2018

Streamlining Hospital Administrative Procedures to Reduce Costs

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Walden University
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Abstract

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BS, Armstrong Atlantic State University, 2005

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Abstract

Americans spent nearly $2.6 trillion, or $8,000 per person for medical and administrative costs in 2010. By 2015, healthcare spending in the United States increased to 5.8% reaching $3.2 trillion or $9,990 per individual. By tackling healthcare administrative costs, it is estimated that healthcare providers could reduce these costs by $20 billion yearly. This case study explored strategies for streamlining hospital administrative procedures to reduce costs. The business process reengineering model formed the conceptual framework for this study. Data were gathered through semistructured face-to-face interviews guided by open-ended questions with a purposeful sample of 4 hospital managers in Atlanta, Georgia. This study identifies important themes regarding cost reduction and hospital administration based on participant interviews. Themes included participants' unfavorable perspectives of the Spell out PPACA (PPACA) legislation, employment of physicians, PPACA reimbursement method, follow-up services, hospital administrative governance, and lack of business education. The themes comprised steps hospital managers could take to streamline administrative procedures to reduce costs. The implications for positive social change included the potential to provide strategies for streamlined processes that could lead to savings passed on to patients from low socio-economic backgrounds through accessibility to affordable healthcare services.

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Dedication

I thank God, the author and finisher of my fate for giving me the gift of intellect to complete my doctoral journey. I thank him for answering my countless prayers for the strength and means to move forward every step of the way during the tedious doctoral journey despite the challenges and obstacles that came my way. Thanks for being my pillar and backbone. I owe so much thanks to my mother, Catherine Ngozi Onukogu for her unwavering love and support. Your zeal and enthusiasm towards my success inspires me to attain greater heights in my life. Your moral support and encouragements fueled my strengths towards completing my doctoral study. I love you.

Acknowledgments

I would like to offer special thanks and gratitude to my committee chair and mentor, Dr. Brandon Simmons and his predecessors who also contributed to my success in this difficult journey. I would also like to acknowledge and thank my second committee member Dr. Jamie Klein for her valuable suggestions, which contributed to the development and enrichment of my doctoral study. I am also grateful for my university research reviewer (URR) Dr. Janet Booker for her invaluable contributions to the completion of my doctoral study. Thanks to Dr. Freda Turner, the program director of the Doctor of Business Administration program at Walden University, for establishing a rewarding learning opportunity through this program. Thanks to other Walden University faculty who helped me along the way.

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Section 1: Foundation of the Study

The success of any hospital depends on its financial viability and patient satisfaction. Healthcare geared towards patients involves hospital personnel and managers creating an environment of care that improves the patients' perspective of the results of their treatment while at the hospital. The Health Care and Education Act of 2010, The Patient Protection, and The Affordable Care Act of 2010, together form the Affordable Care Act (ACA), the legislation pertains to the provision of incentive alignment for physicians and hospitals through a structured payment model called the value-based purchasing (VBP) program (Anderson & Wilson, 2011). The Centers for Medicare and Medicaid Services (CMS) administrators implement and oversee the VBP, which contains provisions that base 30% of reimbursement on the patient experience measure and 70% on clinical process measures (Anderson & Wilson, 2011). The patient-centered care is synonymous with patient experience. Patients experience satisfaction with care and achieve positive healthcare outcomes in a patient-centered hospital while hospital teams achieve economic viability. The focus of this study was to determine the strategies for streamlining hospital administrative procedures to reduce costs.

Background of the Problem

The cost of healthcare in the United States continues to increase, and by 2021, healthcare costs could reach $4.8 trillion (Stephens, Manrodt, Ledlow, Wilding, & Boone, 2014). Based on World Bank records, the costs of healthcare in 2011 totaled 17.9% of the gross domestic product (GDP) in the United States (Stephens et al., 2014). Increases in the costs of healthcare make it difficult for families and individuals to gain access and to afford quality healthcare.

With a rise in financial pressures, some hospital administrators are continuously

searching for methods to streamline costs to stay competitive (Moon, Szlezák, Michaud, Jamison, Keusch, Clark, & Bloom, 2010). As the number of hospital admissions increase, hospital managers must adopt management solutions to enable them to meet consumer expectations and provide quality healthcare at minimal costs; hospital managers must find ways to streamline hospital costs, increase revenue, and promote quality service for the communities they serve (Moon et al., 2010). The streamlining of hospital costs would enable healthcare providers to concentrate on patient care (Moon et al., 2010). Although the streamlining of healthcare costs will not be an easy task, it will require collaboration and the standardization of established cost-cutting policies in hospitals (Moon et al., 2010).

Problem Statement

In 2010, Americans spent nearly $2.6 trillion, or $8,000 per person for medical and administrative costs, yet healthcare providers could reduce these costs by $20 billion annually through tackling healthcare administrative costs (Martin, Lassman, Washington, & Catlin, 2012). According to the Institute of Medicine, each physician practicing in a healthcare facility will save an estimated $29,000 yearly by streamlining procedures to reduce healthcare administrative costs for patients and these savings might lead to more resources and time invested in patient care (Cutler, Wilker, & Basch, 2012). The general business problem was the continuing rapid escalation of healthcare costs, which makes affordable healthcare difficult for some individuals. The specific business problem was that some hospital managers lack strategies to streamline administrative procedures to reduce organizational healthcare costs.

Purpose Statement

The purpose of this qualitative single case study was to explore strategies that hospital

managers use to streamline administrative procedures to reduce healthcare costs. The research population was four hospital managers and administrative management personnel from one hospital in Atlanta, Georgia, who had successfully streamlined administrative procedures to reduce costs in their departments. The findings from this study may contribute to social change by providing strategies for streamlined processes that leads to savings passed on to patients from low socio-economic backgrounds through accessibility to affordable healthcare services.

Nature of the Study

Qualitative research entails exploring a phenomenon (Bailey, 2014). I selected a qualitative research method instead of a mixed or quantitative method because a qualitative study pertains to the analysis of unstructured data (Bailey, 2014). I did not select a quantitative research method because it involves a top-down or deductive scientific method to measure the statistical significance of findings (Duvendack & Palmer-Jones, 2013). Qualitative method was a better option to address the specific business problem for this study instead of the quantitative or mixed method because it provides a thorough understanding of human behavior and the reasons behind those behaviors (Duvendack & Palmer-Jones, 2013). A mixed method is a combination of qualitative and quantitative methods to expand the understanding of a phenomenon and was not appropriate for my study because the examination of the research problem did not require quantitative data (Wisdom, Cavaleri, Onwuegbuzie, & Green, 2012).

According to Yin (2014), case study research is an empirical inquiry that researchers use to facilitate the understanding of organizational, group, and individual experiences in a bounded system by examining details in context and a rich description of complex phenomena arising from a study. The case study design was best for addressing the specific business problem

because I was able to explore the personal experiences of hospital managers streamlining hospital administrative procedures to reduce healthcare costs. The phenomenological design is for the description of lived experiences (Wisdom et al., 2012), and was not appropriate for the study of emerging events associated with the strategies to streamline administrative procedures to reduce costs. Researchers use grounded theory to develop theories (Crofts & Bisman, 2010). Since this doctoral study did not involve the development of any new theories, a grounded theory design was not appropriate for the study. Ethnographic studies pertain to cultural characteristics (Crofts & Bisman, 2010), which was not the intent of this study.

Research Question

The main research question guiding this study was: What strategies do hospital managers use to streamline administrative procedures to reduce healthcare costs?

Interview Questions

1. What strategies have you developed and implemented to reduce administrative costs for your hospital operations?
2. How do you assess the effectiveness of strategies as they relate to costs for hospital administrative procedures?
3. Which of these strategies have been effective for reducing administrative costs?
4. Which of these strategies have been the most challenging to implement for reducing administrative costs?
5. What strategies do you use to identify business processes for redesigning the current administrative procedures to reduce administrative costs in your hospital?
6. What other information would you like to share regarding strategies to reduce

administrative costs, and how you pass the cost savings to the patient?

Conceptual Framework

Using the business process reengineering model as the conceptual framework for this case study, I had an opportunity to conduct in-depth research to identify strategies needed by hospital managers to streamline administrative procedures and reduce costs. In 1990, Michael Hammer introduced the business process reengineering (BPR) model, which applied to this research study. With the use of BPR, Hammer (1990) posited that some managers face challenges in eliminating unnecessary work. Researchers can use the BPR model for re-evaluating and achieving success, and capitalize on the use of BPR to re-achieve success in customer satisfaction and cost structure (Hammer, 1990). BPR involves radically redesigning organizational processes to enhance current service, speed, and cost performance (Hammer, 1990). The leading factor for selecting the BPR model for my doctoral study was the value creation in the healthcare field. BPR involves: (a) the development of process objectives and business vision, measurement, and understanding of existing processes; (b) identification of business processes for redesigning; and (c) the building and designing of the prototype of the new process (Hammer, 1990). The business vision comprises business objectives that are specific such as output quality improvement, time, and cost reduction (Hammer, 1990).

Social context and traditional business concerns are factors that have consequences for the future and present operations or viability of business activities, and the society where those businesses operate (Hammer, 1990). In other words, the consequences affect businesses and the society. Several social entrepreneurs and investors have realized that different types of social enterprises, including some non-profit or charitable organizations, can generate returns

(Hammer, 1990). The main strategy I followed was to regard the streamlining of administrative processes as ways to reduce administrative costs for hospitals. The business process reengineering model provided the basis to analyze strategies to streamline administrative procedures because of its focus on the cost structure. With the use of innovative administrative processes to achieve success towards cost reduction, I used Hammer's BPR principles to assess how the hospital included in the study reduced administrative cost (Hammer, 1990). Aragon and Gesell (2003) grounded the primary provider theory, which applied to this doctoral study because it pertains to the initiatives and actions that result in an outcome of quality. I also used the Deming's 1950s Plan, Do, Study, Act cycle (PDSA) which correlated with the BPR model and was an applicable framework for this doctoral study because it pertained to administrative performance improvement in hospitals (Grant & Schmittdiel, 2015).

Operational Definitions

Capitated pay rate: Capitated pay rate is a payment arrangement for healthcare providers designed to disburse sets of payment amounts for each enrolled individual assigned to them through Medicaid or Medicare (Medicaid.gov, n.d.).

Down code: Down code include changes made to a submitted service or procedural code for reimbursement purposes because the code does not meet the requirements for the performed services or procedures (Medicaid.gov, n.d.).

Fee schedule: A fee schedule is an accumulation of pre-existing fees for procedures or services (Proctor & Young-Adams, 2011).

Third-party payers: Third-party payers are companies that provide partial or full financial reimbursement to healthcare providers for procedures or services to individuals or patients

(Proctor & Young-Adams, 2011).

Upcode: Upcode means intentionally upgrading procedure codes to the next level of the reimbursement code for increasing the reimbursement amount without providing documentation to support the action (Proctor & Young-Adams, 2011).

Assumptions, Limitations, and Delimitations

In this section, I describe the assumptions, limitations, and the delimitations of this doctoral study. In a doctoral study, assumptions entail beliefs assumed as truths but not verified (Silverman, 2013). Unique circumstances out of a researcher's control and possible weaknesses of a research such as place and time are limitations in a doctoral study (Silverman, 2013). In a doctoral study, the characteristics that limit the scope, and define the boundaries of the study are delimitations (Silverman, 2013).

Assumptions

Assumptions are situations that are out of control for researchers, but their absence would make a study irrelevant (Bernard, 2013). One of my assumptions for this study was the achievement of data saturation with the few hospital managers included in this study. I also assumed the participants would not withdraw from the study before quality and accurate data collection is complete. I assumed that participants would provide honest, accurate, and complete answers to the interview questions; and that administrators will provide copies of all relevant documents related to administrative procedures and costs.

Limitations

Limitations are potential weaknesses in studies that are out of the control of researchers (Naughton & Shapiro, 2015). A lack of adequate information on organizational management,

structure, and teamwork could exist because of poor information. The findings from the limited number of participants may not be transferrable to other hospitals in my study area or those in different areas of the United States. More specifically, administrative procedures for reducing costs that I identified through my study may not be acceptable or feasible for implementation at hospitals other than the hospital included in my study.

Delimitations

Delimitations are the characteristics that limit the scope of the study and define its boundary (Tanaka, 2011). The participant selection criteria limited participants to hospital managers that are at least bachelor's degree holders with knowledge acquired from a higher educational institution and a minimum of 2 years of experience in the healthcare field. I did not collect information from other hospital personnel, such as doctors and nurses, regarding strategies for reducing administrative costs. In addition, I did not research other non-administrative healthcare management issues that may affect hospital costs. I chose administrative costs for hospital healthcare as the focus of the study because they are comparable and measurable.

Significance of the Study

Streamlining administrative processes in healthcare is a realistic approach to reduce or contain rising healthcare costs (Swayne, Duncan, & Ginter, 2012). The industry is gradually undergoing changes; healthcare practitioners have experienced changes regulating costs and the demand for the accessibility to quality healthcare (Swayne et al., 2012). A structured strategic approach to management could make a difference in the changing healthcare environment (Swayne et al., 2012). My study may contribute to effective and improved business practice by

providing healthcare organizations with changes to existing administrative processes to reduce costs. The study findings may influence medical providers to continue seeking strategies to streamline procedures to reduce administrative costs. I included in the study findings detailed strategies that are effective in reducing healthcare administrative costs that other healthcare managers can evaluate and consider implementing in their healthcare organizations.

Strategic thinking, management, and planning are important in dealing with the healthcare dynamics and effective leadership in healthcare organizations (Swayne, Duncan, & Ginter, 2012). The strategic management process can reflect developments, management of strategies, and conceptualization in the healthcare industry (Swayne et al., 2012). The results of this study may contribute to positive social change by encouraging the use of successful administrative strategies to reduce healthcare costs, which will increase patient access to healthcare services as well as reduce costs.

A Review of the Professional and Academic Literature

When conducting a qualitative research study, the literature review signifies the most important aspect of the process. An in-depth literature review serves as a solid foundation for a meaningful and substantial research study. A thorough literature review provides an opportunity to identify the weaknesses and strengths of different research approaches, inconsistencies and contradictions, research designs and methodologies, and variables that relates to the topic of interest (Onwuegbuzie, Leech, & Collins, 2012). A literature review also differentiates between the gap in a topic of interest and those that need completion.

Increasing healthcare costs in the United States have become a persistent issue and concern for healthcare providers and consumers (Cutler et al., 2012). Health managers should

streamline the reduction of costs and time required for the processing of claims and decreasing of rejected claims percentage (Cutler et al., 2012). The resolution of this problem can be beneficial to healthcare managers who lack the strategies needed for the streamlining of claims processing and improvement of compliance rates (Cutler et al., 2012). Feasible methods for collaboration between business managers and the government in the streamlining of regulatory processes, such as health insurance underwriting, and the release of healthcare funds from regulatory compliance need to be identified and redirected towards improving patient care and reducing healthcare costs (Cutler et al., 2012).

This literature review consists of summaries and descriptions of literature describing the growth of examined problems through the doctoral study as they relate to previous research. The literature review includes relevant information from peer-reviewed journals, governmental sources that provide descriptive information about the problem, and information from other researchers that have conducted research on the problem. This section includes a summary of the theory underlying the doctoral study. I obtained citations mainly through scholarly research journals to identify the gaps in the knowledge associated with the problem pertaining to streamline hospital administrative procedures to reduce costs. The topics discussed in the outline include the history of governmental involvement in the healthcare field, the methodology of healthcare costing, healthcare reimbursement system, and organizational models for the delivery of healthcare. The subsections include the sustainable growth rate, payment capitation and bundling, and the traditional physician practice model.

The strategy used in the research for the literature review of the study included the use of EBSCOhost to search different databases to retrieve peer-reviewed articles and scholarly books

published between 2011 and 2015. The journals include the International Journal of Market Research, The New England Journal of Medicine, Qualitative Research in Accounting and Management, PubMed, Harvard Business Review, Journal of Global Business and Technology with articles on business, health, medical, and science. The search terms used to retrieve peer-reviewed journals include *hospital administrative claims database, hospital expenses, and streamlining rising healthcare costs*. The literature review consists of 115 references from books, peer-reviewed journals, and governmental websites with 94 references (89%) less than 5 years old.

Improvement of Healthcare Cost Management

Individuals in a successful hospital system should embark on the development of an effective organizational model that would promote cost-effectiveness and efficiency (Tucker, 2013). Transparency, improvement measures, process evaluation, the definition of prioritization criteria, stakeholder involvement, and priority setting should be some of the main characteristics of healthcare business models (Whitlock, Lopez, Chang, Helfand, Eder, & Floyd, 2010). Porter (2010) and Berenson, Basch, and Sussex (2011) emphasized healthcare costing as a current concern, and others addressed healthcare structure reform as it pertains to physician reimbursement (McClellan, 2011; Tucker, 2013; Zuvekas, Cohen 2010). Additionally, the positioning of organizational structures for effective healthcare delivery may lead to a reformed organizational model that results in an improvement of value and cost reduction (Goldsmith, 2011; Hunter & Baum, 2012; Kocher & Sahni, 2010; Wise, Alexander, Green, & Cohen, 2012). Differences pertaining to an optimization of organizational structure for the improvement of the value and delivery of healthcare services are also present in literature (Ginsburg, 2011; Jones &

Trieber, 2010; Koning, Verver, Heuvel, Bisgaard, & Does, 2011). To achieve success redesigning healthcare organizational structure to reduce costs and effectively streamline administrative procedures, individuals in the healthcare industry need to gain an understanding of the costs involved in achieving the outcomes (Qazi, 2012). The shifting of attention from organizational structures or processes that focus on physicians to those that concentrate on patients could result in the reduction of healthcare costs (Lee, 2012).

The Government and Healthcare

Although medical procedures and medications have enabled some individuals to live a healthy and long life, affordable healthcare remains a challenge making the reduction of healthcare costs and the streamlining of administrative procedures a priority in the healthcare sector. In the 1900s during the Progressive Era, President Theodore Roosevelt promoted the notion of universal healthcare on a progressive platform (Lee, 2012; Orentlicher, 2012). Over decades, the United States government struggled with persistent ways to reduce healthcare costs. In 1935, President Franklin Roosevelt passed the Social Security Act that established a system to provide old age benefits on a federal level (Orentlicher, 2012; Quaye, 2014). The act served as an avenue to provide funds for building health departments on a local level (Fuchs, 2012; Rajkumar, Conway, & Tavenner, 2014). However, at that time, the American Medical Association feared that mandatory health insurance would take away physician autonomy, and they fought against nationalized healthcare (Rauscher Singh & Wheeler, 2012; Rajkumar, Conway, & Tavenner, 2014).

President Johnson introduced the "*Great Society*" program, which changed healthcare coverage. In 1946, President Truman passed the Hospital Survey and Construction Act to tackle

rising costs of hospital care (Rauscher Singh & Wheeler, 2012; Orentlicher, 2012). In 1965, Johnson signed the Social Security Amendment Act into law that led to the creation of Medicare as the first federal healthcare program in the United States (Fuchs, 2012; Rajkumar, Conway, & Tavenner, 2014). The three parts of the Medicare legislation were the Cohen-Falk Bill that changed to Medicare Part A, the Republican proposal (Part B), and the proposal from the American Medical Association to provide healthcare for disabled individuals under 65 years old and children, which became known as Medicaid (Redhead, 2012; Orentlicher, 2012). Originally, the two types of Medicare coverage were Part A and Part B. In 1997, Congress created the Balanced Budget Act and introduced Medicare Part C (Fuchs, 2012; Reinhardt, 2013).

Medicare Part A covers most expenses for hospitalization. It serves as hospital insurance used for the payment of a wide range of inpatient and critical hospital care, as well as costs incurred at skilled nursing facilities (Lee, 2012; Restuccia, Cohen, Horwitt, & Shwartz, 2012). Although long-term care is not included in Part A, it may cover home healthcare or hospice care. Part A Medicare covers inpatient mental healthcare given in a psychiatric facility (Orentlicher, 2012; Reinhardt, 2013). Medicare Part B serves as a continuation of Medicare Part A because it covers some of the outpatient products and services that the hospital insurance does not cover (Orentlicher, 2012; Rooks, 2011). Individuals can use Part B coverage to pay for a variety of necessary medical expenses not paid during inpatient treatment (Lee, 2012; Rooks, 2011).

Medicare Part C, also known as Medicare Advantage plans, is a private health insurance approved for individuals already enrolled in Medicare Part A and Part B (Fuchs, 2012; Satiani, 2014). Individuals in the Medicare Advantage plan must pay their Part B premium. Medicare Part C provides medical and hospital insurance coverage as well as offers individuals benefits

such as hearing, dental, vision, and prescription drug coverage (Rooks, 2011; Satiani, 2014). Medicare Part C includes options such as coverage for a health maintenance organization (HMO), preferred provider organization, private fee-for-service, special needs plans, HMO point-of-service, and a medical savings account (Fuchs, 2012; Satiani, 2014).

The federal government made investments in the healthcare infrastructure with the concept of universal healthcare (Reinhardt, 2013; Restuccia et al., 2012). The Healthcare Financing Administration (Rajkumar et al., 2014; Redhead, 2012) manages the Centers for Medicare and Medicaid Services, which operate under the Department of Health and Human Services. Since the implementation of Medicare, the costs of healthcare services increased partly because of governmental legislation to extend coverage to the poor, disabled, and the elderly (Rauscher, & Wheeler, 2012). The Healthcare Financing Administration realized that the government allocated a large portion of funds to drug coverage, hospitals, and physicians (Fuchs, 2012; Rajkumar et al., 2014). The Healthcare Financing Administration found a need to reduce the cost of the Medicare Program through the Omnibus Budget Reconciliation Act, which promotes a diagnosis-related payment fee schedule for healthcare providers (United States Department of Labor, n.d.). The provisions within the Omnibus Act created fee regulation schedules and the (RBRVS) fee calculation formula (American Medical Association, 2015). Several health maintenance organizations (HMOs) and Medicare use RBRVS to determine the fees due for payments to medical providers (American Medical Association, 2015). The goal of Medicare for using the RBRVS calculator is to reduce the disparities that exist in reimbursement and billing by healthcare organizations (American Medical Association, 2015).

Healthcare providers can use the Medicare Sustainable Growth Rate formula (SGR) to

increase the RBRVS formula calculation (Ginsburg, 2011a). The Centers for Medicare and Medicaid Services (CMS) used the SGR to control Medicare spending for healthcare services in the United States (Ginsburg, 2011a; Patel, Davis, & Lypson, 2011). Using the SGR to calculate the RBRVS, the gross domestic product (GDP) tied to changes in the fees for healthcare professionals. According to rules under Medicare for the use of SGR in a specific year, if actual Medicare spending surpasses the yearly-targeted rate, a downward adjustment will occur in the reimbursement rates for healthcare providers (American Medical Association, 2015). The introduction of the SGR led to the changes in the reimbursement structure of healthcare providers and for controlling the increase of healthcare expenditures (American Medical Association, 2015).

The attempt to reform the reimbursement system for healthcare providers and reduce healthcare costs for healthcare services led to the 2010 development of the Patient Protection and Affordable Care Act (PPACA) (Marco et al., 2012). On April 16, 2015, President Obama signed a bill into law ending the use of the SGR with the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (Steinbrook, 2015). The Medicare Access and CHIP Reauthorization Act of 2015, nicknamed the Permanent Doc Fix, revised the Balanced Budget Act of 1997, and established a new way to pay physicians when they treat Medicare patients (Patel et al., 2011; Steinbrook, 2015). The Medicare Access and CHIP Reauthorization Act of 2015 are the largest healthcare reform implemented by the federal government since the enactment of the Affordable Care Act (ACA) in 2010 (Okie, 2012; Steinbrook, 2015). This new act capitalizes on the improvement of the reimbursement to Medicare physicians and children's insurance program. The goal of RBRVS was to reduce

reimbursement and billing variations in healthcare organizations (Marco et al., 2012; Patel, 2011). With the RBRVS formula, reimbursement disparities occurred between specialists and physicians because it did not show the relative costs for doctors accurately (Marco et al., 2012; Oberlander, & Perreira, 2012; Okie, 2012).

Individuals also refer to the PPACA as Obamacare or the ACA (Marco et al., 2012; Nutting, Crabtree, Miller, Stange, Stewart, & Jaén, 2011). Each of the ten titles in the PPACA addresses different areas of healthcare reform. They include (a) the quality, (b) affordable healthcare for all Americans, (c) the role of public programs, (d) improving the quality and efficiency of healthcare, (e) prevention of chronic disease and improving public health, (f) healthcare workforce, (g) transparency and program integrity, (h) Improving access to innovative medical therapies, community living assistance services and supports act, (i) revenue provisions, and (j) the reauthorization of the Indian Healthcare Improvement Act (Marco et al., 2012). The implementation of cost control measures under the PPACA legislation includes (a) new requirements for quality reporting, (b) reimbursement reform, (c) the development of operating rules and electronic standards, (d) the prosecution and detection of fraudulent activities in healthcare, (e) the integration of healthcare delivery systems through the establishment of incentive programs, and (f) new patient-centered provisions for outcomes research (Marco et al., 2012; Mosadeqhrad, 2013). Healthcare costs in the United States appear unequally distributed because individuals with chronic illnesses require more care which in turn increases costs.

The government passed the Health Information Technology for Economic and Clinical Health Act (HITECH) along with the PPACA to control costs through preventable measures and coordinated care (Lanham, Laykum, & McDaniel, 2012). The government created a national

electronic health information exchange with the two acts. HITECH is designed specifically to reduce the costs of healthcare through (a) the improvement of the quality of care, (b) reduction of duplicative procedures and medical errors, (c) strengthening of protection and privacy laws for the health information of patients, (d) the establishment of measurement criteria for the performance of providers, and (e) the development of incentive programs for improving health information technology infrastructure (Lanham, Laykum, & McDaniel, 2012). Through the electronic health record systems, the government used the HITECH legislation to establish guidelines to measure healthcare efficiency and quality (Lanham et al., 2012; Marco et al., 2012; Steinbrook, 2015). Healthcare providers can obtain real-time and accurate patient information to make decisions towards supporting and improving healthcare quality.

Under the PPACA legislation, the reimbursement of healthcare providers depends on their abilities to reduce healthcare costs while increasing the quality of service they provide through an evidence-based methodology geared towards process improvement (Mosadeqhrad, 2013; Shelton & Saigal, 2011; Steinbrook, 2015). The coordination of skills and knowledge contributes to the process of quality in healthcare delivery (Mosadeqhrad, 2013; Nelson, 2012). Some researchers argue that the methodology of evidence-based medicine reduce clinical judgment. Researchers also argue that predetermined treatment options affect healthcare costs. Through the PPACA legislation, the healthcare industry is becoming innovative in healthcare delivery and empirical data usage (Nelson, 2012; Shelton & Saigal, 2011). Researchers place much emphasis on process improvement, which requires an examination of cost-effectiveness versus efficacy of treatment in the healthcare industry.

Methodology in Healthcare Costing

The enactment of the PPACA legislation by the Congress targeted the increase in healthcare quality and a decrease in healthcare expenditures (Ginsburg, 2011b; Nelson, 2012). The PPACA legislation places restrictions on Medicaid and Medicare reimbursement rates to contain the costs of healthcare (Ginsburg, 2011b; Keehan et al., 2011; Parker et al., 2012). According to Keehan et al. (2011), reforms are for the establishment and measurement of a comparative value for healthcare services through value-based costing which plays a significant role in the reduction of healthcare costs. Despite the disparity in the strategies to reduce healthcare costs, it is imperative for the viability of the healthcare system in the long-term. The establishment of effective costing for healthcare services through treatment option comparison requires an understanding of the contributions of health and diseases to population health outcomes (Parker et al., 2012).

Gunning and Sickles (2011) argued that the current healthcare costing system is not an accurate reflection of marginal costs for healthcare providers and that relative value scales be used to estimate the costs of healthcare services. With the diversified opinions regarding the costs of healthcare services, the definition of costs from the population health outcomes perspective could provide a means to measure expenditures in the healthcare sector. The goal of stakeholders in the healthcare field is to establish a reliable costing method that reduces healthcare costs and encourages the achievement of healthcare value for the patient (Finkelstein et al., 2012; Ginsburg, 2011b; Keehan et al., 2011). Some researchers argue that the cause of difficulty in healthcare costing is the inaccuracy in pricing healthcare services. Others suggest that costing should include healthcare value about the outcomes relating to the framework of cost reduction (Finkelstein et al., 2012; Ginsburg, 2011b; Keehan et al., 2011). Issues relating to

healthcare costing could be a result of payment systems that encourages volume-driven services instead of value-driven care (Finkelstein et al., 2012; Ginsburg, 2011b; Keehan et al., 2011)

Healthcare professionals should gear health costs and outcomes towards the measurement of value and not the volume of services to manage healthcare costs effectively. For a patient, a total healthcare cost usually involves shared resources from suppliers, facilities, and providers (Finkelstein et al., 2012; Ginsburg, 2011b). During the measurement of true healthcare costs, the actual resource used by each patient should be included in the shared resources and not only the averages of costs for multiple patients. The pricing of services could reflect the differences in market power between sellers and buyers. It could also mirror the subsidization of services that are not profitable such as indigent care (Ginsburg, 2011b). Costing methodologies in healthcare tend not to adjust for risks pertaining to the severity in patient disease processes as it pertains to treatment burden on healthcare providers, which leads to inaccuracy in healthcare pricing.

With the current costing methodologies, healthcare providers with populations of chronically ill individuals face shortfalls in reimbursement, which increases the tendency for them to refer patients to other providers or to upcode instead of striving to manage the health of chronically ill patients (Finkelstein et al., 2012; Ginsburg, 2011b; Keehan et al., 2011). Cost-utility analysis (CUA), cost-effectiveness analysis (CEA), and cost benefit analysis (CBA) are often included in healthcare economic analysis (Gunning & Sickles, 2011). These methodologies reflect the marginal effects of health programs on desired outcomes because they define the costs associated with medical services as they relate to the economic opportunity costs of each service. The variations in healthcare costing often occur because of the disparities in costing methodologies such as micro costing versus gross costing (Finkelstein et al., 2012; Ginsburg,

2011b; Keehan et al., 2011). CEA is beneficial to control healthcare costs because it assesses the improvements in health outcomes pertaining to costs (Gunning & Sickles, 2011). The analyses can be beneficial when applied to population programs such as vaccination interventions or cervical cancer screening (Gunning & Sickles, 2011). The examination of costing methodologies as ways to control healthcare expenditures is important in understanding the evolution of systematic costing methodologies under the PPACA legislation (Finkelstein et al., 2012 & Ginsburg, 2011b)

With the CBA methodology, healthcare professionals assign monetary benefit to the non-monetary outcomes of treatment interventions (Ginsburg, 2011b; & Keehan et al., 2011). According to Finkelstein, Allaire, Burgess, and Somali (2012), the measurement of benefits could occur implicitly or explicitly with explicit benefits reflecting services, supplies, and the monetary expenses attached to equipment. Explicit costs could be minimally invasive and new procedures used to replace expensive surgical intervention to reduce treatment costs. Tai and Bame (2011) highlighted that indirect or implicit costs should include the opportunity costs of an intervention, treatment, and procedure. Finkelstein et al. (2012) suggested the use of CBA to determine the effects of gastric banding surgery on the explicit costs of obesity treatments while showing implicit cost savings through a few days lost from work and the improvement of productivity for workers.

The further assessment of healthcare costing can occur through the improvement of health outcomes as it relates to costs by cost-effectiveness analysis (Gunning & Sickles, 2011). Cost-effectiveness analysis measures the benefits of resources in non-monetary format such as alternative treatments or approaches that improves outcomes of health (Finkelstein et al. 2012;

Gunning & Sickles, 2011). Through the quality assessment of life years (QALY) measurement, the CEA cost methodology places monetary representation on the value of life (Gunning & Sickles, 2011; Tai & Bame, 2011). QALY determines health outcomes and resource allocation with the lifespan of individuals or populations. For instance, CEA use can measure the effectiveness or quality of screening programs for cancer survival rates as it relates to early diagnosis and detection of cancer cases (Finkelstein et al. 2012; Gunning & Sickles, 2011). Some researchers suggest that the use of CEA does not assess the expenditures accumulated throughout the entire length of an intervention because the methodology uses a piecemeal approach comparing the program to alternative interventions for cost allocation (Gunning & Sickles, 2011; Tai & Bame, 2011). The use of CEA as part of the PPACA legislation for comparative effectiveness research may deter the use of expensive treatments with positive benefits in small populations of patients (Gunning & Sickles, 2011; Tai & Bame, 2011). The use of CEA as an assessment methodology for cost-effectiveness of treatments and the examination of opportunities for systemic cost control across populations would suggest a shift from individual to population health outcomes.

Cost-utility analysis can measure the capabilities of treatment benefits based on the outcomes of population (Finkelstein et al. 2012; Gunning & Sickles, 2011). It uses QALY to measure the benchmark of aggregate healthcare costs. QALY allows the opportunity to measure or compare the efficiency of treatment interventions based on the quality or length of life for different disease processes (Gunning & Sickles, 2011; Tai & Bame, 2011). Health policymakers often use CUA and QALY to efficiently determine healthcare reimbursement, develop clinical guidelines, and compare health benefits (Gunning & Sickles, 2011; Tai & Bame, 2011). The

determination of QALYs requires the valuation of all costs involved in a fixed-budget and the identification of a set monetary QALY threshold as a standard for cost-effectiveness used for medical treatment (Finkelstein et al. 2012; Gunning & Sickles, 2011). Although the benchmark for QALY exists in medical standard, much literature does not exist detailing the research conducted on the benchmark.

The use of QALY as a CUA is prohibited by the PPACA legislation because it tends to encourage the government to be overly involved in medical decision-making and it discounts the value of life regarding discrimination based on disability and age (Finkelstein et al. 2012; Gunning & Sickles, 2011). It also encourages the rationing of care. Although the CUA, CEA, and CBA cost methodologies focuses mainly on aggregate outcomes and benefits, analysts and researchers debate on whether the costing methodologies are feasible and if the QALY can be a benchmark for the allocation of medical resources in health populations (Gunning & Sickles, 2011; Tai & Bame, 2011). Researchers and analysts question the application of the cost methodologies to the health outcomes of patients in terms of services provided by healthcare providers. To assess medical intervention feasibilities, budget impact analyzes, cost identification, and cost benefits should be included in the economic evaluations of individual healthcare programs or interventions (Gunning & Sickles, 2011; Tai & Bame, 2011).

Cost-weighting systems such as macro costing, activity-based costing, and micro costing can be used to assign costs to Health Services with a focus on the quality of consumed resources and assigned prices (Finkelstein et al. 2012; Gunning & Sickles, 2011). The differences in costing could be a result of the use of costing methodologies rather than the performance of healthcare providers and a question of whether the valuation of the cost components is accurate.

Healthcare professionals can view the total cost of healthcare as a cycle of care that entails the medical condition of patients in its entirety and not only the cost of individual treatments. It may require a shift in cost methodology from the volume of services to a cost measurement deriving value from achieved outcomes. Costing methodologies pertains to activities and processes that minimize aggregate healthcare expenditures in the long-term (Finkelstein et al. 2012; Gunning & Sickles, 2011). Although the approaches require intensive resources, they may face potential delineation between true economic costs and accounting costs that comprises of both implicit and explicit costs (Gunning & Sickles, 2011; Tai & Bame, 2011). The healthcare system in the United States is very complex with many independent units for measuring costs to reflect financial and organizational processes of the healthcare system.

Reimbursement Reform for Healthcare Providers

One of the main causes of increasing healthcare costs is the reimbursement model for services provided by healthcare professionals. According to McClellan (2011) variations in per-capita, Medicare spending for physician services ranges from $4,000 to $8,000 depending on geographical location. Landon, Reschovsky, O'Malley, Pham, and Hadley (2011) highlighted that reimbursement for physician services comprises of 21.2% of total spending in the healthcare sector. Predominant fee-for-service models, such as the Blue Cross Blue Shield, used in the past were reasonable and customary (Landon et al., 2011). Healthcare cost containment methods used in the past to minimize spending went through reimbursement regulations (Landon et al., 2011). Because of changes in services, issues pertaining to healthcare access, and provider oppositions, price regulation tend not to produce desired results (Landon et al., 2011).

Tucker (2013) noted that some healthcare providers are encouraged by the fee-for-service

methodologies to increase the quantity of care while rewarding volume instead of outcome. In other words, healthcare providers capitalize on the services and volume of patients they bill because of the incentives provided through the fee-for-service system. Healthcare reimbursement methodologies appear to be counterproductive and ineffective because they encourage unequal payments for identical services based on the specialty of healthcare providers. They also disconnect between used resources and reimbursements, and encourage volume billing and variations in geographic fees (Tucker, 2013).

Fee-for-Service Methodology

Through the Omnibus Budget Reconciliation Act, the government formed governmental regulations as fee schedules, which are the authorized payments through Medicare (Berenson et al., 2011). The government also introduced the resource-based relative value scale (RBRVS) fee calculation formula used as a tool for healthcare reimbursement (Berenson et al., 2011). The RBRVS formula reduced disparities and variations in reimbursement and billing through healthcare organizations. Berenson et al. (2011) specified that the healthcare reimbursement system use a fee-for-service methodology not defined properly and results in interpretations with coding definitions that are unambiguous and unclear. With the RBRVS system, physician reimbursement depends on numerical codes for services provided by healthcare professionals or current procedural terminology (CPT) codes (Berenson et al., 2011). According to Rooks Jr. (2011), the criteria for evaluation and management codes must meet two out of three parts which comprises of the complexities involved in the medical process of decision-making, physical examination, and a patient history. The code level for a visit depends on the criteria and the time spent with a patient face-to-face (Rooks, 2011).

Healthcare professionals use CPT codes for physician reimbursement by the RBRVS weighting formula that comprises of estimated physician malpractice cost per capita, the cost to produce service, and the complexity of work (Rooks, 2011). A reimbursement system that depends on the coding of services does not take into consideration the work done by healthcare providers behind the scenes especially while they are not directly providing care to a patient (Rooks, 2011). Instead of considering value, it tends to incentivize volume. The most common way to reduce the cost of healthcare is through provider reimbursement reduction. McClellan (2011) and Gunning and Sickles (2011) noted issues associated with the RBRVS formula such as improper calculation of malpractice expenses, practice expenses, and the work of physicians' relative value units. Gunning and Sickles (2011) also mentioned that no compensation exists for quality of service, which causes some healthcare providers to become reluctant to provide optimal attention to patients. According to Wilensky (2012), the fee-for-service system encourages fragmentation in the delivery of care because it does not consider the value of care, and instead focuses on volume billing. With the historical disparity in the weighting formula and the promotion of volume billing, the use of RBRVS to control healthcare expenditures has become unsuccessful (Rooks, 2011). The fee-for-service system has led to a limitation of the mechanism of reward for quality in patient care and outcome. Rooks Jr. (2011) surmised that when reimbursement is on face-to-face time, it is not consistent with quality of care because reimbursement for healthcare professionals should entail activities that are important in the provision of exemplary care and outside the face-to-face encounter. Berenson et al. (2011) noted that the ambiguity in the coding definitions could lead healthcare providers to miscode services suggesting levels of coding that are more advantageous financially. Because of the subjectivity in

CPT coding definitions, miscoding of visits to healthcare facilities could eventually lead to billing fraud accusations (Rooks, 2011).

Although the choice of code usage enables healthcare providers to have discretion over service pricing, Medicare sets individual service reimbursement rates. Medicare expanded the guidelines for coding to make the definition of the coding system better. Berenson et al. (2011) emphasized that the coding guidelines do not include important elements of care management and decision-making particularly for patients with multiple diseases. Healthcare professionals may overly document patient visits to medical facilities to provide justifications for using higher coding levels for value of services. On the other hand, the fear of facing penalties for the misrepresentation of office visits could cause some healthcare professionals to ignore coding guidelines, and downcode the services they provide based on their assessment of the value of services (Berenson et al., 2011). Brunt (2011) emphasized that healthcare providers are frequently upcoding office visits because the coding definitions and guidelines are subjective. Healthcare providers need a more realistic reimbursement methodology in the healthcare field because of the ambiguity that exists in the coding definitions pertaining to the intensity and complexity of services provided by healthcare professionals.

The United States Congress introduced the SGR as part of the Balanced Budget Act to minimize the expenditures in reimbursement for healthcare professionals (Berenson et al., 2011; Brunt, 2011; Colchamiro, 2012). The SGR formula moves Medicare reimbursement methodology from a volume-based payment system to a system that reflects the GDP (Colchamiro, 2012; Froimson et al., 2013). With the SGR formula, the annual calculation for Medicare is based on several factors such as expenditures as they relate to changes made in the

healthcare regulations and laws, the average changes in real GDP per capita over a 10-year period, average amount of Medicare beneficiaries, and service fees for healthcare professionals (Colchamiro, 2012; Greenapple, 2013; McClellan, 2011). Ginsburg (2011a) noted that the SGR formula ties economic fluctuations to yearly updates of the Medicare fee schedule as it relates to the Medicare Economic Index. Because of the consequences of the SGR calculations, a decrease in the reimbursement of healthcare providers occurred causing them to lobby the United States Congress for block reductions.

In 2010, an increase in the spending projection of $330 billion through 2020 occurred because Congress postponed a 24.9% reduction in reimbursement for healthcare professionals (Ginsburg, 2011a). Although the reform of reimbursement methodologies attempts to reduce the costs of healthcare, the continuous postponement of reimbursement for healthcare providers and the consequences involved in using the SGR formula calculation makes it difficult to achieve results in reducing healthcare costs. Different reasons exist for rate reductions and the spiraling increase in payments for healthcare services (Colchamiro, 2012). Healthcare providers experience limitations in the use of the SGR calculator that involve a cost-containment policy encouraging volume billing by healthcare professionals and the lack of formula to differentiate between ineffective and effective quality of care.

Ginsburg (2011a) suggested that when the reimbursement is calculated with the SGR formula, the fluctuations in the Unites States economy to the use of patient services leads to the deferral of reimbursement reductions by Congress causing increases in rate cuts. Healthcare professionals tend to agree to an outcome-oriented reimbursement methodology but disagree to the use of quality outcomes because it threatens their autonomy when used as a payment-based

methodology (Colchamiro, 2012; Greenapple, 2013). Some healthcare providers, such as physicians, have achieved success in blocking reform in the reimbursement methodology but they might face the responsibility or consequences of the system's inability to contain costs (Colchamiro, 2012).

Medicare Payment Bundling and Capitation

Medicare introduced the use of the Medicare Economic Index (MEI), which constituted a change in the yearly costs of operations for healthcare services (Berenson et al., 2011; McClellan, 2011). The MEI led to a bundled system of payment for inpatient hospital care based on the classification of diseases for patients known as the diagnosis-related group (Brunt, 2011; Colchamiro, 2012; McClellan, 2011). The bundled payment methodology requires healthcare providers and hospitals to share a payment rate for services provided to patients. Bundling could also entail shared reimbursement with other healthcare providers who perform outpatient care (McClellan, 2011; Rooks, 2011). McClellan (2011) emphasized that Medicare has further included payment bundling for post-surgical, home care, and post-acute care in a way that includes post-procedure care for a 60 to 90 days period. Healthcare professionals can use an episode-based and bundled approach of reimbursement to encourage collaboration among healthcare providers to contain costs, improve care, and to distribute compensations and incentives equally (Greenapple, 2013; Rooks, 2011). McClellan (2011) noted that although researchers have not proven the effects of bundling on spending growth and the intensity of care, the potential for reducing aggregate costs per visit exists.

According to Froimson et al. (2013), the Centers for Medicare and Medicaid Services developed alternative methodologies of payment for the reduction of healthcare spending while

encouraging an improvement of the quality of care. The discussion pertaining to healthcare payment reform and the development of patient-centered medical home (PCMH) under the PPACA legislation is continuous along with the development for a broad bundling payment methodology for multiple healthcare providers (Froimson et al., 2013; Wilensky, 2012). Fixed-budget payment or capitation is a type of bundling for all services provided by healthcare professionals into a single payment regardless of the amount of care provided to patients. McClellan (2011) noted that the primary reimbursement methodology for private care such as HMOs was capitation. A reduction in capitation as a reimbursement methodology resulted from the complaints from healthcare providers. Those complaints came from the inability of healthcare providers to negotiate reimbursement fees with insurance companies, administrative complexities in the negotiation and calculation of capitation rates, and a reduction in patient membership because of limitations in the choice of providers and services (McClellan, 2011; Tai & Bame, 2011; Tucker, 2013).

Capitation does not control the cost of healthcare and raises concerns about incentives for the provision of care, and the quality of patient care (Finkelstein et al. 2012; McClellan, 2011). Based on the trend to a population-based healthcare, the need for the reform of reimbursement for healthcare professions has increased because of the lack of ability to control costs in the current healthcare system (Gunning & Sickles, 2011; McClellan, 2011). Frakt and Mayes (2012) emphasized that instead of using previous systems of capitation, healthcare providers should adopt a modernized capitation method that combines the provision of quality care and a preset fee-for-service budget. Manchikanti et al. (2012) suggested additional changes to reimbursement models to increase reporting measures for the physician quality reporting system, establishing a

value-based payment modifier for physician payments, introducing an electronic prescription of incentive program, and the revision of the RBRVS reimbursement formula. The restructuring of the reimbursement system will require changes in the financing and accounting processes, an understanding of new metrics, and the provision of adequate incentives for healthcare professionals for the delivery of quality care (Manchikanti et al., 2012; McClellan, 2011).

Delivery of Care and Organizational Models

A gap exists in the peer-reviewed literature in terms of the organizational structures for healthcare business models. Information in medical society literature and practice guidelines for the structural parts of medical practice is scarce. Few studies focus on the examination of the framework surrounding single provider practices. Individuals can examine the organizational components of practices by healthcare providers through practice-based medicine. It is also appropriate for the examination of billing and clinical processes and for the description of diversified organizational characteristics such as the contractual relationships, specialty, complexity, and size (McClellan, 2011; Nutting et al., 2011). Traditional healthcare practices usually involve patient care that is volume-driven, reactive patient care, minimal performance data, and high overhead (Marco et al., 2012; Tai & Bame, 2011). Healthcare delivery reform that is patient-centered could require extensive changes compared to the traditional healthcare business models. Most healthcare practices operate on models that capitalize on the autonomy of healthcare providers with healthcare personnel supporting patient treatments on a back administrative and front clinical organizational structure.

According to Nutting et al. (2011), healthcare providers should adopt an authoritative position over employees. For example, if physicians were to be in an authoritarian position, they

would assume complete responsibility for business processes, operations, and patient care. VanVactor (2013) highlighted that if healthcare providers exercise autonomy, clinical and administrative employees would act as supplements by coordinating the flow of patients and acting as the gatekeepers of medical practices. Realistically, total autonomy by healthcare providers could only happen under limited circumstances because healthcare providers must answer to stakeholders such as the courts, lawyers, professional associations, hospitals, managed care plans, private payers, government entities, and patients (Marco et al., 2012; Nutting et al., 2011). The business models for healthcare providers consist of diverse organizational structures that include group practices, partnerships, associations, and independent practices (Clark, Friedman, Crosson, & Fadus, 2011; Kapp, 2011; VanVactor, 2013). The least stable is the independent practice structure because it is either dependent on referrals or patients (Marco et al., 2012; VanVactor, 2013). Healthcare providers should have both medical acumen and business knowledge. Partnerships and associations enable healthcare providers to share ancillary staff, take advantage of the economies of scale, and form cooperative arrangements while maintaining independence (Clark et al., 2011; Jones & Trieber, 2010; Kapp, 2011; VanVactor, 2013). Group practices offer healthcare providers economies of scale, bureaucratic mechanisms for the management of diverse operational requirements, profit sharing with peer regulation requirements, and the security of sharing financial risks (Clark et al., 2011; Koning, Verver, Heuvel, Bisgaard, & Does, 2011; VanVactor, 2013).

The definitions of organizational models vary by medical and payment specialty categories and include capitation or private pay, and fee-for-service (Nutting et al., 2011; Wise, Alexander, Green, & Cohen, 2012). The concept of retainer or concierge medicine is an

emerging trend among healthcare providers because it focuses on the provision of enhanced care to patients beyond traditional practices (Clark et al., 2011; Kapp, 2011; Nutting et al., 2011). Market forces such as increases in bureaucratic regulations and financial constraints have led to the development of new practice models for healthcare providers (Clark et al., 2011; Kapp, 2011; Nutting et al., 2011). Concierge medicine is a business arrangement between patients and their healthcare providers that includes membership fees entitling patients to different services such as (a) 24 hours access to providers, (b) next or same day appointments for non-emergent care, (c) preventive services that are not usually offered by most health insurance plans, and (d) house calls (Clark et al., 2011; Huddle & Centor, 2011; Kapp, 2011; Nutting et al., 2011). Patients must pay fees for retainer services annually. Huddle and Centor (2011) emphasized the benefits for healthcare professionals, which includes a fulfilling practice experience, personalized attention to patients, less administrative requirements, and a decrease in patient load.

Although the potential of concierge medicine becoming an innovative business model exists, some researchers still have concerns pertaining to accessibility to medical care, ethics, and costs. The professional dissatisfaction with concierge medicine include loss of autonomy, low reimbursement, heavy workloads for physicians, and an increase in bureaucratic regulations relating to the establishment of concierge practice (Clark et al., 2011; Huddle & Centor, 2011; Kapp, 2011). Patients tend to demand specialized care because of limited contact with physicians, lengthy appointment wait times, and increases in the cost of health insurance (Clark et al., 2011; Huddle & Centor, 2011; Kapp, 2011). In addition, many patients pay high premiums and deductibles for minimal encounters with healthcare professionals, which cause them to search for alternative healthcare options to improve value, affordability, satisfaction, and access

(Huddle & Centor, 2011; Kapp, 2011; Wise, Alexander, Green, & Cohen, 2012). Although concierge medicine appears to be beneficial for healthcare providers, and improves the value and quality of care for patients, legal and ethical concerns still exist regarding concierge practices. Social class disparity and limited access to healthcare are some of the issues created by concierge medicine (Clark et al., 2011; Huddle & Centor, 2011; Kapp, 2011; Koning, Verver, Heuvel, Bisgaard, & Does, 2011).

The argument of concierge medicine critics is that the model establishes a two-tiered healthcare system that grants the wealthy more access to superior services and care (Clark et al, 2011; Huddle & Centor, 2011; Kapp, 2011). Private health insurance contributes to a tiered system because of cost. Concierge medicine could contribute another tier to the unequal healthcare system (Huddle & Centor, 2011; Kapp, 2011; Orentlicher, 2012). Despite the minimal shift of physicians towards concierge medicine, the potential to exacerbate the shortage of healthcare providers still exists because patients that cannot or are unwilling to pay a retainer still need to find new healthcare providers and it reduces their access to healthcare (Huddle & Centor, 2011; Kapp, 2011; Orentlicher, 2012; Lee, 2012). Retainer medicine might activate the cross-subsidization system forcing patients with insurance to carry the cost of healthcare for uninsured individuals (Kapp, 2011; Orentlicher, 2012; Onwuegbuzie, Leech, & Collins, 2012). Concierge medicine raises ethical issues and concerns. A question raised by Huddle and Centor (2011) is whether concierge medicine is socially unjust for healthcare providers to be obligated to treat all patients despite their inability to make payments.

Even though the quest for social justice is imperative with an obligation to provide quality access to healthcare for all individuals in society, the argument posed by Huddle and

Centor (2011) is the accessibility to healthcare is not an obligation for healthcare providers. Orentlicher (2012) specified that the PPACA legislation provides patients the ability to obtain coverage for health insurance, but physicians are not obligated to treat patients. Kapp (2011) further stated that healthcare providers prefer that patients should have quality access to healthcare, but the conscription of services provided by physicians is not a tangible means to promote social justice. Healthcare providers tend to carry out social obligations when they treat patients ethically and competently within a regulated healthcare structure dictated as an obligation by society (Clark et al., 2011; Cutler et al., 2012; Kapp, 2011). One of the main legal issues lurking around concierge medicine is insurance billing (Clark et al., 2011; Huddle & Centor, 2011; Kapp, 2011). Many concierge patients pay retainer fees and use their health insurance for outpatient services and hospitalization. Physicians often have concerns that their insurance will not completely cover their fees since many insurance carriers prohibit balance billing (Berenson, Basch, and Sussex, 2011; Clark et al., 2011; Huddle & Centor, 2011; Kapp, 2011).

According to Clark, Friedman, Crosson, and Fadus (2011), concerns exists among healthcare professionals about the violation of the False Claims Act for the lack of properly gathering payments for patient services from Medicare. Although concierge medicine appears to be an innovative alternative model for patient care, it raises questions pertaining to the accessibility to medical care, ethics, and costs (Clark et al., 2011; Huddle & Centor, 2011; Kapp, 2011). As the healthcare industry strives to better the struggles faced by providers and patients, scientific research is important in demonstrating that concierge care leads to better health outcomes and reduces costs.

BPR Model and Administrative Procedures

The BPR model entails the redesigning of core business processes that results in dramatically improving quality, productivity, and cycle time (Hammer, 1990). With the BPR model, hospitals can start on a clean slate and rethink existing healthcare administrative processes to reduce costs and deliver value to patients. They can adopt a new administrative system that places more emphases on the needs of patients. Through BPR, hospitals can reduce organizational layers and engage in increased productive activities by redesigning functional organizations into cross-functional teams and by improving decision-making (Hammer, 1990). They can implement the PCMH model or the value-based methodology. The BPR model is a drastic change initiative that encourages managers to improve business processes across the organization, rethink issues pertaining to an organization and people, reorganize businesses into cross-functional teams with end to end responsibilities for processes, redesign core processes, and refocus company values on patient needs (Hammer, 1990). Hospitals can use BPR to improve the sustenance of performances on key processes that affects patients. The BPR model can be used to decrease cycle time and healthcare costs.

Many researchers who base their work on hospital research activities usually focus predominantly on quality of care measured based on hospital satisfaction (Stacey, 2011). Some theories, such as the primary provider theory, pertain to the variations in healthcare costs, quality patient care, and patient satisfaction (Beal, 2013). BPR correlates with the primary provider theory because BPR focuses on the improvement of quality and cost reduction (Hammer, 1990). The primary provider theory focuses on patient quality care and satisfaction (Beal, 2013), and this theory operates on the principle or concept that the achievement of patient satisfaction,

quality outcomes, and patient care does not depend on clinical competency alone (Mosadeqhrad, 2013). Aragon and Gesell (2003) grounded the primary provider theory, which is applicable to this doctoral study because it pertains to the initiatives and actions that result in an outcome of quality. According to Spence, Murray, Tang, Butler, and Albert (2011), healthcare providers or hospital managers will gain insights on the issues that affect patient care through effective interaction and communication, which ties into BPR in the reduction of organizational layers and engaging in increased productive activities by redesigning functional organizations into cross-functional teams, and by improving decision-making. Healthcare managers can use BPR to determine patient satisfaction, quality outcomes, and reduction of healthcare costs in hospitals.

The disruptive innovation theory also supports this doctoral study and correlates with BPR because it focuses on the identification and understanding of complex problems in an organization (Spence et al., 2011). For hospital managers to redesign and improve core administrative processes, they must identify the problems in the existing processes. Hospital administrators have encountered dramatic and rapid changes in the healthcare system (Stacey, 2011). BPR can enable hospital managers and administrators to improve performance sustainability on processes that affect the hospital and its patients. Disruptive innovation theory could enable researchers to predict when changes made in an industry or business caused disruption in business practices, culture, business management and technology (Spence et al., 2011). Like the disruptive innovation theory, BPR also focuses on the implementation of changes to core processes using technology to enable improvements (Hammer, 1990). The disruptive innovative theory captures any disruption in healthcare implemented through regulatory changes in the federal government (Spence et al., 2011). For example, the ACA, also

known as Obama Care, constitutes a reform in the healthcare sector that improves and expands healthcare accessibility and reduces spending through taxes and regulations (Kerfoot, Anderson, & Douglas, 2013). Through the implementation of the Obama Care, legislators introduced changes to the healthcare system, which affected reimbursements, technology, and requirements for the reporting of healthcare processes (Kerfoot et al., 2013). The ACA has changed almost everything about healthcare from the way healthcare professionals provide patient care to the place where they administer care, and the success measurements (Kerfoot et al., 2013).

Deming's 1950s plan do study act model also correlates with the BPR model and it is an applicable framework for this doctoral study because it pertains to administrative performance improvement in hospitals (Grant & Schmittdiel, 2015). According to Stikes and Barbier (2013), strategic initiatives usually involve programs for quality improvement with steps to determine the measurement and monitoring of success. Some healthcare researchers often use PDSA when conducting research (Grant & Schmittdiel, 2015; Tripathi et al., 2013). Because this case study involved the observable activities of hospital managers to streamline administrative procedures for the reduction of healthcare costs, the PDSA tied into the BPR model, which was an appropriate framework for this study. The framework of this doctoral study depends on an assumption that the healthcare system is adaptive, complex, unique, unpredictable, and dynamic in nature (Stacey, 2011). With the BPR model, healthcare managers can form a complex adaptive, homogeneous, and organized healthcare administrative system that operates in a harmonious pattern (Hammer, 1990). According to Stacey (2011), the complex adaptive systems theory also incorporates the complexity and chaos theories. Researchers that study sociodynamics often develop mathematical modeling approaches to understand the influence of

the actions of individuals on social system behavior. As an element of the complex adaptive system, complexity consists of heterogeneity (Stacey, 2011). The word adaptive represents the ability to develop or change, and system constitutes the combination of different elements that forms a whole (Stacey, 2011). The healthcare industry consists of a complex adaptive system comprised of self-organization, interdependencies, co-evolutionary systems, and emergent behaviors facilitated through the BPR model by redesigning core processes (Stacey, 2011). A complex adaptive system consists of interconnected entities that are comprised of independent and diverse components acting according to set rules modified through the BPR model to fit individual entity behavior (Stacey, 2011).

According to Paina and Peters (2012), applying the complex adaptive systems theory to issues in the healthcare system is beneficial because the methodology may assist policy analysts in the exploration of innovative approaches for the implementation of healthcare services in different populations. Because of the unpredictable nature of the healthcare industry, the application of the complexity theory principles in healthcare could be beneficial during the implementation and development of policy changes in the medical delivery system (Stacey, 2011). Through the BPR model, complexity science is beneficial to develop innovative solutions for healthcare issues. Healthcare systems consist of different groups including policymakers, patients, and providers who deliver services through different avenues requiring self-learning, innovation, and adaptability (Stacey, 2011). The healthcare system appears fragmented with different entities that are emergent, interdependent, and diverse. The behavior of each entity changes continuously because of regulations by external and internal stakeholders (Stacey, 2011). Through the BPR model, the organizational layers in the different groups can be reduced

and redesigned to eliminate unproductive activities and improve decision-making (Hammer, 1990). With the BPR model, healthcare administrators develop medical teams responsible for the provision of quality healthcare to patients and reduction of healthcare costs by eliminating unproductive or redundant administrative activities. To establish a model of care, healthcare managers and administrators would use the PCMH approach, which allows primary care providers to coordinate and manage the care of all areas of a patient's health with a specific team of healthcare providers.

Value-Based Methodology and PCMH Care

The control of healthcare expenditures remains a debatable issue particularly as it pertains to the reimbursement of healthcare providers. Through the enactment of the PPACA legislation, the federal government attempted to improve the value and quality of medical services (Lee, 2012). The reimbursement of services provided by healthcare providers requires discussions about the delivery of healthcare services in the future and the introduction of healthcare business models that compensate providers and meet the requirements of the PPACA legislation (Lee, 2012). Value-based methodology and medical home care for patients are concepts that are important in the process of healthcare reform. The concept of value is lucrative because it depends on individual definition and ways the concept affects those individuals.

Healthcare value should include a performance framework as it relates to outcome, costs, and improvement (Lee, 2012). The evaluation of cost reduction without consideration for outcome would lead to limitations in the effectiveness and efficiency of care. Lee (2012) noted that redesigning the delivery of care should entail more than a reduction in the reimbursement for healthcare providers and the definition of value of care from a patient perspective. Lee further

surmised that the patient perspective of value usually circulates around outcomes that they consider relevant, the costs associated with achieving the outcomes, and ways that healthcare community measures, improves, and defines value. The measurement of value should be a combination of the activities related to patient care and healthcare providers meeting their needs. Patient medical needs can be determined through the disease process of a patient, which would comprise a set of treatments for the conditions through the provision and integration of complicated and secondary disease treatment processes (Lee, 2012).

The treatment of disease processes could involve many interventions and specialties (Lee, 2012). An example of a value-based approach to care is the creation of value for patients through a combined effort of teamwork by healthcare providers (Lee, 2012). A value-based approach would entail an approach of high performance systems that includes teams of healthcare professionals along with incentives to match the delivery of quality healthcare. Ginsburg (2011a) emphasized that a value-based model should serve as a prospective payment methodology and that its primary focus should be on the reimbursement of various units of service such as care needs or episodes of care that combines value and quality to reflect payments for healthcare providers. Lee (2012) suggested that healthcare should be designed to reflect high value of quality care that matches commitment to the measurement of outcomes, thorough planning for patient needs, and a quest for the improvement of care (Lee, 2012). Responsible teams of healthcare professionals that provide high value care to patients are required to implement the value-based approach (Lee, 2012).

PCMH is a model of care that requires a primary provider to coordinate and manage all aspects of patients' health with a team of healthcare providers (Wise et al., 2012). PCMHs are

vital in the transformation of patient care. According to the Agency for Healthcare Research and Quality (2013), PCMH is an organizational model for primary care that promotes the delivery of the core functionalities of primary medical care. To establish PCMHs, physician-centric care processes needs to include several members of a healthcare team (Wise et al., 2012). The patient would need to be the center of attention. The improvement of the quality of care and the accessibility of healthcare has to be prioritized (Wise et al., 2012). The main purpose of the PCMH concept is to increase the value of medical care by delivering high quality of medical services at low costs. According to Goldsmith (2011), many healthcare providers encounter problems related to business viability if the growth in business expenses does not match the growth in reimbursement of medical expenses. The fee-for-service payment methodology often does not properly reflect the activities and time invested in treating the rising complexities of disease processes in different patient populations leading to a reduced quality of care for patients (Goldsmith, 2011). The situation has led healthcare providers to initiate increases in ancillary testing services and volume billing to compensate for income losses (Goldsmith, 2011). Although reactive patient care capitalizes on the documentation of patient histories, clinical decision-making, and the performing of physical examinations, these factors are no longer sufficiently effective to capture the level of care activities required for individuals with chronic health conditions. Longworth (2013) and Goldsmith (2011) emphasized that the PCMH model entails the deviation from reactive care under a model that focuses on the healthcare provider to a more proactive and patient centric model. Proactive care involves the tracking of patient health over time with emphasis placed on the management of chronic diseases and wellness to minimize hospital admissions and emergency room visits. Healthcare integration is important for

the PCMH organizational model. According to Korda and Eldridge (2011), the four pillars of care or core competencies in the delivery of patient care are (a) alignment of payment incentives, (b) technology and infrastructure, (c) cross-team communication and collaboration, (d) coordination, and team-based care. Nutting et al. (2011) also emphasized four pillars of care that result in low cost and high quality of care that includes sustained personal relationships, comprehensive care, coordinated care, and access to first-contact care. Combining these pillars of care with payment reform for healthcare providers and integrated care delivery may lead to the opportunity of health outcome improvement at reduced costs. Collaborative, continuous, and coordinated relationships between personal care teams and patients are the core components of the PCMH model. Wise et al. (2012) and Van Vactor (2013) surmised that the integration of PCMHs would entail an expansion of the healthcare provider collaboration. Such integration would require adjustments implemented in the patient mix.

Reimbursement and Financing

The states and federal government jointly fund the Medicaid Program. Through the Federal Medical Assistance Percentage (FMAP), the federal government pays the different states a specific percentage of the program expenditures (Medicaid. gov, n.d.). The federal government to determine the per capita income criteria of the states uses the FMAP. On an average, the regular FMAP of states is 57%, but it usually varies between 50% and 75% for both states with lower per capita and the wealthier states (Medicaid.gov, n.d.). The regular maximum FMAP is 82% (Medicaid. gov, n.d.). The FMAPs adjustments occur every 3 years for the states to consider economic fluctuations and published in the Federal Register annually (Medicaid.gov, n.d.).

State Plan and Payment Methodology for Medicaid Services

States must be able to fund their Medicaid expenditures for the services and care offered under their state Medicaid plans. The sources of funding recognized for the state share of Medicaid payments are as follows: the legislative appropriations to the single state agency, provider donations and permissible taxes, certified public expenditures, and inter-governmental transfers (Medicaid.gov, n.d.). The Centers for Medicare and Medicaid Services (CMS) must verify that the sources for state funding meet regulatory and statutory requirements prior to the approval of state plan amendments. The verification by the CMS is also required for the authorization of federal financial participation to cover services (Medicaid.gov, n.d.).

Delivery of Service and Payment Rates of Providers

Under federal requirements, states can form their specific Medicaid provider payment rates. Generally, states pay for healthcare services through managed care arrangements or fee-for-service (Medicaid.gov, n.d.). States must pay providers directly for services under the fee-for-service arrangement (Medicaid.gov, n.d.). The states develop their payment rates based on factors such as the cost of service provision, a review of payments made in the private market by commercial payers, and the percentage of Medicare payments for similar services. With the managed care arrangements, states enter into contractual agreements with organizations that provide care to individuals through pay providers and networks (Medicaid.gov, n.d). Healthcare professionals administer about 70% of healthcare services to enrollees through the managed care delivery systems where providers are paid based on a capitated pay rate (Medicaid.gov, n.d). Healthcare professionals update Medicaid payment rates based on specified trending factors such as a Medicaid economic index (Frakt & Mayes, 2012).

The Medicaid economic index depends on the inflation adjustment rate determined by different states. The Medicaid state plan contains the descriptions of details pertaining to the methodologies for the rates of services. States are required to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services if they want to make changes to the ways that Medicaid providers receive payment for their services (Medicaid.gov, n.d.). The states requesting changes in the Medicaid payment method must issue public notifications about the changes before the effective date of the amendment. The purpose of the notification is to inform stakeholders or medical providers about the changes made to the Medicaid payment rates (Medicaid.gov, n.d.).

The Centers for Medicare and Medicaid (CMS) services review amendments made to the Medicaid state reimbursement plans to ensure they are consistent with federal regulations and statues as well as the Social Security Act. The CMS State Plan Amendment reimbursement methodologies require that states should ensure that payments are consistent as it pertains to quality of care and economy (Medicaid.gov, n.d.). The purpose of the reimbursement methodologies is to make payments sufficient to enlist several providers, so they offer their care and services to the general population in different geographical areas (Medicaid.gov, n.d.). Regulations, such as the Code of Federal Regulations (CFR), provide states with guidance for the implementation of Medicaid plans that are consistent with the Social Security Act (Medicaid.gov, n.d.).

Laws Affecting Hospital Administrative Procedures and Healthcare Delivery Costs

The fast changes occurring in health care policy have led to the creation of the PPACA implemented by the federal government to serve as a safety and quality mandate (Liang &

Mackey, 2011). The purpose of the ACA of 2010 by the Obama Administration is for the improvement of healthcare delivery (Liang & Mackey, 2011). Although safety and quality have been important components of the healthcare system, the PPACA provides initiatives and a healthcare reform that expands the paradigm of healthcare to include safety and quality measurement with a focus on consumerism and financial incentives. The ACA includes pay for performance or value-based incentive payment plans (Liang & Mackey, 2011). The administrators of the program provide rewards to hospitals for reported positive inpatient quality measures (Liang & Mackey, 2011). On the other hand, the pay for performance plan does not provide incentives to hospitals for medical conditions acquired at the hospital or for readmissions (Liang & Mackey, 2011). The ACA of 2010 tackles the needs that healthcare providers face in the healthcare delivery system (Liang & Mackey, 2011). The Institute of Medicine Researchers discovered that medical errors are the cause of thousands of annual deaths (Liang & Mackey, 2011). According to Liang and Mackey (2011), in 2010, the medical errors caused by healthcare providers contributed an additional $19.5 billion to the healthcare costs. Based on the ACA mandates, a 20% reduction in Medicaid payment accumulates in top quartile readmission rates for preventable diseases if the patient readmission falls within a timeframe of seven days and 10% for readmissions occurring within 15 days (Liang & Mackey, 2011). High rates of medical harm to patients will cost hospital administrators a 1% reduction in Medicaid payments (Liang & Mackey, 2011). Examples of medical harm are infections contracted from hospitals, and medical and medication errors. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) also affect reimbursement rates depending on the physician and patient experience scores (Liang & Mackey, 2011). In 2013, the government made hospitals eligible to receive

incentive payments depending on the performances in 17 clinical processes based on the measurements or standards of CMS administrators. The hospital eligibility criteria also include four measurement standards set by HCAHPS (Fowler et al., 2013). If hospital administrators improve annually in admission rates, caregiver experiences, patient experiences, outcomes, and clinical processes, they earn points for improvements. In 2013, according to rules from CMS, Medicare administrators started to determine hospital reimbursements based on performance measurements. Thirty percent of patient satisfaction is decided through the incentive payments and 70% on improved clinical results (CMS, 2013). Accountable care organizations (ACO) administrators began to receive bulk payments for the services they provide. The administrators started to distribute the payments to healthcare providers. The ACO administrators also began to receive incentive payments for the delivery of care at costs below the benchmark (CMS, 2013). Hospital administrators realized the need to promote patient care and healing and to improve processes for the maximization of incentive payments (Davis, Abrams, & Stremikis, 2011). To ensure the viability of hospitals and positive patient experiences, incentive payments became necessary financially and socially (Rauscher, Singh, & Wheeler, 2012; Volland, 2014). Aside from the primary function of the HCAHPS scores being to regulate hospital reimbursement rates, the scores also appear on the Internet. Healthcare consumers can make informed decisions with increased transparency based on the HCAHPS scores and from the patient perspective of quality care. The transparency will encourage healthcare providers to improve the care given to patients (Villanueva & McCall, 2012). Physicians that effectively work with other providers to improve patient outcomes will be successful in the new healthcare atmosphere. Current healthcare provider models have evolved through ACOs (Kocher, Emanuel, & DeParle, 2013).

Administrators from CMS created a new model designed to encourage healthcare providers to pay more attention to shared clinical outcome goals and outstanding patient experiences (Kocher et al., 2013). Administrators from healthcare organizations that redesign care processes to be more reliable, and who offer higher value and quality to patients receive financial rewards (Kocher et al., 2013). The goal of the VBP plan introduced by CMS was to encourage a reduction of 20% in the rate of hospital readmission by the end of 2013 to save the government an estimated $15 billion and potentially prevent 1.6 million hospitalizations (Kocher & Adashi, 2011).

Reasons for Cost Increases in Healthcare Administration

In the United States, increasing healthcare costs are affected by various factors such as (a) defensive medicine, (b) aging of the population, (c) malpractice costs, (d) physician fees, (e) high administrative costs, (f) overuse of specialty care, (g) use of costly new drugs and technologies, (h) marketing of new devices and new drugs, and (i) the use of costly drugs and technologies (Werner, Kolstad, Stewart, & Polsky, 2011). Some researchers have capitalized on the aging population as one of the factors affecting the rise of healthcare costs. The aging population does not have much impact on healthcare costs because the current aging population has not increased disproportionately enough to have such effects (Turner et al., 2014). In addition, medical advances have delayed serious illnesses in the aging population (Turner et al., 2014). The aging population may affect healthcare costs as the proportion of the aging population increases (Turner et al., 2014).

Defensive medicine pertains to the diagnostic treatments and tests administered by healthcare providers that not clinically warranted, but enables them to prevent the possibilities of

malpractice litigation (Turner et al., 2014). For example, to prevent the likelihood of adverse outcomes, physicians may hospitalize patients placed on outpatient treatment care to prevent lawsuits (Turner et al., 2014). The measurement of the actual attributable costs of defensive medicine is difficult. The estimated costs of defensive medicine vary and tend to be greater than direct malpractice costs (Turner et al., 2014). The uncertainty of the effect of defensive medicine on healthcare costs lies in the subjectivity of its definition. For example, the definition originates through the reason for a healthcare provider performing a test on a patient and not how uncommon or unlikely the ailment or disease occurs (Turner et al., 2014). The motivation of a healthcare provider to administer a treatment is hard to determine, and their assessment for testing needs can vary for a given case unless a situation warrants specific, sensitive, and clear guidelines. Calculating potential cost savings from defensive medicine are usually not straightforward. To decrease the amount of defensive testing, a change in marginal costs, which includes the withholding of additional unit of service or the cost of providing service, must occur (Turner et al., 2014). A change in marginal costs results in a difference in reimbursements and actual charges (Turner et al., 2014).

The issue of medical malpractice (Winkelman, Antiel, Davey, Tilburt, & Song, 2012) directly affects the cost of healthcare. The direct costs originate through malpractice insurance premiums paid by medical device and drug manufacturers, healthcare institutions, physicians, and other healthcare providers (Reinhardt, 2013; Turner et al., 2014; Winkelman et al., 2012). The premiums, which covers malpractice insurance company profits and overhead, and claim settlements are from healthcare revenues (Reinhardt, 2013; Turner et al., 2014; Winkelman et al., 2012). The premiums can be onerous and the threat of lawsuits for healthcare providers

heightened for those in some geographic areas and in high-risk specialties (Reinhardt, 2013; Turner et al., 2014; Winkelman et al., 2012). Although a major reduction in malpractice settlements could affect some physician practices significantly, this reduction will not result in much reduction in total healthcare costs (Reinhardt, 2013; Turner et al., 2014; Winkelman et al., 2012). Physicians in the United States receive more compensation than other professionals and physicians in several other countries (Reinhardt, 2013; Turner et al., 2014; Winkelman et al., 2012). These compensation disparities exist because physicians in the United States spend more money on their medical education and malpractice insurance, and they have higher office overhead (Winkelman et al., 2012). A reduction in physician fees will not have much effect on overall healthcare costs (Reinhardt, 2013; Turner et al., 2014; Winkelman et al., 2012).

Most administrative costs accumulate through private insurance particularly from processes that do not improve medical care, underwriting, and marketing (Reinhardt, 2013; Turner et al., 2014; Winkelman et al., 2012). The ACA limits the amount of money spent from private insurance on administrative costs (Reinhardt, 2013; Turner et al., 2014; Winkelman et al., 2012). Processes such as coding and claim submission can be time-consuming and complicated because of the existence of many private insurance plans in the same geographic area increasing costs for healthcare providers (Reinhardt, 2013; Winkelman et al., 2012).

Specialists continuously provide more care because of an increase in the desire of patients to get their services and a decrease in the number of primary care physicians (Parker et al., 2012). Compared to primary care, specialty care is usually more expensive because specialists have more fees and they tend to conduct more tests to treat less common diagnoses than their primary care counterparts (Parker et al., 2012). The treatment and evaluation of

patients managed by a primary care physician may require multiple specialists. The excessive use of expensive new drugs and technologies is a result of intensive marketing and advertising to consumers and physicians (Tyagi, Cook, Olson, & Belohlav, 2013). Some of the new measures are not more effective than the less expensive and older ones (Restuccia, Cohen, Horwitt, & Schwartz, 2012).

The costs of drugs have increased because of a rise in the cost involved in developing new drugs (Wilkinson, Pal, & Couldry, 2011). The cost to develop drugs reduces the economic incentive involved in introducing new drugs because of the possibility of low profit potential even with drugs that could significantly benefit the public health, such as antibiotics or vaccines, or those that affect groups such as the establishment of medications to treat rare diseases (Wilkinson et al., 2011).

The use of costly new drugs and technologies is the largest factor contributing to healthcare costs whether the use is appropriate or inappropriate (Wilkinson et al., 2011). Some costly and new treatments are ineffective, used inappropriately for patients who may not benefit from them, and only offer marginal advantages (Wolosin, Ayala, & Fulton, 2012). The use of costly treatments could vary based on geographic areas and among some physician practices located in specific geographic areas (Wolosin et al., 2012). Health outcomes are not necessarily better in some areas with high spending compared to areas with low spending for some health disorders (Werner, Kolstad, Stewart, & Polsky, 2011). Governmental and corporate subsidization eliminates some economic disincentives to the use of healthcare and contribute to an increase in the use of healthcare and costs (Vargas, Chuang, & Lee, 2014).

Transition

The purpose of this study was to explore strategies that hospital managers need to streamline administrative procedures to reduce costs. In Section 1, I discussed (a) the background of the problem, (b) problem statement, (c) purpose statement, and (d) nature of the study, (e) research question, (f) interview questions, (g) conceptual framework, (h) operational definitions, (i) significance of the study, (j) assumptions, (k) limitations, and (l) delimitations of the study. In the literature review section, I also discussed (a) the historical perspective, (b) reimbursement methodologies, and (c) current healthcare costing. Specifically, the sections included the government and healthcare, methodology in healthcare costing, reimbursement reform for healthcare providers, fee-for-service methodology, Medicare payment bundling, and capitation, delivery of care and organizational models, prospective changes in the healthcare delivery system, reimbursement and financing, state plan and payment methodology for Medicaid services, delivery of service and payment rates of providers. I also discussed the historical perspective, reimbursement methodologies, and current healthcare costing.

In Section 2, I provided a description of the rationale for the use of a qualitative case study. I also discussed the research design to explore strategies that hospital managers need to streamline administrative procedures to reduce costs. I presented (a) the role of the researcher, (b) participants, (c) research method, (d) research design, (e) population and sampling, (f) ethical research, (g) research method, (h) research design, (i) population and sampling, (j) instrumentation, (k) data collection instruments, (l) data, (m) collection technique, (n) data organization techniques, (o) data analysis and, (p) reliability and validity. Section 3 contained (a) the software, (b) the data analysis including the interview questions, (c) issues surrounding

reliability and validity, (d) and the data interpretation and presentation. In Section 3, I also presented the research findings and ways they could relate to professional practice. Section 3 contained implications for social change and a call for action. Through this study, future researchers will find recommendations for further research. I concluded Section 3 with a description of ways that the theoretical framework related to the findings of the study.

Section 2: The Project

The purpose of this qualitative case study was to explore strategies that hospital managers need to streamline administrative procedures to reduce costs. The exploration of strategies for the streamlining of administrative procedures consisted of different components of healthcare such as reimbursement and financing, state plan and payment methodology for Medicaid services, delivery of service and payment rates of providers. The task of implementing healthcare reform will likely leave many unresolved issues and continual long-term reassessment will be required (Marco et al., 2012). In Section 1, I introduced the background of the problem relating to the streamlining of administrative procedures for the reduction of healthcare costs. I also summarized the role of the government in the evolution of the healthcare sector and the different mandates introduced over a period to govern accessibility to healthcare and the reduction of costs. In Section 2, I describe my role as the researcher, my justification for population and sampling methods, data collection instruments and organization techniques. I also address ethical research, the research method and design, study population and sampling, analysis, and the validity and reliability of the study.

Purpose Statement

The purpose of this qualitative single case study was to explore strategies that hospital managers use to streamline administrative procedures to reduce healthcare costs. The research population consisted of four hospital managers and administrative management personnel from one hospital in Atlanta, Georgia, who have successfully streamlined administrative procedures to reduce costs in their departments. The findings from this study may contribute to social change by providing strategies for streamlined processes that leads to savings passed on to patients from

low socio-economic backgrounds through accessibility to affordable healthcare services.

Role of the Researcher

My role as the researcher for this study was to collect, interpret, and analyze data and results gathered from archival data and participant interviews (Wahyuni, 2012). Wahyuni (2012) emphasized the researcher in a qualitative study is the primary data collection instrument. As the researcher for this qualitative single case study, I acted as the primary data collection instrument.

After obtaining my undergraduate degree in health sciences with a specialization in public health, I worked as a patient representative and Medicaid specialist assisting individuals from low socio-economic background to obtain Medicaid coverage and to get hospitals to waive their accumulated medical bills. I also worked closely with the caseworkers to provide those individuals with medical care at a reduced or no cost. I am familiar with healthcare administrative procedures.

I mitigated bias throughout the data collection process. I conducted the data collection process in an ethical manner per guidelines in The Belmont Report (National Institutes of Health, 2014). The focus of The Belmont Report is to identify the basic ethical principles that govern biomedical and behavioral research involving human participants. The research guidelines under The Belmont Report include the following: (a) the boundaries between behavioral and biomedical research and the routine and accepted practice of medicine; (b) the role of assessment of benefit and risk criteria to determine if research involving human participants is appropriate; (c) appropriate guidelines for research participant selection; (d) and the definition and nature of informed consent in different research settings (National Institute of Health, 2014). According to Dalton (2013), researchers can use the seven pillars of information literacy as a tool for research

bias mitigation and by using tools such as (a) identify, (b) scope, (c) plan, (d) gather, (e) evaluate, (f) manage, and (g) present in the data collection process to limit bias. Merriam (2013) emphasized that qualitative researchers have the responsibility of developing or establishing procedures to conduct investigations about a phenomenon. Wahyuni (2012) highlighted the role of researchers to facilitate participant sharing of experiences and perspectives about the phenomenon. Participants sharing their experiences took place through the selection and development of interview questions, data analysis, and data collection (Wahyuni, 2012).

Through triangulation, I crosschecked gathered information to produce accurate results and ensure certainty in data collection. With triangulation, I increased the validity and credibility of the study results by using diversified data sources and ultimately reducing participant and researcher bias (Wahyuni, 2012). The interpretive nature of qualitative research results makes the existence of personal bias inevitable (Hancock & Algozzine, 2011). To ensure that a study conclusion is neutral, researchers should recognize their personal roles and biases pertaining to the research study topic and actively attempt to identify and eliminate those biases. To minimize contradictory information and bias, I used peer debriefing to obtain clarity when analyzing findings and themes. I endeavored to develop a close relationship with the hospital managers to become an insider. According to Unluer (2012), the three advantages of being an insider include (a) established intimacy, (b) natural entrenchment, and (c) cultural awareness. Unluer (2012) emphasized that the involvement of researchers in the day-to-day activities of their study subjects assists in the minimization of alterations in social interaction flow. The establishment of intimacy with the participants enabled me to assert, verify, and determine the truth (Unluer, 2012). My firsthand observation and experience as an insider enabled me to develop an

understanding of the hospital administrative processes.

Using semistructured interviews and observations, I sought explanations from hospital managers on strategies they need to streamline administrative procedures to reduce costs. An interview protocol enables researchers to mitigate bias and focus mainly on the research topic as it pertains to the conduct of the interviews in a study (Jacob & Furgerson, 2012). Interview protocols are important tools that keep researchers focused on the study topic during the interview (Yin, 2014) and provide guidance and structure throughout the interview process (Jacob & Furgerson, 2012). Interview protocols serve as preparation tools for the anticipation of possible problems while reporting research study findings (Yin, 2014). To mitigate bias as emphasized by Silverman (2013), I used an interview protocol (see Appendix B) that enabled me to ask the same questions and present the same information to the study participants. According to Yin (2014), case study researchers address a wide range of behavioral, attitudinal, and historical issues. As an insider, I gained profound knowledge of hospital administrative practices and processes. Torto (2011) highlighted that the collegial relationships of researchers are beneficial because colleagues can provide perspectives and insights into the works of their fellow colleagues.

Participants

I identified and recruited the study participants based on the Walden IRB and The Belmont Report guidelines and protocols. As specified in The Belmont Report, I avoided intentionally or voluntarily recruiting any individual from vulnerable populations. According to Damianakis and Woodford (2012) and Yin (2014), researchers can satisfy the appropriateness of the population for a qualitative research study by identifying multiple units with different

participants in the same setting. The participants in this study included hospital managers who work for a public hospital on the south side of Atlanta, Georgia. Study participants included (a) a purposeful sample of four individuals currently working as (b) a hospital manager at the study hospital with a minimum of a bachelor's degree, and (c) 5 years of experience in their field of work. The population for this proposed study is suitable because the participants provided detailed information about the rise in healthcare costs and strategies for reducing healthcare administrative costs. I established a working relationship with potential participants by visiting the case study hospital and building a rapport with the hospital managers. I eventually asked them if they wanted to participate in my doctoral study.

Kolb (2012) and Robinson (2014) emphasized that researchers can select a study population that specifically meets the criteria to answer research questions through the deliberate selection of participants. I contacted the hospital managers to participate in this study through email invitation. I followed up with them through email prior to data collection to verify their willingness to participate voluntarily in this study. According to Suri (2011), researchers need to identify study participants willing to provide in-depth information pertaining to the research phenomenon. I chose hospital managers for the study because they would provide in-depth information about ways to streamline healthcare administrative procedures to reduce costs. To enable me to comply with my responsibilities to the participants, I engaged in a consistent and purposeful communication with the participants through email or phone to form and maintain professional relationships with the participants. I established a researcher and expert relationship with the study participants by acknowledging their expertise and contribution to the study.

Through a systematic approach, I formed a researcher and participant partnership by (a)

issuing a formal email or letter that detailed the goals of the research study, (b) informing study participants regarding expectations of the time commitment and effort required for participation in the study, (c) assuring participants of ethical protections implemented throughout the study, (d) assuring participants of the confidentiality of their responses and documents provided for the study (see Appendix F), and (e) informing participants regarding the security procedures for collecting and storing study information during and after the study.

Research Method and Design

In an effort to understand activities surrounding social situations, healthcare researchers may select a quantitative, qualitative, or, mixed methods approach to conduct a research study. According to Thomas and Magilvy (2011), qualitative research studies can be beneficial for interpreting or understanding experiences through diverse research avenues. Researchers can use qualitative methodology to examine the experiences of participants arising through common daily life occurrences through pictures or words (Thomas & Magilvy, 2011).

Research Method

According to Chenail (2011a), qualitative inquiry can be beneficial for healthcare research studies that examine the experiences of healthcare providers while providing care to patients and for communicating issues that arise during the enhancement or evaluation of healthcare delivery. Unlike qualitative research, researchers can use quantitative research to capture statistical and numerical data that are linear and used in theoretical testing and measuring variables (Chenail, 2011a). Researchers have a more comprehensive way of validating and extending the qualitative and quantitative methods with a mixed method giving them a clearer

understanding of a phenomenon (Brannen & Moss, 2012). Although mixed methods research has its benefits, Voils, Crandell, Chang, Leeman, and Sandelowski (2011) suggested that researchers make inquiries for quantitative and qualitative findings, which must be amendable for synthesis with diverse sources of evidence for informational value. The best-suited method for this study is qualitative because it allows researchers the opportunity to examine patterns and themes, identify specific features of a phenomenon from the experiences of individuals that lived the phenomenon (Brannen & Moss, 2012). The qualitative approach enabled me to explore the complexities involved in the healthcare systems.

Conducting a study to explore strategies hospital managers need to streamline administrative procedures to reduce costs required a qualitative case study approach because it is a viable methodology used in a research continuum to reflect the experiences of participants. Qualitative research provides an opportunity to identify how individuals construct or interpret their worlds, and the meanings that they attach to their experiences (Brannen & Moss, 2012). Schleifer and Rothman (2012) highlighted the use of qualitative research to examine individual attitudes and for the assessment of similarities between study participants. I was able to investigate the how and why of the decision-making behind the streamlining of administrative costs in a hospital with the qualitative method. Qualitative research enabled me to gain the perspective of individual participants about a phenomenon that relates to their experiences and commonalities as participants. Qualitative research may unveil barriers and attitudes faced by healthcare providers during the implementation of delivery models. Chenail (2011a) elaborated on parallels between qualitative and humanistic inquiries providing participants and researchers with a methodology for constructing interpretations of personal experiences. According to

Lanham et al. (2012), the use of qualitative methodology is advantageous to study complex behaviors related to communication patterns and practice relationships among individuals involved in medical practices. The use of qualitative research in this study led to beneficial information involved in the different issues associated with the streamlining of administrative procedures to reduce healthcare costs.

A quantitative study was not appropriate for exploring the reduction of healthcare costs because quantitative research measures factual objectives to a hypothesis. Quantitative research is for the examination of relationships with variables as they relate to statistical measurements (Duvendack & Palmer-Jones, 2013). According to Bailey (2014), a qualitative study pertains to the analysis of unstructured data, which is the reason I selected a qualitative research method instead of a mixed or quantitative method. According to Duvendack and Palmer-Jones (2013) quantitative research method involves a top-down or deductive scientific method to measure statistical significance of findings which is the reason I did not select a quantitative research method. Duvendack and Palmer-Jones further described qualitative method as a method that provides a thorough understanding of human behavior and the reasons behind those behaviors, which makes qualitative method better suited to address the specific business problem for this study instead of the quantitative or mixed method.

In the healthcare sector, quantitative research is advantageous when used for healthcare topics related to clinical effectiveness as opposed to those pertaining to healthcare providers, organizational structures, and healthcare delivery system (Duvendack & Palmer-Jones, 2013). Although a combination of quantitative and qualitative methodologies is beneficial for healthcare research, a mixed method approach was not suitable for this study because it cannot address the

assumptions and personal experiences of healthcare professionals through that research method. A mixed methodology enables researchers to examine a combination of diversified evidence pertaining to healthcare policies and practices (Voils et al., 2011). Mixed methodology is also beneficial when researchers want to integrate information gathered from qualitative and quantitative approach (Mengshoel, 2012). Mixed methods may be more appropriate for healthcare studies geared towards the development of a survey instrument through quantitative research while using a qualitative methodology to examine participant experiences, preferences, and beliefs. A qualitative inquiry was advantageous for studying the strategies that hospital managers need to streamline administrative procedures to reduce costs because the purpose of this study was to explore the possibilities of the evolution of a phenomenon from the personal experiences of participants.

Research Design

According to Yin (2014), case study research is an empirical inquiry that facilitates the understanding of organizational, group, and individual experiences in a bounded system by examining details in context and a rich description of complex phenomena arising from a study. The case study design was best suited for addressing the specific business problem because it allowed for the exploring of the personal experiences of hospital managers streamlining hospital administrative procedures to reduce healthcare costs. Researchers use a phenomenological design to describe lived experiences (Crofts & Bisman, 2010), and does not allow for the study of emerging events associated with the strategies to streamline administrative procedures to reduce costs. Researchers use grounded theory to develop theories (Crofts & Bisman, 2010). Since this doctoral study did not involve the development of any new theories, a grounded theory

design was not appropriate for the study. Ethnographic studies describe cultural characteristics (Crofts & Bisman, 2010), which was not the intent of this study.

To explore the strategies that hospital managers need to streamline administrative procedures towards the reduction of healthcare costs, I examined the phenomenon from a case study perspective. A case study approach enables a researcher to research multiple analyses levels, groups of organizations, or formal organizations (Bernard, 2013; Sangster-Gormley, 2013; Yin, 2014). I explored the personal experiences of hospital managers struggling to reduce healthcare costs through streamlining administrative procedures using a case study approach. According to Yin (2014), case study research is an empirical inquiry used to explore a tangible context in the occurrence of a contemporary phenomenon. Case study research enhances the understanding of events when the limits or the confines are not obvious. Sangster-Gormley (2013) noted the use of a case study design enables researchers to acknowledge the depth and intricacies of a phenomenon. Hancock and Algozzine (2011) suggested that case studies are not only comprehensive but also derived from different data sources. Radley and Chamberlain (2012) placed emphasis on the lack of clarity between a context and a phenomenon by referring to the various ways that patients exhibit different symptoms for disease processes. The bounds between the phenomenon and context could be ill defined, but the limitations of the study may provide the bounds for the case (Yin, 2014). Chreim, Williams, and Coller (2012) conducted a qualitative case study for the exploration of the transformation of healthcare services in an integrated organizational model. Sangster-Gormley, Martin-Misener, and Burge (2013) used a case study approach for the identification and implementation of processes that are advantageous to nurse practitioners in healthcare organizations. The use of a case study design to make

inquiries in the study was beneficial in exploring the variations in physician experiences as they pertain to the PPACA legislation because of the lucrative nature of the changing healthcare system (Bernard, 2013). The experiences of the physicians varied in unique ways because of the impact of the legislation to their specific practices. To achieve data saturation in the qualitative method single case study, I selected a sample size distinct and appropriate for my study as specified by Yin (2014). The sample consisted of four participants and relevant documents from the study hospital in Atlanta, Georgia. To verify that I had achieved data saturation, I made sure that no new codes, themes, or information emerged from the data.

I also considered other qualitative research designs including ethnography, grounded theory, narrative, and phenomenology for my study. According to Yin (2014), case study research is an empirical inquiry that facilitates the understanding of organizational, group, and individual experiences in a bounded system by examining details in context and a rich description of complex phenomena arising from a study. The case study design was best suited for addressing the specific business problem because it allowed for the exploring of the personal experiences of hospital managers streamlining hospital administrative procedures to reduce healthcare costs. Researchers use a phenomenological design to describe lived experiences (Crofts & Bisman, 2010), which did not allow for the study of emerging events associated with the strategies to streamline administrative procedures to reduce costs. Researchers use grounded theory to develop theories (Crofts & Bisman, 2010). Since this doctoral study did not involve the development of any new theories, a grounded theory design was not appropriate for addressing my research question. Ethnographic studies pertain to the description of cultural characteristics (Crofts & Bisman, 2010), which was not the intent of this study.

Merriam (2013) noted that the focus of phenomenology is on individual interpretations of the world. Pringle, Drummond, McLafferty, and Hendry (2011) surmised that the work of a phenomenologist is to interpret experiences from a participant's perception. Wertz, Nosek, McNiesh, and Marlow (2011) suggested that researchers portray humans in phenomenological research assumptions as sociable and-self interpretive beings that share understanding and meanings through imaging and dialogue. On the other hand, grounded theory is for the explanation of relationships and interactions from a theoretical perspective (Wertz et al., 2011). Merriam differentiated grounded theory from other methods of inquiry through the building of theories for the explanation of event changes over a period. Chenail (2011) surmised that the use of ethnography is for the study of individuals and their beliefs in a cultural orientation context. Ethnography is beneficial for objectively accounting for human experiences, and for addressing the conceptual issues of their behaviors. The use of a case study design was advantageous for this study to explore the strategies that hospital managers need to streamline administrative procedures towards the reduction of healthcare costs.

Population and Sampling

In maintaining traditional business models, healthcare providers encounter various challenges, such as financial constraints and provision of low cost quality care with the changes that occurred with the PPACA legislation (McClellan, 2011; Oberlander, & Perreira, 2012). This study entailed the use of open-ended interview questions with four hospital managers at a hospital on the south side of Atlanta, Georgia. The participants had a minimum of a bachelor's degree and 5 years of experience working in a hospital administrative position or as a hospital manager. The participants had experience in implementing strategies to streamline administrative

procedures to reduce costs. These participants enabled me to gather rich data from healthcare professionals with experiences in managing healthcare costs related to administrative procedures.

The sampling method that I used in this study was purposeful sampling. According to Suri (2011), purposeful sampling enables researchers to capture rich information from participants who have pertinent information in a field of study. According to Yin (2014), the inability to gain access to a wide variety for the population of interest and bias could stand as weaknesses in purposeful sampling. Purposeful sampling places limitations on sample sizes (Edwards, 2014; Roy, Zvonkovic, Goldberg, Sharp, and LaRossa, 2015; Suri, 2011). An example of purposeful sampling is the recruitment of participants who are healthcare providers and patients with a disease to study the adherence success of a therapy or treatment (Edwards, 2014; Roy et al., 2015; Suri, 2011). To provide information that relates to the research objective of exploring the strategies needed to streamline administrative procedures to reduce healthcare costs, hospital managers were the most knowledgeable participants to interview for this study.

According to Damianakis and Woodford (2012), purposive sampling is a subjective or selective sampling used to select individuals based on the purpose of a study. Based on Damianakis and Woodford's (2012) recommendation, I used purposive sampling to select study participants by deliberately selecting each participant based on their detailed knowledge of streamlining administrative procedures to reduce healthcare costs. Based on Yin's (2014) recommendations, researchers need to select more than one participant for a case study. Researchers accomplish data saturation for studies when they compare the different cases until subtle or no changes exist in codes and themes. I interviewed each participant and reviewed relevant hospital documents, such as administrative office charts, and other financial records

depicting the costs of services at the hospital, until I accomplished data saturation for the study.

There are few published guidelines for the justification of sample size in qualitative studies available (McClellan, 2011; Oberlander & Perreira, 2012; Suri, 2011). Some of the literature geared towards the establishment of a criterion for sample size in a qualitative research study pertains to data saturation (McClellan, 2011; Oberlander & Perreira, 2012; Suri, 2011). In a single case study, nonrandom selection of participants is important (Yin, 2014). According to Stuart, Bradshaw, and Leaf (2015), the selection of participants through purposive selection will bring credibility to a study and enable researchers to achieve a detailed and rich study. The specific selection criteria for this study enabled me to narrow the study population to hospital personnel and managers with various lived experiences that pertained to the streamlining of healthcare administrative procedures to reduce healthcare costs.

According to Thomas and Magilvy (2011), small sample sizes can be adequate for providing insight in research. Unluer (2012) surmised that small sample sizes are appropriate when a researcher is an insider. Yin (2014) declared that a sample size must be large enough for researchers to derive redundancy of response or saturation. The sample sizes need to be sufficient for the identification of consistent patterns leaving the researcher with no additional information to learn (Yin, 2014). Regarding the hospital strategic initiatives, the members of the hospital management were knowledgeable about strategic plans to streamline administrative procedures. With a small sample size, the interview response data along with an analysis of relevant documents resulted in data saturation. The strength of my proposed sampling method was that exploring how the PPACA legislation might affect hospital business models and the streamlining of administrative procedures could provide insights into ways that the changes may affect

healthcare delivery to patients and reduce healthcare costs.

According to O'Reilly and Parker (2013), data saturation is a criterion used in ensuring the collection of quality and adequate data to support a study. I achieved data saturation in the study when data did not produce new codes and themes, or reveal new information when collected data were analyzed (Crow et al. 2011; O'Reilly & Parker 2013; Yin, 2014). To achieve data saturation in this qualitative single case study, I selected a sample size distinct and appropriate for my study as specified by Yin (2014). Based on Yin's (2014) explanation, the logic of replication applies to single case studies when researchers gain results through theoretical and literal replication. Literal replication pertains to the replication of results, and theoretical replication yields results that contrast for predictability reasons (Crow et al. 2011; O'Reilly & Parker 2013; Yin, 2014). Based on Yin's (2014) recommendation, and because this qualitative research study did not include proposed hypotheses, theoretical replication was not applicable to this study.

According to Crow et al. (2011), O'Reilly and Parker (2013), and Yin (2014), researchers can achieve replication through cases using three or four participants for each case on a topic, which can also apply to single case studies. To achieve data saturation, I interviewed four hospital managers and analyzed relevant documents from the study hospital in Atlanta, Georgia until the data reached saturation. Based on recommendations for successfully achieving data saturation in qualitative research made by Crowe et al. (2011), O'Reilly and Parker (2013), and Yin (2014), if the selected participants provide contradictory information, I continued interviewing participants for more in-depth information and clarification on conflicting information. I retested the data by using methodological triangulation to achieve data saturation

to provide convincing and adequate evidence to support the research question. When I collected sufficient information to replicate my study and no new information or new themes emerged, I knew that the data were saturated.

Data saturation is the guiding principle of researchers during data collection and serves as a criterion to establish quality in qualitative research (Crowe et al., 2011; O'Reilly & Parker, 2013; Yin, 2014). Data reach saturation when no new information, themes, or concepts are derived after the verification of notes from previously interviewed participants (Crowe et al., 2011; O'Reilly and Parker, 2013; Yin, 2014). An example of the use of sample size in a qualitative research study is when a given number of participants examine measures pertaining to the productivity, infrastructure, and financial performance of a group of professionals to develop strategies focused on the improvement of efficiency and quality (Crowe et al., 2011; O'Reilly & Parker, 2013; Yin, 2014). Lockyer et al. (2011) conducted interviews with four participants for the exploration of the experiences of physicians changing their medical practices to a new community. For my doctoral study, four participants were sufficient to reach data saturation. According to Damianakis and Woodford (2012), and Yin (2014), researchers can satisfy the appropriateness of the population for a qualitative research study by identifying multiple units with different participants in the same setting. I used triangulation to achieve data saturation by triangulating important company documents, such as case histories and hospital records, and data from interviews of all four participants to ensure rich collected data for analysis.

Ethical Research

Participant in this qualitative study refers to an individual who participated in the study. According to Merriam (2013), every participant should be informed about the benefits and risks

involved in participating in a study. I did not intentionally select a member of the protected class or vulnerable population for participation in this study (National Institute of Health, 2014). All participants for this study met the age required by the guidelines for ethical research in *The Belmont Report* (U.S. Department of Health & Human Services, National Institute of Health [NIH], 2014). Prior to commencing any data collection, I applied for and received approval for the study by the Walden University IRB. My interview protocol (see Appendix A and B) that assured respect for individuals, justice, and beneficence in compliance with the requirements outlined in *The Belmont Report* determined IRB approval (NIH, 2014). In addition to Walden IRB approval, the hospital director for the study hospital granted approval for the study (see Appendix D). After receiving both approvals, I began to identify and recruit study participants that were members of the hospital administrative team. The U.S. Department of Health and Human Services and the CFR, Chapter 45, detail requirements for ethical research. The information from the CFR 45 and the Health and Human Services includes required steps for the consenting process and the guidelines for the ethical treatment of human subjects.

Each participant received a consent form that included information on (a) the background of the study (b) a declaration of consent, (c) contacts exclusion criteria, (d) privacy, (e) payment, (f) risks and benefits, (g) the voluntary nature of the study, and (h) the research methods. The background of the study consisted of an introduction to the topic and problem addressed in the study. The declaration of consent requested the consent of the study participants to use the responses gathered from the interviews in the study. Privacy assured the participants of the confidentiality of their information. I did not require the participants to pay any fees and no compensation was offered to any individual for participation in the study. I ensured the

participants of the absence of risk to them for participating in the study. I explained to the participants the benefits of the study to future researchers and other hospital managers. I explained the qualitative research method to the participants and that they could choose to remain in the study or withdraw at any time without a justification by notifying me through email or telephone, even after the conclusion of data collection. Upon withdrawal, I would have removed and destroyed collected data from the study files for any participant that decided to withdraw, but no participant withdrew from the study.

I secured a signed letter of cooperation from the authorized administrator of the participating hospital that granted permission to use names, documents, and premises that pertained to the study. Once the hospital administrator granted permission to use documents, names, and premises, and returned a signed letter of cooperation prior to the interviews (see Appendix D), I obtained written consent from each participant and provided each one with a copy of their consent form to retain for their records. I sent a participating letter of inquiry to the potential participants within the participating hospital who met the participation criteria for the proposed study. When the participants returned the signed consent form, which included participants' permission to audio record the interview, I reviewed the informed consent forms with the participants, asked if they had any questions, and provided any requested clarification (see Appendix C). If a participant did not agree to audio recording their interview I would have informed the participants that I would take handwritten notes on their responses to interview questions (see Appendix B), but all participants consented to audio recording of their interviews. After the participants and participating hospital administrator signed the consent agreements, I provided the organization a signed copy of the letter of cooperation and each participant a copy

of the signed consent form. I informed participants that they might withdraw from the study at any time without providing a reason even after data collection was complete. They could have requested to withdraw from the study in writing, through email, or by a telephone call to me. Following the ethical approach described by Fein and Kulik (2011), I explained the purpose of the study, my responsibility to the participants, and my role as a researcher to each participant before the interview process began. The risk for participating in this study was minimal, but the degree or probability of risk was not more than risks encountered in ordinary daily life. The interview questions were not threatening or offensive. Participants had no risks to reputation, employability, or financial standing as the questions pertained to the practice of hospital managers in this study. All study participants voluntarily agreed to participate and signed a copy of the consent form. Even though some of the participants might be business acquaintances, no conflict of interest or change in relationship status occurred between any participant and me because of a participant's decision to participate or not participate in this study. I did not offer incentives for participation in this study.

I saved all data obtained from transcriptions, face-to-face interviews, and audio recordings in an encrypted computer file or locked in a file cabinet located in my home office where I am the only individual with access to the cabinet. All data and study information will be stored for 5 years following the completion of the study. I will destroy printed files by shredding and permanently erase all digital data after 5 years to ensure the confidentiality of all participants.

Based on guidance recommended to researchers by Bernard and Ryan (2010), I used a coding system for data to identify participants for data analysis without referencing the practice

name or organization of the participant. To ensure the protection of the identities of individual participants, I named and coded file conventions and other personal information by using a fictitious company name to conceal the identity of the hospital used in the study. For example, I named the hospital company A, and labeled each participant as P1, P2, P3, and P4. To protect the identifiable information of participants and the participating hospital, the identity of the participants was not included in the database created from the interviews. I used the numbering system to identify each participant.

My adherence to Walden University's IRB guidelines and procedures pertaining to conducting research enabled me to ensure compliance with ethical standards prior to and during the research study. I removed the name of the hospital from the proposal to protect the identity of the hospital. I obtained IRB approval and an approval number (03-21-17-0231052) prior to contacting the hospital and potential study participants. Participant recruitment and interviews commenced following IRB approval for this study. The IRB required that researchers not harm participants and that risks to participants must be at a minimum by protecting the identifiable information of the participants and their organization (Bernard & Ryan, 2010). I conducted each interview in a way that neither the responses nor the questions compromised the personal or professional welfare of the participants as instructed by the Walden University IRB. I am the only individual with access to the study data. I stored all personal logs, interview notes, transcripts, recordings of interviews, and signed consent forms in a password protected flash drive and a locked fireproof safe. I am the only individual with the password to access the data. I will store all study data for a period of 5 years following the completion of this study. At the end of 5 years, I will shred all logs, notes, signed and written consent forms, and handwritten

interviews. I will delete and permanently destroy all digital records, such as scanned documents and emails, scanned interview notes, and recordings by reformatting the flash drive and the recorder. I will permanently delete stored information in back-up files in the NVivo v10 software.

Data Collection Instruments

Researchers conducting qualitative studies are the primary instrument for data collection because participants share their experiences through interpersonal interactions with researchers (Chenail, 2011b). I served as the primary instrument for data collection to explore the strategies that hospital managers need for streamlining administrative procedures to reduce healthcare costs. Prior to data collection, I conducted expert review of the interview questions to enhance rigor and quality as recommended by Barss (2012). According to Barss (2012), probing questions can be advantageous to build rapport and develop trust with the participants.

I collected data through semistructured face-to-face interviews guided by open-ended questions with healthcare providers. I followed up with them through email prior to data collection to verify their willingness to participate voluntarily in this study. Once I received the participants' return emails expressing their willingness to participate in the study, I scheduled and conducted a face-to-face interview with each participant. Each participant received a consent form as an email attachment that explained the privacy and ethical protection of the participants. After the confirmation of their willingness to participate in the study, I met with each participant to (a) explain the study, (b) review the consent form, (c) answer any questions they may have, and (d) obtain their signature on the consent form. I provided participants a copy of the consent form to retain for their records. I explained that participation in the study will enable me to

explore strategies that hospital managers need for the streamlining of administrative procedures to reduce healthcare costs. I saved all digitized study data in a password-encrypted computer file, and stored printed information related to the study in a locked file cabinet in my home office that only I could access. At the end of 5 years following the completion of this study, I will destroy all study data by shredding all printed information and electronically erasing all digitized files. I made data available to my DBA committee upon request.

According to Yin (2014), case study researchers must collect and analyze multiple data sources. Relevant documents from a study organization usually serve as the second source of data for data triangulation (Yin, 2014). Wahyuni (2012) surmised the importance of interviewing participants for qualitative case studies to encourage them to share their personal experiences. Personal interviews are advantageous for enabling the researcher to probe the answers of participants (Wahyuni, 2012). Goldman and Swayze (2012) emphasized the difficulty for individuals to gain access to healthcare providers for personal interviews because of time constraints. I gathered and analyzed data through open-ended face-to-face interview questions. I triangulated data from the interviews with relevant organization documents as a second source of data. The rigor and dependability of a data collection instrument are important in measuring the extent to which the questionnaires and interviews answer the research questions, objectives, and goals of the study (Wahyuni, 2012). According to Wahyuni (2012), in qualitative research, dependability corresponds with reliability. I provided a list of identical interview questions for the participants and a detailed explanation of the research process to achieve reliability of the data collection instrument. Researchers can ask for follow-up information and clarification if they are confused about the meaning of the information provided by the participants to assist

them in ensuring reliability with interviews (Chenail, 2011b). Researchers can use the pyramid of evidence to ensure the validity of data collection and to strengthen the data (Chenail, 2011b). The lack of preparation can make researchers, as the data collection instrument, the greatest threat to validity (Chenail, 2011). To ensure the validity and reliability of the data collection instrument in this study, I confirmed that the participants answered each interview question, and that the preparation for interviews provided consistency of the interview questions for all participants meaning that each study participant had to answer the same set of questions. I also asked follow-up probes during the interviews to get more clarification on responses that participants provide. As a completion of the data collection process, I asked participants probing questions pertaining to the costs associated with the implementation of healthcare administrative strategies in the organization. I also conducted member checking after I summarized the individual responses of each participant on each question seven days after the interviews were completed. Chenail (2011b) emphasized that for transcription purposes, a question and answer format is important for the recording of conversations. Appendix B includes a copy of the semistructured interview protocol for data collection in this study.

Data Collection Technique

The data collection technique for this study included collection of relevant documents from the hospital and data from participant interviews collected through face-to-face, semistructured interviews guided by open-ended questions. Wahyuni (2012) surmised that when gathering primary data, researchers should use semistructured interviews conducted with experts in the field of interest. The advantage of semistructured interviews is the synchronous communication that exists verbally and non-verbally between the interviewer and the

interviewee (Wahyuni). The disadvantage of semistructured interviews is that the interviewer may guide the interviewee in a special direction with his or her behavior (Wahyuni). In the questioning process, semistructured interviews guided by open-ended questions allow for latitude enabling participants to describe their unique interpretations of the phenomenon. The participants who voluntarily agreed to participate in this study were entitled to an interview appointment at a convenient time and location as well as a copy of the study participation consent form. Qualitative researchers conduct expert reviews as an evaluation strategy to improve studies and to ensure that collected data answers the research questions (Jacob & Ferguson, 2012; McDermott & Lanahan, 2012; Rowley, 2012). The merit of an expert review of the interview questions is the strategy built to improve the quality of the questions and ensuring that the questions are clear and concise to the participants while providing relevant information for the study (Jacob & Ferguson, 2012; McDermott & Lanahan, 2012; Rowley, 2012). According to Rowley (2012), researchers can conduct a mock interview with a member of the target population to accomplish an expert review for the study. According to Jacob and Ferguson (2012), the purpose of an expert review is to receive feedback and fine-tune the interview protocol and the research instrument. A limitation of expert reviews is that the results could comprise of opinions instead of facts study (Jacob & Ferguson, 2012; McDermott & Lanahan, 2012; Rowley, 2012). To conduct an expert review of the interview questions prior to data collection, I performed a mock interview with a healthcare personnel and hospital managers from the study hospital, with 5 years of experience in the healthcare industry. I also asked an administrator from another hospital that has streamlined administrative procedures to reduce costs, to review my study protocols and interview questions to enhance the quality of my

interviews and interview data (see Appendix A and B). I did not involve the individuals selected for the mock interview or pilot test in the study in any other way.

Merriam (2013) emphasized the need for participants and researchers to engage in the act of face-to-face interviewing when faced with the difficulty of observing participants' attitudes, feelings, and behaviors regarding a phenomenon. Face-to-face interviews are suitable for gaining impressions and information, and are effective for data collection because of logistic issues such as availability and distance. Cook (2012) noted that several participants in his study preferred email questionnaires because of the measure of anonymity they provide. The email questionnaire consisted of identical questions to those included in the face-to-face interviews. I emailed a copy of the questions to each participant prior to their interview so that they could prepare their thoughts regarding how to respond to each question during the face-to-face interview. The face-to-face interviews included responses to six questions captured with an audio recorder when each participant granted their permission for recording in writing. I used my laptop as the recording device and a recording software called audacity. Alternatively, if a participant refused to be audio-recorded, I would have taken notes during the interview. I began each interview with an overview of the goal of the interview with an emphasis on (a) the need for recording the interview, (b) voluntary nature of the study, and (c) confidentiality. I reviewed the consent form and provided each participant an opportunity to ask questions and review the consent form before the interview began. To prevent intrusions by nonparticipants, I conducted each interview in a quiet, private location. The participants had the opportunity to review the audio recording during the interview if they chose.

As suggested by Sorsa et al. (2015) and Thomas and Magilvy (2011), I conducted

member checking with the study participants to help improve the credibility, transferability, and accuracy of the study. After the completion of the interview, I conducted member checking by summarizing and interpreting participants' responses to each question and restating the answers from the interview to ensure an accurate interpretation of the data. I conducted member checking within 7 days of the completion of each interview by paraphrasing the participants' responses for each question, and emailing each participant a copy of the summary of their responses. I also followed up with a phone call to schedule meetings to review my summary of participants' response to each question in the document to ensure that I accurately interpreted each participant's message for the interview questions. Due to the amount of time required to conduct member checking, I engaged in the process within one week of completing the interview. The length of each interview was approximately 60 minutes, but some interviews could have taken longer depending on the time required for each participant to provide their responses to each question. After the completion of the interview, I transcribed the audio file to a Microsoft Word document on my computer and saved it to a folder designated for face-to-face interviews. I assigned participants a unique identification number to protect their confidentiality, such as participant one or participant two.

Wahyuni (2012) emphasized the importance of researchers developing follow up questions and engaging in member checking. I transcribed all handwritten notes and audio recordings obtained during the face-to-face interviews within seven days after each interview. After collecting data, I prepared summaries of each participant's responses to each question. Debriefing allows participants to have the opportunity for catharsis (Wahyuni, 2012). The developed follow up question probes for this study ensured accuracy in the understanding of

participant responses while gathering additional data for a detailed and richer description of the phenomenon of interest.

Yin (2014) emphasized the use of diversified sources of evidence when conducting case study research because they enable researchers to strengthen the rigor and accuracy of the study. Relevant hospital documents were the source of information for triangulation of data in this study. I used the relevant themes identified in the literature review in the data analyzes. I chose not to conduct a pilot study because of the possibilities of limitations to the valuable access and time of participants who already have busy schedules running the affairs of the study hospital.

I sent a copy of the interview to each participant and followed up with a telephone call to review their responses and make needed changes as the member checking process. I paraphrased, coded common themes, conducted preliminary analyses of the information obtained from the interviews, and established member checking of the collected data as noted by Thomas and Magilvy (2011). According to Thomas and Magilvy (2011), member checking involved the process of asking participants to assess their intended thoughts conveyed in their statements. In qualitative research, member checking is appropriate after researchers conclude and take account of their findings using brief reports to the participants who were involved in the interview process (Sorsa, Kiikkala, & Astedt-Kurki, 2015). After I paraphrased the statements of the participants, I conducted member checking, identified reoccurring codes, themes, and conducted preliminary data analysis of the collected documents and transcripts. With the member checking, all the participants were able to identify errors or omissions, verify that my interpretations were accurate and complete, and make any changes. Participants were also able to review all the additions or revisions made during member checking through encrypted and secured email. To

ensure confirmability, dependability, transferability, and credibility, researchers should conduct member checking (Ocak, 2011). Member checking is time sensitive and the process is best completed within a reasonable timeframe after the completion of the interview (Torrance, 2012). When much time elapses between the data collection, data interpretation, and member checking, the participants could forget their statements or they may not be able to validate or recall important information (Goldblatt, Karnieli-Miller, & Neumann, 2011). I conducted member checking and interviews within 7 days and the transcription of the interviews to ensure accuracy, completeness, and credibility. For the member checking, I paraphrased the participants' responses for each question, and emailed each participant a copy of the summary of their responses. I also followed up with a phone call to schedule meetings to review my summary of participants' response to each question in the document to ensure that I accurately interpreted each participant's message for the interview questions. After the interviews and the member checking, I sent thank you emails to the study participants (see Appendix C).

Data Organization Technique

According to Anyan (2013), data organization techniques are important in maintaining the integrity of transcribed physical documents, audio recordings, and recorded interviews. After completing the data collection process, I organized all data for analysis. According to Leech and Onwuegbuzie (2011), researchers can use NVivo to (a) organize journals, (b) audio recordings, (c) handwritten interview notes, (d) field notes, and (e) interviews. In qualitative research, NVivo software assists researchers with interpreting study phenomena, evaluation, and coding themes (Fielding, 2012; Rowley, 2012). NVivo 10 software ensures that researchers maintain consistency in qualitative research by enhancing audit analysis, transparency, and data accuracy

(Fielding, 2012; Rowley, 2012). I organized data for the study by verifying the accuracy and completeness of the interpretations of responses to interview questions through member checking. I uploaded the interpretations, as corrected by individual participants, to NVivo 10 for analysis. I used NVivo 10, Microsoft Word 2010, and Microsoft Excel 2010 computer software applications to organize the interview data. I documented the transcribed participant interviews in Microsoft Word, and documented the number of participants and their interview schedules in Microsoft Excel. I summarized interview responses and conducted member checking using Microsoft Word. Once the data were organized and summarized, for further analysis of common themes, I uploaded the data into the NVivo 10 software for analysis. With the NVivo v10 software, I was able to organize raw data into themes identifiable in the conceptual framework and literature review sections. I coded phrases, words, and similar themes identified in the transcripts and documents. Based on the suggestions by Hammer and Berland (2014), I coded data using different ranges of single words from individual words to full sentences and to a whole page using the relevant hospital documents, the reflexive journal, interview notes, and interview transcripts. Finally, as the data collection instrument, I coded the perceptions of participants from each interview. I organized coding by further identifying common themes, frequencies, differences, and similarities as suggested by Lee and Chavis (2012). I will store all data collected for this study, including storage of digital information such as electronic consent forms, email questionnaires, and audio recordings, in a password-encrypted computer file for a minimum of 5 years. I will also store printed information from the study such as the reflexive journal, relevant company documents, and transcriptions in a secure file cabinet for a minimum of 5 years. I used the label *Data Collection File* to identify the main data folder. The labels for

the subfolders included *consent forms, email questionnaires, relevant company documents, and audio recordings.* Data from the participant interviews were labeled Participant one through Participant 4, and I (a) kept the identity of the organization and the participants coded, (b) stored raw data in a locked file cabinet and all back-up copies of electronic data with password-encrypted files in an external hard drive, (c) stored the locked file cabinet in my home office where I am the only individual with access to its contents, and (d) I will destroy all the data after 5 years to protect the confidentiality of the study participants by shredding printed data and erasing electronic files from the hard drive. To ensure confidentiality of the study participants, I am the only individual with access to the raw data. I organized the interview notes, documents, reflexive journal, transcripts, and recordings using the unique coding identifiers such as (a) Identifier *Company A* represented the hospital, (b) Identifier *P1, P2, P3,* and *P4* represented each participant, (c) Identifier *C1* represented the organizational contract agreement, (d) Identifier *r* represented audio-recorded interviews, (e) Identifier *RJ* represented reflexive journal, (f) Identifier *h* represented handwritten interviews.

Data Analysis

Data analysis entails the synthesis, integration, and sorting of the information gathered by the researchers through reading and observation (Merriam, 2013; Smith & Firth, 2011; Yin 2014). I used the themes produced in the study and identified through the literature that included (a) streamlining of hospital administrative procedures, (b) lack of business education, and (c) strategies to reduce administrative healthcare costs. To explore the diversified perspectives pertaining to exploring strategies that hospital managers need to streamline administrative procedures to reduce costs, the central research question from which the interview questions

originated is: What strategies do hospital managers need to streamline administrative procedures to reduce costs?

As suggested by Yin (2014), I (a) gathered the data, (b) disassembled the data, (c) reassembled the data, (d) provided interpretations for the meaning of the data, and (e) summarized the conclusions. As the first step in the data analysis process, I reviewed the completed interviews. The semistructured interview protocol for this study is included in Appendix A. I coded the interviews and searched for themes. The themes included services, environment, and interactions. Additional themes included technology and governance. In the literature review, technology was a sub-theme of the environment. Subthemes from the interactions included hospital managers' communication, behaviors, and methods. Successful coding resulted in topics aligning with the theoretical constructs of the study such as (a) hospital managers' communication; (b) reduction of healthcare costs, (c) services and innovation, (d) interaction of providers with patients, and (e) Deming's model of PDSA. According to Yin (2014), Crowe et al. (2011) and Smith and Firth (2011), responses connected to theory through successful coding.

According to the recommendation of Yin (2014), Crowe et al. (2011), Smith, and Firth (2011), after the transcription of the interview into a word document format, I used the NVivo 10 software program to sort and code the data into different themes for analysis. After researching different data analysis programs, I found that NVivo 10 was the optimal data analysis choice for this study. Merriam (2013) emphasized the different advantages involved in the use of computer-assisted software programs such as the ability to observe the relationships among themes and codes through a visual model, closely examining data to enhance the rigor of the study, and

organizing a filing system for the analysis of data. Computer software can be advantageous for confirming findings, content analysis, data linking, and coding (Houghton, Casey, Shaw & Murphy, 2013; Merriam, 2013; Yin, 2014). Conducting data analysis with NVivo is valuable because the program enables a researcher to code data from documents, questionnaires, and interviews consistently (Houghton et al., 2013; Merriam, 2013; Yin, 2014). With the software, I was able to sub-code patterns and themes for analyzing participant questionnaires and interviews (Yin, 2014).

I placed much emphasis on triangulation as means of data analysis guidance for this study. Bracketing provides critical self-reflection for researcher biases and theoretical predispositions (Crowe et al., 2011; Houghton et al., 2013; Smith & Firth, 2011; Yin 2014). According to Houghton et al. (2013), the advantage of using case study research is the opportunity to provide complete representation of a phenomenon by using diverse data sources through triangulation. Yin (2014) surmised that conceptual frameworks could serve as guidance for data analysis in case study research and provide boundaries towards the structuring of data analysis around a research question. The use of triangulation enabled me to understand the complexity of the nature of the phenomenon while I explored the subjective experiences of healthcare managers. According to Denzin and Lincoln (2011), the four categories of triangulation include (a) methodological triangulation, (b) theoretical triangulation, (c) investigator triangulation, and (d) data triangulation. Investigator triangulation pertains to the participation of more than one coder or more than one researcher (Denzin & Lincoln, 2011). Since this study is a doctoral study, investigator triangulation was not appropriate. Data triangulation pertains to the comparison of data from different participants taken at different

times. Denzin and Lincoln (2011) emphasized that when researchers use (a) multiple participants, (b) selects different places for data collection, and (c) select different times for data collection; the study will have credence. In this study, although different participants answered a set of questions, observations happened at different times and different locations in the hospital. The primary method of triangulation was between methods. The occurrence of theoretical triangulation takes place when researchers apply multiple theories towards the explanation of the same phenomenon (Denzin & Lincoln, 2011). For this study, triangulation occurred through the application of the BPR model. During the interview coding process, data emerged that reflected the theoretical constructs included in this study. Additional field notes, observations, and data collection was a result of data supporting the theoretical framework of this study. Methodological triangulation may be between or within methods. Methodological triangulation pertains to the application of various techniques for data collection and analysis, and between methodological triangulation refers to the use of dissimilar methods for the exploration of the same case (Denzin & Lincoln, 2011). The three sources of data for triangulation in this study were themes from the (a) field notes (direct and participant observation), (b) data from the interviews (interview notes, member checking, transcript review) and (c) relevant data from organization documents (company document analysis). Methodological triangulation assisted in assuring that data reached saturation, thus increasing the credibility of the study findings and ensuring the completeness of the data collected (Yin, 2014). Based on Yin's (2014) recommendation, I used methodological triangulation to understand the various results generated from multiple sources of data. This study included between-method triangulation occurring by document analysis, observations, and interviews. The triangulation resulted in the expansion of

the breadth and depth of the methods and means to reduce costs. The verification strategies of theory, method, and data could have contributed to validity, rigor, and reliability of the study incrementally (Crowe et al., 2011; Smith & Firth, 2011; Yin, 2014). The second source of data for triangulation is relevant documents from the hospital. According to Wahyuni (2012), data collection from various sources will assist in the compilation of relevant and comprehensive documentation to improve the robustness of research findings. Merriam (2013) suggested that researchers should use triangulation to confirm the emerging research findings. Triangulation is beneficial for the integration of different sources of evidence to ensure data reliability and validity (Merriam, 2013).

The conceptual framework for this study developed from the BPR model because healthcare systems are unpredictable, interconnected, and emergent in nature (Burns, Bradley, Weiner, & Shortell, 2012). BPR model was an optimal means in evaluating and understanding healthcare delivery systems because of the need for new and integrated approaches ensuring the cost-effective and efficient delivery of care. According to Burns et al. (2012), the delivery aspect of the healthcare industry reflects a model of system integration between clinical systems and healthcare providers. The delivery portion of the healthcare industry creates micro-systems (individual patient care) on a large-scale network of mesosystems (population delivery care models), and macro-systems industry regulation (Burns et al., 2012).

Influences from within and across the healthcare system need the negotiation and coordination of social structures to be able to deliver care in certain situations resulting in unpredictable contingencies where global and formal rules do not apply (Burns et al., 2012). The healthcare system appears fragmented with physician practices comprising of various agents

acting independently while responding to external and internal stakeholder actions (Burns et al., 2012). Exploring strategies that hospital managers need to streamline administrative procedures to reduce costs provided an understanding of how organizational components must work in harmony for the improvement of patient care and the reduction of healthcare costs.

According to Reysen, Hall, and Puryear (2014), acquaintance bias occurs when researchers appoint their acquaintances as research participants because they can influence a participant's responses. As emphasized by Reysen et al. (2014), I mitigated bias by only interviewing participants with whom I do not share any personal or professional relationship. Researchers can use bracketing to mitigate preconceptions or bias that could influence the research outcome or process (Tufford & Newman, 2012). To mitigate preconceptions and bias, I bracketed my personal opinions and experiences throughout the data collection and analysis process. According to Holmes (2015), journaling is the preparation of a comprehensive reflexive journal used in bracketing the reflections of researchers particularly when the researchers are the research instruments in the research process. Al-karasneh (2014) emphasized that journaling is a data collection method used in documenting a researcher's self-reflection, assumptions, viewpoints, and role in the research that could influence the phenomenon under investigation. For this study, the bracketing technique for mitigating bias was reflexive journaling. Through the journaling process, I documented reflections on the research study from the beginning to the end of the study process. Researchers can assemble and organize data into concepts and themes by using explanatory and descriptive coding for data analysis (Cook, 2012). The participants' perceptions included discussions about opinions regarding the strategies for streamlining hospital administrative procedures to reduce costs.

Reliability and Validity

To ensure quality in research findings, rigor is an important component in any research study (Scholtes, Terwee, & Poolman, 2011; Thomas & Magilvy, 2011; Yin, 2014). In a quantitative research study, researchers endeavor to achieve quality and rigor by conducting reliability and validity tests (Scholtes, Terwee, & Poolman, 2011; Thomas & Magilvy, 2011; Yin, 2014). Reliability and validity are quality measures for quantitative research (Scholtes, Terwee, & Poolman, 2011; Thomas & Magilvy, 2011; Yin, 2014). Credibility, transferability, confirmability, and dependability are quality measures for qualitative research (Gunnell, Schellenberg, Wilson, Crocker, Mack, & Zumbo, 2014; Scholtes et al., 2011; Thomas & Magilvy, 2011).

Reliability

The achievement of reliability in qualitative research equates to the ability to duplicate the various components of the study, the accuracy with data recording processes, and the consistency of data collection (Scholtes et al., 2011; Thomas & Magilvy, 2011; Yin, 2014). According to Thomas and Magilvy (2011), researchers can assure reliability in qualitative studies when the research has an audit trail that details a systematic analysis of processes or recording of research for the study. Reliability pertains to the level to which more than one observer perceives the occurrence of a phenomenon (Gunnell et al., 2014; Scholtes et al., 2011; Thomas & Magilvy, 2011). By carefully recording and transcribing interview responses, the study participants' understanding of the strategies necessary to streamline hospital administrative procedures to reduce costs emerged. These strategies emerged through a thorough interview process that I recorded and carefully transcribed. During field note taking and observation, recordings included

how and whether the hospital managers practiced the measures that participants identified. I took notes and observed the participants during the interview. According to Yin (2014), the strength of the chain of evidence strengthens case study dependability. Researchers can build the chain of evidence by linking multiple forms of data (Gunnell et al., 2014; Scholtes et al., 2011; Yin, 2014). The interview with the study participants added to the chain of evidence of this study. Researchers can ensure trustworthiness when four respondents give similar answers to interview questions. Researchers can achieve data saturation when (a) multiple respondents provide similar answers, (b) the collected data become replicable, and (c) no new themes emerge (Scholtes, Terwee, & Poolman, 2011; Thomas & Magilvy, 2011; Yin, 2014). I ensured that the participants understood the questions and that the coding reflected the interview respondents' thoughts through member checking. I checked whether the responses for the hospital managers were similar. Dependability increases when the transcribed and coded field notes reflect the revealed themes through the coding of the interview responses. For this study, the coded field notes reflected the evidence of the themes originating from the coded interview responses. The research is dependable when data results have similar themes (Adams & Wieman, 2011; Ali & Yusof, 2011; Thomas & Magilvy, 2011). I attempted to identify similar themes to better assure dependability.

Dependability

Dependability pertains to the degree to which a third party may audit or explain the research methods (Gunnell et al., 2014; Thomas & Magilvy, 2011; Yin, 2014). An audit trail may include (a) discussing data interpretation, (b) explaining data analysis procedures (c) discussing how data collection took place and the study timeframe, (d) discussing participant selection, and

(e) describing the purpose of the study with an auditor. For this study, the hospital administrative chair audited and reviewed the research study's design and the implementation of the design because they were familiar with the strategies for streamlining healthcare administrative procedures to reduce healthcare costs. The review process included (a) description of the purpose of the study, (b) discussion of reasons behind selection of participants for the study, (c) discussion of the transcription and interpretation of the interview responses, and (d) the discussion of the interpretation. Qualitative research is contextual, and a researcher examines a phenomenon from a human perspective (Gunnell et al., 2014; Merriam, 2013; Yin, 2014). Merriam (2013) noted that individuals might have difficulty achieving reliability in the quantitative sense. Wahyuni (2012) compared dependability to reliability in qualitative research through the detailing of research processes and design so that future researchers would have a similar framework to follow. Merriam (2013) highlighted that when the researcher is the data collection instrument, the researcher may increase reliability through data analysis, coding, training, and practice in interviewing. When researchers are the data collection instruments, they need to use reflexivity for considering possible sources of bias that could reduce dependability in qualitative studies (Merriam, 2013; Scholtes et al., 2011; Yin, 2014). To ensure dependability of this study, I (a) audited interview questions for consistency, (b) checked the transcripts for errors, (c) used member checking for external examination of notes and data, and (d) documented all data analysis and collection procedures and steps. To achieve dependability, I ensured that the study included a detailed description of protocols that would enable future researchers to emulate the process to achieve similar results. The complete process entailed: (a) the purpose of the study; (b) the research design and its implementation; (c) sample selection; (d) techniques used

for data collection; and (e) coding, analysis, and the techniques used for establishing validity and reliability.

Validity

Researchers use confirmability, transferability, and credibility to validate qualitative studies. According to Thomas and Magilvy (2011), (a) confirmability, (b) transferability, and (c) credibility provide some degree of truth to qualitative research. Through semistructured interviews, I expected hospital managers to share information on strategies for streamlining of hospital administrative procedures to reduce costs. I analyzed the interview question responses by comparing them to observed behaviors and hospital documents. I gathered additional data through document analysis and observations for use in triangulating the data. Themes emerged from different data sources that contributed to the validity of the study.

Credibility

Credibility is a criterion for assessing a qualitative study that enables individuals to understand experiences through participant interpretations (Scholtes et al., 2011; Thomas and Magilvy, 2011; Yilmaz, 2013). Through member checking, I ensured the credibility of this study. I validated the research project when the participants consider the results credible or correct based on the transferability of data and study findings aligning with the conceptual framework (Scholtes et al., 2011; Yilmaz, 2013; Yin, 2014). Crowe et al. (2011) emphasized that respondent validation happens when study participants review findings and confirm that the results are reflective of the intended meaning of participants shared during an interview process. Member checking, or informant feedback is a technique that researchers use to improve transferability,

credibility, applicability, and accuracy (Scholtes et al., 2011; Yilmaz, 2013; Yin, 2014). Through member checking, participants verified the interpretation of responses to the interview questions. The participants understood the process of identifying themes in the data and shared how the responses aligned with or failed to align with the themes identified in the literature review. If the participants had mentioned that the answers were not in alignment with the different themes, I would have asked the participants to clarify their personal responses. According to Crowe et al. (2011), researchers check trustworthiness and rigor through participant review of transcribed data including the confirmation of interpretations and accuracy. Member checking assists researchers to bridge any gap that could occur between transcription and data collection. To achieve credibility in this study, I used a triangulation technique during data analysis until the results logically followed the constructs unveiled by previous scholars and the study participants verified the findings through member checking. If new constructs had emerged, the constructs would have become new themes in the body of knowledge.

Confirmability

Yilmaz (2013) highlighted that confirmability occurs when the auditor confirms findings. The hospital managers, who were experts in the field of administrative procedures, verified the accuracy of interview interpretation by verifying their individual interviews. Throughout the process of data collection and analysis, the checking and rechecking of data and the emergent themes assisted in confirming the consistency of data. Recorded interviews enabled researchers to check and recheck the interpretation of data (Scholtes et al., 2011; Yilmaz, 2013; Yin, 2014). I confirmed data by storing copies of field notes and documents. The documentation of the processes for checking data would enable a third-party to confirm the data. According to Thomas

and Magilvy (2011), researcher bias is inevitable in qualitative studies. Since researchers form interview questionnaires based on individual experiences, they are not reliable for objectivity.

Transferability

Transferability takes place when data can be transferred to a similar location or setting (Scholtes et al., 2011; Yilmaz, 2013; Yin, 2014). According to Thomas and Magilvy (2011), transferability is the extent in which the findings of an inquiry could apply to other subjects or contexts. The researcher does not determine the transferability of study findings; rather, the reader determines transferability (Merriam, 2013; Thomas & Magilvy, 2011; Yin, 2014). During research, the experiences in one setting could be applicable to other settings through an evaluation of the attributes in one setting that may enable practitioners to build on existing experiences in other places. Duplicable policies and processes will enable transferability among locations. The information may be useful to practitioners in other contexts and the findings could be beneficial in similar contexts. Future researchers could decide the transferability of the information to apply to new studies.

Transferability and credibility in qualitative studies are parallel to external and internal validity in quantitative studies (Merriam, 2013; Scholtes et al., 2011; Yin, 2014). Thomas and Magilvy (2011) noted that transparency in a study involves accuracy for a recognizable experience by others experiencing a similar phenomenon. Rigor is determined through the extent that an inquiry applies to other individuals or in other contexts (Adams & Wieman, 2011; Ali & Yusof, 2011; Thomas & Magilvy, 2011). The achievement of credibility in qualitative studies entails a thorough description and detailing of the personal experiences gathered from in-depth interviews with the participants of a study (Adams & Wieman, 2011; Ali & Yusof, 2011;

Thomas & Magilvy, 2011). To ensure trustworthiness of this study, I used the NVivo 10 software program to check transcripts for similarities across the study participants. I also used verbatim transcription of participant interviews for the establishment of internal validity. I summarized responses to each question and conducted member checking. I used verbatim transcriptions to double check the summaries of responses to enhance the credibility of the study. To establish rigor for this study, I triangulated the data by using documentary evidence and participant questionnaires and interviews with hospital managers from diverse backgrounds and specialties. Researchers can use data triangulation to increase the strength of the study findings (Chenail, 2011; Merriam, 2013; Yin, 2014). Merriam (2013) highlighted that a greater range of application for understanding a phenomenon is achievable through sample variation. The concept of triangulation enables researchers to ensure that validity is achievable in qualitative studies when the use of various forms of data collection increases the interpretation, understanding, and scope of the phenomenon (Chenail, 2011; Merriam, 2013; Yin, 2014). The guidelines to mitigate quality in this study included the exploring of alternative explanations for the phenomenon, integration of contradictory information, awareness of experiences with contrasting interpretations, and the use of multiple participants.

Trustworthiness is the degree to which the investigation of researchers reflects the objective of the researcher's intended study (Chenail, 2011; Thomas & Magilvy, 2011; Yin, 2014). Validity is the level of accuracy of the observed phenomenon (Chenail, 2011; Thomas & Magilvy, 2011; Yin, 2014). This study included the methods and means of streamlining hospital administrative procedures to reduce costs. The degree of accuracy for the methods to achieve cost reduction became apparent through data triangulation. In this study, methodological

triangulation included document review, observations, and interviews. Multiple forms of data that resulted in similar conclusions supported the conclusion for data validation. I validated results against prior works through pattern and code matching of data. I ensured trustworthiness of the study through triangulation.

Data Saturation

According to O'Reilly and Parker (2013), researchers can achieve saturation with demonstrated or replicated redundancy in relevant data with no new emerging information. Chenail (2011) emphasized that sample size is important towards achieving data saturation. Based on the recommendation of Sirriyeh, Lawton, Gardner, and Armitage (2012), saturation is achievable through (a) engagement of researchers in the field of study, (b) theoretical sampling, (c) and a cohesive sample. Through the selection of a purposeful sample, data collection efforts, and conducting multiple interviews with hospital managers, I reached data saturation. Data saturation may also be achieved through a review of relevant documents (Crowe et al. 2011; Sirriyeh, Lawton, Gardner, and Armitage 2012; Yin, 2014). Researchers must compare a case until subtle or no changes exist in codes and themes meaning that data have reached saturation. I interviewed each participant and conducted an analysis of the relevant organization documents until data reached saturation. To verify that I have achieved data saturation, I ensured that no new codes, themes, or information emerged from the data. To achieve data saturation in the qualitative method single case study, I selected a sample size distinct and appropriate for my study as specified by Yin (2014). The sample consisted of four participants and relevant documents from the study hospital in Atlanta, Georgia. Based on a recommendation by Crowe et al. (2011), if the selected participants provided contradictory information, I would have

conducted the interviews a second time. I sought further in-depth clarification from the originally selected hospital managers to provide convincing and adequate evidence to support the research question. When I had sufficient information to replicate my study and no new information or new themes emerged, I knew that the study data were saturated. Lockyer et al. (2011) conducted interviews with four participants for the exploration of the experiences of physicians changing their medical practices to a new community and achieved data saturation. For my doctoral study, four participants were sufficient to reach saturation. I used the data from all four participants to ensure that I collected rich data for analysis. The four participants included healthcare managers.

According to Thomas and Magilvy (2011), small sample sizes can be adequate for providing insight in research. Unluer (2012) surmised that small sample sizes are appropriate when a researcher is an insider. Yin (2014) declared that a sample size be large enough for researchers to derive redundancy of response or saturation. The sample sizes need to be sufficient for the identification of consistent patterns leaving the researcher with nothing further to learn (Yin, 2014). Regarding the hospital strategic initiatives, the members of the hospital management were knowledgeable about strategic plans to streamline administrative procedures. With a small sample size, the interview response data resulted in data saturation. The strength of the sampling method is that exploring how the PPACA legislation might affect hospital business models, and the streamlining of administrative procedures, could provide insights to ways that the changes may affect healthcare delivery to patients and a reduction in healthcare costs.

Transition and Summary

Section 2 contained the specifics of the proposed study. The areas addressed in Section 2 were population and sampling, research method and design, participant criteria, and the role of

the researcher. In Section 2, I also discussed the reliability and validity, data analysis technique, data collection, and the ethical research. In Section 2, I elaborated on methodological triangulation, confirmability, dependability, transferability, and my intentions to establish credibility. I formed the outline of the research design, method, and analysis for the proposed study based on the central research question: What strategies do hospital managers need to streamline administrative procedures to reduce costs?

The case study comprised of the analysis and examination of circumstances, experiences, and existing events from the participants or hospital managers. The primary method of data collection depended mainly on in-depth interviews with the use of purposeful sampling of hospital managers at the study hospital in Atlanta, Georgia. I validated the interview questions with healthcare professionals who had extensive expertise in the strategies for streamlining hospital administrative procedures to reduce costs. All participant interviews went through analysis, transcription, and validation with a case analysis approach and saturation. In addition, in Section 2, I outlined the measures that I took to ensure conformability, transferability, validity, credibility, and reliability. Finally, in Section 2, I discussed the methodological framework originating from the study foundation in Section 1 of the proposed study.

In Section 3, I presented the research results with implications for change and applications to professional practices. My intention was that the proposed study would provide the results that could be appropriate for strategies for streamlining hospital administrative procedures to reduce costs.

Section 3: Application to Professional Practice and Implications for Change

The purpose of this study was to explore strategies that hospital managers need to streamline administrative procedures to reduce costs. In Section 2, I provided a description of the rationale for the use of a qualitative case study. I also discussed the research design to explore strategies that hospital managers need to streamline administrative procedures to reduce costs. I presented (a) the role of the researcher, (b) participants, (c) research method, (d) research design, (e) population and sampling, (f) ethical research, (g) research method, (h) research design, (i) population and sampling, (j) instrumentation, (k) data collection instruments, (l) data, (m) collection technique, (n) data organization techniques, (o) data analysis and, (p) reliability and validity. Section 3 contains (a) a descrption of the software I used for my analysis, (b) the data analysis including the interview questions, (c) issues surrounding reliability and validity, (d) and the data interpretation and presentation. In Section 3, I also present the research findings and ways they could relate to professional practice. Section 3 contains implications for social change and a call for action. Based on my findings, I also provide recommendations for further research. I conclude Section 3 with a description of ways that the theoretical framework related to the findings of the study.

Introduction

After the ACA, hospital managers and administrative personnel began to seek ways to streamline administrative procedures to reduce costs and improve quality of healthcare (Kennedy, Craig, Wetsel, Reimels, & Wright, 2013; Phillips, Gift, Gelot, Duong, & Tapp, 2013). The financial viability of hospitals became contingent upon patient experiences and healthcare

outcomes (Rauscher et al., 2012; Reinhardt, 2013). The purpose of this study was to determine the strategies that hospital managers used to streamline hospital administrative procedures to reduce costs. To understand the strategies required to reduce healthcare costs, I conducted a qualitative case study involving an interview of four hospital managers in a hospital setting where the teams had successfully implemented strategies for streamlining hospital administrative procedures and achieved reduced healthcare costs. I audio-recorded, transcribed, and analyzed the interviews. From interviews with hospital managers, analysis of hospital documents, and observations of hospital caregiver behaviors, themes pertaining to strategies to streamline hospital administrative procedures and reduction of costs emerged. The themes included (a) participants' unfavorable perspectives of the PPACA legislation, (b) employment of physicians, (c) PPACA reimbursement method, (d) follow-up services, (e) hospital administrative governance, and (f) lack of business education.

Presentation of the Findings

The overarching research question for this study was the following: What strategies do hospital managers need to streamline administrative procedures to reduce costs? To answer the research question, I conducted interviews with four hospital managers, gathered data from hospital documents, and observed the interactions between caregivers. Throughout the observations, the staff members added to the data with their candid comments. During the data collection process, I followed up with the hospital managers with some emerging questions. The data analysis process led to categorical themes resulting from multiple data sources. The themes were a framework for the case study, which focuses on the strategies hospital managers need to streamline administrative procedures to reduce costs. The themes that resulted from the method

triangulation included (a) participants' unfavorable perspectives of the PPACA legislation, (b) employment of physicians, (c) PPACA reimbursement method, (d) follow-up services, (e) hospital administrative governance, and (f) lack of business education. The themes comprised of actionable steps hospital managers could take to streamline administrative procedures to reduce costs. The following questions promoted rich exploration of the strategies to streamline administrative procedures to reduce costs.

1. What strategies have you developed and implemented to reduce administrative costs for your hospital operations?
2. How do you assess the effectiveness of strategies as they relate to costs for hospital administrative procedures?
3. Which of these strategies have been effective for reducing administrative costs?
4. Which of these strategies have been the most challenging to implement for reducing administrative costs?
5. What strategies do you use to identify business processes for redesigning the current administrative procedures to reduce administrative costs in your hospital?
6. What other information would you like to share regarding strategies to reduce administrative costs, and how you pass the cost savings to the patient?

To explore the strategies to streamline administrative procedures to reduce costs, a qualitative case study was the optimal approach. I selected the participants using a purposeful sampling of hospital managers. Upon agreement to participate in the research study, the participants received a face-to-face consent form for an interview request and an interview appointment. The interviews were audio-recorded and transcribed. NVivo 10 software aided in

the coding and analysis of data gathered from the interviews to uncover themes. To ensure the reliability of the study and discover trends, I asked all the participants identical questions. By asking follow-up questions, I was able to capture participants' unexpected thoughts, gather detailed descriptions of their experiences, and clarify responses. The participants were credible sources of information pertaining to the research question because of their individual experiences with the strategies to streamline administrative procedures to reduce costs.

The findings of the doctoral study confirm the information presented in the literature review and new studies relating to the reduction in healthcare costs. The literature review included relevant information from peer-reviewed journals, governmental sources that provided descriptive information about the problem, and information from other researchers that had conducted research on the problem of healthcare costs. Increasing healthcare costs in the United States have become a persistent issue and concern for healthcare providers and consumers (Cutler et al., 2012). Health managers should streamline the reduction of costs. Individuals in a successful hospital system should engage in developing effective organizational models that would promote efficiency and cost-effectiveness (Tucker, 2013). Porter (2010) and Berenson, Basch, and Sussex (2011) emphasized that healthcare costing has become a major concern in the United States, and others addressed healthcare structure reform from a physician reimbursement standpoint (McClellan, 2011; Tucker, 2013; Zuvekas, Cohen 2010). Additionally, the positioning of organizational structures for effective healthcare delivery may lead to a reformed organizational model that results in cost reduction and improvement of value (Goldsmith, 2011; Hunter & Baum, 2012; Kocher & Sahni, 2010; Wise, Alexander, Green, & Cohen, 2012). To achieve success redesigning healthcare organizational structure to reduce costs and effectively

streamline administrative procedures, individuals in the healthcare industry need to acquire an understanding of the costs involved in achieving the desired outcomes (Qazi, 2012). The shifting of attention from organizational structures or processes that concentrates on physicians to those that focus on patients could lead to reduction of healthcare costs (Lee, 2012).

Caregiver and patient interactions included the methods and behaviors of interactions between patients and caregivers. The hospital services that patients received also encompassed social services personnel, chaplains, auxiliary service members, pharmacists, and the nursing staff. Hospital technology also tied into an important aspect of caregivers' job descriptions and services provided to patients. Hospital governance pertains to interactions between caregivers, governance of performance improvement, and staff empowerment. Caregivers emphasized that quality care required that hospital administrative staff should ensure that members of the caregiver team be granted an opportunity to contribute their input towards the improvement of hospital processes. A culture of continuous innovation and improvement ensured that the hospital team provided high quality and consistent care to patients and reduced costs.

In terms of cost structure and customer satisfaction, researchers can use the BPR model for re-evaluating and achieving success (Hammer, 1990). According to Hammer (1990), individuals can use the BPR model to redesign organizational processes to improve cost reduction and performance, speed, and service. The leading factor for selecting the BPR model for my doctoral study was the value creation in the healthcare field. BPR involves: (a) the development of process objectives and business vision, measurement, and understanding of existing processes; (b) identification of business processes for redesigning; and (c) the building and designing of the prototype of the new process (Hammer, 1990). The business process

reengineering model provided the basis to analyze strategies to streamline administrative procedures because of its focus on the cost structure. I used Hammer's BPR principles to assess how the hospital included in the study reduced administrative cost (Hammer, 1990). Aragon and Gesell (2003) grounded the primary provider theory, which applied to this doctoral study because it pertains to the initiatives and actions that result in an outcome of quality. I also used the Deming's 1950s Plan, Do, Study, Act cycle (PDSA) which correlated with the BPR model and was an applicable framework for this doctoral study because it pertained to administrative performance improvement in hospitals (Grant & Schmittdiel, 2015).

The application of the business process reengineering model (BPR) towards the data analysis of this study enabled the facilitation in examining the unpredictable nature of the healthcare industry especially in the implementation of policies affecting the costs of healthcare. In understanding the multifaceted and evolving nature of the healthcare industry, I applied the use of the BPR model (Kennedy et al., 2013; Phillips et al., 2013). I used the BPR model to construct themes to conceptualize thoughts and ideas pertaining to the strategies to streamline administrative procedures to reduce costs when faced with stressors such as insurance regulations and patient needs. The themes that resulted from the method triangulation included (a) participants' unfavorable perspectives of the PPACA legislation, (b) employment of physicians, (c) PPACA reimbursement method, (d) follow-up services, (e) hospital administrative governance, and (f) lack of business education. After analyzing and coding the interview data, perspectives related to how the Obamacare legislation or ACA affects healthcare costs became apparent. Participants' perspectives towards the ACA legislation as it relates to the reduction of healthcare costs were unfavorable. The study participants expressed their mixed feelings towards

the PPACA legislation particularly its negative effect on individuals and healthcare providers (Participant 4, personal communication, May 19, 2017). Individuals had limited availability to healthcare and an increase in the costs of insurance. Some healthcare providers agree that the PPACA legislation was worth the idea, but others thought that it was a wrong decision made by the government (Sommers & Bindman, 2012). The study participants believed the PPACA was politically motivated to benefit some insurance companies, some hospitals, technological groups, and pharmaceutical companies (Participant 1, personal communication, May 19, 2017). The study participants emphasized that physicians were becoming employees of large physician groups because of the hardship encountered through the PPACA legislation. The study participants stated that they contracted physicians through an agency (Participant 1, personal communication, May 19, 2017). The views of the study participants correlated with the physician employment detailed in the literature review (Goldsmith, 2011; Hunter & Baum, 2012; Kocher & Sahni, 2010; Wise et al., 2012). The participants mentioned that physicians' dissatisfaction with managed care and threat to their financial security forced physicians to sought employment opportunities in the hospitals.

The viability of a hospital depends heavily on the reimbursement methodologies and its ability to streamline administrative procedures to reduce costs. The study participants noted that it was difficult to sustain healthcare when the costs for the provision of medical care is more than payments received from insurance companies, Medicare, and Medicaid (Participant 2, personal communication, May 5, 2017). Quality driven compensation is important despite the shortcomings involved in fee-for-service (Berenson et al., 2011; Brunt, 2011; Colchamiro, 2012; McClellan, 2011; Rooks, 2011).

For follow-up services, patients at the case study hospital received care coordinators who ensured that the care teams provided services to the patients. According to Warren (2012), patients have their unique after care needs. The care coordinators oversaw the discharge planning process while the hospital administrators assisted with care given to the patients after they left the hospital (Participant 1, personal communication, May 19, 2017; Medical chart, May 5, 2017). The creation of an environment for success is important for the streamlining of administrative procedures to reduce costs and hospital administrative governance. The culture in the study hospital implied that the hospital managers used the PDSA framework, and the BPR model for organizational processes redesigning to improve cost performance, speed, and service. To implement actions and initiatives, as mentioned by Aragon and Gesell (2003), the hospital administrators also used the primary provider theory to produce quality outcomes. The hospital managers had a framework of effective communication and receiving feedback from the staff.

Regarding the lack of business education, hospital managers need to have business knowledge and medical acumen to achieve success in operating a hospital (Weingarten, Schindler, Siegel & Landau, 2013). Healthcare professionals will lack the ability and knowledge of ways to deliver quality and valuable medical care without an understanding of healthcare economics (Participant 2, personal communication, May 5, 2017; Weingarten et al., 2013). Because of the economic accountability required for the measurement of healthcare quality, business education is imperative for healthcare managers.

Theme 1: Participants' Unfavorable Perspectives of the PPACA Legislation

The interview question pertaining to the participants' general opinion about the affordable care act was exploratory in nature. According to Sommers and Bindman (2012) and Quaye

(2014), caregivers had mixed opinions about the positive and negative aspects of the legislation. According to the fourth study participant, everything went downhill with the implementation of the PPACA (Participant 4, personal communication, May 19, 2017). Individuals faced an increase in insurance costs, which in turn limited the availability of care. An industry survey suggested that 44% of healthcare providers thought that the PPACA legislation headed towards the wrong direction and 44% thought that the legislation was worth the idea (Sommers & Bindman, 2012). The participants stated that the idea to make healthcare affordable to Americans is good, but the thought process behind the PPACA legislation is poor. It is improperly implemented, politically motivated to benefit pharmaceutical, technological groups, some hospitals, and insurance companies; it is confusing (Participant 1, personal communication, May 19, 2017).

Quaye (2014) stated that 47.2% of the respondents were opposed to the affordable care act legislation. The study participants were opposed to the ACA legislation. The participants believed that the PPACA legislation was created by insurance company lobbyists or individuals influenced by them (Participant 2, personal communication, May 5, 2017). It seems the centralization of healthcare control by the federal government and enriching the insurance companies are the main objectives of the PPACA legislation. According to Kingsdale (2014), the implementation of the PPACA mandate became a source of frustration for Americans because of the mismanagement of the HealthCare.gov website, which also contributed to the participants' negative perception towards the legislation. Although the participants agreed that the main objective of the legislation to provide affordable health insurance for Americans was a brilliant idea, they complained that the design and implementation of the legislation was inadequate and

confusing. The participants stated that the legislation was complex. They also mentioned that the politics surrounding the legislation favored the promotion of benefits for interest groups such as insurance, pharmaceutical, and technology groups instead of patients and physicians. According to the fourth participant, the PPACA legislation made it difficult for physicians to establish and maintain independent practices. "Most physicians I know who had their own private practices have shut their doors. Many of them are employees in different hospitals and healthcare organizations (Participant 4, personal communication, May 19, 2017)." The attitudes of the participants towards the PPACA legislation were consistent with the citation of industry articles in the literature review regarding physicians' perspectives about the loss of autonomy with governmental involvement in healthcare (Marco et al., 2012; Nutting, Crabtree, Miller, Stange, Stewart, & Jaén, 2011). The participants' suggested that the loss of autonomy fueled negative attitudes of physicians towards hospital managers controlling financial and medical decision-making. The increasing regulatory environment for quality accountability and cost under the PPACA legislation requirements led to physician loss of autonomy and attitudes in healthcare settings.

The study findings in this section confirmed the peer-reviewed studies in the literature review section and new studies on the PPACA legislation. The coordination of knowledge and skills contributes to the process of quality in healthcare delivery (Mosadeqhrad, 2013; Nelson, 2012). Some researchers argue that clinical judgment reduces with the methodology of evidence-based medicine. Researchers also argue that predetermined treatment options affect healthcare costs. Through the PPACA legislation, the healthcare industry is becoming innovative in empirical data usage and healthcare delivery (Nelson, 2012; Shelton & Saigal, 2011).

Researchers place much emphasis on process improvement, which requires an examination of cost-effectiveness versus efficacy of treatment in the healthcare industry.

The enactment of the PPACA legislation by the Congress targeted a decrease in healthcare expenditures and the increase in healthcare quality (Ginsburg, 2011b; Nelson, 2012). In an attempt to contain the costs of healthcare, the PPACA legislation places restrictions on Medicare and Medicaid reimbursement rates (Ginsburg, 2011b; Keehan et al., 2011; Parker et al., 2012). According to Keehan et al. (2011), reforms are for the measurement and establishment of a comparative value for healthcare services through value-based costing which plays a significant role in the reduction of healthcare costs. Despite the disparity in the strategies of healthcare cost reduction, it is imperative for the viability of the healthcare system in the long-term. The establishment of effective costing for healthcare services through treatment option comparison requires an understanding of the contributions of diseases and health to population health outcomes (Parker et al., 2012).

Gunning and Sickles (2011) argued that relative value scales be used to estimate the costs of healthcare services and that the current healthcare costing system is not an accurate reflection of marginal costs for healthcare providers. With different opinions regarding the costs of healthcare services, the definition of costs from the population health outcomes perspective could provide a means to measure expenditures in the healthcare sector. The goal of stakeholders in the healthcare field is to encourage the achievement of healthcare value for the patient and establish a reliable costing method that reduces healthcare costs (Finkelstein et al., 2012; Ginsburg, 2011b; Keehan et al., 2011). Some researchers argue that the inaccuracy in pricing healthcare services causes difficulty in healthcare costing. Others suggest that costing should

include healthcare value about the outcomes relating to the framework of cost reduction (Finkelstein et al., 2012; Ginsburg, 2011b; Keehan et al., 2011). Issues relating to healthcare costing could be a result of payment systems that encourages volume-driven services instead of value-driven care (Finkelstein et al., 2012; Ginsburg, 2011b; Keehan et al., 2011)

Healthcare professionals should channel outcomes and health costs towards the measurement of value and not the volume of services to manage healthcare costs effectively. A total healthcare cost usually involves shared resources from facilities, suppliers, and providers for a patient (Finkelstein et al., 2012; Ginsburg, 2011b). The actual resource used by each patient should be included in the shared resources and not only the averages of costs for multiple patients during the measurement of true healthcare costs. The pricing of services could reflect the differences in market power between buyers and sellers. It could also mirror the subsidization of services that are not profitable such as indigent care (Ginsburg, 2011b). Costing methodologies in healthcare tend not to adjust for risks pertaining to the severity in patient disease processes as it pertains to treatment burden on healthcare providers, which leads to inaccuracy in healthcare pricing.

Theme 2: Employment of Physicians

In exploring the employment of physicians as it pertains to the streamlining of administrative procedures to reduce costs in the hospital setting, the study participants mentioned that many physicians are becoming employees of large physician groups and hospitals because of an increase in hardship caused by the PPACA legislation. The study participants mentioned that they contract physicians, especially surgeons, as needed through an agency. For instance, the first participant stated, “one of the administrative procedures we implement to reduce costs is that we

group our surgery appointments on days we contract different types of physicians to reduce the number of times we need them in a week (Participant 1, personal communication, May 19, 2017).” “For example, with surgery cases, we schedule the surgery procedures for those days we contract surgeons to reduce the number of times we must pay the agency to contract them (, personal communication, May 19, 2017).” Participants’ views aligned with the research from the literature reviewing physician employment because of the PPACA legislation (Goldsmith, 2011; Hunter & Baum, 2012; Kocher & Sahni, 2010; Wise et al., 2012). The participants noted that threat to financial security and dissatisfaction with managed care are the reasons physicians search for employment opportunities in hospitals instead of continuing with the traditional independent provider model. The second participant believed that because of its financial feasibility, more physicians would continue to opt for an employment-based practice instead of establishing private practices (, personal communication, May 5, 2017). According to Charles, Ortiz-Pujols, Ricketts, Fraher, Neuwahl, Cairns, & Sheldon (2013), researchers emphasized that more than half of practicing physicians in the United States work for large group practices or hospitals. Rural surgeons accept employment contracts with hospitals. Charles et al., (2013) also stated that the reasons for the trends are long work hours, risk of malpractice, and decreasing reimbursement. For example, the fourth participant stated, “some physicians would rather be employed because of the frustrations they experience with loss of autonomy, increased demand on time, low reimbursement, and heavy workloads (Participant 4, personal communication, May 19, 2017).”

Through practice-based medicine, individuals can examine the organizational components of practices by healthcare providers. It is also appropriate for the examination of

billing and clinical processes and for the description of diversified organizational characteristics such as the contractual relationships, size, specialty, and complexity (McClellan, 2011; Nutting et al., 2011). Traditional healthcare practices usually involve patient care that is volume-driven, with reactive patient care, minimal performance data, and has high overhead (Marco et al., 2012; Tai & Bame, 2011). Compared to the traditional healthcare business models, healthcare delivery reform that is patient-centered could require extensive changes. Most healthcare practices operate on models that capitalize on the autonomy of healthcare providers with healthcare personnel supporting patient treatments on a front clinical and back administrative organizational structure.

Healthcare providers should adopt an authoritative position over employees (Nutting et al., 2011). For example, if physicians were to be in an authoritarian position, they would assume complete responsibility for operations, business processes, and patient care. If healthcare providers exercise autonomy, administrative and clinical employees would act as supplements by coordinating the flow of patients and acting as the gatekeepers of medical practices (VanVactor, 2013). Because healthcare providers must answer to stakeholders such as the professional associations, courts, lawyers, hospitals, managed care plans, patients, government entities, and private payers, total autonomy by healthcare providers could only happen under limited circumstances (Marco et al., 2012; Nutting et al., 2011). The business models for healthcare providers consist of diverse organizational structures that include group practices, independent practices, partnerships, and associations (Clark, Friedman, Crosson, & Fadus, 2011; Kapp, 2011; VanVactor, 2013). The least stable is the independent practice structure because it is either dependent on patients or referrals (Marco et al., 2012; VanVactor, 2013). Healthcare providers

should have both business knowledge and medical acumen. Associations and partnerships enable healthcare providers to share ancillary staff; form cooperative arrangements while maintaining independence, and take advantage of the economies of scale (Clark et al., 2011; Jones & Trieber, 2010; Kapp, 2011; VanVactor, 2013). Group practices offer healthcare providers economies of scale, profit sharing with peer regulation requirements, bureaucratic mechanisms for the management of diverse operational requirements, and the security of sharing financial risks (Clark et al., 2011; Koning, Verver, Heuvel, Bisgaard, & Does, 2011; VanVactor, 2013).

The definitions of organizational models vary by fee-for-service, medical and payment specialty categories and include capitation or private pay (Nutting et al., 2011; Wise, Alexander, Green, & Cohen, 2012). Because it focuses on the provision of enhanced care to patients beyond traditional practices, the concept of retainer or concierge medicine is an emerging trend among healthcare providers (Clark et al., 2011; Kapp, 2011; Nutting et al., 2011). Market forces such as financial constraints and increases in bureaucratic regulations have led to the development of new practice models for healthcare providers (Clark et al., 2011; Kapp, 2011; Nutting et al., 2011). Concierge medicine is a business arrangement between healthcare providers and patients that includes membership fees entitling patients to different services such as (a) next or same day appointments for non-emergent care, (b) 24 hours access to providers, (c) preventive services that are not usually offered by most health insurance plans, and (d) house calls (Clark et al., 2011; Huddle & Centor, 2011; Kapp, 2011; Nutting et al., 2011). Annually, patients must pay fees for retainer services. Huddle and Centor (2011) emphasized the benefits for healthcare professionals, which includes a decrease in patient load fulfilling practice experience, personalized attention to patients, and less administrative requirements.

Although the potential of concierge medicine becoming an innovative business model exists, some researchers still have concerns pertaining to accessibility to medical care, ethics, and costs. The professional dissatisfaction with concierge medicine include loss of autonomy, low reimbursement, heavy workloads for physicians, and an increase in bureaucratic regulations relating to the establishment of concierge practice (Clark et al., 2011; Huddle & Centor, 2011; Kapp, 2011). Patients tend to demand specialized care because of limited contact with physicians, lengthy appointment wait times, and increases in the cost of health insurance (Clark et al., 2011; Huddle & Centor, 2011; Kapp, 2011). In addition, many patients pay high deductibles and premiums and for minimal encounters with healthcare professionals, which cause them to search for alternative healthcare options to improve value, access, affordability, and satisfaction (Huddle & Centor, 2011; Kapp, 2011; Wise, Alexander, Green, & Cohen, 2012). Although concierge medicine appears to be beneficial for healthcare providers, and improves the quality and value of care for patients, ethical and legal concerns still exist regarding concierge practices. Limited access to healthcare and social class disparity are some of the issues created by concierge medicine (Clark et al., 2011; Huddle & Centor, 2011; Kapp, 2011; Koning, Verver, Heuvel, Bisgaard, & Does, 2011).

The argument of concierge medicine critics is that the model establishes a two-tiered healthcare system that grants the wealthy more access to superior care and services (Clark et al, 2011; Huddle & Centor, 2011; Kapp, 2011). Because of cost, private health insurance contributes to a tiered system. Concierge medicine could contribute another tier to the unequal healthcare system (Huddle & Centor, 2011; Kapp, 2011; Orentlicher, 2012). Aside the minimal shift of physicians towards concierge medicine, the potential to exacerbate the shortage of

healthcare providers still exists because patients that cannot or are unwilling to pay a retainer still need to find new healthcare providers and it reduces their access to healthcare (Huddle & Centor, 2011; Kapp, 2011; Orentlicher, 2012; Lee, 2012). Retainer medicine might activate the cross-subsidization system forcing patients with insurance to carry the cost of healthcare for uninsured individuals (Kapp, 2011; Orentlicher, 2012; Onwuegbuzie, Leech, & Collins, 2012). Concierge medicine raises concerns and ethical issues. A question raised by Huddle and Centor (2011) is whether concierge medicine is socially unjust for healthcare providers to be obligated to treat all patients despite their inability to make payments.

The argument posed by Huddle and Centor (2011) is the accessibility to healthcare is not an obligation for healthcare providers even though the quest for social justice is imperative with an obligation to provide quality access to healthcare for all individuals in the society. Orentlicher (2012) specified that the PPACA legislation provides patients the ability to obtain coverage for health insurance, but physicians are not obligated to treat patients. Kapp (2011) further stated that the conscription of services provided by physicians is not a tangible means to promote social justice. Healthcare providers prefer that patients should have quality access to healthcare. Healthcare providers tend to carry out social obligations when they treat patients competently and ethically within a regulated healthcare structure dictated as an obligation by society (Clark et al., 2011; Cutler et al., 2012; Kapp, 2011). One of the main legal issues lurking around concierge medicine is insurance billing (Clark et al., 2011; Huddle & Centor, 2011; Kapp, 2011). Several concierge patients pay retainer fees and use their health insurance for outpatient hospitalization and services. Since many insurance carriers prohibit balance billing, physicians often have concerns that their insurance will not completely cover their fees (Berenson, Basch, and Sussex,

2011; Clark et al., 2011; Huddle & Centor, 2011; Kapp, 2011).

According to Clark, Friedman, Crosson, and Fadus (2011), for the lack of properly gathering payments for patient services from Medicare, concerns exist among healthcare professionals about the violation of the False Claims Act. Although concierge medicine appears to be an innovative alternative model for patient care, it raises questions concerning to the accessibility to medical care, costs, and ethics (Clark et al., 2011; Huddle & Centor, 2011; Kapp, 2011). As the healthcare industry strives to better the struggles faced by patients and providers, scientific research is important in demonstrating that concierge care leads to reduced costs and to better health outcomes.

Theme 3: PPACA Reimbursement Method

When exploring the strategies that hospital managers need to streamline administrative procedures to reduce costs, reimbursement methodologies plays an integral part of the viability of a hospital. The study participants expressed their concerns about the current fee-for-service reimbursement method through the PPACA. They noted that the sustainability of healthcare is difficult if the actual cost of providing medical care is greater than the payment received from Medicaid, Medicare, and insurance companies. The participants agreed that although fee-for-service has its shortcomings, quality driven compensation is also important (Participant 2, personal communication, May 5, 2017). In the documentation from the literature review, researchers emphasized the pros and cons of the current fee-for-service reimbursement system under the PPACA legislation (Berenson et al., 2011; Brunt, 2011; Colchamiro, 2012; McClellan, 2011; Rooks, 2011). Fee-for-service reimbursement method works to an extent because healthcare providers feel they are getting payments for their work (Participant 1, personal

communication, May 19, 2017). Landon et al. (2011) noted that reimbursement for healthcare services in the United States accounted for approximately 21.2% of total healthcare spending. According to Tucker (2013), the current fee-for-service encourages healthcare providers to increase the quantity of care because it rewards volume instead of outcomes. The participants emphasized that their main concern with value-based reimbursement system is the definition of care (Participant 3, personal communication, May 5, 2017).

Implementing a value-based model as a prospective payment method in the healthcare system would channel the reimbursement focus towards a broader unit of service; for example, the dispensing of care over time that incorporates value and quality into healthcare provider payments (Ginsburg, 2011a). The fourth participant stated, "Whose definition of quality will determine the reimbursement given to healthcare providers?" quality tracking could be factual or skewed leading to a misinterpretation of the definition (Participant 4, personal communication, May 19, 2017). Individuals who oppose the PPACA reimbursement reform often argue that the quality component is like the capitation system under the HMO model, which extended the concerns about the quality of patient care and did not control healthcare costs (Zuvekas & Cohen, 2010). The study participants agreed that reinstating a healthcare reimbursement model like the HMO would reduce reimbursement for healthcare providers because of its quality component. Frakt and Mayes (2012), surmised that introducing new reimbursement models will lead to the provision of quality incentives for healthcare delivery. The first participant emphasized, "most times, it seems Medicare, Medicaid, and insurance companies ask for providers with low cost services. Basically, they incentivize those providers who provide patient care for less money (Participant 1, personal communication, May 19, 2017)." Some of the study

participants favored a combination of value-based and fee-for-service reimbursement models, but their main concern was the ambiguity in the definition of quality healthcare.

Additional comments from the study participants regarding PPACA reimbursement system indicated a lack of information from insurance companies and the government about ways the reimbursement system may affect their business practices. Most of the participants were uncertain about billing and reimbursement under the PPACA because they were not aware of (a) the reimbursement pricing, (b) billing policies, (c) financial feasibility of accepting PPACA insurance, (d) where to send the PPACA claim forms, and (e) how to be an in-network provider with the PPACA plans.

The findings of the study confirm the information in the literature review pertaining to PPACA reimbursement method. The reimbursement of healthcare providers depends on their abilities to reduce healthcare costs while increasing the quality of service they provide through an evidence-based methodology geared towards process improvement under the PPACA legislation (Mosadeqhrad, 2013; Shelton & Saigal, 2011; Steinbrook, 2015). Healthcare providers with populations of chronically ill individuals face shortfalls in reimbursement with the current costing methodologies, which increases the tendency for them to refer patients to other providers or to upcode instead of striving to manage the health of chronically ill patients (Finkelstein et al., 2012; Ginsburg, 2011b; Keehan et al., 2011). The healthcare economic analysis comprises of cost-utility analysis (CUA), cost-effectiveness analysis (CEA), and cost benefit analysis (CBA) (Gunning & Sickles, 2011). Because they define the costs associated with medical services as they relate to the economic opportunity costs of each service, these methodologies reflect the marginal effects of health programs on desired outcomes. The

variations in healthcare costing often occur because of the disparities in costing methodologies such as gross costing versus micro costing (Finkelstein et al., 2012; Ginsburg, 2011b; Keehan et al., 2011). CEA is beneficial to control healthcare costs because it assesses the improvements in health outcomes pertaining to costs (Gunning & Sickles, 2011). The analyses can be beneficial when applied to population programs such as cervical cancer screening or vaccination interventions (Gunning & Sickles, 2011). The examination of costing methodologies as ways to control healthcare expenditures is important in understanding the evolution of systematic costing methodologies under the PPACA legislation (Finkelstein et al., 2012 & Ginsburg, 2011b)

Healthcare professionals assign monetary benefit to the non-monetary outcomes of treatment interventions with the CBA methodology (Ginsburg, 2011b; & Keehan et al., 2011). According to Finkelstein, Allaire, Burgess, and Somali (2012), the measurement of benefits could occur explicitly or implicitly with explicit benefits reflecting supplies, services, and the monetary expenses attached to equipment. Explicit costs could be minimally invasive and new procedures used to replace expensive surgical intervention to reduce treatment costs. Tai and Bame (2011) highlighted that indirect or implicit costs should include the opportunity costs of an intervention, procedure, and treatment. Finkelstein et al. (2012) suggested the use of CBA to determine the effects of gastric banding surgery on the explicit costs of obesity treatments while showing implicit cost savings through a few days lost from work and the improvement of productivity for workers.

The further assessment of healthcare costing can occur through the improvement of health outcomes as it relates to costs by cost-effectiveness analysis (Gunning & Sickles, 2011). Cost-effectiveness analysis measures the benefits of resources in non-monetary format such as

approaches that improves outcomes of health or alternative treatments (Finkelstein et al. 2012; Gunning & Sickles, 2011). The CEA cost methodology places monetary representation on the value of life through the quality assessment of life years (QALY) measurement (Gunning & Sickles, 2011; Tai & Bame, 2011). QALY determines resource allocation and health outcomes with the lifespan of populations or individuals. For instance, CEA use can measure the quality or effectiveness of screening programs for cancer survival rates as it relates to detection of cancer cases and early diagnosis (Finkelstein et al. 2012; Gunning & Sickles, 2011). Some researchers suggest that the use of CEA does not assess the expenditures accumulated throughout the entire length of an intervention because the methodology uses a piecemeal approach comparing the program to alternative interventions for cost allocation (Gunning & Sickles, 2011; Tai & Bame, 2011). The use of CEA as part of the PPACA legislation for comparative effectiveness research may deter the use of expensive treatments with positive benefits in small populations of patients (Gunning & Sickles, 2011; Tai & Bame, 2011). The use of CEA as an assessment methodology for cost-effectiveness of treatments and the examination of opportunities for systemic cost control across populations would suggest a shift from individual to population health outcomes.

Based on the outcomes of population, cost-utility analysis can measure the capabilities of treatment benefits (Finkelstein et al. 2012; Gunning & Sickles, 2011). It uses QALY to measure the benchmark of aggregate healthcare costs. QALY allows the opportunity to compare or measure the efficiency of treatment interventions based on the length or quality of life for different disease processes (Gunning & Sickles, 2011; Tai & Bame, 2011). Health policymakers often use QALY and CUA to determine healthcare reimbursement, compare health benefits, and develop clinical guidelines (Gunning & Sickles, 2011; Tai & Bame, 2011). The determination of

QALYs requires the valuation of all costs involved in a fixed-budget and the identification of a set monetary QALY threshold as a standard for cost-effectiveness used for medical treatment (Finkelstein et al. 2012; Gunning & Sickles, 2011). Although the benchmark for QALY exists in medical standard, much literature does not exist detailing the research conducted on the benchmark.

The use of QALY as a CUA is prohibited by the PPACA legislation because it discounts the value of life regarding discrimination based on disability and age and it tends to encourage the government to be overly involved in medical decision-making (Finkelstein et al. 2012; Gunning & Sickles, 2011). It also encourages the rationing of care. Although the CEA, CUA, and CBA cost methodologies focuses mainly on aggregate outcomes and benefits, researchers and analysts debate on whether the costing methodologies are feasible and if the QALY can be a benchmark for the allocation of medical resources in health populations (Gunning & Sickles, 2011; Tai & Bame, 2011). Analysts and researchers question the application of the cost methodologies to the health outcomes of patients in terms of services provided by healthcare providers. To assess medical intervention feasibilities, cost identification, budget impact analyses, and cost benefits should be included in the economic evaluations of individual healthcare interventions or programs (Gunning & Sickles, 2011; Tai & Bame, 2011).

Cost-weighting systems such as macro costing, micro costing, and activity-based costing can be used to assign costs to Health Services with a focus on assigned prices and the quality of consumed resources (Finkelstein et al. 2012; Gunning & Sickles, 2011). The differences in costing could be a result of the use of costing methodologies rather than the performance of healthcare providers and a question of whether the valuation of the cost components is accurate.

Healthcare professionals can view the total cost of healthcare as a cycle of care that entails the medical condition of patients in its entirety and not only the cost of individual treatments. It may require a shift in cost methodology from the volume of services to a cost measurement deriving value from achieved outcomes. Costing methodologies pertains to processes and activities that minimize aggregate healthcare expenditures in the long-term (Finkelstein et al. 2012; Gunning & Sickles, 2011). Although the approaches require intensive resources, they may face potential delineation between accounting costs and true economic costs that comprises of both explicit and implicit costs (Gunning & Sickles, 2011; Tai & Bame, 2011). The healthcare system in the United States is very complex with many independent units for measuring costs to reflect organizational and financial processes of the healthcare system.

One of the main causes of increasing healthcare costs is the reimbursement model for services provided by healthcare professionals. According to McClellan (2011) variations in per-capita, Medicare spending for physician services ranges from $4,000 to $8,000 depending on geographical location. Landon, Reschovsky, O'Malley, Pham, and Hadley (2011) highlighted that reimbursement for physician services comprises of 21.2% of total spending in the healthcare sector. Predominant fee-for-service models, such as the Blue Cross Blue Shield, used in the past were customary and reasonable (Landon et al., 2011). Healthcare cost containment methods used in the past to minimize spending went through reimbursement regulations (Landon et al., 2011). Price regulation tends not to produce desired results because of provider oppositions, changes in services, and issues pertaining to healthcare access (Landon et al., 2011).

Tucker (2013) noted that while rewarding volume instead of outcome, some healthcare providers are encouraged by the fee-for-service methodologies to increase the quantity of care. In

other words, because of the incentives provided through the fee-for-service system, healthcare providers capitalize on the volume and services of patients they bill. Healthcare reimbursement methodologies appear to be ineffective and counterproductive because they encourage unequal payments for identical services based on the specialty of healthcare providers. They also disconnect between used reimbursements and resources, and encourage variations and volume billing in geographic fees (Tucker, 2013).

Through the Omnibus Budget Reconciliation Act, the government formed governmental regulations as fee schedules, which are the authorized payments through Medicare (Berenson et al., 2011). The government also introduced the resource-based relative value scale (RBRVS) fee calculation formula used as a tool for healthcare reimbursement (Berenson et al., 2011). Through healthcare organizations, the RBRVS formula reduced disparities and variations in reimbursement and billing. Berenson et al. (2011) specified that the healthcare reimbursement system use a fee-for-service methodology not defined properly and results in interpretations with coding definitions that are unclear and unambiguous. With the RBRVS system, physician reimbursement depends on current procedural terminology (CPT) codes or numerical codes for services provided by healthcare professionals (Berenson et al., 2011). According to Rooks Jr. (2011), the criteria for evaluation and management codes must meet two out of three parts which comprises of the complexities involved in the medical process of patient history, decision-making, and physical examination. The code level for a visit depends on the time spent with a patient face-to-face and the criteria (Rooks, 2011).

Healthcare professionals use CPT codes for physician reimbursement by the RBRVS weighting formula that comprises of the complexity of work, estimated physician malpractice

cost per capita, and the cost to produce service (Rooks, 2011). A reimbursement system that depends on the coding of services does not take into consideration the work done by healthcare providers behind the scenes especially while they are not directly providing care to a patient (Rooks, 2011). It tends to incentivize volume instead of considering value. The most common way to reduce the cost of healthcare is through provider reimbursement reduction. McClellan (2011) and Gunning and Sickles (2011) noted issues associated with the RBRVS formula such as practice expenses, improper calculation of malpractice expenses, and the work of physicians' relative value units. Gunning and Sickles (2011) also mentioned that no compensation exists for quality of service, which causes some healthcare providers to become reluctant to provide optimal attention to patients. According to Wilensky (2012), the fee-for-service system encourages fragmentation in the delivery of care because it does not consider the value of care, and instead focuses on volume billing. With the promotion of volume billing and the historical disparity in the weighting formula, the use of RBRVS to control healthcare expenditures has become unsuccessful (Rooks, 2011). The fee-for-service system has led to a limitation of the mechanism of reward for quality in outcome and patient care. Rooks Jr. (2011) surmised that when reimbursement is on face-to-face time, it is not consistent with quality of care because reimbursement for healthcare professionals should entail outside the face-to-face encounter, and activities that are important in the provision of exemplary care. Berenson et al. (2011) noted that the ambiguity in the coding definitions could lead healthcare providers to miscode services suggesting levels of coding that are more financially advantageous. Miscoding of visits to healthcare facilities could eventually lead to billing fraud accusations because of the subjectivity in CPT coding definitions (Rooks, 2011).

Medicare sets individual service reimbursement rates even though the choice of code usage enables healthcare providers to have discretion over service pricing. To make the definition of the coding system better, Medicare expanded the guidelines for coding. Berenson et al. (2011) emphasized that the coding guidelines do not include important decision-making and elements of care management especially for patients with multiple diseases. To provide justifications for using higher coding levels for value of services, healthcare professionals may overly document patient visits to medical facilities. On the other hand, the fear of facing penalties for the misrepresentation of office visits could cause some healthcare professionals to downcode the services they provide based on their assessment of the value of services and ignore coding guidelines (Berenson et al., 2011). Brunt (2011) emphasized that because the coding definitions and guidelines are subjective, healthcare providers are frequently upcoding office visits. Because of the ambiguity that exists in the coding definitions, pertaining to the intensity and complexity of services provided by healthcare professionals, healthcare providers need a more realistic reimbursement methodology in the healthcare field.

To minimize the expenditures in reimbursement for healthcare professionals, the United States Congress introduced the SGR as part of the Balanced Budget Act (Berenson et al., 2011; Brunt, 2011; Colchamiro, 2012). The SGR formula moves Medicare reimbursement methodology to a system that reflects the GDP from a volume-based payment system (Colchamiro, 2012; Froimson et al., 2013). With the SGR formula, the annual calculation for Medicare is based on several factors such as expenditures as they relate to changes made in the healthcare laws and regulations, average amount of Medicare beneficiaries, the average changes in real GDP per capita over a 10-year period, and service fees for healthcare professionals

(Colchamiro, 2012; Greenapple, 2013; McClellan, 2011). Ginsburg (2011a) noted that the SGR formula, as it relates to the Medicare Economic Index, ties economic fluctuations to yearly updates of the Medicare fee schedule. Because of the consequences of the SGR calculations, a decrease in the reimbursement of healthcare providers occurred causing them to lobby the United States Congress for block reductions.

In 2010, an increase in the spending projection of $330 billion through 2020 occurred because Congress postponed a 24.9% reduction in reimbursement for healthcare professionals (Ginsburg, 2011a). Although the reform of reimbursement methodologies attempts to reduce the costs of healthcare, the consequences involved in using the SGR formula calculation and continuous postponement of reimbursement for healthcare providers makes it difficult to achieve results in reducing healthcare costs. Different reasons exist for the spiraling increase in payments for healthcare services and the rate reductions (Colchamiro, 2012). Healthcare providers experience the lack of formula to differentiate between effective and ineffective quality of care and limitations in the use of the SGR calculator that involve a cost-containment policy encouraging volume billing by healthcare professionals.

Ginsburg (2011a) suggested that the fluctuations in the Unites States economy to the use of patient services leads to the deferral of reimbursement reductions by Congress causing increases in rate cuts when the reimbursement is calculated with the SGR formula. Because it threatens their autonomy when used as a payment-based methodology, healthcare professionals tend to disagree to the use of quality outcomes, but agree to an outcome-oriented reimbursement methodology (Colchamiro, 2012; Greenapple, 2013). Some healthcare providers, such as physicians, have achieved success in blocking reform in the reimbursement methodology but

they might face the responsibility or consequences of the system's inability to contain costs (Colchamiro, 2012).

Medicare introduced the use of the Medicare Economic Index (MEI), which constituted a change in the yearly costs of operations for healthcare services (Berenson et al., 2011; McClellan, 2011). The MEI led to a bundled system of payment for inpatient hospital care based on the classification of diseases for patients known as the diagnosis-related group (Brunt, 2011; Colchamiro, 2012; McClellan, 2011). The bundled payment methodology requires hospitals and healthcare providers to share a payment rate for services provided to patients. Bundling could also entail shared reimbursement with other healthcare providers who perform outpatient care (McClellan, 2011; Rooks, 2011). McClellan (2011) emphasized that Medicare has further included payment bundling for post-surgical, post-acute care, and home care in a way that includes post-procedure care for a 60 to 90 days period. Healthcare professionals can use a bundled and an episode-based approach of reimbursement to encourage collaboration among healthcare providers to improve care, contain costs, and to distribute compensations and incentives equally (Greenapple, 2013; Rooks, 2011). McClellan (2011) noted that although researchers have not proven the effects of bundling on the intensity of care and spending growth, the potential for reducing aggregate costs per visit exists.

According to Froimson et al. (2013), the Centers for Medicare and Medicaid Services developed alternative methodologies of payment for the reduction of healthcare spending while encouraging an improvement of the quality of care. The discussion pertaining to the development of patient-centered medical home (PCMH) under the PPACA legislation and healthcare payment reform is continuous along with the development for a broad bundling payment methodology for

multiple healthcare providers (Froimson et al., 2013; Wilensky, 2012). Capitation or fixed-budget payment is a type of bundling for all services provided by healthcare professionals into a single payment regardless of the amount of care provided to patients. McClellan (2011) noted that the primary reimbursement methodology for private care such as HMOs was capitation. A reduction in capitation as a reimbursement methodology resulted from the complaints from healthcare providers. Those complaints came from the administrative complexities in the negotiation and calculation of capitation rates, a reduction in patient membership because of limitations in the choice of providers and services, and the inability of healthcare providers to negotiate reimbursement fees with insurance companies (McClellan, 2011; Tai & Bame, 2011; Tucker, 2013).

Capitation raises concerns about incentives for the provision of care, and the quality of patient care, and does not control the cost of healthcare (Finkelstein et al. 2012; McClellan, 2011). Based on the trend to a population-based healthcare, the need for the reform of reimbursement for healthcare professions has increased because of the lack of ability to control costs in the current healthcare system (Gunning & Sickles, 2011; McClellan, 2011). Frakt and Mayes (2012) emphasized that healthcare providers should adopt a modernized capitation method that combines the provision of quality care and a preset fee-for-service budget instead of using previous systems of capitation. Manchikanti et al. (2012) suggested additional changes to reimbursement models to increase reporting measures for the physician quality reporting system, introducing an electronic prescription of incentive program, establishing a value-based payment modifier for physician payments, and the revision of the RBRVS reimbursement formula. The restructuring of the reimbursement system will require changes in the financing and accounting

processes, the provision of adequate incentives for healthcare professionals for the delivery of quality car, and an understanding of new metrics (Manchikanti et al., 2012; McClellan, 2011).

Theme 4: Follow-up Services

Every patient admitted to the case study hospital received care coordinators. The care coordinators were responsible for ensuring that the care teams provided services specifically to each patient based on their needs. Every patient had unique needs regarding after care, whether it is physical therapy, transportation to the hospital appointments, hospice care, and equipment needs (Warren, 2012). The care coordinators arranged the discharge planning process (Medical chart, May 5, 2017). Some patients had strong family support system, but some lacked that privilege (Participant 1, personal communication, May 19, 2017). The hospital's administrators assisted in arranging care for the patients once they left the hospital. Integrating the continuum of care from labs to physician services, and outpatient services ensures that patients get higher quality of healthcare and lower costs (Hwang, Chang, LaClair, & Paz, 2013). Follow-up services were imperative because they saved patients and the hospital money by reducing the rate of readmission and ensuring that patients healed without incidents (Medical chart, May 5, 2017). "After surgery, if patients cannot afford some equipment or materials such as surgical boots, we cannot discharge them. Instead, we provide them with the materials they need and sometimes forfeit the cost if their insurance, Medicaid, or Medicare did not cover that item. Providing the needs of patients before discharge ensures that their conditions do not worsen when they get home. When patients are satisfied with our services, they leave positive feedbacks about our company online and refer their friends and family to our hospital (Participant 2, personal communication, May 5, 2017)." Within 30 days of discharge, patients must have a follow-up

appointment (CMS, 2013). To improve resulting outcomes and caregiver-patient communication, discharge instructions are best through conversation and in writing (Kennedy et al., 2013). On the day of discharge, patients met the care coordinators to ensure understanding of their discharge instructions.

Theme 5: Hospital Administrative Governance

Hospital administrative governance emerged as an important aspect of streamlining administrative procedures to reduce costs by creating an environment for success. For example, participant 2 stated, "We believe in retaining and retraining our staff to eliminate the costs associated with hiring and training new employees (Participant 2, personal communication, May 5, 2017)." The culture in the study hospital suggested that the hospital managers used the framework of PDSA, and BPR to redesign organizational processes to enhance current service, speed, and cost performance. They also applied the primary provider theory to implement initiatives and actions resulting in quality outcomes (Aragon & Gesell, 2003). The use of different forms of technology in the case study hospital was in line with the BPR model and the primary provider theory. As such, the hospital managers and administrative staff had a framework for the hospital operations. The strategies for implementing the hospital managers' identified framework included feedback from staff and forms of communication. For example, participant 2 stated, "before any surgical procedure, we preorder with bulk pricing and prepackage surgical kits to fit the needs of patients. Instead of opening items not needed and engage in excessive ordering of products, we encourage our medical staff to reuse some items to reduce costs. We also encourage our physicians and nurses to use their pre-packaged medical items and give us any feedback on any additional items that they need included in the kits

(medical chart, May 5, 2017; Participant 2, personal communication, May 5, 2017).” Participant 3 added, “Inventory management is one of the key factors in cost reduction in this hospital. We reevaluate our list of inventories every month to reduce the ordering or rarely used items and eliminate those not needed. We also encourage our staff to be cautious of product usage and prevent unnecessary wastage (Participant 3, personal communication, May 5, 2017; medical chart, May 5, 2017).” The fourth Participant emphasized, “encouraging our staff to have an economical mindset saves the hospital and patients money and could add more money in the pockets if our employees.” The hospital managers also governed the affairs of the hospital through employee engagement, which included the training and retraining of staff and matching employee skills to tasks. Participant 1 stated, “The employee turnover rate in this hospital is low. We retrain employees to perform their assigned duties and if we no longer need them for a position or if they want another position within the hospital, we retrained them for other positions. Our employees are versatile (Participant 1, personal communication, May 19, 2017).” Participant 2 added, “We hardly terminate our employees. They have to be horrible and lack good work ethics to warrant termination (, personal communication, May 5, 2017).”

The BPR model pertains to the redesigning of core business processes that results in dramatically improving cycle time, quality, and productivity (Hammer, 1990). With the BPR model, hospitals can rethink existing healthcare administrative processes to reduce costs and deliver value to patients, and start on a clean slate. They can adopt a new administrative system that emphasizes the needs of patients. By redesigning functional organizations into cross-functional teams and by improving decision-making through BPR, hospitals can reduce organizational layers and engage in increased productive activities (Hammer, 1990). They can

implement the PCMH model or the value-based methodology. The BPR model is a drastic change initiative that encourages managers to improve business processes across the organization, reorganize businesses into cross-functional teams with end-to-end responsibilities for processes, rethink issues pertaining to an organization and people, refocus company values on patient needs, and redesign core processes (Hammer, 1990). Hospitals can use BPR to improve the sustenance of performances on key processes that affects patients. The BPR model can be used to decrease healthcare costs and cycle time.

Several researchers who base their work on hospital research activities usually focus mainly on quality of care measured based on hospital satisfaction (Stacey, 2011). Some theories, such as the primary provider theory, pertain to the variations in healthcare costs, patient satisfaction, and quality patient care (Beal, 2013). Because BPR focuses on the improvement of cost reduction and quality, BPR correlates with the primary provider theory (Hammer, 1990). The primary provider theory focuses on patient quality care and satisfaction (Beal, 2013), and this theory operates on the principle or concept that the achievement of patient satisfaction, and patient care quality outcomes does not depend on clinical competency alone (Mosadeqhrad, 2013). Aragon and Gesell (2003) grounded the primary provider theory, which is applicable to this doctoral study because it pertains to the actions and initiatives that result in an outcome of quality. According to Spence, Murray, Tang, Butler, and Albert (2011), hospital managers or healthcare providers will gain insights on the issues that affect patient care through communication and effective interaction, which ties into BPR in the reduction of organizational layers and engaging in increased productive activities by improving decision-making and by redesigning functional organizations into cross-functional teams. Healthcare managers can use

BPR to determine patient satisfaction, quality outcomes, and reduction of healthcare costs in hospitals.

Because it focuses on the understanding and identification of complex problems in an organization, the disruptive innovation theory also supports this doctoral study and correlates with BPR (Spence et al., 2011). Hospital managers must identify the problems in the existing processes to redesign and improve core administrative processes. Hospital administrators have encountered rapid and dramatic changes in the healthcare system (Stacey, 2011). BPR can enable administrators and hospital managers to improve performance sustainability on processes that affect the hospital and its patients. Disruptive innovation theory could enable researchers to predict when changes made in a business or industry caused disruption in business practices, culture, technology, and business management (Spence et al., 2011). BPR also focuses on the implementation of changes to core processes using technology to enable improvements like the disruptive innovation theory (Hammer, 1990). Through regulatory changes in the federal government, the disruptive innovative theory captures any implemented disruption in healthcare (Spence et al., 2011). For example, the ACA, also known as Obama Care, constitutes a reform in the healthcare sector that expands and improves healthcare accessibility and reduces spending through regulations and taxes (Kerfoot, Anderson, & Douglas, 2013). Legislators introduced changes to the healthcare system through the implementation of the Obama Care, which affected technology, reimbursements, and requirements for the reporting of healthcare processes (Kerfoot et al., 2013). The ACA has changed almost everything about healthcare from the success measurements to the place where they administer care and the way healthcare professionals provide patient care (Kerfoot et al., 2013).

Deming's 1950s plan do study act model also correlates with the BPR model and it is an applicable framework for this doctoral study because it pertains to administrative performance improvement in hospitals (Grant & Schmittdiel, 2015). Strategic initiatives usually involve programs for quality improvement with steps to determine the monitoring and measurement of success (Stikes & Barbier, 2013). When conducting research, some healthcare researchers often use PDSA (Grant & Schmittdiel, 2015; Tripathi et al., 2013). The PDSA ties into the BPR model which was an appropriate framework for this study because this case study involved the observable activities of hospital managers to streamline administrative procedures for the reduction of healthcare costs. The framework of this doctoral study depends on an assumption that the healthcare system is complex, adaptive, unique, dynamic, and unpredictable in nature (Stacey, 2011). Healthcare managers can form a complex adaptive, organized, and homogeneous healthcare administrative system that operates in a harmonious pattern with the BPR model (Hammer, 1990). The complex adaptive systems theory also incorporates the complexity and chaos theories (Stacey, 2011). To understand the influence of the actions of individuals on social system behavior, researchers that study sociodynamics often develop mathematical modeling approaches. As an element of the complex adaptive system, complexity consists of heterogeneity (Stacey, 2011). The word adaptive means the ability to change or develop, and system constitutes the combination of different elements that forms a whole (Stacey, 2011). The healthcare industry consists of a complex adaptive system comprised of interdependencies, co-evolutionary systems, self-organization, and emergent behaviors facilitated through the BPR model by redesigning core processes (Stacey, 2011). A complex adaptive system consists of interconnected entities that are comprised of diverse and independent components acting

according to set rules modified through the BPR model to fit individual entity behavior (Stacey, 2011).

In the exploration of innovative approaches for the implementation of healthcare services in different populations, applying the complex adaptive systems theory to issues in the healthcare system is important because the methodology may assist policy analysts (Paina & Peters, 2012). Because of the unpredictable nature of the healthcare industry, the application of the complexity theory principles in healthcare could be beneficial during the implementation and development of policy changes in the medical delivery system (Stacey, 2011). Complexity science is beneficial to develop innovative solutions for healthcare issues through the BPR model. Healthcare systems consist of different groups including providers, policymakers, and patients who deliver services through different avenues requiring adaptability, self-learning, and innovation (Stacey, 2011). The healthcare system appears fragmented with different entities that are diverse, emergent, and interdependent. The behavior of each entity changes continuously because of regulations by internal and external stakeholders (Stacey, 2011). Through the BPR model, the organizational layers in the different groups can be redesigned and reduced and improve decision-making and eliminate unproductive activities (Hammer, 1990). Healthcare administrators develop medical teams, with the BPR model, responsible for the provision of quality healthcare to patients and reduction of healthcare costs by eliminating redundant or unproductive administrative activities. Healthcare managers and administrators would use the PCMH approach. The approach allows primary care providers to manage and coordinate the care of all areas of a patient's health with a specific team of healthcare providers.

Theme 6: Lack of Business Education

Hospital managers need to possess medical acumen and business knowledge to operate a successful hospital (Weingarten, Schindler, Siegel & Landau, 2013). Without a thorough understanding of the healthcare economics, healthcare professionals will lack the ability to deliver medical care that increases value and quality in a complex industry and to deliver less expensive medical care (Weingarten et al., 2013). The case study participants responded that they did not receive formal business training in school. The fourth participant stated, "I do not recall taking any business classes in school (Participant 4, personal communication, May 19, 2017)." Health policy and business education are becoming essential assets in the medical fields because of the requirements to measure the quality of healthcare in the form of economic accountability through the affordable care act (Hwang et al., 2013). The need for healthcare professionals to acquire business training in school would be beneficial because they will have a greater understanding of ways to improve healthcare quality and decrease costs (Aragon & Gesell, 2003). An obstacle to the integration of health policy in school curricula is that most schools do not employ specialized faculty in health policy analysis and health economics (Hwang et al., 2013; Weingarten et al., 2013). The case study participants agreed that business training in school is important. The second participant commented, "Unless you attend business school, nobody receives business training. We go by a trial and error method. We figure out what works as we go along (Participant 2, personal communication, May 5, 2017)."

Applications to Professional Practice

Through the case study, I realized that most of the participants believed that the thought process behind the PPACA legislation to provide underinsured and uninsured Americans with

affordable health insurance was an honorable goal. They also thought that the implementation and design of the PPACA legislation created several unfavorable opinions and unanswered questions. The components of the PPACA legislation shows the complications surrounding the healthcare industry and how much the industry consists of diversified groups of stakeholders, such as policymakers, patients, and providers interconnected through the services they provide, which requires innovation and adaptability. Healthcare trends gravitate towards a population health method that focuses on quality outcomes and reduced healthcare costs.

A change in healthcare reimbursement methodology may require proactive medical care delivery emphasizing the use of integrated medical team that consists of diversified healthcare providers' education in healthcare policy and economics for cost accountability. Although the PPACA legislation supports the establishment of ACOs, and patient-centered medical home to reduce costs, they may not work because of previous stigma associated with health maintenance organization system. Under the HMO system, doctors were wary about the involvement of administrative staff in capitation reimbursement and medical decision-making (Fuchs, 2012; Satiani, 2014). Because of the scarcity of diversity in medical specialties, patient logistics, and financial constraints, PCMHs and ACOs may not apply to rural settings. Researchers may apply the study findings to professional business practices through the implementation of innovative and cost-effective organizational model that pertains to individual patient populations. Hospital managers can improve business performance by using the recommendations and findings from this study to design, implement, and inspire change to reduce costs and effectively manage the revenue gains and losses of hospitals (Fowler et al., 2013). Changes in patient hospital experiences create a positive social impact because the perception of a higher quality of

care would increase patient satisfaction and in turn, lead to repeat business for the hospital (Borah, Rock, Wood, Roellinger, Johnson, & Naessens, 2012; Chatterjee, Joynt, Orav, & Jha, 2012). Hospital managers may wish to implement strategies to improve the experiences of patients in their facilities. They may also remember that patient care extends far beyond the hospital environment. Patient wellness and health is a continuum of care beginning from their family environments, through interactions with healthcare professionals in the hospital environment, follow-up care and then back to patients' homes (Participant 2, personal communication, May 5, 2017). According to Verrof, Marr, and Wennberg (2013) in a concluded study, 5.3% of medical costs lowered because of support enhanced through decision-making. The health coaching that facilitated the enhanced support included (a) internet support, (b) mail; (c) follow up calls, and (d) emails. Wellness and health is not a single point of care; it is a continuum of care, which could lead to increased patient satisfaction, and healthcare costs reduction (Verrof et al., 2013).

Implications for Social Change

Researchers may use the findings from this study to promote positive social change that would potentially provide strategies for streamlined processes that leads to savings passed on to patients from low socio-economic backgrounds through accessibility to affordable healthcare services. Hospital managers may develop and promote strategies to deliver medical care geared towards the improvement of health and reduction of costs to the aggregate population and healthcare facilities. At the time of this study, the implementation of the PPACA legislation had been a source of frustration for the American public because of governmental mismanagement of the mandate (Kingsdale, 2014). In addition, many previously insured Americans did not meet the

minimum coverage standards under the PPACA legislation causing them to lose their health insurance coverage (Orentlicher, 2014). Although statistics pertaining to insurance coverage for patients were unconfirmed at the inception of the PPACA legislation, the effect of the mandate on the practices of healthcare professionals was unaddressed (Kingsdale, 2014; Orentlicher, 2014). The results of this study may influence the lives of healthcare professionals, patients, and hospital managers within the realm of healthcare reform through the development of integrated healthcare delivery models that promotes quality care and cost reduction. Supporting the needs of the growing population and controlling healthcare costs prove ineffective under the traditional healthcare business models. Healthcare business models should surround cost effectiveness, quality, and patient satisfaction considering a focus in population health.

An improvement in hospital viability, the lives of individuals, and communities served will enhance through an improvement in hospital governance (Urden & Ecoff, 2013). The plans and actions hospital managers take towards the improvement of the hospital environment will shape the future of healthcare delivery in America (Kingsdale, 2014; Orentlicher, 2014; Urden & Ecoff, 2013). Patient experiences and healthcare costs could improve in unprecedented ways with tangible changes in care processes. Improved patient outcomes springing from technology, education, and communication in the continuum of care will change the lives of individuals and their families and could reduce healthcare costs (CMS, 2013). The cultural changes required for the improvement of patient care could improve the lives of caregivers and their families. My published findings might provide practices that influence ways hospital managers could streamline strategies to reduce costs in the hospitals. Changes that hospital managers could implement include improved provider-patient communication, provider-provider

communication, care processes, enhanced patient safety, and patient accessibility to medical information through advanced technologies.

Recommendations for Action

Leaders in healthcare entities could examine ways the design and implementation of the PPACA legislation components could address the unanswered questions and confusion surrounding the mandate. Communication and the dissemination of information with healthcare professionals would be beneficial and ease the confusion in gathering information from the caregiver population pertaining to the best model for the delivery of care. Because of lack of diversity in medical specialties, patient logistics, and financial constraints, physician-centric business models outlined in the literature review may not apply to rural settings. The case study participants offered several recommendations as plans of action emerging from the study. My recommendations based on the interviews are as follows: The inclusion of basic business classes in undergraduate and graduate schools will enable healthcare professionals to implement cost-effective strategies for hospital managers, caregivers, and patients to reduce overall healthcare spending. Further study is necessary for the use of mid-level practitioners who may serve as independent care providers providing solution to the shortage in physicians caused partly because of the unfavorable PPACA legislation conditions towards the medical profession. Reimbursement reform should comprise quality and a fee-for-service system. The system should take into consideration problems pertaining to the positive and negative outcomes involving patient care. The patient-centered medical home and the ACO healthcare models are likely to achieve success if the integration of hospitals and physicians merge in a manner creating a sense of governance, motivation, and ownership.

Hospital governance determines the failure or success of an organization by assuring that hospitals operate under a strong supporting framework (Fuchs, 2012; Satiani, 2014). Hospital managers and administrators in the case study hospital set the path for the organization's healthcare professionals to follow by implementing a framework with a record of success. The hospital managers established a culture of respect, courtesy, teamwork, innovation, and employee engagement. Further recommendations resulting from the case study are as follows: To create an environment for success, hospital managers and administrators should implement a culture that contains proven business practices (Robbins, Garman, Song, & McAlearney, 2012). The culture in a hospital setting should be one of continuous improvement, safety, and quality (Fowler et al., 2013). The case study hospital has a framework supported by the BPR model, Deming's PDSA, and the primary provider theory. Hospital managers should ensure that the leadership and administrative team define, through a clear written plan, a framework for care. Hospital managers should plan and initiate actions to implement necessary changes with tools readily available. According to Stelfox, Boyd, Straus, and Gagliardi (2013), the first step in the improvement of patient outcome and cost reduction is the determination of measuring quality of care. The case study hospital agrees in delivering exceptional patient care with compassion and skill (Participant 1, personal communication, May 19, 2017). The study hospital administrative team has successfully implemented a culture of skilled care and compassion (Participant 3, personal communication, May 5, 2017). The degree of engagement in a hospital setting differs between departments. Patient satisfaction and enhanced engagement continues to improve when employees feel they have a voice in quality outcome (Cant & Erdis, 2012; Morrow, Fang, Fintel, Granger, Katz, Kushner, & Winkelman, 2012). Hospital managers should set standards enabling

employees to have means to share their thoughts on systems and processes to improve performance and engagement that would result in patient and employee satisfaction. The creation of performance improvement teams comprised of physicians and caregivers enhances engagement and collaboration between departments, which could lead to reduced costs and improved quality of care (Hwang et al., 2013). According to Robbins et al. (2012), engaged employees improve the quality of care, which results in patient satisfaction and reduction of costs. The implementation of a framework for patient and caregiver interactions enabled hospital managers and administrators to ensure consistency throughout the hospital service team. Hospital managers should ensure that employees undergo periodic training on expectations for standardized patient interactions, communication, and care. To assist in securing patient satisfaction, hospital managers should ensure that the hospital environment meets the needs of patients and their families (Warren, 2012). Hospital leaders should provide a welcoming, clean, and safe environment to encourage patients positively recommending the hospital to their families and friends (AHRQ, 2013). The hospital administrators should provide convenient access to technology, comfortable waiting rooms, food services, and accessible parking. To meet the continuum of care for the patients, hospital leaders must provide adequate hospital services. Regular communication from patients and caregivers and among healthcare professionals is important in achieving quality care (Hwang et al., 2013). To improve internal communications, hospital managers need to implement daily huddles, multidisciplinary rounds, daily bed board meetings, and electronic medical records (Hwang et al., 2013). Ensuring the communication of members of the care team, such as pharmacists, nurses, and physicians, is essential to patient care (Hwang et al., 2013). Hospital managers should create an opportunity for the

standardization of processes between groups to improve care. They could post a database of information on the initiatives, plans, and processes caregivers across the organization would need to implement to improve patient satisfaction and reduce costs. To ensure that caregivers understand the processes, hospital administrators could create process flow diagrams for all the workflows. Innovation has emerged as an important evolution in healthcare (Warren, 2012). The case study's administrative team incorporated different types of hospital technology, which includes electronic medical records, advanced nurse-call system technology, and high definition televisions. Although the advancement in technology has enhanced the delivery of healthcare, there are still opportunities to improve electronic medical records in terms of standardized inputs, care plans, and process flows (Participant 4, personal communication, May 19, 2017). Hospital managers should ensure that employees receive training continuously throughout the organization as processes evolve (Aydin, 2013). Training in the case study hospital emerged as a necessary process to ensure that existing and new employees can carry out the expected framework of care throughout the hospital. With advancement in technology, the hospital staff should train and keep appropriate documentation for future reference.

Although the findings of this study are beneficial to hospital managers, patients, and healthcare professionals, the Centers for Medicare and Medicaid Services, Department of Health and Human Services, and the American Medical Association can use the findings of the study to assess the different components of the PPACA legislation needing attention. Hospital managers can also use the study findings to mitigate the evolution of business models that reduces costs and satisfies the needs of healthcare stakeholders. Previous research addressed pressing issues with the rising healthcare costs in the United States.

The design of this study was to explore the strategies to streamline administrative procedures to reduce costs. Business journals and scholarly papers should be the medium used in disseminating the results of this study. The study results will enable healthcare organizations gain insights into the obstacles that healthcare professionals, such as physicians, and hospital managers face in complying with the PPACA legislation particularly when they lack support, business acumen, and information. Hospital managers, administrators, and healthcare researchers may gather information to assist in the improvement of nationwide hospital administration practices. The sharing of that information through avenues such as professional conferences could assist hospital managers in other hospitals to learn about proven methods of enhancing patient care process and the reduction of costs.

Recommendations for Further Research

The continuously evolving healthcare industry is also changing rapidly under the PPACA legislation. Through adequate information on organizational management, structure, and teamwork from the case study hospital, I discovered several themes throughout this study requiring the need for further research. With a comparison of initiatives and plans that other hospital managers and administrators implemented, researchers could identify actions that may be transferrable to other hospitals or study populations. Since hospital culture may affect the effectiveness of patient satisfaction, researchers may be able to identify generalized practices to improve hospital cultures. Different hospitals have unique cultures considering the various employee dynamics that could affect the behaviors of caregivers. An opportunity exists to research patient satisfaction in hospitals in different cultures. As stated in the limitation section of this study, the findings from the limited number of participants may not be transferrable to

other hospitals in my study area or those in different areas of the United States. More specifically, administrative procedures for reducing costs that I identified through my study may not be acceptable or feasible for implementation at hospitals other than the hospital included in my study. Duplicating this study in different geographical areas in the United States would be beneficial to determine the differences and similarities of strategies that hospital managers use to streamline administrative procedures to reduce costs in comparison to those found in Atlanta, Georgia. In addition, conducting a qualitative analysis for determining patient perception of the quality of care they received from different hospitals under the PPACA legislation may assist hospital managers to develop innovative processes to provide quality care and reduce costs. Other areas of further study could relate to the examination of hospital managers' and healthcare professionals' attitude concerning the PPACA legislation since its inception.

Reflections

The information in this study provided me the means to explore the strategies hospital managers need to streamline administrative procedures to reduce costs. Since the healthcare industry has diverse stakeholders and is highly complex, the examination of one area of healthcare without an acknowledgement of the interdependent components of the system is difficult. Since the introduction of the PPACA legislation, I did not have much knowledge about the reimbursement of healthcare professionals and hospitals under the legislation and its effect on healthcare costs. The information I gathered from this study increased my understanding of the ramifications of the PPACA legislation on medical practices, healthcare costs, and its influence on the quality of health patients receive. To check for sources of personal bias, I used reflexivity. To ensure the reliability of the study, I used member checking during the interview

process to summarize and restate the information to the participants allowing me to enable catharsis and verify the accuracy of my interpretations. To ensure validity, triangulation of the data occurred using peer-reviewed literature and participant interviews from a hospital located on the south side of Atlanta, Georgia. The case study participants were cooperative and willing to participate in the study. Without the participants' support, this study would not have been successful. In reflecting on the DBA doctoral study process, and particularly during the research process, I learned that a confirmation of confidentiality encouraged the participants to speak about their experiences within the case study organization.

Summary and Study Conclusions

The culture in the case study hospital included mutual respect between hospital managers, administrative team, physicians, and nursing staff. The framework of care created and implemented by the hospital managers through hospital governance, interactions between staff members and the available tools for care such as technology are integrated parts involved in the streamlining of healthcare administrative procedures to reduce costs. Although the framework and tools are important, managing costs is also imperative in maintaining a successful hospital. To remain competitive, hospitals need to use communication, services, and innovative tools effectively to drive satisfaction for the hospitals and the patients. A successful business enterprise creates room for improvement in an organization (Cutler et al., 2012; Onwuegbuzie et al., 2012). The caregivers at the case study hospital are actively involved in process improvements, enhanced communication between hospital administrators and caregivers, employee retention and recognition. The hospital managers uphold care through compassion and proper matching of skills. Reputation predicts business success (Ali, Alvi, & Ali, 2012). The

hospital managers encourage the utmost care given to patients to gain positive feedback and for referrals even if they must sometimes forfeit proper compensation for services rendered or items used during care. In the case study hospital, the caregivers displayed compassion, respect, and courtesy to each patient. The services offered in the hospital and the interactions between hospital managers and caregivers reflected an environment where patients from any socioeconomic class can go and received skilled care.

In conclusion, the initiation of strategies towards improving administrative procedures to reduce costs is important for the financial viability of a hospital. The communication of strategies between caregivers, administrators, and hospital managers and the provision of resources and tools to implement those strategies is critical for success. As hospital managers implement strategies to streamline administrative procedures to reduce costs, caregivers need to ensure that they do not compromise patient safety. A culture of care, compassion, and skill is important to achieve patient satisfaction and reduce costs. The objective of the PPACA legislation is to transform the delivery, structure, organizational, and financing of healthcare to improve the quality of healthcare and decrease costs (Redhead, 2012). Perceptions of the participants included discussions pertaining to unfavorable opinions regarding the PPACA legislation and reimbursement under the mandate. I identified six emergent themes from the face-to-face interviews using NVivo 10 data analysis software that includes (a) participants' unfavorable perspectives of the PPACA legislation, (b) employment of physicians, (c) PPACA reimbursement method, (d) follow-up services, (e) hospital administrative governance, and (f) lack of business education. The themes could assist healthcare professionals to understand the shortcomings of the PPACA legislation and realize that many issues are still unaddressed under

the mandate. Healthcare professionals, such as physicians, agree that the legislation threaten their decision-making autonomy and results in financial constraints in the medical sector. Under the dynamics of the PPACA legislation, the focus on population requires innovative healthcare delivery methods that focus on quality, patient-centeredness, and cost-effectiveness.

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Appendix A: Pre-Interview Protocol

Selecting Respondents

- I will contact the study participants initially through phone calls.

Setting Interview Time and Place

- I will conduct the interview in the private offices of the participants at times conducive for them.

Explaining the Study and Consent

- I will recap the study purpose and participant consent form.

Appendix B: Interview Protocol

The aim of this interview is to answer the research question on strategies hospital managers use to streamline administrative procedures to reduce healthcare costs.
I will complete the following steps during each interview.

1. I will begin the interview 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 each participant with 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 needed to participate in the interview; (b) the interview will be audio recorded. If a participant chooses not to be recorded, I will take handwritten notes; and (c) I will present a summary of the interview to each participant to validate my interpretations of their responses to each interview question.
4. I will explain to each participant that their participation is voluntary, and they can withdraw from the study at any time without prior notice and through email or verbal request, even after data collection completion.
5. I will provide my contact information to each participant in case he or she decides to withdraw from the study.
6. As an indication of their agreement to participate in the study, I will obtain participants' signatures on the consent form.
7. After collecting the signed consent form, I will provide the participant a copy of the consent form for his or her records.
8. During the interview recording, I will use a sequential coding system to identify the participants, and not their names. For example, I will assign each participant an identifying pseudonym, such as A1, B1, and C1. I will explain that I will be the only person with access to the name of each participant associated with each pseudonym and the identification of data from their interview in my database is only with their assigned pseudonym.
9. If permitted, after a participant signs a consent form, I will record the interview, 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 received granted permission for the participant to provide copies of documents related to the streamlining of administrative procedures such as graphs, schedules, charts, or other internal records related to administrative procedures the organization is comfortable sharing which been approved by the authorized representative of the company in the letter of cooperation.
12. I will end the interview and thank the participants for taking the time to participate.

Appendix C: Interview Questions

1. What strategies do hospital managers use to streamline administrative procedures to reduce healthcare costs?
   a. Based on your experience, what are the benefits of using a third-party logistics provider?
   b. What strategies have you developed and implemented to reduce administrative costs for your hospital operations?
   c. How do you assess the effectiveness of strategies as they relate to costs for hospital administrative procedures?
   d. Which of these strategies have been effective for reducing administrative costs?
   e. Which of these strategies have been the most challenging to implement for reducing administrative costs?
   f. What strategies do you use to identify business processes for redesigning the current administrative procedures to reduce administrative costs in your hospital?
   g. What other information would you like to share regarding strategies to reduce administrative costs, and how you pass the cost savings to the patient?

Appendix D: Letter of Cooperation from A Research Partner

WALDEN UNIVERSITY

Request for Permission to Invite Participants and Use Documents

Dear Research Partner,

I am a doctoral student at Walden University seeking a Doctor of Business Administration degree with a specialization in Project Management. I am conducting a research study entitled "strategies for streamlining hospital administrative procedures to reduce costs." The purpose of my research study is to explore strategies that hospital managers use to streamline administrative procedures to reduce healthcare costs.

The requirements for eligibility of employees of the hospital selected are as follows:

- The hospital must operate in Atlanta, Georgia.
- Participants must be hospital managers with a bachelor's degree and at least 5 years of experience in their field.

As the researcher of this study, I will request voluntary participation by eligible personnel within your hospital. The requested participation in face-to-face interviews will involve answering open-ended questions. The participants may choose to withdraw from participating or not to participate in this study at any time without penalty or forfeiture of benefit to the individuals. The results of this research study may be published, but neither the participants' or the organization's names or positions will be disclosed, and the identity of the participants will not be compromised by the participants' responses. For confidentiality and protection of the participants' identity, the participants' responses will be assigned a letter and numeric code, and I will maintain the master transcript of the interviews in confidence. I will use any company documents released to me specifically for my research and not discuss or disclose any confidential information with others, including family or friends.

I have included a research partner letter of cooperation to obtain your permission to invite participants, conduct interviews, and request participants to review my summary of interviews to ensure I have accurately summarized the information. In addition I am requesting your permission to use and reproduce documents related to your company's use of administrative procedures in reducing healthcare costs.
These documents can be graphs, charts, schedules, or other internal records related to the streamlining of administrative procedures to reduce costs. If you agree to participate in my research, please complete and return the attached form.

Please contact me if you have any questions regarding this research study. You can reach me by phone at XXX or by email at claret.onukogu@waldenu.edu.

Please print or save a copy of this letter of cooperation for your records.
Sincerely,

_____
Claret Onukogu

WALDEN UNIVERSITY

Research Partner Letter of Cooperation

Research Partner's Name: _____

Signing Official's Name: _____

Date: _____

Dear Claret Onukogu,

Based on my review of your research proposal, I give permission for you to recruit personnel from our organization to participate in the study entitled "strategies for streamlining hospital administrative procedures to reduce costs."

As part of this study, I authorize you to invite participants, conduct interviews, and request participants to review your summary of interviews to ensure you have accurately summarized the information. You can share the results of your study with the participants and the organization. Individuals' participation will be at their own discretion voluntary.

I understand that our organization's responsibilities include:

- Participation in one-hour face-to-face interviews by the hospital managers.
- Grant permission for participants to provide copies of documents related to the hospital's administrative procedures such as schedules, charts, graphs, or other internal records related to cost reduction that our organization is comfortable sharing.
- Participation in reviewing the researcher's summary of the interview to ensure accuracy of data, which may take approximately 30 to 45 minutes.

We reserve the right to withdraw from the study at any time if our circumstances change.

I authorize you to recruit individuals in this organization to participate as part of this study. I will provide you a list of names of individuals that meet your inclusion criteria and you may contact them directly, or I may forward an invitation to hospital managers directing them to contact you directly if they are interested in participating in the study. Individuals' participation will be voluntary and at their discretion.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain confidential and will not be provided to anyone outside of the student researcher's supervising staff/faculty without permission from the Walden

University Institutional Review Board (IRB) and an authorized representative of this organization.

_____ _____

Signature of Authorized Official Date

_____

Title

_____

Organization

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person's typed name, their email address, or any other identifying marker. Walden University staff verify any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).

Appendix E: Invitation to Participate in the Study

WALDEN UNIVERSITY
Invitation to Participate in a Research Study

Date:

Re: Doctoral Study Research that may interest you

Dear Sir/Madam,

My name is Claret Onukogu, a doctoral student in the Business Administration Program at Walden University. As part of my doctoral research study, I invite you to participate in my research study on strategies for streamlining hospital administrative procedures to reduce costs. I will arrange for a face-to-face interview in a private and comfortable place at a date and time that are convenient for you if you accept my invitation to participate in this study. The interview will be recorded and will last approximately one hour, or until you feel you have answered the interview questions. The summary of the interview will be reported in the study.

Participation in this study is voluntary, and you may withdraw at any time, even after the interview. I will contact you at least 48 hours in advance of the interview to explain the study. The information discussed during the interview as well as the identity of the participants and the organization will remain confidential. Your individual responses will not be published or disclosed. I have received permission from your organization's authorized representative to request participants to provide copies of documents related to the hospital's administrative procedures such as schedules, charts, graphs, or other internal records related to cost reductions that your organization is comfortable sharing. I hope you will participate in my study. Please feel free to contact me by phone at (770)-905-3925 or by email at claret.onukogu@waldenu.edu. I will contact you within the next 10 days to answer your questions about my research and to ask for your participation. Thank you for your consideration of my request.

Sincerely,

Claret Onukogu

Appendix F: Confidentiality Agreement

WALDEN UNIVERSITY
Confidentiality Agreement

Name of Signer:

During the course of my activity in collecting data for this research on the strategies for streamlining hospital administrative procedures to reduce costs, I will have access to information that is confidential and should not be disclosed. I acknowledge that improper disclosure of confidential information can be damaging to the participant and that information must remain confidential.

By signing this Confidentiality Agreement, I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way copy, divulge, release, loan, sell, alter, or destroy any confidential information except as properly authorized.
3. 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.
4. I will not make any unauthorized modifications, inquiries, transmissions, or purging of confidential information.
5. I agree that my obligations under this agreement will continue after completion of the research study that I will perform.
6. I will only use or access systems or devices that I am officially authorized to access, and I will not demonstrate the function or operation of systems or devices to unauthorized individuals.
7. I understand that a violation of this agreement will have legal implications.

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

Signature: Date: