was to fill the gap in knowledge regarding how practice managers conceive and implement their leadership and management duties. I utilized Simon's (1960) ideology of decision-making strategies in a management environment to guide the study and assist with eliciting practice managers' responses throughout the data collection, data analysis, and data interpretation processes. The findings of the study are significant, as the results of the practice managers' responses provide qualitative indications that could have positive influences toward the delivery of practice, theory, and social change aspects of primary health care in a managed-care paradigm.

Significance to Practice

To promote quality health care services, health care organizations are expected to be empathetic and compassionate to patients' needs and provide physicians with the tools

they need to deliver quality health care services (Piña et al., 2015; Zabaleta-del-Olmo et al., 2015). To meet physicians' and patients' expectations, it is necessary that health care organizations have committed, sustainable, and competent leadership and management teams in place that can direct the delivery of quality health care services (Alhaddi, 2015; Arroliga et al., 2014; Melo et al. 2014; Trastek et al, 2014). Health care is a complex, evolving business process that must be appropriately led and managed to deliver quality, cost effective health care services, in particular primary health care (Concannon et al., 2014; Cottrell et al., 2015; Herremans et al., 2016). Practice managers are accountable for meeting those expectations and must have appropriate strategies in place that can achieve their organizations' business objectives.

The results of practice managers' responses describe that practice managers should make improvements to their organizational structures to gain a competitive edge in the health care industry. Practice managers advocate that health care is a business and gaining a competitive edge is paramount. Therefore, certain processes must be in place to ensure that their organizations are at the top of the health care industry. Accordingly, practice managers should continuously review their policies and procedures to assess if their strategies in place are effective. This suggests that when practice managers make decisions, they must weigh all the risks associated with the desired outcomes, then they must heavily invest their resources, such as financial and social capital, to produce long-term, high-level ROIs.

It appears that practice managers must seek ways to promote quality primary health care in their departments during challenging times by engaging in collaborative

interactions with their stakeholders. This insinuates a necessity for shaping meaningful rapports that can create better opportunities to acquire stakeholders' perspectives and advance practice managers' overall business objectives. It appears that practice managers are ready to progress forward by adopting methodologies to get their stakeholders to share the same vision needed to create a harmonious organizational climate that leads to being competitive.

Significance to Theory

As noted, a managed-care paradigm is an entity of management. By virtue of practice managers' roles, they are the decision makers in their primary health care departments. The study was a means for exploring and delineating practice managers' decision-making strategies in primary health care, specifically, when the practice managers deployed a managed-care paradigm as one of their strategic business objectives. Simon's (1960) ideology of decision-making strategies in a management environment served as a guide for navigating the study. Simon stated that decision-making strategies are constructed on a succession of exchanges, such as intelligence, design, and choice processes, with respect to bounded rationality/rational choice and exchange processes. Additional insight was gained from eliciting practice managers' responses and presented further knowledge for inclusion in the health care literature.

The outcomes of practice managers' responses indicate that practice managers must be able to create well-organized business operations. They must be able to apply applicable organizational structures in their primary health care departments by means of executing effective decision-making strategies. Successful practice managers must survey

themselves to ascertain if changes are necessary, intermingle with their stakeholders to scrutinize their perspectives of current situations, use stakeholders/group relationships to obtain a competitive advantage, and make frequent assessments of their overall primary health care departments to sustain and propel their business and client relationships. This necessitates that practice managers are the benchmark for excellence at their health care organizations. Practice managers' actions, behaviors, and attitudes must display positive leadership and management values/ethics that can generate an organizational tone/climate that must influence interactions, collaborations, communications, and efficiencies in their health care organizations (Lee, 2015; Wai & Bojei, 2015; Yardley et al., 2015).

When deploying aspects of Simon's (1960) ideology, it appears mandatory for practice managers to explore various opportunities to include their stakeholders with their business decisions. This includes weighing the risks, benefits, and alternate choices that meet the needs of everyone involved. This implicates as practice managers allowing their stakeholders to guide the managed-care paradigm by bestowing choices or alternatives to them, then allowing their stakeholders to decide what is a suitable course of action to take that meets their needs. This approach is likely to generate positive actions, behaviors, and attitudes that, theoretically, could yield effective results.

Significance to Social Change

In the current health care literature, scholars have not clearly delineated how practice managers make decisions. Closing the gap in knowledge in the health care literature could add to positive social changes, as practice managers' decision-making strategies have the potential to improve patients' ability to access primary health care

services, strengthen physicians' capacity to deliver effective health care treatments, and support collaborative physicians' and patients' interactions. Based on practice managers' perspectives of the research phenomenon, this study reveals data that have the potential to support practice managers' endeavors to create positive social change within their span of control. The following underscores practice managers' efforts to bring about positive social change through social and financial capital resources, such as:

1. conduct community town hall meetings and open house-style health care workshops to seek feedback from stakeholders and to ensure that they understand how the health care organizations conduct their business;
2. present seminars with MCOs to provide education on the operation of a managed-care paradigm;
3. promote population health care management to ensure that wellness within the community populace is the expectation;
4. valuing what stakeholders feel, think, say, and how they react to certain actions, as this place an emphasis on stakeholders' significance in the community;
5. institute a nurse-patient telephone call system to keep up with patients' needs and make them a part of the team;
6. implement home health care and telemedicine to patients that cannot physically meet with their PCP;
7. construct free primary health care clinics for patients that cannot afford basic health care; and

8. partner with pharmaceutical vendors to provide medicines at no cost or reduced cost.

Emerging research implies that the delivery of health care services is an important commodity for every U.S. citizens to possess (Addicott & Shortell, 2014; Hawthorne et al., 2014). Health care organizations are expected to provide patients with open ease of access to health care services and allow physicians to share scientific research evidence that is beneficial when delivering quality health care treatments to patients served in their health care communities (Piña et al., 2015; Zabaleta-del-Olmo et al., 2015).

Conclusions

Since the inception of Dr. Barbara Starfield's initial visualization of primary health care modeling, practice managers have been challenged with making humane decisions to improve the social justice of those seeking adequate health care by means of primary health care in some form of a managed-care paradigm. Health care is a complex, evolving business. Practice managers assigned to primary health care departments are expected to effectively lead and manage their business operations with regards to cost, quality, and value that influence those that they serve. The 14 practice managers ($n = 2$, pilot study; $n = 12$, main study) in this study faced numerous difficult challenges regarding establishing and cultivating a climate of excellence with business and client relationships in their organizations. Throughout the data collection process, the practice managers gave their insight on how they make strategic decisions that affect, or could be perceived to affect, a climate of excellence with their business and client relationships, primary health care, physicians, and patients in a managed-care paradigm.

The results of the interviewing data reveal that practice managers continuously review their policies and procedures to assess if their strategies in place are effective. It appears that practice managers methodically create programs that contribute to pathways for receiving primary health care, such as home health care, free health care clinics, subsidized health care, free transportation, or better access to health care. This solidifies that practice managers' strive to give their stakeholders positive health care experiences that could manipulate their positive expectations and positive outcomes. Further, practice managers build alliances with MCOs, physicians, and patients to control the cost, quality, and value of the health care services that they deliver (McManus et al., 2015; Russo et al., 2015). Upward positive alliances could assist practice managers become change agents and improve their overall decision-making strategies, establish and cultivate interactions with their stakeholders that could construct robust relationships, reinforce partnerships with their stakeholders for enhanced collaborations, and strengthen accountability during social and financial capital expenditures. I anticipate that the results of my study could serve as an instrument to bridge the gap in knowledge regarding practice mangers' decision-making strategies in a managed-care paradigm and add to the gap in the health care literature. This could add to positive social changes, as practice managers' decision-making strategies could improve patients' abilities to access their primary health care services, strengthen physicians' capacity to deliver valuable health care treatments to their patients, and support collaborative physicians' and patients' interactions.

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Appendix A: Interview Protocol

Interview Protocol

Pre Interview Discussion

Research Topic and Problem

There is a gap in knowledge regarding practice managers' decision-making strategies that affect, or can be perceived to affect, a climate of excellence with business and client relationships, primary health care, physicians, and patients in a managed-care paradigm.

Purpose for Interview

To address the research topic/problem, the interview is a qualitative research to engage in an in-dep exploration to gain deep, rich knowledge that could lead to what aspects influence practice manager's decision-making strategies and delineate how they conceive and implement their strategic processes in a managed-care paradigm.

Ethical Procedures

Before conducting the study, an Institution Review Board (IRB; IRB approval # 06-15-16-0371173) approval was approved by Walden University. Walden University's IRB assist with ensuring that all human rights of practice managers are protected before, during, and after the study. All data collected are held in strict confidence. Interview participation is voluntary. All practice managers have the right to refuse to be interviewed, stop the interview at any time, and/or refuse to have the information they provided to be used in the study. The interview is audio recorded for accuracy of data collected and to assist when the data is transcribed.

Interview Consent

Practice managers can consent or not consent to participate in the study.

Questions

Are there any questions before the start of the interview?

Interview Questioning Guide

Opening Interview Prompt

In 2015, the Agency for Healthcare Research and Quality declared that the main goal of health care organizations should be to identify the most effect ways to organize, manage, finance, and deliver high quality patient care within its span of control. What are your thoughts about this statement?

Interview Questions

1. What does it mean to establish and cultivate climate of excellence in health care organizations?
   a. Why do you think practice managers are important in health care organizations' efforts to establish and cultivate a climate of excellence?
   b. How do you establish and cultivate a climate of excellence at your health care organization?
2. What does it mean to deploy a managed-care paradigm at your health care organization?
   a. How do managed-care organizations affect your health care organization?
   b. How do you manage your relationships with managed-care organizations?

3. Why is primary health care important when deploying a managed paradigm at your health care organization?
    a. Describe your definition of what the term “health care experiences” mean?
    b. Describe what is value-based patient care in primary health care?
    c. How do you manage health care cost at your primary health care department to ensure that it aligns with your health care organizations’ business objectives in a managed-care paradigm?
    d. How do you manage patients’ access to care at your primary health care department to ensure that it aligns with your health care organization’s business objectives in a managed-care paradigm?
4. Why are physicians important to primary health care departments at your health care organization when deploying a managed-care paradigm?
    a. Describe your relationships with physicians at your primary health care department?
    b. How do you manage physicians’ actions and behaviors when they deliver health care treatments to patients at your primary health care department to ensure that they align with your health care organization’s business objectives in a managed-care paradigm?
    c. How do you manage the relationship between physicians’ expectations for primary health care delivery and your health care organization’s business objectives in a managed-care paradigm?

5. Why are patients important to primary health care departments at your health care organization when deploying a managed-care paradigm?
    a. Can you describe your relationships with patients at your primary health care department?
    b. How do you manage patients' actions and behaviors when they receive health care treatments from physicians at your primary health care department to ensure that the end results align with your health care organization's business objectives in a managed-care paradigm?
    c. How do you manage the relationship between patients' expectations for primary health care treatments and your health care organization's business objectives in a managed-care paradigm?

End the Interview

Interview Closing Prompt

Thank you for providing data during the interview and participating in the study. All data collected are confidential and your privacy is respected. If you have any additional questions or concerns about the study in the future, please contact me. I will provide you with a copy of your interview transcript for your review to verify that I have documented your responses to the interview questions accurately. If additional data is required, I will contact you. I will check with you for the duration of the study to ensure that all procedural and ethically requirements are meet for the completed dissertation.

Questions

Are there any questions before the interview ends?

Appendix B: Recruitment Letter

XX/XX/2016

Greetings XXXXXXX,

My name is Lawrence R. Ford and I am a doctoral student at Walden University pursuing a Ph.D. in Management with a specialization in Leadership and Organizational Change. I am conducting a research study on how practice managers working in primary health care departments make strategic decisions in a managed-care paradigm. The purpose of my research study is to conduct qualitative exploratory research and engage in an in-depth exploration to delineate aspects of practice managers' decision-making strategies, as they establish and cultivate a climate of excellence with business and client relationships in a managed-care paradigm.

I invite you to participate in my research study. Your participation in my research study is voluntary and any data collected during the research is strictly confidential. Enclosed with this letter is a copy of the informed consent form for your review. If you agree to participate in my research study, I respectfully request that you share your decision-making perspective during one face-to-face, audio recorded interview that should last about 45 minutes to 60 minutes. Before the interview, I will ask you to review and sign the informed consent form. The data that you provide during the interview will be used for my research dissertation and possible for future publication. If you are interested in participating in my research study, or if you have any questions or concerns, please contact me via email at lawrence.ford@ waldenu.edu or via telephone at (XXX)

XXX-XXXX. My Chairperson/supervising faculty is Dr. Lilburn Hoehn. If needed, you can contact him via email at lilburn.hoehn@waldenu.edu or via telephone at (XXX) XXX-XXXX. Within the next few days, I will contact you to answer any questions or concerns that you may have regarding my research study. Thank you in advance for your consideration.

Best Regards,

Lawrence R. Ford

Lawrence R. Ford
Doctoral Student, Walden University