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Strategies for Successful Implementation of Change Initiatives in Health Care

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Abstract

Strategies for Successful Implementation of Change Initiatives in Health Care Organizations

by

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MS, Western Governors University, 2011

BS, University of Phoenix, 2008

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Changing regulations, increased competition, and evolving customers' expectations have necessitated significant organizational changes in the health care industry. This multiple case study investigated the strategies of senior managers from 3 California health care organizations to implement significant change initiatives. The participating organizations had a positive reputation for successfully implementing change. Data from interviews and a review of organizational documents were analyzed through the conceptual lens of Lewin's phases of change model and Kotter's 8-step process for implementing change. The analysis revealed 3 general themes: communications, training, and employee involvement. The managers of each participating organization emphasized the importance of keeping employees informed, and the importance of continuous bidirectional communication between all levels of the organization. They emphasized that communication facilitated a smooth and timely implementation of the planned change; they also noted the importance of training to assist employees in adapting to new job requirements and new technology. However, it was noted that the managers did not undergo any formal training in change implementation. Participants also emphasized the importance of employee involvement in the form of consultation concerning aspects of the implementation. Contrary to Lewin and Kotter's assumptions, the employees had no say in the initial decision to change, how to change or when to change. These findings have positive social change implications by assisting managers of health care organizations to improve their strategies for implementing change initiatives.

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Dedication

I would like to dedicate this study to my three children, Drenna Lynn, Ryzen Chance, and Velocity Lynn, who allowed me to achieve my goals and be a role model for them. This study is also dedicated to my loving husband, Julio, who never let me quit when the times got tough and for always being a shoulder to cry on. To my parents for their continuous support and always being a listening ear when I needed to talk it all out. To Tiffani and Brittany, my beloved sisters, who always love me no matter what and push me to keep going.

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Section 1: Foundation of the Study

In today's dynamic and uncertain business environment, organizational change is an essential part of an organization's life (Vakola, 2013). However, the literature on costly failed change initiatives abounds (Naotunna, 2013). Change is challenging in the health care industry, and more than ever managers need to understand how to successfully implement change initiatives in the health care industry to avoid high-cost failures (Jones & Recardo, 2013; Mosadeghrad, 2013). This section includes a discussion of the background of the problem, the problem, the purpose of the study, the research questions, the significance of the study, the nature of the study, key definitions of terms, and a comprehensive literature review.

Background of the Problem

Change in an organization is challenging to plan for but is essential for survival (Swanson & Creed, 2014). Mental and chronic diseases and an aging population necessitate vast changes in the health care industry (Anders & Cassidy, 2014). Historically change initiatives in a health care organization have been necessitated by changes in technology and medicine, but recently have also been driven by increasing rules and regulations accompanying the Affordable Care Act (ACA) (Longenecker & Longenecker, 2014). The low success rate of change initiative implementation indicates a need for further research on change initiatives to find implementation strategies that improve the success of change implementation in health care organizations (Longenecker & Longenecker, 2014).

Factors affecting change initiative implementation include (a) an organization's culture and change capacity (Buono & Subbiah, 2014), (b) readiness for organizational change (Choi & Ruona, 2011), (c) resistance to change by employees (Simoes & Esposito, 2014), and (d) the capability of managers to communicate and facilitate the need for change (Nordin, 2013). The growing number of factors that a leader must overcome for a successful change initiative increases the need for effective organizational change and improvement (Longenecker & Longenecker, 2014). Senior health care managers need strategies for implementation of change initiatives. Findings of this study may contribute to professional practice by providing implementation strategies that health care managers may use to implement change in their organizations.

Problem Statement

Urgency surrounds the need for successful change implementations in the health care industry due to new regulations, increases in patient volume, and emerging technology (Longenecker & Longenecker, 2014). However, many researchers have claimed that up to 70% of change initiatives fail across all industries (Jacobs, van Witteloostuijn, & Christe-Zeyse, 2013). The general business problem is the inability for some health care managers to implement change initiatives resulting in the high failure rate of change initiatives in health care organizations. The specific business problem is that some senior health care managers lack implementation strategies for change initiatives.

Purpose Statement

The purpose of this qualitative multiple case study was to explore implementation strategies for change initiatives used by some senior health care managers. The specific population consisted of three senior health care managers from each of three different health care organizations located in Hanford, California, who have successfully implemented change initiatives in their organizations. The findings from this study may contribute to professional practice by providing implementation strategies that health care managers may use to successfully implement change in their organizations; findings may further contribute to social change through the improvement of health care delivery.

Nature of the Study

Research methods used in business research include qualitative, quantitative, and mixed methods. The qualitative methodologist searches for patterns and meanings in the perceptions of the participants (Marshall & Rossman, 2011). In a qualitative study, questions are open-ended, which helps researchers delve deeply into a specific phenomenon (Szyjka, 2012). Quantitative methods are statistics oriented and used to test an experimental hypothesis (Yilmaz, 2013). A quantitative approach was not appropriate for this study because my purpose was not to test a hypothesis. A mixed-methods approach is a combination of quantitative and qualitative methods to compensate for weaknesses of each (Small, 2011). This approach was not appropriate for my study because the purpose was not to complement or test data. I used a qualitative method in this study to enable me to explore the why and how of the phenomenon through the

experiences of senior health care managers regarding implementation strategies for organizational change through the collection, analysis, and interpretation of data.

Qualitative research designs include case study, ethnography, and phenomenology. A researcher uses an ethnographic design to focus on a pattern within a specific culture (Petty, Thomson, & Stew, 2012), which was not the intent of this study. A phenomenological design enables a researcher to explore a specific phenomenon through the lived experiences of the participants (Petty et al., 2012) and may provide clarity about the phenomenon (Moustakas, 1994). Exploring lived experiences of participants was not the purpose of this study. According to Yin (2014), researchers use a case study design to explore a phenomenon within a physical world situation that has multiple sources of evidence. A case study design was appropriate for this study because it enabled me to investigate and complete an in-depth analysis of the implementation strategies used during change initiatives by health care managers in specific organizations.

Research Question

The central research question for this study was the following: What implementation strategies do some senior health care managers use for change initiatives?

Interview Questions

I asked the following open-ended questions through semistructured interviews with senior health care managers to explore the implementation strategies for change initiatives in health care organizations:

1. What has been your experience with implementing change initiatives?
2. What implementation strategies have you utilized for change initiatives?
3. What steps did you follow when implementing a change initiative?
    a. How did you plan these steps?
    b. Who in the organization was involved in the planning process for the change initiative?
    c. What communication methods did you utilize during the implementation of change initiatives?
4. What implementation strategies resulted in successful implementation of the intended changes in your organization?
    a. Based on your experience with these changes initiatives, what were the strengths of your implementation strategy?
    b. What were the weaknesses of your implementation strategy?
5. What implementation strategies failed to result in successful implementation of the intended changes in your organization? Please explain why they were not successful.
6. What additional information regarding the implementation of change initiatives would you like to share?

Conceptual Framework

Lewin's (1947) phases of change model and Kotter's (1995) eight-step process for implementing change served as the conceptual framework for this study. Unfreezing, change, and refreezing are the three-phases of Lewin's model. Lewin emphasized the

significance of change as a process and not as a separate platform. Kotter's eight steps for implementing change were based on lessons learned from cases he observed to be successful: (a) create urgency to overcome complacency, (b) build a team of leaders and managers to drive the change, (c) create an effective vision and strategy, (d) tell everyone about the change vision, (e) empower employees to apply the vision to work, (f) present short-term benchmarks and wins, (g) keep the momentum of change with more changes, and (h) cultivate a culture of change.

In this study, I asked the participants interview questions and analyzed relevant documents from the organizations. Kotter's (1995) model was applicable to this study because it provided direction on how to successfully implement changes. I analyzed whether Kotter's eight-step process and Lewin's phases of change model had any influence on successful implementation strategies.

Operational Definitions

Change capacity: The ability of an organization to make changes continuously as a typical practice of expecting and reacting to the changes in its environment (Buono & Subbiah, 2014).

Change readiness: The frame of mind that employees have when encountering changes in an organization (Vakola, 2013).

Strategy: A dynamic force that involves a continuous search for opportunities, a recognition of initiatives that will be the most beneficial, and implementation of initiatives quickly and efficiently (Kotter, 2012).

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions are vital to the study but are not within the researcher's control (Bernard, 2013). An assumption is something the researcher is not able to confirm but assumes to be true (Silverman, 2013). I assumed that participants would be honest, open, and accurate in their answers.

Limitations

Limitations are weaknesses of a study that are beyond the control of the researcher (Babbie, 2015). One limitation of my study was that the sample size of three organizations may not represent other organizations in my region. A second limitation was the participant's ability to identify with his or her personal biases regarding a success or failed change initiative. A third limitation was that the results of the study might not transfer to other industries or organizations since qualitative research is not generalizable.

Delimitations

Elements in a study that establish the boundaries and define the scope of the study are delimitations (Mitchell & Jolley, 2012). The purpose of this study was to explore implementation strategies developed and implemented by some senior health care managers located in Hanford, California. The questions only addressed strategies for implementation initiatives and did not address other administrative issues in health care management. In addition, personnel other than senior health care managers involved in change initiatives were not included in the study.

Significance of the Study

Contribution to Business Practice

Failed change initiatives in organizations can lead to financial loss (Longenecker & Longenecker, 2014). The findings from this study may contribute to existing information on strategies for successful implementation of change initiatives. The beneficiaries of successfully implemented change initiatives in the health care industry may include (a) patients who may benefit from a reduction in wait times and more time with health care staff, (b) health care staff who may experience less frustration, and (c) organization leaders who may experience enhanced performance in the quality of care provided (Moore & Buchanan, 2013). Assisting senior health care leaders in understanding implementation strategies for change initiatives may benefit the health care industry by (a) improving employee morale, (b) increasing productivity, (c) enhancing efficiency, (d) increasing employee retention, (e) improving patient services, and (f) lowering cost.

Implications for Social Change

The findings from this study may assist organizations in all industries, and specifically health care organizations, improve their success in implementing change. Improvements in the health care system may create benefits for society such as enhanced patient care and lower mortality rates.

A Review of the Professional and Academic Literature

The purpose of this qualitative multiple case study was to explore implementation strategies for change initiatives used by some senior health care managers. The specific

population consisted of three senior health care managers from each of three different health care organizations located in Hanford, California, who had successfully implemented change initiatives in their organizations. The findings from this study may contribute to professional practice by providing strategies for health care managers to use for successfully implementing change in their organizations. I conducted multiple searches in the Walden Library database and then expanded the search using Google Scholar. The primary databases included ProQuest, Thoreau, SAGE, and EBSCOhost. I reviewed peer-reviewed journals, books, expert reports, and dissertations. Table 1 shows the number and type of sources used in the literature review.

Table 1

Sources Used in the Literature Review

	Total	Total more than 5 years old at graduation date	Percentage of references within 5 years of 2016 graduation (2012-2016)
Peer-reviewed journals	73	9	86%
Books	0	0	0%
Journal that are not peer-reviewed	0	0	0%
Total	73	9	86%

The literature review consists of four main subsections: (a) the conceptual framework and studies including the conceptual framework, (b) factors and barriers to change, (c) implementation strategies, and (d) the health care industry. The conceptual

framework for this study was Lewin's (1947) phases of change and Kotter's (1995) eight-step process for implementing change model. The first subsection of this literature review includes a summary of previous research based on Lewin's and Kotter's models. The Lean strategy, Six Sigma, total quality management (TQM), and Leavitt's organizational change model are frameworks included in the literature review to provide further perspective on both Kotter and Lewin's models. The second subsection on implementation strategies includes a summary of the existing research on the different strategies for implementation of a change initiative. The third subsection is a summary of factors that influence change, such as (a) communication, (b) culture, (c) resistance to change, (d) readiness to change, and (e) trust in implementation of change initiatives. The last subsection of the literature review presents the health care industry's (a) current issues, (b) effects of failed change initiatives, and (c) implementation strategy studies.

Conceptual Framework

Two important change models supporting this study are Lewin's (1947) three-phase model and Kotter's (1995) eight-step model of implementing change. In this section, I describe the two models in detail and synthesize recent studies based on these models, particularly studies focused on changes in health care. Included in this section is a discussion of the Lean strategy, Six Sigma, TQM, and Leavitt's organizational change model that either align or contrast with the models of Kotter and Lewin.

Lewin's three-phase model. Grounded in force field theory, Lewin (1947) introduced the idea of a change model consisting of three steps or phases to creating successful organizational change. Lewin suggested that change occurs in three phases of

unfreezing, moving, and refreezing. Later researchers investigated the viability of Lewin's model, and as stated by Swanson and Creed (2014) time erodes the fine points, dulls the shine, and blunts the edge. Researchers have conducted research to clarify and expands on the points made by Lewin in his original research.

Lewin (1947) focused on change efforts to be on a group and not individuals. When group values remain the same, an individual will continue to resist; however, if the group standard is first changed, then the individual resistance is reduced (Lewin, 1947). The first stage, unfreezing, refers to the process of destabilizing the status quo by identifying dissatisfaction in the status (Lewin, 1947). According to Lewin, different cases and changes may face different problems at the unfreezing stage. Researchers such as Burnes and Cooke (2013) have added their interpretation and further explanation of Lewin's original vague process. Inducing guilt or survival anxiety involves nurturing the belief among the organizational members that change is necessary if the organization is to survive (Burnes & Cooke, 2013). At this stage, old behaviors make way for the successful adoption of new behaviors or processes (Burnes & Cooke, 2013).

At the second stage, moving, the status quo is not sustainable, and change is introduced (Lewin, 1947). Those affected by change start to feel guilt and survival anxiety, and they question their physiological safety by resisting the change (Lewin, 1947). In this stage, the organizational leaders should first identify what needs to be changed and how to implement changes. Leaders should then develop an implementation strategy to meet these goals or change targets (Burnes & Cooke, 2013). Because of the complexity of forces that can affect groups as well as the members of these groups during

a change process, leaders should take into account all of these forces using trial and error to explore all possible options to bring about change (Burnes & Cooke, 2013).

The third stage of this model, refreezing, occurs after changes result in an ideal state. Refreezing is necessary to stabilize the group at a new quasistationary equilibrium (Lewin, 1947). For refreezing to occur, group life cannot return to its previous state; instead, it must gain permanency (Lewin, 1947). The new ways and behaviors adopted from the change process must correspond with or match the overall group personality as well as the environment of the organization, or this may result in a new round of disconfirmation and change (Burnes & Cooke, 2013). Change is a group activity to make sure the norms and routines accommodate new individual behaviors (Lewin, 1947). The necessity for refreezing is so the members do not return to previous behaviors (Burnes & Cooke, 2013).

The three-phase model has been widely applied in many studies (Scheuer, 2015; Van den Heuvel, Demerouti, Bakker, & Schaufeli, 2013) to introduce organizational changes. Scheuer (2015) and Van den Heuvel et al. (2013) showed that Lewin's model constitutes an operational framework that can be used to predict human behavior, especially resistance to change, while offering a solution for ensuring changes will be successful amid resistance.

Kotter's eight-step process leading to change. Another important change model used in my conceptual framework was Kotter's (1995) eight-step process for implementing change. This model is useful in planning, implementing, and sustaining the change process (Kotter, 1995). The foundation of the eight-step model addresses the eight

common mistakes that organizations make when implementing change (Kotter, 1995). To help organizations avoid mistakes in implementing change initiatives, Kotter promoted inspiration and empowerment driven by strong leadership. The eight-step process to implementing change included the following: (a) create urgency to overcome complacency, (b) build a team of leaders and managers to drive the change, (c) create an effective vision and strategy, (d) tell everyone about the change vision, (e) empower employees to apply the vision to work, (f) present short-term benchmarks and wins, (g) keep the momentum of change with more changes, and (h) cultivate a culture of change.

The first step in Kotter's (1995) change process is establishing a sense of urgency. The purpose of this step is to lead project managers in creating a sense of urgency in the organization, especially among top management (Kotter, 1995). Top management is responsible for initiating and motivating change in the organization, and a greater sense of urgency may contribute to organizing a project team with the credibility and power to guide change efforts (Kotter, 1995). This group is also responsible for convincing key stakeholders of the necessity for investing their time and efforts in the change plan. The goal is to create a need in top management and cause them to communicate the vision of change to the employees. According to Kotter's observations of companies that failed during implementation, 50% failed at the phase of creating urgency. Failing to create a sense of urgency may stem from not having enough leaders but instead having too many managers (Kotter, 1995). Kotter asserted that there must be a minimum of 75% buy in of a company's management that the status quo cannot continue. In the change process, promoting urgency involves using visuals to show what will happen to the organization

without the change, establishing goals for everyone, creating cross-sectional teams, evaluating methods of measuring success, offering rewards, and openly discussing organizational weaknesses (Van den Heuvel et al., 2013).

The second step in Kotter's (1995) model is the creation of a guiding coalition. The project manager and management must create a strong coalition of leaders in the organization to guide the change effort (Kotter, 1995). The goal is for the coalition to continue to grow; otherwise efforts will stagnate and nothing will change (Kotter, 1995). Kotter pointed out that coalition members typically include senior managers as the foundation of the group, but the coalition also includes members not in management. Kotter asserted that because guided coalitions are a mixed group, the customary hierarchy is not always followed because the customary hierarchy is usually not working. The guiding coalition is driven by the first step but will need additional help to make the coalition come together, such as retreats or anything to develop trust and shared ideas (Kotter, 1995).

The third step in Kotter's (1995) model is developing a strategy and vision for the future. This involves the creation of a well-defined vision and strategy that simplifies the path the organization needs to follow (Kotter, 1995). Kotter asserted that a vision should be simple enough to communicate it in five minutes or less and be understood. When creating a vision, change managers must lead the coalition team to adopt characteristics such as desirability, focus, flexibility, communication, feasibility, and imagination (Tvedt & Saksvik, 2012).

The forth step in Kotter's (1995) model is communicating the change vision and strategic plan to members of the change process. The vision and strategic plan gain value only after the entire organization becomes aware (Kotter, 1995). Kotter advocated that change managers avoid undercommunicating the message or giving inconsistent messages to elicit maximum support from subordinates. Kotter recommended that management use multiple forums to communicate the vision and change through training sessions, memos, meetings, performance appraisals, newsletters, and company intranet. In this step, leaders communicate the vision by leading by example to subordinates. Lastly, communication of the vision requires those communicating the vision to believe and be examples of the vision (Kotter, 1995).

The fifth step in Kotter's (1995) model is empowering employees for broad-based action. The empowering process is aimed at removing obstacles to the change process, such as resistance and indifference in subordinate employees (Kotter, 1995). This involves employee engagement to promote new ideas within the constraints of the new vision. Empowerment involves allowing as many willing participants as possible to participate because it promotes a better outcome (Kotter, 1995).

The sixth step in Kotter's (1995) model is creating short-term wins by setting easily achievable goals and manageable small initiatives. This step helps to avoid the loss of momentum and keeps the stakeholders from becoming complacent (Kotter, 1995). Short-term goals and small initiatives help to motivate people so they can see that there is progress being made (Kotter, 1995). Short-term goals and initiatives encourage

employees to not give up because their efforts are working and to ensure the sense of urgency and vision is not lost (Kotter, 1995).

The seventh step in Kotter's (1995) model is consolidating improvements and the maintenance of momentum for change. This requires the vision and change to be embedded into the organization's culture (Kotter, 1995). This step in the model recognizes that new approaches and subjects are fragile and require time to be instilled in the culture (Kotter, 1995). It is imperative that management does not declare a victory before the culture internalizes the vision because doing so may stop the changes and revert to the traditional ways (Kotter, 1995).

The eighth step in in Kotter's (1995) model requires the institutionalization of the new approaches, or incorporation of the new changes in the organizational structure and culture. Management can ensure that the changes are rooted in the culture using two main strategies (Kotter, 1995). Kotter argued that management must make an effort to show employees how performance has improved due to the new vision and changes. The second strategy is to make sure the next generation of managers is fully committed to the new ways; otherwise the changes will not be sustained (Kotter, 1995).

Many researchers used Kotter's eight-step model in their studies of organizational change. Porter, Devine, Vivanti, Ferguson, and O'Sullivan (2015) used Kotter's eight-step model to study how the nutrition care process (NCP) implementation package was perceived by Australian dietitians before and after they implemented the package. Porter et al. (2015) surveyed 35 dietitians from two hospitals that underwent informal NCP implementation, as well as 35 dietitians from hospitals that were still planning to

implement NCP. The participants completed an online questionnaire addressing their knowledge of NCP, how important they perceived the change to be, and their concerns about barriers and training (Porter et al., 2015). Porter et al. established that those who worked for the hospitals that had already implemented the NCP had higher knowledge scores and were more familiar with what NCP entailed and offered. As such, they were more confident in supporting the NCP. On the other hand, dietitians who worked for hospitals that had not implemented the NCP had more fears and anxiety over the change and were reluctant to make changes. Barriers to implementation included lack of knowledge, support, training, and resources. Most of them were worried that they did not have enough training to implement NCP and believed that if trained sufficiently, they would be more confident to implement the NCP. Dietitians who worked for hospitals that had already implemented the NCP and resisted it faced the barriers of busy workloads and work status. Facilitators of NCP implementation included allocated time to practice and consistent training and tutorials. Dietitians with supportive managers, as well as dietitians given the chance to understand how the change would benefit their practice, were more likely to implement NCP (Porter et al., 2015). Given these findings, the researchers claimed that Kotter's eight-step process for implementing change was acknowledged as the most suitable change model with the framework integrated into the package development and implementation (Porter et al., 2015).

Factors That Affect Change

Several factors shape change initiatives. These factors serve as either facilitators of change or barriers to change. Some of the most important factors discussed in this

section include communication, culture, resistance to change, readiness to change, and trust (By, Armenakis, & Burnes, 2015; Christensen, 2014).

Communication and culture. Communication and culture are important for change initiatives to work. In change projects, people change, not the organization, and successful changes occur when an individual's changes match those of the organization. There are essentials or critical success factors behind effective management of change, which include awareness, desire, knowledge, ability, and reinforcement (Christensen, 2014). Christensen (2014) conducted literature reviews and a pilot study to design a survey to explore if certain communication factors can affect attempts to make organizational changes. Christensen (2014) administered the survey to employees who experienced changes, employees who had recently finished a change process, and those who had yet to experience changes. Christensen (2014) found that contact, central leadership, availability of information, influence, and barriers to improvement can affect communication and therefore, success of changes.

Awareness is a critical success factor as the manager leads employees to a conscious understanding of the needs and implications of the planned changes (Lies, 2012; Simoes & Esposito, 2014). The key task for the manager and leader is the building of user acceptance of the plans and the creation of positive employee attitudes (Georgalis, Samaratunge, Kimberley, & Lu, 2015). A manager needs to get deeper into the organization's issues by ensuring the needs are identified both from the organization's and employee's points of view (Georgalis et al., 2015). Effective managers not only

identify needs, but also back up their findings with diagnosis and facts before carrying out any change process.

This step also creates a working relationship between management and employees as they identify needs. This identification involves educating employees about the needs and benefits of the change management system to build user acceptance (Shah, 2014; Shin, Taylor, & Seo, 2012). Studies found that as part of the user acceptance process is the securing of support from organization leaders (Cullen, Edwards, Casper, & Gue, 2014; Hwang, Arabiat, & Shin, 2015; Johannsdottir, Olafsson, & Davidsdottir, 2015; Rufo, 2012).

Employees should also be knowledgeable of the change processes. Knowledge regarding an impending change is insufficient; they must also know the processes to make the change happen (Van den Heuvel et al., 2013). In particular, Van den Heuvel et al. (2013) found that providing change information to employees could lead to positive adaptive behaviour over time because employees are able to engage in meaning making over the changes entailed. As the literature reveals, the changing of business strategy entails a change in structure. Organizational changes and innovation entail changes in the organizational dimensions, in the people, culture, structure, strategy, performance measure, processes, and technology, which must all be communicated (Bassey, Solomon, & Omono, 2014; Jacobs et al., 2013).

Managers need to be aware of the cultural preferences and differences that exist in the organization (By et al., 2015). The organizational culture affects how business processes and interactions occur, and for this reason, change management must factor in

organizational culture. The organizational structure is an important dimension because it guides how leadership, communication, and business functions are processed. Moreover, other dimensions such as strategy and processes determine goal setting, planning, strategy, mission, and direction of the organization (By et al., 2015). The purpose of change management is to improve the overall performance of the organization, and therefore change planners must consider these key dimensions (By et al., 2015).

By factoring in key dimensions in change management, a plan reduces the risks of resistance to change from the staff (Hornstein, 2015). A poor record of accomplishment of organizational change efforts has been associated with poor identification of needs with key dimensions. Poor linkage of `change with key dimensions elicits negative impressions and stress from the people in the organization (Smollan, 2015). Martin (2011) associated this need for linking needs and expectations to the key dimensions as an important step in the elimination of the barriers to change.

The conceptualizing phase is what Martin (2011) termed the need for linking needs and expectations to the key dimensions to eliminate obstacles to change. This phase defines the change management strategy and equips it with resources, performance targets, and people. Change managers must identify and allocate the change process duties to personnel. Smollan (2015) identified several organizational stress indicators present during a major change process. In particular, organizations and staff stress when major decisions and changes are made, new assignments are announced, reorganization occurs, new bosses appear, and change in procedure occurs (Smollan, 2015).

Experienced managers must be involved with change management if it is to be effective in an organization (Holten & Brenner, 2015; Smollan, 2015). Though such leaders will not work full time on the change process, they can offer insight into what the organizational culture requires of a new manager. To bring about resource allocation to the change process, delegation of duties is vital (Holten & Brenner, 2015) This will ensure the change process not only emanates from one individual, but also involves the workforce. Such a change process follows the teleological model for planned change in which participants agree and move together towards shared organizational goals (Van de Ven & Sun, 2011). The model implies consensus between the employees and the new management, which is important for the new change to happen smoothly.

One more important step for successful organizational change is the reinforcement of employees in the change process. An effective change management plan must attend to the people involved (Van de Ven & Sun, 2011). Explaining the need for changes to the staff is vital. Doing so reduces the lack of consensus due to individual and group biases arising from errors in critical thinking, recognition, poor decision-making and group thinking (Van de Ven & Sun, 2011). Van de Ven and Sun (2011) realized that a breakdown in change management occurs when managers focus on the correcting of the processes and the people involved rather than in the change management process itself. The breakdown is because of a failure in the explanation for the need to change to those involved. In the process, the change takes effect without the consent of those involved. Securing their consent entails recognizing their opinions, thoughts, and needs in regards to the change process (Van de Ven & Sun, 2011).

The lack of recognizing that people matter in the change process creates a situation for resistance to change to prevail (Kuster et al., 2015). Therefore, for the change process to be effective, the change plan accounts for the needs of the staff directly under the leader's authority. Moreover, the change process must include key people in order for the process to receive minimum resistance (Kuster et al., 2015). Key people are higher-ranking managers, peer managers, and subordinate staff within the department (Kuster et al., 2015).

The change process must be motivated from the top. Employees often follow the example of their leaders; therefore, the acceptance of new changes by top management also leads to acceptance by subordinates (Bull & Brown, 2012). For change to be effective, the communication of the change process and messages should come from the top to employees in a clear, concise message. Communication between change managers and employees is an effective motivation or reinforcement tool during the change process (Bull & Brown, 2012). During the implementation of the changes, a key variable is the communication of prompt and clear messages to employees to create dialogue and decrease resistance and anxiety of the changes (Bull & Brown, 2012).

Resistance to change. Resistance to change can be an important barrier to change. However, at the same time, resistance to change is an indication that the people resisting the change care about something or the organization in particular (Klonek, Lehmann-Willenbrock, & Kauffeld, 2014). Klonek et al. (2014) claimed that resistance to change only affects the change process significantly if not properly addressed. The way in which the organizations perceives the resistance will drive whether the resistance will

hurt the process or improve it (Bateh, Castaneda, & Farah, 2013). However, Klonek et al. asserted that apathy or indifference to changes is worse compared to resistance, because resisting is the natural response of humans as a defense mechanism, and therefore, should not be considered a barrier, but instead be respected.

According to Klonek et al. (2014), organizational members do not like being forced into the unknown, and therefore, would resist on the assumption that they could lose something of value if they agree to the change. The findings of Bennebroek Gravenhorst, Werkman, and Boonstra (2003), however, would go against the findings of these early studies. The researchers found that resistance is only natural during ineffective change processes. On the other hand, positive changes are unlikely to draw resistance. Therefore, Bennebroek Gravenhorst et al. (2003) claimed that resistance is a normal human reaction to any form of change.

Readiness to change. Readiness to change can also act as a facilitator or a barrier to change processes. According to Holt, Armenakis, Field, and Harris (2007), readiness is one of the premiere factors that would shape employees' initial support for specific change initiatives. Readiness collectively shows how cognitively and emotionally inclined organizational members are towards a plan to alter the status quo (Holt et al., 2007). According to Holt et al., the four factors affecting readiness are content, process, context, and the individuals adopting the change readiness.

McKay, Kuntz, and Naswall (2013) designed a study to determine whether change-related communications, opportunities to participate in change, as well as the level of employees' affective commitment to change, can be shaped by employees'

readiness and resistance attitudes. These researchers believed that readiness can play a role in change-resistant attitudes, but the relationship between the two is largely under-investigated. Using data gathered from survey responses of 102 employees in changing organizations across New Zealand and Australia, McKay et al. (2013) found that unique relationships exist among change readiness and change-related communications, empowerment to participate, as well as affective commitment of the employees. Results also showed that readiness for change could shape employees' intentions to resist changes (McKay et al., 2013). Enz (2012) also emphasized that in service industries, participative, employee-centered implementation of change initiatives can be the most effective.

Choi and Ruona (2011) found that individual readiness affects organizational change. In particular, being ready reflects the concept of *unfreezing* in Lewin's (1947) three-phase change model and is critical for change initiatives to be successful. Choi and Ruona (2011) claimed that focusing instead on individual readiness as opposed to resistance might be useful when carrying out change initiatives. They studied the construct and its effect on organizational change using a review of literature. The findings revealed individuals have a higher rate of being ready for change if normative-reductive change strategies are in place and if the people that would be affected by the change perceive their work environment to be learning-oriented (Choi & Ruona, 2011).

Trust. The level of trust between followers and their leaders can affect change initiatives and their implementation. Chalutz Ben-Gal and Tzafrir (2011) highlighted the role of trust by examining the relationship between interpersonal and organizational

factors affecting consultant-client relationships and the effectiveness of an organizational change initiative. Designing two studies, one qualitative and one quantitative, the researchers concluded that high levels of commitment to change can positively shape the implementation of change initiatives. The first study included interviews while the second study used quantitative methods to expand the first study. Chalutz Ben-Gal and Tzafrir (2011) claimed that commitment to change is the consequence of high levels of dyadic trust. In addition, consultant commitment to change can also partially affect the link between trust and successful organizational change implementation (Chalutz Ben-Gal & Tzafrir, 2011).

Implementation of Change

Several ways that organizations may implement changes exist, and known as the Six Sigma strategy and the Lean Strategy. Using Six Sigma and Lean showed the greatest results when applied to improvement projects.

Six Sigma strategy. One change strategy is the Six Sigma Strategy**.** Six Sigma is a quality management system or a high and consistent standard of quality output (Conger, 2015; Drohomeretski, Gouvea de Costa, Pinheiro de Lima, & Garbuio, 2014; Evans & Lindsay, 2014; Laureani & Antony, 2012). Six Sigma shapes itself in the form of specific improvement projects following a standard five-phase pattern that includes (a) defining of the requirements, (b) measuring of performance, (c) analyzing the process, (d) improving the process, and (e) controlling the new process (Singh & Malhotra, 2014).

Small and medium-sized organizations as well as larger companies listed in the Fortune 500 have successfully implemented Six Sigma to improve performance (Singh &

Malhotra, 2014). The broad objective of Six Sigma is to improve upon the business processes at the heart of an organization's mission; therefore, the system is equally beneficial for profit and non-profit organizations (Evans & Lindsay, 2014). Originally, the basis of Six Sigma was statistical techniques used by managers to assess manufacturing process performance. With the gradual advancement in the process, Six Sigma has become a widely applicable system of improvement involving process improvement, process reengineering, and process redesign. The objective of Six Sigma is to improve a process to the extent that only negligible probability that it will produce unsatisfactory outputs (Basu & Wright, 2012).

The inspiration of the implementation phase of Six Sigma was the project methodologies of W. Edwards Deming, one of the founding fathers of the quality movement (Basu & Wright, 2012). He used statistical process control to raise productivity in American factories during World War II. One of the project methodologies was to define, measure, analyze, improve, and control (DMAIC) for improving an existing business process (Easton & Rosenzweig, 2012). The steps include (a) define customer requirement, (b) measure existing performance satisfaction, (c) analyze the existing process (d) improve the process, and (e) control the new process (Easton & Rosenzweig, 2012). A second project methodology was to define, measure, analyze, design, and verify (DMADV) for creation of new projects or system design (Easton & Rosenzweig, 2012). The steps include: (a) define system goals; (b) measure and identify factors; (c) analyze in developing and designing alternatives; (d) design

details, optimize the design, and plan for design verification; and (e) verify the design and set up pilot projects (Easton & Rosenzweig, 2012).

To be effective, Six Sigma requires an overall implementation leader and a steering committee at a senior level to provide and oversee a vision for the process (Laureani & Antony, 2012; Suresh, Antony, Kumar, & Douglas, 2012). The principal responsibility of this committee is to nominate process areas for improvement. Each area of improvement constitutes a separate project and has its own Six Sigma project team and champion. The project team comprises staff members experienced in the process under observation. When the projects are of small scale, the project team will consist of the operational staff members (Hilton & Sohal, 2012). Staff involved in the leadership of projects may possess varying grades of qualification in Six Sigma. For example, Master Black Belts are in-house consultants in Six Sigma who dedicate all their time to it; they are especially skilled in the statistical techniques and can work on several projects simultaneously (Hilton & Sohal, 2012). Black Belts also dedicate all their time in Six Sigma and lead specific projects (Hilton & Sohal, 2012). Green Belts lead projects, but are managers who hold other job responsibilities (Hilton & Sohal, 2012).

Six Sigma projects require a large amount of training for leaders and for the process operating staff members that build up the project teams. Empowerment is the feature of the system in which improvements may flow from the bottom to the top. Team members take on the important role of bringing about the improvement work under review (Pande, Neuman, & Cavanagh, 2014). During the implementation phase, use of project management techniques accompanies the use of Six Sigma.

Lean strategy for continuous improvement. Lean strategy for continuous improvement focuses on reducing waste and making operation processes more efficient. Lean strategy encourages value addition to the business through elimination of waste from the production process. The Lean strategy is a tool that supports both Kotter and Lewin's model. The foundation of Lean is the elimination of waste by analyzing the process (Drohomeretski et al., 2014), and Kotter's and Lewin's foundation is built upon change as a process (Kotter, 2012). It enables companies to gain a competitive edge on quality, delivery, and price. Lean manufacturing derived from the Toyota Production System (TPS) and named Lean in 1990s (Drohomeretski et al., 2014). Adopted by the change management industry, Lean reduces waste and improves customer satisfaction (Drohomeretski et al., 2014).

A common misconception in the change management industry is that the Lean strategy works well only for the manufacturing businesses since this is where it originated. However, Lean is effective for both production and service industries. Business organizations, health care, government departments, banking services, and the hotel industry apply Lean principles (Drohomeretski et al., 2014). For its effective implementation, Lean strategy requires a complete transformation of the prevailing business operation. The Lean approach takes a long-term view of the process under review (Drohomeretski et al., 2014).

Lean and Six Sigma are often used together as a quality management system to continuously improve an organization (Akbulut-Bailey, Motwani, & Smedley, 2012; Mason, Nicolay, & Darzi, 2015; Stanton et al., 2014). The focus of both is on the core

values of improving upon process quality through optimum utilization of resources and by maintenance of high levels of customer satisfaction. When applied together, the methods bring about maximum output (Mason et al., 2015). Six Sigma is useful in applying statistical methods for controlling variation and output quality through the probability of eliminating the defects that increase waste and cause customer dissatisfaction (Mason et al., 2015). In contrast, Lean manufacturing possesses the capacity to improve the speed of the process and reduce the cost of wastage and unnecessary inventory pile up. Both of these systems are committed to adding value to business, increasing product and service quality, and enabling companies to survive and improve in the highly competitive marketplace (Mason et al., 2015).

The purpose of the development of Lean/Six Sigma was the improvement of quality by eliminating waste and building strong customer satisfaction. Many service firms are also now adopting Lean/Six Sigma to make their business processes more effective and efficient (Psychogios, Atanasovski, & Tsironis, 2012). Banks use this tool as their strategy for growth, lowering operating costs, and improving customer satisfaction through a stringent customer complaints resolution mechanism (Oliya, Saleh Owlia, Dehdashti, & Olfat, 2012; Xu, Zhang, & Ye, 2013).

Hospitals and clinics face the problem of patient waiting time (Al Owad, Karim, & Ma, 2014). Due to tight schedules, many patients are not willing to endure long waiting times and are reluctant to make appointments, or in many cases, to visit clinics with a long list of patients, even if these clinics provide high quality services. Therefore,

hospitals and clinics have adopted the Six Sigma strategy to improve patient waiting times (Al Owad et al., 2014).

The Lean/Six Sigma strategy can reduce errors or keep them at an accepted tolerance limit (Psychogios et al., 2012). The ultimate process aim is to reduce the variation in the process output and achieve a sigma level of performance. The basis for performance measures is customer requirements (Psychogios et al., 2012). The aim may seem high, but a single defect can lead to the loss of a customer. Lean/Six Sigma is a more effective measure of quality management and continuous improvement because it provides an in-depth analysis of problems and a solution in the form of statistical measurement focusing on the removal of those problems.

Total quality management. According to Chiarini (2013), the industry practitioner often considers total quality management (TQM) and Six Sigma as the same. Nonetheless, they are two different components of the quality management system that work on the principle of continuous improvement. However, the Six Sigma quality management tool to achieve "Six Sigma-6σ" (the common Six Sigma symbol) level of quality comes from the TQM approach of quality management system. The basic difference between the two is that Six Sigma is more of a mathematical process of performance improvement that can easily measure quality standards. Six Sigma would be a vacant concept without the application of practical tools identified by the TQM approach in the quality management system (Chiarini, 2013).

Quality management characteristics of Six Sigma derived from the TQM process include the involvement of the whole organization in continually improving the process

and systems under control, with each person assigned responsibility for quality assurance. These characteristics focus on customer satisfaction, including the "internal customer," as well as active participation of everyone in the organization (Chiarini, 2013). Moreover, the TQM process involves high investment in training and educating staff on quality control and system implementation, and strong team building with the strength of 'empowerment' among the team leaders. Empowerment means distributing relevant information to all levels of organization. Finally, the process entails considering customers and suppliers to be an integral part of the improvement process to make sure product design meets expectations (Chiarini, 2013). In contrast, Six Sigma assists in developing strategic goals, vision, metrics, and incorporating data in powerful analytical tools derived from the statistical process control mechanism with the profound consideration and appreciation of normal distribution (Malik & Blumenfeld, 2012).

Lean Six Sigma. In order to deliver high quality products and services to their customers and to have increased levels of profitability with minimum cost, organizations need to implement a system of continuous improvement. Rigorous quality control measures, mechanisms, and processes are necessary to achieve a system of continuous improvement (Malik & Blumenfeld, 2012). A quality management system is likely to address all these issues through a combination of Lean and Six Sigma known as Lean Six Sigma. Even though the two systems have different definitions, their conceptual context is quite similar; therefore, organizations are applying them simultaneously or as a substitute for one another (Herzog & Tonchia, 2014; Naslund, 2013). Organizations have

benefited from implementing Lean Six Sigma by improved quality and reduced waste (Assarlind & Backman, 2013).

The implementation of the two systems is apparent in diverse industry groups including manufacturing, service, mining, and construction to evaluate their system procedures and effectiveness in a wide range of industries (Herzog & Tonchia, 2014; Naslund, 2013). Lean Six Sigma, although initially developed for the manufacturing industry, is equally beneficial in the service industry (Jacobs, Swink, & Linderman, 2015). Financial institutions, educational institutions, hospitals, and clinics have applied Lean Six Sigma and reaped its benefits (Jacobs et al., 2015). The implementation of the system requires participation of all employees and a commitment of personnel from top to bottom. Everyone in an organization is educated and trained with the system so that they can run the process within their capacity at the optimum level (Jacobs et al., 2015).

For the system to be effective, scrutiny of whether additional value to the business must occur. For this purpose, an organization must ensure the system is genuinely customer-focused, and that the people are using the data and facts in the statistical application for results. This proactive approach means improving the system while having a tolerance for failure (Swink & Jacobs, 2012). When organizations adopt the process of Lean Six Sigma, they undergo process improvement, process re-engineering, and process redesign. This process adds value to the system by decreasing wastage, improving product quality, and fostering greater customer satisfaction at a lower cost. Companies that have implemented Lean Six Sigma approaches reported high levels of savings in their projects (Swinks & Jacobs, 2012). Lean Six Sigma is applicable to every

level of the operation process by optimizing performance, decreasing waste and cost, and maximizing profit. If the senior managers and employees are fully committed to bringing a change within the organization, then Lean Six Sigma may be applied (Swink & Jacobs, 2012).

Leavitt's organizational change model. Organizational change can be successful based on the interdependence of four main components, which are structure, people, technology, and tasks (Leavitt, 1965). Leavitt's research on the organizational change model and Kotter's research both focus on people as a founding structure to change. The people are the ones carrying out the task of change and therefore need to be a focal point of the change (Leavitt, 1965).

Leavitt's organizational change model also offers managers the framework for starting the thinking phase of the project (Mcleod & Doolin, 2012). In his model, Leavitt (1965) theorized that a change in one component leads to a change in others. The diamond change model is another name for Leavitt's model because the four sides represent the four factors in his model (Leavitt, 1965). Leavitt (1965) expressed in his model that the project manager needs to change or modify the people component with respect to the other three components. This implies that change of people in tasks involves changes in the activities included in the project (McLeod & Doolin, 2012). Apart from changes in the people, changes in structure are also required. In this phase, the model assists managers in fitting the components required for the project together to the best of their knowledge. The implementation of the model involves change in technology, which affects the tasks of stakeholders and employees' performance, and

requires people to adopt new responsibilities or roles. Effective management of change is a key success factor in technological change project implementation (McLeod & Doolin, 2012). In Leavitt's model, involving people to accept change and allowing change to happen are necessary (McLeod & Doolin, 2012).

The four components of Leavitt's model are technology, people, tasks, and structure (Leavitt, 1965). People are employees of an organization and carry out tasks in the project change phase. If a project is occurring in an organization or project team, the people carry out tasks associated with the project (McLeod & Doolin, 2012). According to Leavitt, the project manager needs to view people in terms of their knowledge, skills, and productivity, not as accountants, managers, or receptionists (McLeod & Doolin, 2012).

In Leavitt's model he required the project manager to change or modify the people component with respect to the other three components. This implies that changing people's tasks involves changing project activity. Therefore, if the project manager makes changes to tasks, the employees will require education and training to become familiar with the new methods (McLeod & Doolin, 2012). In regards to structure, changes in people's tasks involve a change in job roles and require training for employees for new duties and responsibilities (McLeod & Doolin, 2012). Lastly, the change in people in technology involves shifts to new technology (McLeod & Doolin, 2012). This also requires intensive training for the employee to manage the new technology efficiently and effectively (McLeod & Doolin, 2012).

The second component in Leavitt's change model is tasks (Leavitt, 1965). A component of this model is the project manager include goals along with tasks in this component (McLeod & Doolin, 2012). The project manager must analyze two things: (a) what they are seeking to achieve; and (b) the change process activities (McLeod & Doolin, 2012). This component requires the project manager to focus on qualitative aspects of goals and tasks instead of the actual goals and tasks. Changes in tasks are the results of changes in people, structure, and technology in Leavitt's model (Leavitt, 1965).

The third component in Leavitt's change model is structure of the organization and its relationships, as well as the coordination among management, employees, departments, and communication patterns (Leavitt, 1965). Structure also includes responsibility and authority flowing through the organization or project (McLeod & Doolin, 2012). Changes in the structure of a project must align with changes to other components. In Leavitt's model he presented that changes in people, such as hiring more qualified and skilled employees, requires different supervisory skills in comparison to supervisory skills used to hire less qualified employees (McLeod & Doolin, 2012). Changes, such as empowering employees or project team through training workshops, lead to the reduction of supervisory and management posts, resulting in a flatter organizational structure (McLeod & Doolin, 2012). Changes in tasks, such as the creating of a new department or role in a project, requires more people to carry out the additional tasks (McLeod & Doolin, 2012).

Lastly, in his model, Leavitt (1965) addressed the role of technology in the change process. Technology provides the tools that aid or facilitate people to carry out

their tasks, such as software applications and computers. In Leavitt's model, technology changes in accordance with changes to other components. Changes in people, including the hiring of computer literate workers such as engineers, drive the project manager to take full advantage of a skilled work force (McLeod & Doolin, 2012). Therefore, technology changes in accordance with changes in qualifications, skills, and knowledge of the workforce (McLeod & Doolin, 2012). Changes in tasks and goals also require a change in technology to handle the additional processes integrated into a project (McLeod & Doolin, 2012). Finally, a change in structure, such as the reduction of employees on a project, may drive the project manager to automate some tasks (McLeod & Doolin, 2012). Therefore, Leavitt presents that change management of any project to be viewed not as a set of soft factors, but as a business process like other organizational business processes. The goal of the model is to lead project managers toward planned, managed, and rational change management (McLeod & Doolin, 2012).

Leavitt identified in his diamond-change model that identifying the elements of change in terms of four main components, which are people, tasks, structure, and technology (McLeod & Doolin, 2012). The planning phase of the project change process utilizes Leavitt's model because it illustrates the importance of aligning structure, task, technology, and people to bring about change. Leavitt's research offers managers the framework for starting the thinking phase of the project. The model assists managers to fit the components required for the project together to the best of their knowledge. Apart from identifying the elements required for change, the model will also assist in making a connection or showing the interdependence of the elements (McLeod & Doolin, 2012).

The Leavitt model is useful because the change process is only successful if changes in individuals match changes in the organization and the model identifies the role of the people in the change process (McLeod & Doolin, 2012). The change process in theory is successful if it incorporates the participation of everyone from management to employees or subordinates. Leavitt recognized the role of people in their capacity as financial advisers or planners, but recognizes them in terms of their expertise, skills, and knowledge (McLeod & Doolin, 2012). The model will increase the motivation and involvement of managers and subordinates by recognizing them as individuals with the knowledge and skills required in the change process. Moreover, the model has proven successful for managers who plan and implement changes in the organization (McLeod & Doolin, 2012). The model requires change managers to focus on both the change process as well as the change content, as well as the ability to integrate content and process in organizational change (McLeod & Doolin, 2012).

Implementing Changes in Health Care

Hospitals are under increased pressure to meet the challenge of improving their quality of work even though they have to contend with different problems, such as shortages in nurses or lack of resources. Some of the same factors hindering changes in the health care industry affect change in other industries. For example, a study by Hussein and Hussein (2013) showed that nursing educators' attitudes toward evidence-based practice (EPB) could serve as a barrier to effective change initiatives, such as shifting to new information technologies. If nursing educators have positive attitudes toward a change, they are more likely to use these new technologies. In contrast, nurses

who have negative perceptions of the effects of information technology on patient care would lead to nurses' fear on using these new technologies (Khachian, Manoochehri, Pazargadi, & Esmaeili Vardanjani, 2012).

Portoghese et al. (2012) tested a theoretical model linking the effects of expectations on commitment to change and assessed whether change-related communication can act as a mediating variable between the exchanges of leaders and their followers, as well as affect expectations for change outcomes. Using a predictive, non-experimental design in a sample of 395 nurses randomly chosen and structural equation modeling, the researchers found that having positive expectations can directly influence affective commitment to change (Portoghese et al., 2012). In contrast, negative expectations directly affect one's consistent adherence and commitment to change (Portoghese et al., 2012). The researchers also found that leader-member exchange and communication can both shape nurses' decisions to adapt change or their expectations of the change (Portoghese et al., 2012). Nurses' expectations regarding the change have a strong relationship to their commitment to change (Portoghese et al., 2012).

Summary

I reviewed the existing literature that was relevant and included both the key success factors and barriers to effective changes specific to health care. A discussion on the health care industry included (a) research on health care and change, (b) research on success for change, (c) failed changes, and (d) the need to constantly evolve and change for quality improvement. The current study addresses the specific problem some senior health care managers lack implementation strategies for change initiatives, which,

according to Longenecker and Longenecker (2014), is a timely topic because of the increasing factors requiring rapid change in the health care industry.

Transition

Section 1 included a discussion of the background, of the problem statement, of the purpose of the current study, the research question for the study, the significance of the current study, the qualitative nature of the study, and a review of the professional academic literature related to the research problem. Section 2 includes an introduction of the qualitative method as the selected method for the study, and an explanation of the rationale for selecting a multiple case study as the research design. An in-depth review of the professional and academic literature included the conceptual framework I used as the lens for viewing data collected for the study.

Section 2 includes my description of the project including methods and research designs used to guide this study based on the purpose and applications to professional practice and implication for change. I discussed the methodology for the proposed study and presented a detailed explanation of my rationale for selecting a qualitative multiple case study design. My role as the researcher, data collection procedures, population, sampling, reliability and validity, and data analysis are also included.

In Section 3, I conclude with a presentation of the study results, a discussion of the findings of the study, and an explanation of how the findings may contribute to future research and management practices in health care. Section 3 also includes recommendations for further research and reflections on my study.

Section 2: The Project

The literature review in Section 1 included evidence that senior health care managers need implementation strategies when implementing change initiatives. The specific business problem was that some senior health care managers lack implementation strategies for change initiatives. Section 2 begins with a restatement of the purpose of the study, a discussion of my role as the researcher, and a description of the study participants. A description of the research method and design, as well as the justification for their use, is in included in this section. Section 2 also includes a discussion of research ethics, data collection, organization technique, analysis, and validity and reliability.

Purpose Statement

The purpose of this qualitative multiple case study was to explore implementation strategies for change initiatives used by some senior health care managers. The specific population consisted of three senior health care managers from each of three different health care organizations located in Hanford, California, who successfully implemented change initiatives in their organizations. The findings from this study may contribute to professional practice by providing implementation strategies that health care managers may use to successfully implement change in their organizations. The findings from this study may contribute to social change through the improvement of health care delivery.

Role of the Researcher

My role as researcher was to conduct the research, collect the data through semistructured interviews guided by open-ended questions, collect company documents

related to the study, analyze the data, and present study findings. As the researcher for this study, I served as the primary data collection instrument (Marshall & Rossman, 2011). As the researcher, I needed to be transparent with the participants of the study regarding my experience with the research topic of implementing strategies for change initiatives in health care organizations. The purpose of open coding of the data is to achieve the mitigation of personal biases in the interpretation of interview responses to capture every common theme or category in the interviews (Elo et al., 2014). In this study, the analysis of data involved summarizing the interview responses through the lens of Kotter and Lewin. I mitigated my bias by not guiding participants' responses to interview questions and ensuring the interview questions reflected no bias.

I used an interview protocol in my case study. According to Yin (2014), an interview protocol allows for uniformity of interview questions for each of the participants. By using an interview protocol, I asked each participant the same questions in the same manner. The interview questions (Appendix A) included the interview questions and probing questions. The interview protocol (Appendix B) included the interview process.

Steps taken for mitigating researcher bias included a process of critical reflection and the double-checking of interview data with participants to reduce the potential for misinterpretation through member checking (Elo et al., 2014). According to Yang and Banamah (2013), asking respondents to review the interview summary for accuracy assists in mitigating bias. Additionally, I conducted member checking by summarizing and interpreting the data from the interviews collected, and asking respondents to review

the interview summary and provide feedback regarding the accuracy after the interview session.

The researcher should acknowledge biases by documenting them in the study (Petty et al., 2012). As recommended by Elo et al. (2014), I was transparent with my participants regarding my experiences, and I strove to set aside my biases and personal views on change implementation while conducting this research. Acknowledgement and mitigation of these preconceptions assisted me in not influencing my research.

A technique such as bracketing experiences prior to the research can help the researcher in qualitative research to mitigate preconceptions by setting aside the preconceptions by acknowledging them (Tufford & Newman, 2010). Bracketing can diminish personal notions that can harm the research by increasing a researcher's awareness of the biases they hold (Tufford & Newman, 2010). A researcher must document and analyze the attitudes of the participants, not their own, and be an active listener (Bevan, 2014). The researcher is the one who will conduct the interviews and take notes on each interview (Doody & Noonan, 2013). Researchers bracket their experience by recognizing their biases prior to data collection (Moustakas, 1994). Once researchers are aware of their personal biases, they are able to set their biases aside (Moustakas, 1994).

I bracketed my experiences and preconceptions to mitigate bias in all stages of the process by disclosing to the participants and readers of this study my personal experiences of implementing change initiatives within organizations. Within the industry of local government agencies, my involvement has been with implementation strategies

including procedural changes, technology changes, and new processes. I have also served as a subordinate on the receiving end of an implementation strategy from a senior manager. My involvement with implementing significant strategy changes included both successes and failures. I have not implemented any changes within the health care industry. I did not allow my experience with implementation strategies to cloud my judgment when conducting this research. My bias on the implementation strategies were not included in the data analyzed for this study.

I based my findings on the participants' responses in the interviews and my review of relevant documents from the participating organizations. The invalidation of information presented in this case study would have occurred if I had used my personal opinions as a basis for validating the foundation of the study. I did not include my personal opinions regarding the subject matter in the data that I analyzed to answer the research question. All data were from the interview respondents. I had no relationship with any of the participants or the organizations I included in this study.

Studies that involve human subjects and human affairs must follow ethical standards (Yin, 2014). The Belmont Report (U.S. Department of Health and Human Services, 1979) summarized ethical standards that researchers must follow when conducting research studies and includes (a) participants' right to maintain their anonymity and confidentiality, (b) voluntarily participation without any consequences or repercussions, and (c) beneficence and justice. I informed participants of their right to maintain their anonymity in the study findings and confidentiality of their interview responses. The participants voluntarily participated in the study and were able to

withdraw from the study at any time, even after the completion of data collection, without any consequences or repercussions. As the researcher, I ensured that I respected all participants, and I upheld beneficence and justice as required by federal research guidelines. I followed the guidelines set forth in the Belmont Report and protected the rights of all participants. I obtained formal approval and study approval number 05-06-16-0461941 from the Walden University Institutional Review Board (IRB) prior to contacting the participants and collecting the data.

Participants

The study population consisted of senior health care managers from three health care organizations located in Hanford, California, who had successfully implemented change initiatives in their organizations. Establishing criteria that participants must meet ensures the participants have the proper experience and knowledge needed to answer the research question (Englander, 2012; Richardson, Davey, & Swint, 2013; Suri, 2011). A senior health care manager from each of the three health care organizations participated in semistructured interviews guided by open-ended questions to share their strategies for communicating and implementing change initiatives in their organizations. Eligibility criteria for senior health care managers included (a) age 18 or older, (b) minimum of 5 years of experience as a senior health care manager, (c) experience with successfully implementing change initiatives in a health care organization, and (d) current employment with a health care organization in Hanford, California.

I recruited senior health care managers through purposeful sampling. Purposive sampling allows for selection of participants so that they meet the criteria to answer the

interview questions (Morse, Lowery, & Steury, 2014; Richardson et al., 2013; Robinson, 2014). I emailed invitations to different senior health care managers of health care organizations who had successfully implemented change initiatives in their organizations to request their participation in the study. I identified these senior managers from a search in the yellow pages under health care. I conducted a search in the yellow pages to identify health care organizations. I then used the Internet to determine a direct contact. Once I found a senior manager, I made contact with the manager and used the criteria for the study to determine whether the senior manager met the criteria to participate. This led to a participant pool of senior managers who had experience successfully implementing change initiatives. I built working relationships with the senior health care managers by conducting recruitment with them to participate in the study and continuously communicating with them and providing details of the study. In my initial contact with the managers, I explained the purpose of the study and the benefits of them participating. By participating in this study, managers added to the knowledge of strategies for implementing change initiatives to improve the health care profession's ability to implement change initiatives. I followed up the email invitation with a telephone call to discuss the study and answer their questions or concerns.

Research Method and Design

In this subsection, I describe the research method and design for my study, and explain why they were best suited for answering my research question.

Research Method

I selected a qualitative method for this study. A qualitative method is best suited for in-depth research through interview and observation (Marshall & Rossman, 2011), and is especially useful for gathering information about experiences and meanings of the participants of a particular population. The qualitative method allows for open-ended responses, which the quantitative method does not (Hurt & Mclaughlin, 2012). Qualitative data from open-ended interview questions best addressed the research question for this study because they provided information and insight in participants' own words. Researchers use a qualitative method to research the why and how instead of only studying the what, where, and when (Petty et al., 2012). In seeking to answer a question, qualitative researchers use systematic predefined procedures when collecting data and generating findings that are not predetermined (Yin, 2014). The information derived from a qualitative study provides in-depth knowledge regarding the experiences and meanings of the participants (Petty et al., 2012). A qualitative study may facilitate collection of information on the many aspects of a research question through the different views of the participants (Kisely & Kendall, 2011). I conducted a qualitative multiple case study to answer the research question addressing implementation strategies that senior health care managers need for change initiatives.

Researchers use quantitative methods to test a theory or experiment (Babbie, 2015; Marshall & Rossman, 2011) and are statistics oriented (Marshall & Rossman, 2011). In this study, I did not test a theory or conduct an experiment, so a quantitative method was inappropriate. A quantitative method cannot accurately reflect human

response because quantitative methodology requires the use of standardized measures (Bernard, 2013). The purpose of this study was to understand human experiences, which made the quantitative method unsuitable for answering the research question. The quantitative method is best suited for studies that are designed to determine the relationship between the variables (Bernard, 2013), which was not the purpose of my study.

A mixed method includes the combination of both qualitative and quantitative methods (Bernard, 2013; Corley, 2012; Wisdom, Cavaleri, Onwuegbuzie, & Green, 2012). My study was not reliant on quantitative data to determine a relationship between variables through statistical analysis. Therefore, a mixed-methods approach was not suitable for answering my research question.

This study required qualitative data obtained from open-ended responses and analysis of patterns, themes, and content to answer the research question. A qualitative study may provide many perspectives relating to the research question through the different views of the participants (Kisely & Kendall, 2011). Unlike quantitative studies, qualitative studies allow for the in-depth exploration of a particular phenomenon within its uncontrolled environment, which justifies a relatively small number of participants (Mitchell & Jolley, 2012). Moreover, qualitative methodology offers the advantage of gathering and presenting rich data, particularly when conducting interviews (Yin, 2014), and enables researchers to provide detailed descriptions of the activities (Merriam, 2014).

Research Design

Qualitative research designs considered for this study included (a) ethnography, (b) phenomenology, and (c) case studies. Ethnography research involves personal immersion in the culture of a particular group drawing data from the daily events, experiences of the people, personal feelings, or insights regarding events that occur over a relatively long period of time (Merriam, 2014). Researchers use an ethnographic design to focus on culture, which was not the intent of this study. For a phenomenological study, the purpose of the research is to explore the in-depth lived experiences and perceptions of the participants (Moustakas, 1994), which would not have provided the data needed to answer the research question for this study. The purpose of this study was not to (a) construct a narrative, (b) develop a theory grounded in the research data, (c) study a cultural or social group in a natural setting, or (d) understand a phenomenon. The purpose of this study was to identify implementation strategies used during change initiatives by health care managers. Therefore, a case study was the most appropriate qualitative design for this study.

I conducted a multiple case study to collect and analyze data to answer my research question, which was: What implementation strategies do senior health care managers use to implement change initiatives. As explained by Yin (2014), the case study design is for researchers to explore an event in its complexity within a physical world situation and within restricted boundaries. A case study design was appropriate for this study because it enabled me to investigate and complete an in-depth analysis of the implementation strategies used during change initiatives by health care managers in the study population.

Researchers use case study designs when they are attempting to obtain and expand the propositions of a particular situation or case in a group of people (Merriam, 2014). The researcher's goal, therefore, is not to build an underlying theory from the investigation by analyzing themes emerging from qualitative data obtained from interviews or qualitative surveys (Merriam, 2014). Yin (2014) explained the main objective for research based on a case study is to provide a holistic viewpoint of an issue(s) or case(s) within a bounded set or singular system. A case study is well suited when the goal of the research is to investigate outcomes and describe the connections between actions and a particular case from a specified group of people (Yin, 2014).

In conducting a multiple case study, I ensured data saturation. Saturation refers to the point when no new information emerges from the participants' interviews or if the responses are redundant (O'Reilly & Parker, 2013; Patton, 2002). According to Yin (2014), one participant from each case may not be sufficient to achieve data saturation and new participants may be required. According to Burmeister and Aitken (2012), the number of participants do not result in data saturation, but the depth of data within those interviews can. I did not include a large number of participants, because I focused on three participants with the depth and breadth of knowledge and experience to address my research question. I achieved data saturation when no new information emerged from interviews and organization document review. I continued interviewing the same participants and reviewing the organization documents until no new themes emerged in my study data.

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Population and Sampling

The study population consisted of senior health care managers from three health care organizations located in Hanford, California, who had successfully implemented change initiatives in their organizations. Establishing criteria that participants must meet will guarantee representation of the research phenomena (Englander, 2012). The appropriate selection of the population may improve transparency of the study (Robinson,

2014; Suri, 2011). Eligibility criteria for senior health care managers included (a) age 18 or older, (b) a minimum of 5 years of experience as a senior health care manager, (c) experience with successfully implementing change initiatives in a health care organization, and (d) current employment with a health care organization in Hanford, California. I interviewed senior health care managers from each of the three health care organizations to share their strategies for communicating and implementing change in their organizations.

Determining a sufficient number of participants for a qualitative study depends less on reaching a specific percentage of the population and more on the depth and breadth of information gathered from the population through deep inquiry (Patton, 2002). The right number of participants for a case study should be three to five (Yin, 2014). A larger number of participants or cases would be better by leading to higher confidence in the study findings (Yin, 2014). On the other hand, Patton (2002) recommended that the best minimum sample size should allow for expansion until data saturation occurs. Saturation refers to the point when no new information emerges from the participants' interviews or responses become redundant (Patton, 2002). For this study, the minimum number was one health care manager from each of the three health care organizations. Rowley (2012) suggested that one to 10 participants may be sufficient in a qualitative case study, but the recruitment of additional participants should continue until saturation occurs. I continued interviewing the same participants and reviewing relevant organization documents to reach data saturation.

The interview setting was a location selected in a discussion between the participant and myself. The location of each interview was away from the participant's place of employment. In addition, each setting was in a quiet, private location free from interruptions and distractions as recommended by Yin (2014).

Qualitative researchers use purposive and theoretical sampling (Kisely & Kendall, 2011). Researchers use purposive sampling to select respondents that are likely to have the information needed to answer the research questions and save effort, time, and money in the selection process (Patton, 2002). I used purposive sampling to select organizations and managers for this study. Purposeful sampling allows the researcher to select the participants for a study because of the particular value they will bring to that study (Suri, 2011). I conducted purposeful sampling to select a specific group of participants targeted for the study as recommended by Suri (2011). Researchers use a limited purposive sample size to seek specific knowledge (Roy, Zvonkovic, Goldberg, Sharp, & LaRossa, 2015). A purposive sample enables a researcher to recruit members of a particular group of individuals who fulfill characteristics or criteria pertinent to the study and its purpose (Yang & Banamah, 2013), which was appropriate for this study.

Ethical Research

Researchers using human participants in their research must follow approved ethical guidelines and regulations (Merriam, 2014). The Belmont Report summarized ethical standards that researchers must consider and follow when conducting research studies that include (a) participants as autonomous agents, (b) incur no harm or beneficence to participants, and (c) treat participants equally (U.S. Department of Health

and Human Services, 1979). Based on these guidelines and Walden University Institutional Review Board (IRB) guidelines, I obtained approval for this study from the Walden University IRB prior to contacting the participants and collecting data. The ethical issues considered by a researcher in any study should include maintaining the confidentiality and safety of the study participants as well as protecting their human rights (Miller, Birch, Mauthner, & Jessop, 2012). All of the study participants were age 18 years old or older and had at least 5 years of experience as a senior health care manager. Ethical considerations for this study included (a) obtaining the study participants' informed consent, (b) maintaining their privacy and the security of their identities, and (c) protecting the confidentiality of the information they provide (Jacob & Ferguson, 2012; Savin-Baden & Major, 2013).

I met with the study participants to (a) review their rights as outlined on the informed consent form, (b) answer their questions, and (c) obtain their signatures on the informed consent form. The informed consent form included a detailed explanation of the purpose of the study as well as the participants' rights, welfare, safety, confidentiality, and voluntary participation. Through the informed consent process, I explained that participants would incur no costs or foreseeable risks while they were involved in the study, and they would receive no compensation for their participation. I shared the findings of the study with the respondents. The informed consent form explicitly stated that study participants may or may not agree to participate. The participants could decide to withdraw from the study at any time during the study even after completion of

interviews without any consequences. Participants were able to withdraw from the study by email, a phone call, or in person.

As discussed by Marshall and Rossman (2011), participants must provide consent to participate and ethical standards require that participants must have free will. Researchers protect the anonymity of participants by assigning pseudonyms or codes to each participant instead of disclosing their names (Babbie, 2015; Punch, 2013; Webster, Lewis, & Brown, 2013). Pseudonyms assigned to participants in this study served as the only identifiable information on the data form. Each participant received a code such as P1, P2, P3, until all participants had a unique code that only I was able to connect with the identity of individual participants. This strategy facilitated removal of the identifying information of the study participants from data files and study documents.

I saved electronic copies of the data from the interview responses on my personal computer in password-protected files and retained physical data forms, such as printed copies of the interview transcripts of the study participants, in a locked file cabinet only accessible to myself. As recommended by Punch (2013) and required by the Walden University IRB, the retention period for the study-related data and documents is 5 years following the completion of this study. At the end of the 5-year period, I will shred all printed information and delete all electronic files related to the study.

Data Collection Instruments

The researcher is the primary data collection instrument in qualitative research (Eide & Showalter, 2012). I collected data through semistructured interviews (Appendix A) guided by six open-ended questions and all interview responses were audio recorded

for the purpose of documentation. Patton (2002) recommended that interviews that are open-ended in nature give participants the opportunity to express their ideas and feelings openly without being constrained by a set of choices (Patton, 2002). My study included open-ended interview questions to obtain detailed responses from the respondents. Responses to an open-ended question are unrestricted and not constrained by a set of choices, which is ideal for a qualitative study (Streubert & Carpenter, 2011). Using open-ended questions provided the health care managers with the opportunity to share any and as much information as possible about their experiences with change implementation strategies.

Researchers ask participants identical questions to increase consistency (Tucker, Yeow, & Viki, 2013). I asked all interview respondents the same set of open-ended questions in the same order to ensure trustworthiness, transferability, and credibility of information provided by each participant. I designed the interview questions to ask the participants about implementation strategies that senior health care managers need for change initiatives.

After a senior health care manager of a participating organization signed a document release form (Appendix C), I obtained documents related to the communication of a change initiative from each organization. The specific documents needed for this study was not determined until I met with each organization representative to inquire about documents relevant to this study and obtain written consent to acquire a copy of those documents. Each organization provided documents related to the communication of

an implemented change initiative at their organization. I acquired these documents after I completed the interviews with health care managers.

I used expert review to enhance the reliability and validity of my interview questions (Jacob & Ferguson, 2012). As recommended by Thomas and Magilvy (2011) for interview questionnaires, I conducted an expert review before conducting the interviews to ensure that the interview questions were adequate for soliciting in-depth information needed to answer the research question for this study. According to Rowley (2012), expert review ensures the interview questions are clear and concise. I selected two health care managers that met the selection criteria for the study that worked in a geographic area outside of my study area. I asked them to review and comment on the interview questions for addressing the purpose of this study. Based on the input of the expert review, I did not need to revise the questions.

I used member checking to enhance the reliability and validity of my data. Member checking requires that participants review the summary of the interview for accuracy (Chronister, Marsiglio, Linville, Lantrip & 2014), which adds credibility to the study (Rennie, 2012). After the interviews were audio recorded, I transcribed and summarized them, then conducted member checking within 7 days after the interview process to ensure that my summaries and interpretations of the interview responses were accurate. If I inaccurately portrayed any information from a participant's interview, I noted the corrections based on the feedback from the participant. The purpose of conducting member checking in a short time after an interview is completed is to have

the participants recollect their interview responses while the interview is fresh in their mind (Torrance, 2012).

Data Collection Technique

Planned structured questions are called semistructured interviews are based on planned questions that are structured, but are flexible enough to have open discussions (Wahyuni, 2012). This study included semistructured face-to-face interviews guided by open-ended questions to collect data from senior health care managers. I audio recorded each interview for the purpose of documentation. Researchers use audio recording of interview to record the verbatim transcript of an interview (Doody & Noonan, 2013; Speer & Stokoe, 2014; Wahyuni, 2012).

I conducted an expert review of the questions to enhance study validity and reliability. I followed the advice of Lash et al. (2014) to conduct an expert review of the questions since the interview questions were self-developed. An expert review may improve the quality of the interview questions (Rowley, 2012). Jacob and Ferguson (2012) recommended expert review to test the accuracy of the interview questions and the relevancy of the questions for gathering the information needed to address the research question. Disadvantages of an expert review are that the researcher might face difficulty in identifying a dependable expert reviewer (Heikkinen, Huttunen, Syrjälä, & Pesonen, 2012).

Two experts reviewed the questions to check for relevancy and completeness. In the expert review, I recruited two managers that met the selection criteria of the study, except that they worked in a geographic area outside of the study area to do an expert

review of the interview questions. The expert review enhanced the transferability of the interview questionnaire. First, the senior health care managers examined and evaluated the overall comprehension, clarity, ambiguity, and potential difficulty in responding to the questions included in the interview questionnaire. This involved asking the expert reviewers if the questions were clear and sufficient to solicit and capture the needed information to address the research question. Second, the credibility of the interview questionnaire involves the use and reuse of the questionnaire. In this step, the process involves asking an expert reviewer if the questions posed to them are properly addressing the research question of the study (Jacob & Ferguson, 2012). Based on the feedback provided from the expert reviewer I did not need to make any changes to the study questions.

I contacted the health care managers who agreed to participate in the study via telephone or email to schedule an interview. This included arranging a convenient date, location, and time with the respondents for each of the interview sessions. The respondents completed the interviews in approximately 60 minutes. However, the interviews had no set time limit because each interview was highly dependent on the flow of the conversation between the respondent and the interviewer. Each interview session was audio-recorded so that I had a detailed record of the interview responses verbatim.

I personally transcribed all audio recordings of the interviews and coded the interview responses prior to the data analysis. The entire data collection process required approximately three weeks. The data collection and analysis process included (a) expert review of the open-ended questions, (b) the participant recruitment process, (c)

completion of all interviews, (d) document collection, and (e) member checking. According to Chronister et al. (2014), member checking enhances validity and reliability by asking the participants if the interpretations of interview responses are accurate. Member checking is a vital strategy to increase credibility of interview data (Lincoln & Guba, 1985). As described by Harper and Cole (2012), member checking is a quality control strategy. I conducted member checking after the completion of the interviews by asking the participants if my interpretations of their question responses from the interview sessions were accurate and complete representations of their interview responses and intended answers. The member checking process enhanced the creditability and dependability of my study.

Participants did not disclose their names during the audio recording of interviews, and I did not mention the names of the respondents during the interviews or include their names in the study database. I requested relevant organization documents from health care managers that were designated organization representatives with the authority to consent to the release of documents (Appendix C).

Data Organization Techniques

Anyan (2013) suggested that utilizing organizational techniques assists in the reliability of the data. Labeling is important for keeping track and organizing the data from each of the respondents as well as protecting their identities (Davis, 2013). Using a unique code to label data can ensure confidentiality (Davis, 2013; Gajewski, 2013). I assigned identification codes to each participating senior health care manager from each organization. I coded my study data with a "P" to represent each participant and a

numeral to identify each participant. For example, P1 represented the first participant from the first organization and P2 represented a second health care manager for a second organization. I followed this protocol to keep track of the data as well as maintain the confidentiality of the respondents and their organization. I coded each organization document with a unique label of D1, D2, or D3. I followed this protocol to keep track of the data as well as maintain the confidentiality of the respondents and their organization. I created a file for each participant, which contained the informed consent forms, transcripts of their interview responses, and other documents from their organization.

Analysis of interview data involved gathering, comparing, and contrasting the responses obtained from interviews with a minimum of one senior health care manager from each of three health care organizations. First, I transcribed the interview responses to each question by documenting the verbatim responses to each question. I summarized the interview transcripts obtained from the interview responses in a Microsoft Excel sheet. The Excel sheet included the verbatim responses of the respondents for each interview question. I used these responses to create my interview response summaries and interpretations, which I then used to conduct member checking to verify that my interpretations were correct prior to uploading to Nvivo for analysis. I coded the interview responses to create themes or categories to group together relevant information by topic.

I uploaded the data from the Microsoft Excel spreadsheet to NVivo 11 and used the software to help identify themes. According to Silverman (2013), NVivo software enables researchers to code themes, evaluate, and interpret findings. As noted by Rowley

(2012), the use of computer software heightens data accuracy and consistency. NVivo software assists researchers in identifying themes and categories in the data to answer the research question (Trotter, 2012).

I retained all printed data including interview transcripts, research logs, my reflective journal, and my labeling system used to identify each respondent, in a locked file cabinet in my home office that only I can access for a period of 5 years following completion of this study. At the end of the 5-year period, I will shred all printed material and electronically erase all electronic files related to my study.

Data Analysis

This study involved three sources of data, which were (a) interviews, (b) a reflective journal, and (c) the documents from the participating organizations. According to Denzin (2012), data triangulation requires using more than one source of data by gathering different samples through different situations helps build confidence in the results of the study. The four types of triangulation that can enhance a study as described by Yin (2014) are (a) data triangulation, (b) theoretical triangulation, (c) investigator triangulation, and (d) methodological triangulation. Data triangulation is the use of multiple sampling strategies (Wijnhoven, 2012). Theoretical triangulation is the use of more than one theoretical position in analyzing the data (Yin, 2014). I did not find theoretical triangulation appropriate for my study because I was the only data collector, and I analyzed and interpreted all of the study data. Investigator triangulation is the use of multiple researchers (Yin, 2014), which was not appropriate for my study since I was the only data collector. Methodological triangulation allows for multiple data sources

(Wahyuni, 2012). For my study, I used methodological triangulation to analyze the data that I collected from (a) interviews, (b) my reflective journal, and (c) document reviews.

The data analysis in a case study involves a process wherein researchers use several components to analyze data, including meticulous preparation, comprehension, and interpretation development based on rich data gathered from participants (Merriam, 2014). The analysis involves arranging and grouping of interview codes emerging from the interview responses (Merriam, 2014). Themes are highlights of the interview responses that are (a) repetitions, (b) indigenous typographies and categories, (c) metaphors and analogies, (d) transitions, (e) similarities and differences, (f) linguistic connectors, (g) missing data, and (h) theory-related material (Saldaña, 2012). Identifying themes by open coding through segregation of the interview data into words, phrases, sentences, or paragraphs will emphasize the functional relationship between parts and the whole of the entire responses from the interview question (Streubert & Carpenter, 2011). I continued analyzing interviews by identifying common themes and patterns within the interview responses among the different respondents. I correlated themes identified from the interview responses and the participating organization documents with those that I identified in the literature review.

I analyzed the data through the lens of Kotter's eight-step process (Kotter, 1995) and Lewin's phases of change theory (Lewin, 1947). Codes are labels for assigning meaning to the descriptive information or to the topic of categories of the data (Wahyuni, 2012). I used NVivo Version 11 to assist in the coding of interview responses. NVivo 11

is coding software for qualitative data such as interview responses (QSR International, 2007).

After coding the interviews, the next step is to code the documents provided by the organizations (Sarvestani, Bufumbo, Geiger, & Sienko, 2012). From the analysis of the interviews and organization documents, themes emerged that I compared with themes that I identified in the literature review. Coding helps break down the information from the data to differentiate the different themes (Wahyuni, 2012). I coded the data by using single words to sentences that categorized the topics of the interview transcripts and organization's documents. I used these data sources to address the research question. Based on the themes obtained from the open coding process, I addressed the research questions by creating a summary and interpretation of these themes from the themes identified in the literature. The purpose of supporting the themes with the literature is to connect and validate the findings with the methodology and with the conceptual framework (Borrego, Foster, & Froyd, 2014).

Reliability and Validity

A good research study is one that is systematic, ethical, and conducted in a rigorous manner (Merriam, 2014). Credibility, transferability, dependability, and confirmability are each important for establishing the validity of a qualitative research design (Rennie, 2012).

Reliability

Dependability. Marshall and Rossman (2011) suggested that a researcher needs to ensure the data is dependable. Dependability shows that the data in the study is reliable

and allows for replicability (Wahyuni, 2012). I ensured the study data were dependable by asking each participant the same set of interview questions in the same order. Utilizing an interview protocol (Appendix B) improves the researcher's consistency to ask the same set of interview questions to each participant (Silverman, 2013).

Validity

Credibility. Credibility is necessary to a study to ensure that the information provided is accurate (Noble & Smith, 2015). To establish credibility, I interviewed specific respondents that are health care managers from different health care organizations located in Hanford, California, to obtain useful data to answer my research question. These respondents were professionals employed in the field under investigation, which should help to ensure the responses were credible. As a way of ensuring the credibility of the study, I made use of member checking to verify the accuracy of the participants' responses. Member checking involves verifying the interpretations of the interview responses to make sure they fully captured the intent of the respondents (Thomas & Magilvy, 2011). Member checking is the process of asking respondents to review the interpretation summary of the interviews and solicit feedback regarding the summary accuracy after the interview session. Confirmation by the participants ensures that statements provide tacit assumptions objectivity and accuracy to substantiate validity and reliability, bringing credibility to the study (Houghton, Casey, Shaw, & Murphy, 2013).

Confirmability. Confirmability is the reader's ability to confirm the results of a study to ensure that the participant's experiences and not the researchers interpretations

are reflected (Wahyuni, 2012). Member checking is when the interviewer asks respondents to review the interview summary and provide feedback regarding accuracy of the researcher's interpretations (Yang & Banamah, 2013). Conducting member checking can increase confirmability (Yin, 2014). To enhance confirmability, I used member checking in my study.

Transferability. The ability to apply the study to other settings is transferability (Petty et al., 2012). To determine if the study is transferable to other studies, a researcher must include adequate details and case study protocols (Wahyuni, 2012; Yin, 2014). Donatelli and Lee (2013) described transferability as the ability for the procedures to be consistent every time a new researcher conducts the same research. Included in my research method and design section were adequate details so that the reader of my study may determine if the results are transferable to their study. By presenting assumptions in a study, another person wishing to replicate the research can decide if the replication is appropriate (Donatelli & Lee, 2013). I included assumptions that were central to this research to enhance the transferability of the study.

Data saturation. I achieved data saturation when no new information emerged from interviews and organization document review. Saturation refers to the point when no new information emerges from the participants' interviews or if the responses are redundant (O'Reilly & Parker, 2013; Suri, 2011). Kolb (2012) defined data saturation as the point when no changes occur in the themes. To increase the likelihood of achieving data saturation, I conducted follow-up member checking with each participant to review my interpretations of their responses and ask the participant if they had additional

information they could provide. According to Richardson et al. (2013), having the participants review a summary of the interview for accuracy and add missing or unclear information will help reach data saturation.

Transition and Summary

Section 2 included a detailed description and justification for the research method and design. I discussed the study population, sampling plan, data collection instrument and collection procedures, and data analyses. Section 3 presents the study results and recommendations. I included the discussion of the presentation of the findings, applications to professional practice, implications for social change, recommendations for action, recommendations for further research, and reflections.

Section 3: Application for Professional Practice and Implications for Social Change

Introduction

The purpose of this qualitative multiple case study was to explore implementation strategies for change initiatives used by senior health care managers. Scholars have conducted research on change in general (Kash, Spaulding, Johnson, & Gamm, 2014); however; this study focused on implementation strategies for change initiatives specifically in health care organizations located in Hanford, CA. I collected data by conducting semistructured face-to-face interviews with three senior health care managers from three different organizations. The themes identified during analysis were (a) communication, (b) training, and (c) involvement of the employees in decisions. The themes that emerged from data analysis include developing implementation strategies to improve the leader's ability in implementing change initiatives in health care organizations.

Presentation of Findings

During this research, I conducted semistructured interviews and reviewed documents related to strategies to implement change initiatives in health care organizations. I conducted an expert review of the interview questions to ensure they would produce responses to answer the research question. I also used member checking to mitigate bias and enhance validity of the study. I bracketing personal experiences and followed the study protocol (Appendix B) to mitigate preconceived opinions and biases. I used NVivo 11 to help me analyze the research data to determine the themes of the data. The purpose of this study was to answer the central research question: What

implementation strategies do some senior health care managers use for change initiatives?

The three themes that emerged after data collection and analysis were (a) communication, (b) training, and (c) employee involvement in decision-making. The findings from this research showed partial alignment with the conceptual framework of Lewin's (1947) phases of change theory and Kotter's (1995) eight steps to implementing change. The findings from this study also aligned with the studies examined in the literature review.

Emergent Theme 1: Communication

Communication emerged as a theme from interviews with participants and organizational documents. Analysis of interview data revealed communication as a vital component of implementation strategies. Communication flows either vertically or horizontally (Saruhan, 2014). Vertical communication can flow downward, upward, or both (Saruhan, 2014). When communication flows from a higher level to a lower level such as from managers to subordinates, the classification is downward. Examples of downward communication are emails, memos, face-to-face contact, and newsletters (Saruhan, 2014). Upward communication, by contrast, occurs when communication flows from a lower level to a higher level such as from subordinates to management. Two-way communication allows information to flow in both vertical directions. Horizontal communication occurs when individuals are on the same level and communicate back and forth (Saruhan, 2014). The direction of communication flow was

mentioned by participants during interviews and was evident in the organizational documents.

Documents provided by the organizations showed the flow of communication when implementing a change. The first document reviewed for the study included a memo emailed by Organization 2 leaders to notify their employees of an occurring change. The email was an example of downward communication and was the first notification of a change. The notification informed employees that a change would be forthcoming, including details of the change, the purpose of the change, and a request for volunteers to assist with the change. In the email, the leaders asked supervisors to share the information with staff who did not have access to email. The email also invited employees to respond if they had any questions, concerns, or ideas. The invitation for employees to provide insight to the leaders allowed for upward communication. Based on the review of the organizational documents, upward communication seemed critical during the implementation of change.

All three participants discussed communication during interviews. Participants implied that continuous open communication involving all affected employees facilitated a smooth and timely implementation of the planned change. Participant 2 stated,

> I believe it is important for managers and subordinates to communicate back and forth to ensure everyone is clear on what needs to be executed to get the change implemented. The more open we are in communicating with each other, the more seamless the change seems to be.

Participant 1 noted, “When we have open communication with employees, the timelines are met and we have less obstacles because we discuss the issues when they arise.”

The participants’ statements aligned with findings from Longenecker and Longenecker’s (2014) study of 167 hospital frontline leaders, who emphasized that lack of adequate two-way communication from senior leaders contributed to failed implementation of a change initiative. Longenecker and Longenecker (2014) found that effective two-way communication is necessary to have employees buy into the change. Downward communication alone failed to convey the importance of the change and the desired outcome (Longenecker & Longenecker, 2014). If an implementation of change initiatives includes the expectation to yield superior results, then a need exists for superior two-way communication between leaders and followers involved in the implementation of the change initiative (Longenecker & Longenecker, 2014).

Another aspect of communication critical to successfully implementing a change initiative is ensuring that the necessary information gets to the correct people in each level of the organization in a timely manner via the most effective communications channels. Participant 1 stated, “There are many levels of communication that occur during a change and it depends what the change is and what stage of the change we are in.” Examples provided by Participant 1 regarding when communication occurs were (a) pre-change notifications to notify employees of change, (b) during-change communication, and (c) after-implementation communication to receive feedback and make improvements. Participant 2 supported Participant 1’s comment with the statement, “The communication during a change really depends on what the change is and who is

involved in the change. I utilize different communication strategies such as in person or via technology for different times of the rollout." In a follow-up question, Participant 2 implied that for initial notification of the change, company leaders use email to provide the information regarding what the change is and then leaders use face-to-face communication in a meeting to have open dialogue between leaders and followers.

According to the participants in the study, another aspect of communication critical to successfully implementing a change initiative is to find a way to communicate personnel changes in a sensitive manner. When a situation involves staffing changes, each participant said this information should be communicated to the affected employees via face-to-face conversation. Participant 2 explained that not all changes should be communicated through email, such as personnel transfers, personnel reduction, and workload responsibilities. Each of these scenarios requires personal communication to employees who have a sense of ownership in their work. Participant 1 had a similar comment:

> I use email to notify employees of upcoming technology changes and get them excited about it by promoting the benefits of the change. I do not use email for every change. At one point, the organization restructured and changes such as restructuring are not something I would do through email, but would have to have discussions face to face with the employees in small groups because employees are sensitive about these types of changes.

Clear communication of a leader's expectations and goals is another facet of communication that is critical to successfully implementing a change initiative.

Participant 3 noted that, "communicating the why of a change, the expectations, and the goal are imperative if [you] one want[s] employees to be open to implementing changes." This finding aligns with Kash et al.'s (2014) findings from interviews with 61 health leaders in two different organizations. Kash et al. (2014) found expectations of change initiatives must be communicated by the leaders. Additionally, Kotter (1995) discussed how an organization provided employees with large notebooks containing information on implementation of a change, but the information provided in the large notebook did not include the change vision from the leaders. The findings from my study aligned with Kotter's eight-step process for implementing change because communication is the fourth step in Kotter's process. Kotter recommended that the communication of the change vision and plan should be simple, which aligned with responses from my study's participants.

The findings from this study did not align with the second conceptual framework for this study, Lewin's (1947) three phases of implementing change. Employees need (a) understanding, (b) widespread participation, and (c) learning for the change to be successful (Burnes & Cooke, 2013). By contrast, in Lewin's phases of implementing change, employees were a part of the process for determining the necessity of the change and the implementation process for the change. According to the participants in my study, only the leaders were involved in the decision to implement a change. They then forced the change on the employees. Employees could provide input on how to implement the change, as communication was both downward and upward, but the

decision to implement the change was not something that involved the employees directly. The employee's involvement came after managers forced the decision on them.

Participant 1 stated, "I value the employees' input on the process of making the change, but the decision that a change must be made will occur at the management level." Participant 3 implied that "as important as the employee's opinion is, those at the management level need to determine when changes need to be made and then invite the employees to be a part of the change." Participant 3 expanded on this notion stating that the reason for the management-level decision was due to prior history of too many people trying to make a decision without success. Burns and Cooke (2013) explained that for Lewin's (1947) theory of change to occur, there must be a structure and iterative process to identify and analyze the change options before implementation. Consequently, employees need to be involved in understanding the situation prior to bringing about the change (Burnes & Cooke, 2013). Having employees help map out the current reality and constructing the desired reality enables participation and learning in developing the decision of the change (Burnes & Cooke, 2013). When imposing changes on employees by not including them in the iterative process in the decision, the change will have limited benefits (Burnes & Cooke, 2013).

Table 2 presents the frequency with which an aspect of communication was a topic of discussion during the interviews, with the percentage of interview questions answered. Participant 1 and Participant 3 mentioned communication in four of the six interview questions, or 66% of the responses collected. Participant 2 discussed communication in three of the six interview responses.

Table 2

Number of Times Communication Discussed

Questions where participants mentioned communication	Response	Times Discussed	% of
Participant 1, Interview questions 1,3,4,6		11	66%
Participant 2, Interview questions 2,3,4		7	50%
Participant 3, Interview questions 1,3,4,5		12	66%

Emergent Theme 2: Training

The second emergent theme from the analysis of the data indicated that employee training is an important consideration when developing an implementation strategy for a change initiative. All participants emphasized the importance of training for employees whose job or duties must change due to the initiative. Participant 1 stated, "There is training scheduled anytime we have a change in a process. This training increases the comfort level of the employees and makes the process smoother." Participant 2 indicated, "Training is sometimes done in a face-to-face setting or sometimes online; but no matter how the training is offered, I ensure that there is training to help our employees, which may decrease resistance and increase morale." Participant 3 echoed the statements of Participant 1 and Participant 2. The comments of the participants aligned with Swanson et al.'s (2012) findings that offering training to employees regarding change helps to increase employees' comfort level during the implementation process.

Lawrence, Ruppel, and Tworoger (2014) found leaders are those most in need of additional training and support. Lawrence et al. (2014) conducted a qualitative

longitudinal study that included a questionnaire of high-level leaders of a hospital. Lawrence et al. (2014) focused on the emotions that these leaders experienced during the implementation of change initiatives. Findings indicated that leaders receiving training were motivated and committed to the change (Lawrence et al., 2014).

By contrast, the participants in my research study did not express the importance of training for leaders. Instead, participants mentioned concerns about ensuring that followers received training for the upcoming changes. None of the participants thought that they as leaders needed training on how to implement organizational change. Kilekly's (2014) and Lawrence et al.'s (2014) findings indicated that leaders need mentoring and development to be successful when implementing changes. Porter et al. (2015) conducted a case study on a nutrition care process (NCP) implemented in a hospital dietetic department. My participants' comments aligned with Porter et al.'s findings regarding the need for training. Training employees and gaining knowledge does not mean that employees' behavior will change (Porter et al., 2015). Research during the NCP implementation indicated difficulty removing the behaviors learned by employees over years with just one training intervention. Porter et al. recommended ongoing training to ensure sustainability of change. My study participants expressed the importance of training before, during, and after the implementation to ensure a smooth transition. The participants also noted the need to have appropriate resources in place. Participant 1 noted, "It is vital that employees receive training prior to, during, and post implementation of a change initiative. I cannot lead my team to success without providing the necessary training and resources for them."

As suggested by Porter et al. (2015), there are different forms of training such as peer tutorials, mandatory participation in trainings, and development of reference sheets and manuals. During interviews, all participants indicated training for their employees was a key strategy as an important consideration when developing an implementation strategy, yet none of the participants indicated they felt the trainings were effective.

During follow up questions, I asked participants to clarify whether employees seemed to benefit from the trainings, if employees found the need for additional trainings, and if employees seemed prepared for the new tasks and skills after trainings took place. Participant 3 noted that on some implementations additional trainings were needed because feedback from employees indicated they lack preparation for the new processes. In these situations when there was a lack of training, new trainings took place. Participant 1 and Participant 2 both expressed that their employees seemed prepared for the new tasks and that the trainings provided were sufficient and well planned to address the new skills needed.

The conceptual framework of Kotter's (1995) step 5 of empowering employees for broad-based action does not align with the participants beliefs from this study. Participants believed training as important in the development of implementation strategies as encompassed in Kotter's step 5. While participants believed their trainings to be sufficient, the literature showed that trainings do not always include the proper skill sets to apply once the implementation takes place (Kotter, 2012 & Swanson et al., 2012). Kotter (2012) found that most trainings do not include the social skills needed to apply the new skills to their work, and proper follow up trainings do not exist.

Table 3 includes the frequency regarding discussion of training throughout the interview and the percentage of interview questions answered by referencing training as a strategy that contributed to implementing change initiatives. Participant 1 and Participant 2 mentioned training in three of the six interview questions, inclusive of 50% of the responses collected. Participant 3 discussed training in four of the six interview responses, which was 66% of Participant 3's responses (see Table 3).

Table 3

Number of Times Training Discussed

Questions where participants discussed training	Times Discussed	% of Responses
Participant 1, Interview questions 3,4,5	12	50%
Participant 2, Interview questions 3,5,6	10	50%
Participant 3, Interview questions 2,3,5,6	9	66%

Emergent Theme 3: Employee Involvement

Data from the **i**nterviews and organization's documents revealed the participation or involvement of employees as an important strategy when implementing change initiatives. Teamwork and cooperation are important to successful change initiatives, because changes in one unit may affect another unit (Longenecker & Longenecker, 2014). Involvement of the employee who performs the process or task planned for change is important. Participant 2 implied that receiving feedback from all employees affected by the change is significant during an implementation, because an initiative may not succeed without taking pertinent aspects of the change into consideration.

Participants of each organization included in the study sample provided documents regarding change initiatives. All three participating organizations provided a document illustrating a communication of a change initiative implemented in their organization. A document provided by Organization 1 was a copy of a flier provided during a meeting with information on a planned change initiative. The flier requested employees with a desire to participate and help with the change to volunteer their expertise by attending a brainstorming meeting the week following the meeting. The organization asked employees to participate for several reasons. According to Participant 1, requesting participation did not burden the employees with the pressure of a formal requirement to participate, but allowed them to make a decision about having their opinion heard. A second reason was the choice to be a part of the change excited the employee.

Organization 2 and Organization 3 both emailed a notice to their respective departments explaining the decision to change and provide information on the change. The email requested that each department have a representative assess the effect of the change on the department and request participation in the change initiative. Participants believed that by the organization *asking* for involvement in the process, rather than demanding their cooperation, the employees might feel the leaders valued their inclusion.

Participant 2 stated that**,** "It is our job as management to guide these employees and educate them on how the change will benefit them, not just the organization." The data provided insight on the value employees have to their organizations. Though the participants expressed the necessity to involve their employees, they did not include

employees in the decisions to determine the necessary change. Participant comments from the interviews did not align with the literature on the value placed on the employee during a change initiative. Swanson et al. (2012) expressed the importance of (a) the value of the change; (b) the benefit to the employees and the organization; and (c) how the understanding of the value can reduce the employees' resistance to the change. Employee involvement in the decision making process helps employees to understand the value of the change (Swanson et al., 2012).

Step 2 is of Kotter's (1995) eight step model of implementing change is to create a guiding coalition necessary to direct the project's change efforts. According to Kotter, the purpose of the guiding coalition is to work together to build urgency and momentum of the change. In Lewin's (1947) phases of change model, the purpose of the guiding coalition is to create disturbance and dissatisfaction to ensure that all employees will help determine the need for change and how to implement that change. By contrast, the participant's comments and organizational documents provided did not align with the conceptual frameworks. The documents indicated that the building of a guiding coalition began after making the decision for change.

Table 4 includes the frequency with which participants discussed employee involvement throughout the interview and the percentage of interview questions answered referencing involvement as a strategy for implementing change initiatives. Participant 1 discussed employee involvement in four of the six interview questions, inclusive of 66% of the responses collected. Participant 2 discussed employee involvement in three of the six interview responses, which was 50% of Participant 2's

responses. Participant 3 referenced employee involvement two of six interview questions (see Table 4).

Table 4

Number of Times Employee Involvment was Discussed

Questions where participants mentioned employee involvement	Times Discussed	% of Responses
Participant 1, Interview questions 1, 2, 5, 6	8	66%
Participant 2, Interview questions 2,3,5	6	50%
Participant 3, Interview questions 2,4	4	33%

Applications to Professional Practice

According to Kotter (2012), the necessity for organizations to change to remain competitive and survive will increase over the next decade. There are increasing pressures on health care organizations, such as rapidly changing (a) technology; (b) medicine; and (c) rules and regulations (Longenecker & Longenecker, 2014). A demand exists for health care leaders to respond to constantly changing external and internal demands (Lawrence et al., 2014). The demands on health care leaders come from external pressures such as the ACA and public debate, and internal pressures from technology and budget restrictions (Lawrence et al., 2014). This research includes what participants believed is important in developing successful strategies for implementing change initiatives in their health care organizations, which may be helpful information to other business leaders to successfully implement significant change initiatives in their organizations.

Identifying what some leaders have found successful during implementation of change may help other leaders develop successful change strategies (Lawrence et al., 2014). The researcher's findings contribute to the literature regarding how some leaders approached implementing change initiatives in their organization. Comments from participants revealed that through proper training, health care leaders might enhance successful implementation of change initiatives. Strategies including training administered before, during, and after the implementation of change help to ensure employees have the proper resources and skill sets to apply to the new initiative.

Kotter's (1995) eight-step model of change and Lewin's (1947) phases of change model provided the conceptual framework for this research. Analysis of the data found that the participants were limited in their perspectives on viewing implementation strategies through the lens of Kotter and Lewin. Though the participants had a limited perspective of the strategies, elements such as communication, training, and involvement are included in Kotter's eight-step model. Analysis of the data presented that some leaders achieve successful implementation strategies for change initiatives through communication, training, and involvement of employees during a change imitative (see Tables 2,3,4).

Implications for Social Change

A need exists for health care organizations to improve the quality, safety, and efficiency of health care (Lawrence et al., 2014). The results of this research might affect social change by improving health care leadership's ability to develop strategies for continuous improvement. The successful change strategies identified by this research

have social implications because health care organizations must continuously adapt to serve the public and meet the goals of quality, safety, and efficiency. The efficiency of health care may improve when implementing changes appropriately and preparing employees for the new responsibilities change may require.

Recommendations for Action

Current and future health care leaders may consider recommendations based on this research to assist with planning the implementation of change initiatives. I recommend that health care organizations unsure of strategies to implement s based on the findings in this study. Three recommended strategies are (a) communicate the intent and value of the change initiative, (b) incorporate training throughout the implementation of change initiative, and (c) involve employees in the implementation of change initiative.

The first recommendation from this research is to communicate the intent and value of the change initiative effectively. The research found the importance of two-way communication between health care leaders and employees regarding implementation of change initiatives (see Table 2). Communication needs to be downward and upward to allow employees to have a voice in the change. Participants believed they were successful at implementing changes when they allowed communication to flow downward and upward.

The second recommendation from this research is to develop effective training throughout the implementation of a change initiative. Trainings need to be prior to implementation to ensure that employees know and understand expectations. Trainings

during the implementation of change initiatives will teach the employees the new skills needed to change. This research also presented the importance of the leaders receiving training related to implantation of change initiatives.

The third recommendation from this research is for leaders to involve employees in the decision to be a part of the change and in the decision making process. Leaders need to allow their followers to have a say in how an implementation of a change occurs. Demanding employees to accept that a change will occur and then asking for their input does not align with the models of Kotter (1995) or Lewin (1947). Leaders should ask for employee involvement to determine what change should occur and then assist with how the implementation of the change occurs.

By applying these recommended strategies, some senior health managers may promote effective practices to implement change initiatives. Management can use the findings from this study to help reduce the failure rate of change initiatives. I will disseminate the findings of this study to health care professionals and organizations through (a) academic research journals, (b) business journals, and (c) health care journals. Presentation of the findings to management and employees of health care organizations through professional conferences, written materials, and training sessions may help senior health care leaders as well as leaders from other industries. Leaders can expand their knowledge and improve their ability to implement change by attending trainings on implementing change.

Recommendations for Further Research

The purpose of this qualitative multiple case study was to explore implementation strategies for change initiatives used by senior health care managers. Recommendations for future studies include additional qualitative research discussed below and quantitative research to measure outcomes of the recommended implementation strategies.

Conducting the research, I found that the results did not completely align with Kotter (1995) and Lewin's (1947) models and conducting these additional studies may provide further insight to determine if other organizations thoroughly apply Lewin or Kotter in their strategies for implementation of change. Further qualitative research on health care organizations that use Kotter's eight-step process or Lewin's three phases of change may be beneficial to the industry to review their effectiveness in implementing changes. Further qualitative research on post implementation outcomes of specific change initiatives from these organizations may provide additional knowledge of the effectiveness of communication, training, and employee involvement strategies.

Conducting quantitative research may provide different implementation strategies of change initiatives. A quantitative study would allow for determination of the frequency of the different aspects of the recommended strategies (Petty et al., 2012). For example, the frequency of each type of communication involved in a change initiative may determine the potential correlation between types of communication to the outcome of an implementation of change. Through a quantitative study, determinations may include the number and types of trainings conducted and when trainings took place, which may prove useful in extending the findings that training is vital to successful implementation.

Reflections

During this journey at Walden University, I gained extensive knowledge regarding business practices. The doctoral program provided the opportunity to conduct this research regarding implementation strategies of change initiatives in health care. There were many challenges throughout this process.

The choice of the industry to use in this study changed several times, my research question evolved, and my committee members changed. During the process, I learned that when others read this work and offer suggestions, the goal is to help improve the research; consequently, keeping an open mind to these suggestions is important. Before this research, my experience with implementing change initiatives was that many managers lacked strategies to implement a change initiative successfully. My perception came from personal experience observing leaders fail in the implementation of change initiatives and the achievement of the intended goals.

During this study, my perception changed, because the health care leaders who participated in the research provided insight into their success. I came to the realization that while many leaders struggle, there are leaders who give hope to decreasing the failure rate of implementation of change initiatives. Conducting this research also expanded personal knowledge of the research process and its ability to improve management decision-making processes.

Conclusion

The purpose of this qualitative multiple case study was to explore implementation strategies for change initiatives used by some senior health care managers. The findings

from this study indicated that though the rate of failure during change initiatives is high, using specific strategies to implement change initiatives might increase the success of those change initiatives. Change remains inevitable, as conquering the process of implementing change is critical to the success of organizations. The analysis of data emerged three themes, (a) communication, (b) training, and (c) employees involvement. Participants in this research believed their success in implementation of change initiatives was due to communicating properly, training of employees, ensuring leaders received proper training, and involving employees in implementation of change initiatives. The results of this research may provide valuable knowledge for senior health care managers tasked with implementing a change initiative.

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Appendix A. Interview Questions

1. What has been your experience with implementing change initiatives?
2. What implementation strategies have you utilized for change initiatives?
3. What steps did you follow when implementing a change initiative?
    a. How did you plan these steps?
    b. Who in the organization was involved in the planning process for the change initiative?
    c. What communication methods did you utilize during the implementation of change initiatives?
4. What implementation strategies resulted in successful implementation of the intended changes in your organization?
    a. Based on your experience with these changes initiatives, what were the strengths of your implementation strategy?
    b. What were the weaknesses of your implementation strategy?
5. What implementation strategies failed to result in successful implementation of the intended changes in your organization? Please explain why they were not successful.
6. What additional information regarding the implementation of change initiatives would you like to share?

Appendix B: Interview Protocol

The aim of this interview is to answer the research question on strategies that senior health care leaders utilize to implement change initiatives.

I will complete the following steps during each interview.

1. The interview will begin with a brief overview of the research, the purpose, and the time required for the interview.
2. I will thank the participant for agreeing to participate in the interview.
3. I will present a copy of the informed consent form and review the contents of the form with the participant. The items included in the consent form are: (a) the expected length of time to participate in the interview; (b) the interview will be audio recorded and if a participant chooses not to be recorded, handwritten notes will be taken; and (c) a summary of the interview will be presented to each participant to validate my interpretations of their responses to each interview question.
4. I will explain that their participation is voluntary, and they can withdraw from the study at any time without prior notice and through a verbal or email request, even after the completion of data collection.
5. I will provide my contact information to each participant in case he or she decides to withdraw from the study.
6. I will obtain the participant's signature on the consent form as an indication of their agreement to participate in the study.
7. I will collect the signed consent form and provide the participant a copy of the consent form for his or her records.
8. I will use a sequential coding system to identify the participants during the interview recording without using their names. For example, I will assign each participant an identifying pseudonym, such as P1, P2, and P3. I will explain that I will be the only person with access to the name of each participant associated with each pseudonym and that data from their interview will be identified in my database using only their assigned pseudonym.
9. I will record the interview, if permitted, after a participant signs a consent form and begin with open-ended questions, which may include probing questions to expand on the participant's responses.
10. At the end of the question period, I will remind the participant that I will provide him or her with a summary of the interview and my interpretations of their responses to review and validate.
11. Request documents that I have been granted permission for the participant to provide copies of documents related to the use implementation of change initiatives that the organization is comfortable sharing. This has been approved by the authorized representative of the company in document request form (Appendix C).
12. I will end the interview and thank the participant for taking the time to participate.

Appendix C: Document Release Form

TO OBTAIN APPROVAL FOR DOCUMENTS/ARTIFACTS TO BE RELEASED

Dear Organization Representative:

My name is Kristy Trinidad, and I am a student at Walden University seeking a Doctorate of Business Administration with a specialization in Social Impact Management. I am conducting a research study entitled: "Strategies for Successful Implementation of Change Initiatives in Health Care Organizations." An executive or management professional from your organization has agreed to participant in my doctorial study.

I am requesting your permission to use and reproduce organization policy, procedures, and communication related to my study. As the official with the authority to grant permission to release company documents, I am requesting release of documents subject to the following conditions:

- I will use all company documents released to me exclusively for my research and not disclose or discuss any confidential information with others, including friends or family.
- I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as authorized by you as the official company representative.
- I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
- I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
- I agree that my obligations under this agreement will continue in perpetuity after the completion of my study.
- I understand that any violation of this agreement may have legal implications.

By signing this document, I acknowledge that I have read the agreement and that I agree to comply with all the terms and conditions stated above.

_____ _____
Signature Date

I, _____ (print name), in my official capacity as _____ (title) of _____ (company), hereby release the documents listed by title below to Kristy Trinidad for her sole and exclusive use in her Doctor of Business Administration research study at Walden University subject to the above agreement signed by Mrs. Trinidad
Signed this _____day of _____ (month), 2015
_____ (Signature)
_____ (Name Printed)
_____ (Title)
_____ (Name of Organization)

Documents released for use by Kristy Trinidad
Policy and Procedures pertaining to implemented change initiatives
Communication regarding implemented change initiatives

If these are acceptable terms and conditions, please print and sign your name, title, organization, date your signature, and list the titles of the documents you are releasing for my use.

Please print or save this consent form for your records.

Sincerely,

Kristy Trinidad
Doctoral Candidate
Walden University

Appendix D: National Institutes of Health Certificate of Completion for Protecting Health Research Subjects