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College of Management and Technology

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Ashley Polidori

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Walden University
2018

Abstract

Strategies to Sustain a Physician-Led Primary Care Practice

by

Ashley Polidori

MBA, Kaplan University, 2011

BA, Brooks Institute of Photography, 2007

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

Walden University

February 2018

Abstract

Since 2008, physician-led primary care practices have decreased as physician's encounter sustainability challenges because of government regulations and the requirements of the Affordable Care Act. The problem is that some physician-led primary care practice leaders lack strategies to sustain a medical practice longer than 5 years. The purpose of this study was to explore strategies primary-care practice leaders use to sustain a practice longer than 5 years. This study followed a case study design, including a purposeful sampling of 3 physician-led primary care practice leaders in southern Indiana. Open-ended semistructured interviews were conducted and triangulated with company policies and procedures as well as government statistics. Coded data and themes were identified using the complex adaptive systems theory. Three sustainability themes emerged: (1) patient engagement, (2) relationship development and retention, and (3) adaptation and innovation. The recommended action is for physician leaders to apply the strategies to develop their primary care medical practices. Results from the study may contribute a positive social change by presenting strategies to develop and sustain physician-led primary care practices, which could lead to an increase of primary care medical practices, resulting in more patients having access to primary care physicians.

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Dedication

To my two beautiful daughters. You both are bright lights in my life. I hope you know you can do anything - there are no limitations. All you need is patience, perseverance, and persistence.

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Section 1: Foundation of the Study

Implemented on March 23, 2010, the Patient Protection and Affordable Care Act (PPACA or ACA) marked the most monumental domestic policy legislation since the establishment of Medicare in 1965 (Talwalkar, 2014). PPACA has four main objectives: (a) to provide 32 million more Americans with healthcare coverage, (b) to enhance patient outcomes, (c) to control increasing healthcare costs, and (d) increase patient access (Rozensky, 2014). PPACA created a shift in reimbursement management and changed a physician's scope of work; physicians now assume two roles, one as a clinician and the other as a manager (Bohmer, 2013).

Background of the Problem

The regulatory changes of PPACA created sustainability challenges for physician-led primary care practice leaders (Allen et al., 2013). Some noteworthy challenges include managing new reimbursement models and new business models (Bohmer, 2013). PPACA modifies reimbursement from a volume-based system to a value-based system, requiring physicians to have value management strategies to manage value-based incentives and avoid financial penalties (Emanuel et al., 2012). In addition, the paradigm shift from volume to value challenges clinicians and leaders to provide high quality, safe, and effective care at increasingly lower costs (Delsile, 2013). One barrier to implement PPACA and sustain a medical practice is the lack of managerial skills (Blumenthal, Song, Jena, & Ferris, 2013).

Physician-led primary care practitioners not only need skills for value management but also leadership skills to manage and lead new business models (Bohmer,

2013). Blumenthal et al. (2012) revealed clinical leadership to be an essential strategy to guide physician-led primary care practices through the PPACA reform, yet physicians lack leadership strategies. Physician-led primary care practices encounter sustainability challenges because of the implementation of PPACA (Allen et al. 2013). Physician-led primary care practice leaders who adapt to the changing environment can achieve cost reductions, improve outcomes, have a stronger consumer and resource base, and will obtain a sustainable competitive advantage (Delsile, 2013).

Problem Statement

Innovations sought by PPACA were created under the assumption that physicians have the managerial skills to direct clinical and systems-level innovations, but they do not (Blumenthal et al., 2013). Less than 25% of new physicians choose primary care or stay in primary care once graduated; one reason is the daily rigors of managing a physician-led medical practice (Frisch, 2013). The amount of physician-led practices had a significant decrease from a stable 16% from 1998-2008 to 11% in 2013 (Peterson, Baxley, Jaén, & Phillips, 2015). The general business problem was that some physician-led primary care practices encounter sustainability challenges. The specific business problem was that some physician-led primary care practice leaders lack strategies to sustain a medical practice longer than 5 years.

Purpose Statement

The purpose of this qualitative multiple case study was to explore strategies physician-led primary care practice leaders use to sustain a medical practice longer than 5 years. The target population consisted of physician-led primary care practice leaders or

practice managers who have sustained a profitable medical practice longer than 5 years in southern Indiana. The implication for a positive social change is the possible increase of sustainable primary care medical practices, which may increase patient access to primary care physicians.

Nature of the Study

I selected a qualitative methodology for the doctoral study. Qualitative researchers focus on a phenomenon to gather first-hand participant experiences (Moustakas, 1994). A qualitative methodology was appropriate for this study because the purpose was to explore strategies physician-led primary care practice leaders use to sustain a medical practice longer than 5 years. Quantitative studies are applicable when a researcher is trying to determine if a statistical relationship exists between two variables (Babones, 2015), but a quantitative study was not suitable for this study because quantitative methods are not used in investigating a lived experience and limits the study to statistical data. Mixed method studies encompass both qualitative and quantitative designs to collect data (Frels, & Onwuegbuzie, 2013). A mixed method design was not appropriate for this study because a comparison of variables was not the purpose of study.

A multiple case study design was selected for this study. Case studies allow researchers to focus on how something was accomplished and retain an in-depth perspective rather than their experiences with the phenomenon alone (Yin, 2014). Other qualitative designs, such as phenomenological and narrative designs, may be appropriate in different scenarios. A phenomenological study is suitable when a researcher would

like to explore a lived experience that may be atypical (Moustakas, 1994), whereas a case study is used to focus on how a population achieves something. Although this study focused on a response to the health care reform, the response is typical. I viewed a phenomenological design as inappropriate for this study because a phenomenological study allows a researcher to collect data through only interviews (Peters, & Halcomb, 2015), which would have weakened the extent of the study. A narrative design involves gathering stories from two or more individuals and sharing the stories chronologically (Moustakas, 1994). However, collecting stories was not the desired content for this study. A multiple case study was appropriate for this doctoral study because the boundaries between the phenomenon and the content are not evident.

Research Question

The overarching research question was: What strategies do physician-led primary care practice leaders use to sustain a medical practice longer than 5 years?

Interview Questions

The interview questions were as follows:

1. Please describe in detail any business training you have had that has assisted you in building strategies to sustain your medical practice.
2. What strategies have you found of specific importance in sustaining your medical practice longer than 5 years?
3. What relationships have given you the ability to innovate?

4. What internal interactions, such as employee turnover, discrimination, and recruitment, resulted in a noteworthy event affecting the sustainability of your medical practice?
5. What strategies were used to adapt your medical practice to align with PPACA?
6. Please describe in detail any external interactions other than PPACA that significantly affected your medical practice.
7. What strategies do you use to manage unexpected events requiring adaptations in your medical practice?
8. How are innovations or process improvements used in supporting adaptation and sustainability?
9. Please describe in detail the strategies you have used to sustain your medical practice longer than 5 years.
10. Please describe in detail anything else pertinent to the strategies used to sustain your medical practice longer than 5 years that have not yet been addressed.

Conceptual Framework

The complex adaptive systems (CAS) theory was the conceptual framework selected to support this qualitative multiple case study. North et al. (2013) described CAS as diverse, interconnected systems that evolve, have a hierarchy structure, adapt with innovation, and learn through feedback. The CAS theory was founded at the Santa Fe Institute in New Mexico in the mid-1980s (Dann & Barclay, 2006). The CAS grew from Bertalanffy's 1968 systems theory, Gleick's 1988 chaos theory, and Gell-Mann's 1994 complexity theory (Dann, & Barclay, 2006). Key constructs underlying the CAS

theory embody an organizational loop of learning and redesign. The constructs include (a) the organization, (b) interactions, (c) random events, (d) adaptation, (e) and evolution (Dann, & Barclay, 2006).

Many scholars consider health care organizations CAS (e.g., Borgermans et al., 2013; Persaud, 2014). Basole, Bodner, and Rouse (2013) demonstrated a need to address the barriers of innovations to report on the sustainability of health care practices by viewing health care innovations in the perspective of a CAS. CAS can assist in adapting to adversity in by increasing resilience. Dann and Barclay (2006) stated that the CAS applies to management environments. CAS can consider factors, multiple perspectives, and uncertainty involved in healthcare interventions, allowing a researcher to broaden the understanding of others (Basole et al., 2013). The CAS theory allowed this study to encompass multiple facets of an organizational loop of learning and redesign including the organization, interactions, random events, adaptation, and evolution.

Operational Definitions

Accountable care organization: A group of providers who accept joint responsibility for the cost and quality of care for an assigned group of patients (Edwards et al., 2014).

Concierge medicine: When a patient pays an annual fee for increased access to a physician as well as the inclusion of all or almost all services (Cascardo, 2014a).

Direct-pay model: Then a practitioner does not participate in insurance or government plans, and the participant is considered out of network and has the option to submit for reimbursement to their insurance company (Cascardo, 2014a).

Health care alliance: A health care alliance is a collaboration between voluntary organizations, which focus on health care, related issues within a community (Hearld, Alexander, & Mittler, 2012).

Hybrid concierge model: A combination of traditional practice that accepts third party payer plans as well as services for an annual fee to those who receive enhanced services (Cascardo, 2014b).

Patient-centered primary care: A health care system that focuses on the patient's perspective and experience of their health care (Rosenthal et al., 2013).

Physician-centric primary care: Autonomous practices that revolve around the physician's approach to practice (Nutting, Crabtree., & McDaniel, 2012).

Primary care practitioner: Family practitioners, internal medicine practitioners, and pediatricians (Frisch, 2013).

Shared savings: The total cost of care while maintaining or improving the quality and patient experience measures (Mostashari, Sanghavi, & McClellan, 2014).

Sustainable: When a health service center can continuously deliver quality care in a cost-efficient and health-effective manner (Buykx et al., 2012).

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions are a presumption there is stability in a research phenomenon, allowing a review of the research over time (Gergen, Josselson, & Freeman, 2015). I used three assumptions to govern the data collection and analysis of this study. First, I assumed that all the reviewed literature was accurate and a proper representation of the

21st century. Second, I assumed the participants would answer honestly and had a working knowledge of managing a physician-led primary care medical practice. I mitigated this by limiting the participants. The way a researcher interprets something is related to how they understand the world, therefore, a researcher must evaluate past experiences and set aside their biases to understand the participants (Benner, 1994).

Limitations

Limitations assist in the discovery of flaws in the research and defining the study's perimeter (Aguirre, & Bolton, 2014). Three limitations governing the study were participants, transferability, and sample size. First, participants who completed the interviews may not represent the expert view of the problem. Second, findings may not be transferrable to other geographical locations. Finally, variations in the sample size of case studies make the justification for a sample size difficult (Marshall, Cardon, Poddar, and Fontenot, 2013). I mitigated sample size concerns by saturating my findings.

Delimitations

Delimitations are the boundaries of the study set by the researcher (Knafl, Leeman, Havill, Crandell, & Sandelowski, 2015). Delimitations for this study included the problem selected for study, geographical location, sample size, participants, and data saturation. Researchers, including Bohmer (2013), illuminate the problem that some physician leaders lack knowledge on how to manage or lead a physician-led primary care practice. I viewed sustainability through the management and leadership perspective. I focused on identifying an accurate view of how to sustain a profitable medical practice

lasting longer than 5 years in southern Indiana from the perspective of physician-led primary care practice leaders.

The participants were physician leaders or practice managers involved in sustaining a physician-led primary care medical practice. I selected participants by looking in directories of physicians in southern Indiana and asked prequalifying questions to verify they met the requirements of this study. The study sample excluded primary care practices managed by hospitals or large corporations.

Data saturation is appropriate for all forms of qualitative research that have interviews as the primary data source (Marshall, et al. 2013). Marshall et al. (2013) stated that data saturation consists of bringing new participants in until the data is superfluous. I saturated the data and triangulated the research to be confident in my findings.

Significance of the Study

Although studies on how to sustain businesses are available, literature on strategies to sustain a physician-led primary care medical practice were unavailable. I discovered the importance to explore strategies physician-led primary care practice leaders use in their medical practices. In the next section, I discuss how the study may add value to the participants as well as contribute to other practitioners and implications for a social change.

Contribution to Business Practice

I found a lack of information on strategies used to sustain a physician-led primary care medical practice longer than 5 years. This qualitative case study is significant

because it reveals what strategies physician-led primary care practice leaders used to sustain a medical practice longer than 5 years in southern Indiana. The knowledge of the results add value to the participants' business. By seeing positive or negative trends, participants and readers can use this study to contribute to their practice. The readers have an opportunity to create an internal investigation in comparison to the participants studied, allowing them to address issues and enhance positive fixtures.

Implications for Social Change

The shortage of primary care physicians (PCPs) leads to an improper access to primary care physicians. Berry, Beckham, Dettman and Mead (2014) acknowledge that there is a growing need for patient-centered access to primary care services. The results of this study may contribute to a positive social change by reducing the shortage of small business primary care practices, allowing more patients to access PCPs. Physicians may choose to become a PCP after they are aware of successful strategies to operate a physician-led primary care practice. By increasing access to PCPs, people may have the opportunity to increase the longevity of their lives, which could allow them to have a feeling of more worth and dignity. Buykx et al. (2012) discussed the importance of primary health care, which is typically the first contact with a health care system. The loss of this access diminishes health outcomes particularly in remote or rural communities.

A Review of the Professional and Academic Literature

A literature review helps build a foundation to demonstrate trends, helps explain how a study advances knowledge, helps conceptualize the study from defined terms,

helps demonstrate why certain methods are appropriate, and provides a reference point for interpreting findings.

The literature review begins with the application to the applied business problem, which focused on why a qualitative case study was an appropriate choice, then it includes the purpose of the study, as well as the conceptual framework and a critical analysis of supporting and contrasting conceptual models. The literature review next includes a review of governance in health care to demonstrate the ongoing reform changes physician-led primary care practice leaders encounter and they need strategies to adapt and evolve to sustain a medical practice longer than 5 years. Review content also includes health care reform perceptions as well as evolving organization models for the delivery of primary care and barriers of health care reform and ways to manage them. The literature review concludes with a description of the general problem that some physician-led primary care practices are facing sustainability challenges.

Literature collected for the review includes historical, current peer-reviewed, and other scholarly journal articles, books, and government documents that focus on sustainability challenges some physician-led primary care practices encounter. I obtained scholarly journal articles through online databases available through the Walden University Library. Databases included ABI/INFORM Complete, Academic Search Complete/Premier, Business Source Complete, EBSCO ebooks, ProQuest Central, and ProQuest Health and Medical Complete. I also used Google Scholar to research a wide variety of scholarly articles and ebooks. Finally, I used Google to identify government documents relevant to the study topic. Government websites, such as Centers for

Medicare and Medicaid Services, Medicare Payment Advisory Commission, and Social Security Bulletin proved to be the best resources for identified government documents. I used 85% of up-to-date scholarly articles for this doctoral study. The study includes 105 up-to-date scholarly articles, 10 historical peer-reviewed articles, five books, two current government documents, and one historical government document in this doctoral study.

Application to the Applied Business Problem

The purpose of this qualitative multiple case study was to explore strategies physician-led primary care practice leaders use to sustain a medical practice longer than 5 years. In this study, I explored the overarching research question of what strategies physician-led primary care practice leaders use to sustain a medical practice longer than 5 years. I focused on physician-led primary care practice leaders and practice managers that have sustained a medical practice longer than 5 years in southern Indiana. The target population was selected on the belief that they possessed pertinent information to this study. I conducted multiple semistructured interviews with physician leaders and practice managers to identify an accurate view of the strategies being used to sustain a medical practice longer than 5 years in southern Indiana. This approach permitted structure while allowing participants to express their viewpoints. I also examined company policies and procedures as well as government statistics as a means of methodological triangulation.

Exploring the strategies physician-led primary care practice leaders used to sustain a medical practice longer than 5 years may create a positive social change, especially in socio-economical disadvantaged populations who often have threats (e.g.,

small population size, maintaining employees, poor management, geographical location) to sustain their health service centers (Buykx et al., 2012). With the knowledge of what strategies physician-led primary care practice leaders use to sustain a medical practice longer than 5 years, physicians may choose to become a PCP and open a physician-led practice potentially leading to an increase of patient access.

In this study, I used the CAS theory to examine why some physician leaders lack strategies to sustain a primary care practice longer than 5 years. CAS theory embodies an organizational loop of learning and redesign (Dann & Barclay, 2006) and starts from the standpoint that health care organizations are CAS (Persaud, 2014; Borgermans et al., 2013). CAS is applicable at the managerial level (Dann & Barclay, 2006); therefore, it was an appropriate conceptual lens because it allowed me to focus on health care organizations and the strategies used by management to sustain a primary care practice longer than 5 years.

CAS is not the only method to manage a fragmented health care system. Scholars have also recognized the systems theory can be used in a health care setting (Colquhoun et al., 2014), particularly when examining a health care organization from four levels: the patient, the care team (e.g., providers), family members, and the organization supporting the work of care teams (Carayon et al., 2013). CAS is grounded in Bertalanffy's 1968 systems theory, Gell-Mann's 1994 complexity theory, and Gleick's 1988 chaos theory (Dann, & Barclay, 2006). Bertalanffy's system theory demonstrates principles that are applicable at all levels; Gell-Mann's 1994 complexity theory attempts to simulate systems from past scientific theories; and Gleick's 1988 chaos theory discovered that

systems behave in a nonlinear fashion and minor changes can have a large impact (Dann, & Barclay, 2006). I focused on CAS at the management and leadership level to explore what strategies physician-led primary care practice leaders are using to sustain their practices longer than 5 years.

North et al. (2013) described CAS as diverse, interconnected systems that evolve, have a hierarchy structure, adapt with innovation, and learn through feedback. Five key constructs underlay the CAS theory: the organization, which directs and controls interactions; interaction, which includes internal or external interactions that result in random events; random events are conceivably unstable or nonlinear creating no problem to a large problem and create a need for adaptation; adaptation, which creates a need for evolution; and evolution—an emerging phenomenon closes the continuous loop of organizational learning and redesign (Dann, & Barclay, 2006)

I applied the CAS theory's five constructs to the study by exploring strategies used by organizations to manage internal and external interactions. I examined historically sustaining a medical practice to demonstrate the continuous redesign of health care and need to for leaders and organizations to evolve. I also examined sustainable leadership and traditional and emerging care models demonstrating adaptation and evolution of health care organizations are needed to sustain a primary care medical practice. Finally, I focused on strategies to manage the financial aspect of organizational structures in health care reimbursement to demonstrate some physician-led primary care practice leaders need strategies to manage.

Historically Sustaining a Medical Practice

Sustaining a business and health care reform are not new phenomena, but continuous evolution creates a need for physician-led primary care practice leaders to have strategies to sustain their medical practice in a changing environment. The health care reform has been slow and inconsistent, making it difficult to sustain a medical practice (Delisle, 2013).

The first governmental health care intervention emerged in the 1900s. Franklin D. Roosevelt established the oldest health insurance program when he signed the Social Security Act of 1935 to address the economic situation associated with the Great Depression (Altman, 2013). The first federal health care insurance entitlement program was formed in 1965 when President Lyndon B. Johnson signed the Title XVIII Amendment to the 1935 Social Security Act, with the original goal of providing affordable care to the elderly (Fairfax & Feit, 2015). Health insurance programs continued to develop over the century, continuously changing the way physicians sustained their physician-led medical practices.

The creators of Medicare did not initially focus on cost containment but to financially satisfy physicians, ensuring cooperation in the Medicare implementation process (Altman, 2012). The lack of cost containment made strategies less significant to sustain a physician-led primary care practice: physicians charged a fee-for-service (FFS) and received said fee (Altman, 2012). Traditionally FFS focused on the volume of services rather than the value of services provided (Ginsburg, 2012). The primary

strategy to sustain income in a physician-led primary care practice was to retain a large volume of patients (Dorn, 2013).

After Medicare was established, different reimbursement models began to emerge in response to growing expenses and poor patient outcomes (Delisle, 2013). The Social Security Amendments of 1983 created the inpatient prospective payment system, which resulted in a surge of postacute spending (Altman, 2012). Although reform was well underway in the 1980s, Nutting et al. (2012) described a strong presence of physician autonomy and the physician-centric mindset; as a result, a broad set of strategies were not yet significant.

A noteworthy change in physician reimbursement came with the Omnibus Budget Reconciliation Act of 1989, which created a FFS payment schedule based on a resource-based relative value system (Ginsburg, 2012). FFS became comprised of a system valuing physician services using relative value units (RVUs; Medicare Payment Advisory Commission, 2014). The resource-based relative value system fee schedule considers three components—physician work (time and intensity), practice expense, and professional liability insurance—and each adjusts for geographical differences (Medicare Payment Advisory Commission, 2014). The Omnibus Budget Reconciliation Act of 1989 brought awareness of the value of a service rather than only volume.

Patient Protection and Affordable Care Act

President Barack Obama signed PPACA in 2010, creating a shift in reimbursement management and changed a physician's scope of work (Wilkerson, Smith, & Stramp, 2015). Physicians became responsible for two roles: one as a clinician and the

other as a manager/leader (Bohmer, 2013). Section 3007 of PPACA directs the Secretary of Health and Human Services to implement a budget-neutral value-based payment modifier that will be applied to all Medicare physician payments by 2017, penalizing lower-value providers and rewarding higher-value providers (Dorn, 2013). The shift from volume to value makes it essential for physician leaders to have strategies to adapt and evolve with the health care reform to sustain a medical practice longer than 5 years.

The Sustainable Growth Rate (SGR)

The Sustainable Growth Rate (SGR), which is a part of the Balanced Budget Act of 1997, was a continued effort by Congress to reduce the National Healthcare Expenditures (NHE; Medicare Payment Advisory Commission, 2014). SGR further adjusted the FFS schedule, considering the overall economy, estimated medical inflation, and the increase of Medicare beneficiaries (Wilensky, 2014). Moreover, the adjustment used the established RVU system and was multiplied by a conversion factor to create the actual reimbursement amount (Dorn, 2013; Medicare Payment Advisory Commission, 2014; Wilensky, 2014;).

Congress' and physicians' dissatisfaction with SGR led to a decade of repeals (Dorn, 2013; Medicare Payment Advisory Commission, 2014; Wilensky, 2014). The SGR repeal and the Medicare Provider Payment Modernization Act of 2014, also known as the "SGR fix," created two new payment pathways—one which allowed providers to continue FFS payments and the other for providers to participate in value-based models (Reschovsky, Converse, & Rich, 2015). SGR was permanently repealed in 2015 with the

implementation of Medicare Access and CHIP Reauthorization Act (MACRA; Hirsch et al., 2015).

MACRA permanently repealed the flawed SGR formula. MACRA created two new pathways for clinicians to participate in Merit-Based Incentive Payment Systems (MIPS) or alternative payment models (e.g., accountable care organizations or bundled payments) beginning in 2019 (Rosenthal, 2015; Williams, Casale, & Oetgen, 2015). MIPS will replace the current Physician Quality Reporting System, the Value-based Payment Modifier, and Medicare Electronic Health Record (EHR) incentive program with a single consolidated program (Rosenthal, 2015). MIPS will provide credit to primary care clinicians for expanding practice hours and reporting to clinical data registries while alternative payment methods will receive bundled payment incentives (Williams et al., 2015). The ongoing evolution and unsettlement of the health care system demonstrate the need for strategies to adapt to evolve to sustain a medical practice.

Historically, volume was the most significant strategy to sustain a medical practice, and external stakeholders were important. Stakeholders for primary care include but are not limited to policy makers, physicians, leaders, and the community (Valentijn, Schepman, Opheij, & Bruijnzeels, 2013). The history of health care regulation portrays an evolution of external events that required physician-led primary care practice leaders to adapt and use strategies to sustain their practice.

Sustainable Business Strategies

Sustainable business strategies are evolving in a changing environment. Dorn (2013) revealed an increased pressure of government regulations to integrate new reimbursement and business models to sustain a medical practice. Many organizations worldwide use different business excellent frameworks to guide their strategy, business processes, and improvements (Brown, 2014).

Brown (2014) revealed that approaches to sustain award-winning level performance include (a) leadership, (b) communication channels' balancing autonomy and control, (c) use of teams, and (d) bridging internal and external boundaries. The principles discovered by Brown support ongoing learning and innovation parallel to the five key constructs of the CAS. Moreover, there is a direct correlation between Brown's and Delisle's (2013) findings. Delisle discovered eight key factors in sustaining a primary care practice (a) physician alignment and leadership, (b) price risk adjustment, (c) organizational structure, (d) financial management systems, (e) information systems, (f) care transitions, (g) evidence-based medicine, and (h) supply cost management. Porter et al. (2012) established five strategies to improve value: (a) organizing around patients with similar needs, (b) the utilization of team-based services, (c) a value-based system should be in effect, (d) utilization of bundle reimbursement and the award of value improvement, and (e) the utilization of patient-centered medical homes.

Sinsky et al. (2013) conducted a study to search for the joy in practice. The study included a report of 23 high-functioning primary care practices. Sinsky et al., discovered five innovations to make primary care feasible: (a) proactive planned care, (b) team-

based clinical care, (c) sharing clerical tasks, (d) communication improvement, and (e) a shift from physician-centricity.

Throughout the review of the literature, three barriers became clear to sustain a physician-led primary care medical practice: physician alignment and leadership, organizational structure, and financial management. Within those categories, I associated subcategories of pricing and risk adjustment, supply cost management, and information systems.

Sustainable Leadership

Health care regulations are evolving, and some medical doctors do not have adequate leadership strategies to sustain a physician-led primary care practice. The perception of the health care transition is long and includes significant complications for physician leaders (Bohmer, 2013). Dombrowski and Mielke, (2014) revealed a shortage of sustainable leadership strategies to cope with the changing environment (Dombrowski & Mielke, 2014). Some physicians are finding it difficult to adapt to reform since many lack an in-depth comprehension of PPACA's standards and guidelines (Kline, 2015).

Regulatory changes require physicians to manage the quality of care, the cost of care, and new teams making them like chief executive officers (Mostashari, Sanghavi, McClellan, 2014). A physician-led primary care practice leader can be thought of as a CEO managing roughly $18,000,000.00 since a primary care physician typically sees 2,000 patients per year in a traditional practice (McDonough, 2013), and each patient accounts for approximately $9,255 in annual healthcare spending (Centers for Medicare and Medicaid, 2014). Physicians influence 60% of healthcare costs, yet they receive

minimal education on how to manage resources (Agrawal, Taitsman, & Cassel, 2013). Evidence demonstrated the importance for physician-leaders to have strategies to manage resources not only to sustain their medical practice, but to properly implement PPACA.

Blumenthal et al. (2012) revealed a clinical leadership gap and emphasized clinical leadership is essential to guide physician-leaders through reform. Clinical leadership is defined as a physician's ability to serve as both a manager and a leader of diverse teams while striving for optimal care (Blumenthal et al., 2012). Blumenthal, Song, Jena, and Ferris (2013) determined a lack of managerial skills is a barrier to implementing healthcare reform. Nutting et al. (2012) described the difficulty physician leaders encounter to adapt to manage collaborative teams (e.g., PCMH, ACO). Clinical leaders implement quality improvement, patient safety initiatives, increase staff retention, and make an effort to redesign the healthcare system (Blumenthal et al., 2012). Sinsky et al, (2013) discovered previsit planning and previsit laboratory tests were an effective strategy to mitigate disorganization and reduces the volume of work to be completed.

Researchers showed physicians felt inadequately prepared to meet leadership responsibilities increasing the risk of stress and burnout (Blumenthal et al., 2012; Dijkstra, Pols, Remmelts, & Brand, 2015). Hoff (2013) determined younger physicians must adapt to different care models throughout their careers. Blumenthal et al. (2012) suggested mitigating leadership inadequacies by designing formal leadership development programs.

The complex adaptive system (CAS) is a strategy to sustain a primary care medical practice in a changing environment. CAS has five key constructs of

organizational learning and redesign, which can aid management practitioners if utilized correctly (Dann, & Barclay, 2006). Dann and Barclay discovered organizations learn and develop by making incremental adjustments, and comprehensive redesign. The healthcare system is amid an extensive redesign, and physician-led primary care practice leaders must have strategies to adapt and evolve with the healthcare reform.

Physician alignment and leadership is essential strategy to sustain a physician-led primary care practice (Delisle, 2013). A barrier to physician alignment and leadership is a perceived loss of autonomy and the physician-centric mindset. Nutting et al. (2012) determined physicians encounter difficulty to change from the physician-centric vision to managing collaborative teams. Blumenthal et al. (2012) established physicians are wary of management work because of the belief that promoting standardization-of-care process and decision-making undermines a physician’s autonomy, as well as overly time-consuming detracting clinical proficiency. Emanuel and Pearson (2012) discovered a strong perception that PPACA will restrict physician autonomy. Physician leaders must adapt from a physician-centric mentality to sustain a physician-led primary care medical practice (Sinsky et al., 2013).

Literature presented the essentiality for physicians to have leadership and management skills to deliver high quality care in a modern practice. I discovered some barriers discovered amongst scholars. Barriers of adapting to healthcare reform include payment reform, new care delivery models (Delisle, 2013), managing diverse teams (Blumenthal et al., 2012), physician alignment and leadership (Bohmer, 2013; Delisle, 2013), all while simultaneously manage the care of a large number of patients

(Blumenthal et al. 2012). There is minimal information on strategies leaders use to cope with issues such as stakeholders. Matos and Silvestre (2013) suggest promoting a diverse group of stakeholders, encourage learning, and found shifting stakeholder values from a single objective to multiple objectives minimizes conflicting interests.

Lemak et al. (2012) highlighted effective strategies for engaging primary care physicians in program design and implementation processes and creating learning communities to support quality improvement and practice change. Buykx et al. (2012) discovered one primary healthcare center, which is adapting to an external (political, and health system environment) and internal (workforce) changes to ensure sustainability. The primary healthcare center is constantly adapting to service operations: such as workforce supply, which is difficult to retain and recruit in rural areas, and the increased need for linkages with other healthcare providers, infrastructure demands such as technological advances medical information systems, equipment and procedures, leadership and management accountability requirements that address communities expectations, and funding requirement as well as health service managers (Buykx et al., 2012).

Effective leaders must work in a diverse setting and articulate a vision or goal, communicate with outers, build willing support for the vision and empower others (Blumenthal et al., 2012). In addition, a leader must set targets and goals, creating work plans and budgets, hiring appropriate people, communicate these targets and plans to achieve them, delegate work appropriately, monitor work performance and respond to problems in real time.

Organizational Models for the Delivery of Primary Care

Using a business model as a strategy is an emerging concept (Boons, & Ludeke-Freund, 2013). Boons, Ludeke-Freund, (2013) revealed a value proposition, supply chain management, customer interface, and financial models amongst generic models, but determined it may be unclear to realize these features in new models. Delsile (2013) discovered care coordination between the acute and post-acute setting is demanding, and practices have closed the gap by utilizing referral strategy, and collaboration will have a competitive advantage. There has been a positive correlation with restructuring and orienting with stainable market transitions to develop a competitive edge (Loorbach & Wijsman, 2013).

One objective of PPACA is to contain costs, which has lead the emergence of new models for the delivery of healthcare (Rozensky, 2014). Changing a business model is a barrier physician-led primary care practice leaders encounter when sustaining their medical practice. This section focuses on historical and relevant examples of organization models for the delivery of primary care, beginning with the traditional physician practice model, followed by patient-centered medical homes (PCMH), accountable care organizations (ACO) and various payment bundling pilots. The emerging models demonstrate an ongoing evolution physician leaders encounter to sustain their physician-led primary care practices longer than 5 years. This information is important to understand challenges to identify what strategies are needed for physician leaders to sustain a physician-led primary care practice.

In this section, I first discussed the traditional physician practice model and the barriers of leaving the traditional model, then reviewed emerging models most of which are authorized by PPACA and discussed the benefits and challenges of said models. I also discussed Medicare, yet involvements of PPACA are not limited to Medicare. The implications of analysis are that private insurers and Medicaid closely follow Medicare's regulations.

Traditional physician practice model. The traditional model of primary care may also be called physician-centric primary care, which is an autonomous practice revolving around the physician's approach to practice (Nutting et al., 2012). Frisch (2013) noted the traditional model consists of the physician carrying the burden of most tasks in the office including administrative tasks (Frisch, 2013). Traditional primary care practices obtain reimbursement for conducting a procedure for a flat rate for the service provided (Ginsburg, 2012). A key strategy to sustain adequate income for a traditional physician practice model historically was to maintain the volume of services rendered (Ginsburg, 2012). However, as touched on in the SGR section the repeal of SGR with MACRA is changing the environment from FFS to newer models and has created a need for managers to have adequate strategies to evolve with the changing environment to sustain a physician-led primary care practice.

The growing knowledge in defining and measuring the quality of care (e.g. clinical guidelines, and public reporting of compliance) challenges the traditional physician practice model (Bohmer, 2013). Medicare Payment Advisory Commission (MedPAC) (2014) reported it has become difficult to work in a solo practice in

comparison to a larger hospital or organization. MedPAC also recounted younger physicians are more likely to want to work in larger organizations than older physicians, exasperating the primary care shortage. Moreover, MedPAC discovered that larger groups had an easier time adopting new technology and innovations, yet a large corporation is a trade-off for physician autonomy. From a social aspect, the difficulty to operate a physician-led primary care practice may reduce patient access to a primary care physician. From a business management perspective, a physician can lose autonomy if they do not have adequate strategies to sustain a physician-led primary care practice.

Concierge medicine. I discovered three noteworthy variations of the concierge medicine model: traditional, hybrid, and academic retainer practice. The traditional concierge model is when a patient pays an annual fee for increased access to a physician as well as the inclusion of all or almost all services (Cascardo, 2014a). The hybrid concierge model is a combination of traditional practice accepting third-party-payer plans as well as an annual fee for those who desire enhanced services (Cascardo, 2014a). The academic retainer practice is a new form of concierge medicine that appears as a standard primary care concierge practice yet works alongside a traditional academic medical practice (Zhavoronkov, & Cantor, 2013). In academic retainer model, the revenue goes towards both concierge and traditional practice as a subsidy (Zhavoronkov, & Cantor, 2013).

The academic retainer practice is unique since essentially no patient is left behind. The money from the concierge practice funds the less fortunate clients reaching a more economically diverse population. Cascardo (2014b) notes concierge practitioners use the

direct-pay model. Cascardo described the direct-pay model as compensation for a practitioner who does not participate in insurance or government plans. Even though concierge medicine is not a leading model, physician-led primary practice leaders must have strategies to sustain their medical practice, such as marketing Cascardo (2014a).

Patient Centered Medical Home (PCMH). The PCMH is a leading reform model for primary care (Edwards, 2014). The PCMH model uses physicians, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators (Green, et al., 2013). The PCMH approach permits a physician to have their team take care of rudimentary work, giving the clinician more time with patients (Frisch, 2013). Wilensky (2014) added PCMHs focus on providing comprehensive primary care that is patient-centered and coordinated. Henderson, Princell, and Martin (2012) ascertained the goal of a PCMH is to provide patients with a place visit the same, trusted primary care provider, and healthcare team.

Moran and Burson (2014) determined the goals of a PCMH is to provide patients with a more comprehensive, safe, high-quality, affordable, accessible, patient-centered care while providing coordinated care across all sectors of a healthcare system. PCMH's require a physician to have leadership skills and strategy to manage the team-based incentives to sustain their medical practice (Bohmer, 2013). PPACA influences collaboration between physicians to reintroduce primary care as the foundation of healthcare delivery in the United States in hopes to improve healthcare and control healthcare costs (Nicola & Bittle, 2015).

The PCMH payment schedule features a blend of FFS payments, rewarding face-to-face encounters; with an additional bundled payment plan, which supports care coordination (Edwards et al., 2014; Wilensky, 2014). Care coordination includes, but not limited to, telephone calls, emails, patient education, and counseling (Ginsburg, 2012). A care coordinator provides physicians the ability to outsource tasks potentially increasing revenue (Edwards, 2014). Physician-led primary practice leaders must have strategies to manage coordinated care teams to sustain a physician-led primary care practice.

Blumenthal et al. (2013) discovered three barriers of implementing team incentives include frequent clinical team turnover, clinician resistance to the evolution of healthcare, and adoption of reliable and valid team performance measurement systems. Blumenthal noted strategies to mitigate these barriers include: improving clinical team continuity; involving clinicians in incentive design; and using information technology for work team monitoring and assessment.

FFS is prevalent in PCMHs. However, I have found multiple payment strategies for PCMHs. Edwards et al. lists six types of reimbursement strategies for PCMH (a) Enhanced FFS, which is FFS enhanced for recognized PCMHs; (b) FFS with PCMH-specific billing codes, which is billing for new PCMH-related activities; (c) Pay for performance, which is practices paid for meeting the Healthcare Effectiveness Data and Information Set (HEDIS) operational targets; (d) per-member-per-month, which is a capitated fee in addition to FFS billing; (e) Shared Savings, which is when practices are rewarded with the portion of savings if their patient panel increases slower than a preset target; and (f) comprehensive payment, which is the complete risk of cost of care with

primary care practice. Henderson, Princell, and Martin, (2012) demonstrated multiple reimbursement models, and stated the models can be combined in various ways with systems such as rewards, quality, and capitation. Henderson et al. state further research is needed to identify which reimbursement methods are the best for patient satisfaction, clinical outcomes, and decreased costs. Physician-led primary care practice leaders must have strategies to manage new reimbursement models to sustain their medical practice.

Accountable Care Organizations (ACO). ACOs emerged as a model of care delivery with the passage of PPACA (Edwards, 2014). PPACA is providing financial incentives to consolidate and integrate services, yet some physician leaders lack managerial skills needed to adapt or evolve with the healthcare reform. Wilensky (2014) described ACOs as healthcare establishment consisting of public or private facilities, which work together to improve health outcomes, to provide high-quality, coordinated care, and to create a lower cost of care. Edwards et al. (2014) ascertained ACOs comprise of a range of organizations that vary in dominance, payer mix, and risk sharing. ACOs are accountable for the entire continuum of care. Edwards et al. stated although the providers will be working to integrate services each provider would operate in regard to their priorities and expectations. Mostashari, Sanghavi, and McClellan (2014) established ACOs require more intense patient engagement, aligning finances with quality improvement.

I discovered minimal argument that primary care physicians will continue to be paid using the FFS reimbursement methodology until 2017. However, MDs will need to manage potential rewards, penalties, shared savings, and accountability for healthcare

outcomes (Edwards et al., 2014; Wilensky, 2014). PPACA is using of financial incentives to change behavior, such as pay more to physicians who coordinate care and employ information technologies (Wilensky, 2014). Edwards et al. (2014) found ACO contracts do not typically enhance payment for PCPs, yet ACOs allow physicians to utilize more resources to generate revenue. Wilensky (2014) stated new incentives that reward quality of care, and capitated payments, and shared savings will broadly replace FFS. Shared savings is calculated against the budget, based on actual spending of the current year values (Edwards et al., 2014). Physician leaders must have strategies to mitigate the challenges of new reimbursement structures to sustain their primary care practice.

Leaders must use strategies when developing an ACO. For example, an ACO must generate a minimum of 2% savings according to the practices' base-year spending, as well as, meeting 33 quality metrics specified in the CMS implementing regulations (Wilensky, 2014). Wilensky stated ACOs within the Medicare Shared Savings program are not required to accept downside risk (which means to be subject to losses) but would receive higher savings if they agreed to take the risk. Physician leaders must have critical business strategies, such as gaining knowledge and determining how to set up an ACO to sustain a medical practice. When taking a CAS approach to strategic management, an organization focuses on organizational learning and redesign through interactions, random events, adaptation and evolution (Dann, & Barclay, 2006).

One concern mentioned when moving away from the traditional practice was the perception of a loss of autonomy. However, scholars found physician leaders can

collaborate and retain a sense of autonomy. Physician autonomy is more than the complete freedom to provide treatment to their best judgment, but also how to organize the care provided, thus combining autonomy with liberty (Emanuel & Pearson, 2012). Emanuel and Pearson ascertained moving away from the FFS reimbursement and focusing on new ways of delivering care PPACA may enhance physician autonomy, but not all will benefit equally. For example, enhancement of physician autonomy will require more collaboration and different models of working. In addition, Mostashari et al. (2014) discovered an increasing number of primary care physicians perceive physician-led ACOs as an excellent opportunity to retain autonomy. Physician leaders can use the CAS theory as a strategy to collaborate and work with different models of care by using interactions to sustain a physician-led primary care practice.

Managing different models. Evidence exists of different physician-led primary care practitioners are choosing different models of care for various reasons. Confirmation occurred some PCPs are becoming concierge practitioners. The Payment Advisory Commission (2014) revealed providers began a retainer-based practice to simplify the administration. Cascardo (2014b), and McDonough (2013) discovered from 2005 to 2010 concierge doctors had risen five times to over 750. In 2013, McDonough revealed the amount of concierge PCPs in the US was between 5,000 to 5,500. In 2014, scholars estimated the number will grow to 12,000 or more in the U.S. (Cascardo, 2014b). McDonough (2013) noted MedPAC has concern doctors may withdraw from Medicare for a concierge practice increasing the primary care shortage. Some patients and physicians are opting for concierge medicine because neither likes needing approval for a

procedure a medical practitioner considers necessary, as well as new regulations, more administrative duties, and further income cuts (Cascardo, 2014a). A physician-led primary care practice leader must have adequate strategies when selecting the appropriate business model for their primary care practice.

Cascardo (2014a) established risk management is essential when considering a concierge model and suggests consulting a lawyer to describe fees and non-covered services carefully within one's contract. Cascardo (2014a) stated the importance of training staff to deal with the uniqueness of the concierge medicine model because the patients expect a higher level of service. Physicians must have managerial strategies to train and assess risk management in a primary care concierge medical practice. Benefits for choosing a concierge model for physicians include, but are not limited to, more predictable and higher income, which may encourage younger doctors to become a PCP potentially reducing the PCP shortage.

Physicians serve 2,000 patients annually on average in a traditional practice, while medical doctors who have a concierge practice serve 100 to 425 a year with the same income (McDonough, 2013). McDonough notes concierge practices do not need to take patients that covered by insurance; however, many do. McDonough (2013), gave an example of a primary care concierge practitioner in Alexandria, Virginia, who also charged patients $1500.00 per year, which covered the cost of primary care and additional care required additional fees. A readily available physician may appeal to patients, and a lighter workload may appeal to physicians. Physicians must understand

underlying strategies of different practice models to choose the appropriate solution for their physician-led primary care practice.

There is a multitude of reactions to the idea concierge medicine may create a two-tiered healthcare system, and patient abandonment (McDonough, 2013). Regardless of the model, a physician chooses for their physician-led primary care practice, physicians must have business strategies to sustain a physician-led primary care practice. Concierge business leaders can apply the CAS theory as a strategy by interacting with other concierge physicians, business leaders, or legal team to understand how others are successfully structuring their concierge practices.

Many scholars encourage PCPs to leave the traditional model and move toward the evolving PCMH to sustain a physician-led medical practice after the implementation of PPACA (Bleser et al., 2014; Frisch, 2013). Henderson, Princell, and Martin (2012) ascertained a PCMH is an effective way of restructuring the healthcare system to improve healthcare outcomes. A strategy for practice leaders is to focus on the quality of care rather than volume since patients' needs are now shaping all relevant interactions within the healthcare system. The shift in value over volume requires physicians to adapt and allows the emergence of different solutions for individuals and communities.

PPACA is transforming primary care practices into collaborative models such as PCMH and ACO, but the effectiveness in cost containment and quality improvement is unclear. The federal government, state governments, employers, and private insurers are testing restructured reimbursement models as well as sponsored pilot and demonstration programs (Wilensky, 2014). In time, this will aid physician leaders to make a more

educated decision on which model if any they will choose to adapt to the evolution of the healthcare reform. I discovered no clear strategy on which model is the best for physician-led primary care practices, leaders may use the CAS as a strategy to create value-based decisions, and foster relationships to learn, adapt and evolve with the changing environment.

In a pilot program monitoring implementation of multiplayer PCMHs performance improvement was found statistically greater, but did not have a change in utilization or cost of care (Friedberg, Schneider, Rosenthal, Volpp, & Werner, 2014). The pilot practices, accumulated average bonuses of $92,00 per primary care physician over the course of the three-year intervention (Friedberg et al., 2014). In the multipayer medical home pilot, all participating practices received National Committee for Quality Assurance (NCQA) certification Friedberg et al. (2014). Friedberg et al., (2014) revealed limited quality improvements, and they were not associated with reductions in utilization of hospital, emergency department, or ambulatory care services or total costs over three years. The literature suggests PCHM are likely in need of refinement and demonstrating the uncertainty and the need for physician leaders to have strategies to evolve with healthcare reform.

Wilensky (2014) determined most PCMHs had modest savings. For example, United Healthcare (2012) reported small savings around four percent over a two-year period. While Share and Mason (2012) discovered Blue Cross Blue Shield of Michigan had an upward trend in costs for 2011 and 2012 of less than two percent, which is equivalent to less than half of their competitors. Wilensky (2014) found no significant

improvements in various quality metrics and no more than modest savings. There exists a lack of literature demonstrating any actual financial benefits of a PCMH, which may move to a further evolution of the PCMH. Until research discovers the best model for physician-led primary care practices, leaders may use the CAS as a strategy to create value-based decisions, and foster relationships to create organizational learning leading to evolving in a changing environment.

Henderson, Princell, and Martin (2012) found complex interactions take place within a PCMH and need to be taken into account when measuring and assessing outcomes; for example, the quality of care depends on the collaboration of all members of a healthcare team. In addition, there is no clear evidence on whether patient outcomes improve significantly. Henderson et al. (2012) reported patient outcomes after 26 months in a PCMH only revealed minor improvements in condition-specific quality of care measures and no improvement in patient outcomes. Evidence on patient outcomes is important because one goal of PPACA and establishing PCMHs is to improve health outcomes. The lack of evidence on patient outcome in new models further demonstrates physician-led primary care practice leaders need strategies to continue to evolve and adapt with healthcare reform.

Pioneer ACOs reported uneven performance in 2013. Wilensky (2014) determined only 13 of the 32 pioneering ACOs produced enough savings to be shared with Centers for Medicare and Medicaid Services (CMS). Wilensky revealed nine ACOs left the program: two-ceased function as ACOs while seven changed to the regular Medicare Shared Savings Program (Wilensky, 2014). The literature demonstrates 40%

of the pioneering ACOs had savings and 28% were dissatisfied and left the pioneering program. High dissatisfaction is an indicator the ACO program has not completely evolved. Physician leaders may use the CAS key constructs to adapt and evolve in the changing environment to sustain a medical practice. For example, by learning from the past dissatisfaction and applying it to the organization's foundations, adaptation and evolution occur through a redesign (Dann, & Barclay, 2006).

ACOs have a range of services making it well positioned to support primary care practices within an organization. Moreover, Edwards et al. (2014) exposed many ways to invest in primary care resources such as care managers across multiple medical practices, electronic registries, and advanced data management capabilities. ACOs give the ability create effective networks, partnering more closely with specialists, hospitals, diagnostic, and post-acute services (Mostashari, Sanghavi, & McClellan, 2014). Physician leaders must have strategies to manage an organization to sustain a physician-led medical practice.

Mostashari et al. (2014) determined a physician-led ACO has a more evident financial benefit from reducing healthcare costs outside the physician group. A key factor for the implementation of PPACA is to reduce national healthcare expenditures (NHE) (Amara, Adamson, Lew, & Slonim, (2015). Since an ACO has a clearer financial benefit from reducing healthcare costs outside a physician group, and the cost of inpatient care is much larger than outpatient care an ACO may be the most evolved model of primary care. Physician-led primary care practice leaders may use CAS as a strategy to

make significant decisions such as the choosing the most efficient business model to utilize.

PCMHs typically receive payments for primary care services only; in contrast, ACOs are accountable for the entire continuum of care (Edwards, 2014). The lines between PCMHs and ACOs are beginning to be blurred since some PCMHs are starting to integrate the responsibility of the total cost of care through shared savings programs (Edwards, 2014). An ACO receives up to fifty percent of shared savings, without a downside risk, when the ACO maintains or improves the quality of care and patient experience (Mostashari et al., 2014.) Physician leaders may use the key constructs of CAS organizational loop of learning and redesign to gain knowledge on how to effectively manage shared savings to sustain a physician-led primary care practice.

Significant distinctions of shared savings programs are aimed at PCMHs rather than those intended for ACOs. First, with a PCMH, the primary care physician receives shared savings, whereas, with an ACO, the organization determines how the shared savings are distributed (Edwards, 2014). ACOs may not necessarily direct the savings payment to primary care. Second, a PCMH will have fewer patients than an ACO, making the calculations of shared savings less reliable (Edwards, 2014). Therefore, findings on payment or penalty under the shared savings program will likely be more of a random variation. PCMHs may need to meet higher savings thresholds before they qualify for the shared savings making it a disincentive for small PCMHs (Edwards, 2014). Finally, PCMH shared savings programs allow practices to share in savings, but typically will not receive loss because of overspending.

One notion is to integrate PCMH into ACOs. Edwards (2014) ascertained PCMHs could be an excellent foundation for the delivery of care within an ACO. However, ACOs and PCMHs currently encounter many challenges, such as the need for further reform, incentive alignment with the mission of the organization, and affiliating with specialists in the organization (Edwards, 2014). Aligning alliances often present challenges, but are opportunities for both parties (Hearld, Alexander, & Mittler (2012). For example, one participant may want to improve the health in a community regardless of cost, while the other member may prefer more cost control. Physician-led primary care leaders may use a planning committee to manage collaboration, and alignment within an organization to sustain their primary care medical practice longer than 5 years.

Financial Management

Delisle (2013) discovered managing shared financial risk (such as in an ACO) a challenge. For example, if prices are set to low providers may lose money, while high prices may reduce motivation and better service. Bendix (2013) suggested switching and managing risk can decrease malpractice. For example, when a physician decided not to prescribe buprenorphine and naloxone (drugs used to treat opioid addictions), they witnessed a decline in their malpractice since malpractice insurers consider drug addicts.

Medical malpractice companies have been noticing physician companies merging with hospitals and other groups, as a result, narrowing the market creating more competition lowering malpractice prices (Bendix, 2013). However, the ACA encourages managed care-like pay structures, which may be considered economically beneficial yet

is not strictly what is best for the patient (Bendix, 2013). This structure increases liability and may reverse or slow down the downward trend (Bendix, 2013).

Strategies to Manage Financial Reform

PPACA created many changes in structure, making it a necessity for physicians to advance in financial management (Delisle, 2013). Delisle (2013) suggested a strategy of having a dedicated staff to collect, allocate, and manage funds to address the changes in claim processing procedures as well as managing post-acute and payer contracting.

O'Donnell, Williams, and Kilbourne (2013) discussed reimbursement strategies under emerging payment structures to promote integrates mental healthcare using the chronic care model. Although the doctoral study does not focus on mental healthcare, I draw parallels to strategies used in a mental healthcare setting since there is a lack of literature pertaining to the strategies used to sustain a physician-led primary care practice. O'Donnell et al. (2013) discovered reimbursement negotiation is an effective strategy. O'Donnell et al. (2013) suggested working in a group with multiple stakeholders and work toward benchmarks as a team. For example, become a part of an ACO and be involved in the negotiations and focus on how the ACO will reimburse different parts of the organizations. Casalino et al. (2013) also revealed working in a collective is beneficial stating independent physician associations (IPAs) have a much better bargaining power to negotiate a fee for service than a small business practitioner alone.

O'Donnell et al. (2013) stressed the importance of contacting payers to determine the documentation needed and if and how they will reimburse for a specific code.

Moreover, O'Donnell et al. suggested using a group as a strategy to advocate the creation of a new code with payers if providers lack reimbursement for something important.

There have been a few themes discovered while researching perceptions of the reimbursement reform. The themes include the abandonment of FFS, PCP do not want change but understand change is needed, RVU scale no longer reflect actual costs, physicians will make less money, exacerbation of physician shortage, and mental modes as barriers. I discovered literature describing the increasing medical education costs for PCPs as a barrier to sustaining a physician-led primary care practice. The central theme is an uncertainty of how PPACA will affect the sustainability of physician-led primary care practices.

Perceptions of reimbursement reform are important because perceptions influence how one operates within an organization. Evidence demonstrations some physician-led primary care practice leaders are trying to adapt and continue their practices even with the perceptions of regulatory burdens, and uncertainty of reimbursement (Mostashari, Sanghavi, & McClellan, 2014). In contrast, others are joining larger health systems because they believe larger systems are better equipped to address the uncertainty of the reform (Mostashari et al., 2014).

As demonstrated, there has been an evolution of the reimbursement structure over the past century. There exists a perception the value-based modifier will relinquish the FFS model, but Ginsburg (2012) stated the FFS would continue to be the core of reimbursement. Ginsburg identified the change as an improvement and is essential to a practitioner's success. Dorn (2013) agreed that FFS has continued to be prevalent in

reimbursement, but reiterated each program that began as voluntary will become mandatory in 2017 for all Medicare participants, and will likely be adopted by private insurance groups as well. Mandatory requirements have created a need for physician leaders to have strategies to adapt to the healthcare reform to sustain a physician-led primary care practice.

I discovered a significant amount of literature demonstrating PCP leaders do not want to eliminate the FFS model. Tilburt et al. (2013) conducted a study, and only 7% of those physicians were enthusiastic about eliminating the FFS model. Mostashari et al. (2014) concurred by finding PCPs are opposed to cost cutting approaches within the FFS model, including but not limited to, across-the-board payment reductions, limits on coverage, or increased administrative barriers (e.g., prior approvals and payment contesting) that will further reduce their income. Wilensky (2014) established some physicians lack interest in trying new reimbursement structures. The 7% of participants who demonstrated enthusiasm for removing FFS models had a salary plus bonus or salary-only compensation type (Tilburt et al., 2013). Although PCP leaders do not want change, leaders must have strategies to adapt and evolve with healthcare reform to sustain a primary care medical practice.

Although PCPs do not want to eliminate FFS, physicians understand change is needed. PCPs are aware the FFS model does not provide adequate support for promoting continuity of care, using cost-effective treatments, chronic disease care coordination, prevention and adhering to clinical guidelines (Mostashari et al., 2014). Moreover, there is some dispute the FFS reimbursement model supports growth in volume rather than

value and quality of outcomes, and has fragmented care (Delisle, 2013; Dorn, 2013). PCPs acknowledgment of the need to adapt is a positive shift in evolving with the healthcare reform to sustain a physician-led primary care medical practice.

There is minimal argument the RVU scales no longer capture the actual cost of a service creating a need to evolve (Wilensky, 2014). However, Ginsburg had the perspective the combination of flaws had helped continually update the process and move toward the original goal of the 1989 reform. Wilensky (2014) stated the federal government has responded to the ineffective RVU scale by continuing to reevaluate RVUs, which has evolved FFS refocusing on the quality of care. Along with upcoming mandatory changes, primary care practice leaders must have strategies to adapt to the value-based methodology to sustain their physician-led primary care practice.

PPACA creates managerial demands and financial uncertainty exacerbating the PCP shortage in the United States. Multiple researchers mentioned predictions the United States will have a deficit of 45,000 PCP by the 2020s (Green, Savin, & Lu, 2013; Frisch, 2013). I discovered a social aspect to physician shortage, which I will discuss in brevity throughout this doctoral study. However, I will focus on uncertainty and known barriers for physicians to sustain their physician-led primary care medical practices.

Peterson et al. (2015) reported that there is little research on why physician-led primary care practices are rapidly integrating with larger healthcare systems. Moreover, Peterson et al. ascertained the important to discover what it means, why integration is happening, and determined it will be difficult to revive physician-led primary care practices once they are gone. Frisch (2013) revealed the expected shortage of PCPs is

because of four main factors. Less than 25% of new physicians choose to be a PCP; approximately 33% of medical doctors will likely retire in the 2020s; and more than 32M U. S. citizens gained access to health insurance in 2014 due to PPACA (Frisch, 2013). Zhu and Metzler (2012) found fewer physicians are choosing to become PCPs, largely because they no longer receive adequate compensation to cover the costs of operating a practice and paying off school debts. The decline of physician-led primary care practices demonstrates strategies are needed to overcome the barriers involved to sustain a physician-led primary care practice.

PCPs feel underpaid and underappreciated (Wilensky, 2014; Frisch, 2013). Even though PCPs must complete rigorous training is often just as long as other specialties, PCPs ranked as the lowest paid physician. PCPs earn an average of $177,600 while specialties earn on average of $357,000-$405,000 depending on the specialty (Frisch, 2013). Although these salaries may seem high, physicians have the perception they no longer cover the costs of running a medical office and paying off school debt.

Historically, Physician salaries did not increase as quickly as the cost of school. Zhu and Metzler (2012) reported the average school debt was only $27,000 in 1992, while in 2012 more than 85% of medical students who graduated had an average debt of $157,900. Frisch conveyed in 2013 the average school debt was $166,750 thus enticing students to choose a higher-paid specialist position. From Zhu et al.'s findings, I discovered the average cost of school increased 584.81% from 1992-2012. If PCPs have the strategies to manage finances and control debt they may choose to open a physician-led primary care practice when they otherwise may not.

A social aspect of the physician shortage is the growing need for patient-centered access of PCPs. Buykx et al. (2012) revealed rural communities have a difficult time maintaining physicians to meet the acute and chronic care needs. Long (2013) identified the need for Medicare to provide higher reimbursements, but also offer different practice models to increase the willingness of physicians to treat Medicare patients. Healthcare systems are offering new services, such as satellite clinics, same-day and group appointments, as well as utilize nurse practitioners and physician assistants (Berry, Beckham, Dettman, & Mead, 2014) to help alleviate the shortage. The evolving healthcare system has made it essential for medical doctors to have strategies to sustain a physician-led primary care practice and to continue to care for the growing population.

National healthcare expenditures (NHE) grew 3.6% in 2013 reaching $2.9 trillion accounting for 17.4% of Gross Domestic Product (GDP) (Centers for Medicare & Medicaid, 2014). The growth of NHE and GDP is significant since the government is trying to control the cost of healthcare, but the costs remain inconsistent (Newhouse & Garber, 2013). Since the NHE continues to grow after the implementation of PPACA, researchers predict the healthcare system will continue to evolve. Therefore, physician-led primary care practice leaders must have strategies to evolve with the changing environment.

After extensive examination of literature, evidence demonstrated two unique views on geographical variation in Medicare spending, which influence PPACA healthcare reform (Newhouse & Garber 2013). The first view of geographical spending variation focuses on patient health status (Reschovsky, Hadley, & Romano 2013); while

the opposing view focuses on provider practice patterns to explain the geographic spending variation (Franzini et al., 2014; Newhouse & Garber, 2013). Hadley et al., 2014 determined there might be several reasons why geographical reimbursement variations such as some markets may have a lower threshold to diagnose a condition, or some markets may treat an individual more aggressively. For example, the threshold to offer a treatment may vary across geographic regions. The influence of Medicare spending on PPACA is important because it has been the most recent reform affecting sustainability challenges for physician-led primary care practices.

Sustainable Information Technology

One way to sustain a medical practice is by using stainable technologies (Boons & Ludeke-Freund, 2013). The ACA has focused on improving population health their medical experiences and while addressing healthcare expenditures. Congress attempts to accomplish this by the PPACA reform through coordinating care between providers, specialists, and hospitals (Schoen et al., 2012). The idea is of enhanced coordination uses a vital component of information systems, such as electronic health records (EHR) (Delisle, 2013). EHR create an effective coordination automating processes of the exchange of information and increased access to data (Delisle, 2013).

Emanuel et al. (2012) found the PPACA healthcare reform regulations require physician leadership to determine the health information technology (HIT) and infrastructure necessary for coordinating care. Casalino, Wu, Ryan, Copeland, Rittenhouse, Ramsay, and Shortell, (2013) independent practice associations (IPA) can use HIT as a strategy to improve care management for smaller practices.

Electronic healthcare records (EHR) are becoming a global phenomenon. The United Kingdom's National Health Service (NHS) discovered when EHRs are used there is a significant financial benefit by ePrescribing, and there is an acute operational performance in contractual savings, improved patients postoperatively, and widespread accurate clinical information (Kellogg, 2013). Kellogg also revealed EHR systems could potentially save three minutes of nursing time and five minutes of physician time and creates a significant reduction in turnaround times for test results, duplicate test orders, and prescription errors. Schoen et al. (2012) concluded that countries around the world supported health information technology, but a high number of PCPs did not routinely receive timely information from specialists or hospitalists. Schoen et al. claimed US doctors were most likely to report that they spent substantial time grappling with insurance restrictions and that their patients often went without care because of costs.

A barrier to adapting to healthcare reform and payment reform is the ability to navigate increasingly complex HIT (e.g. Blumenthal et al., 2012; Delisle, 2013). Moreover, addressing problems of an EHR system falling offline (Kellog, 2013). Although researchers describe barriers to the implementation of HIT and EHR, Schoen et. al. (2013), discovered the performance feedback from information systems provides a strong incentive and engages physicians to commence changes.

Literature Review Summary

The literature review builds a foundation to demonstrate linkages, trends, and overviews; explaining how the study advances knowledge; conceptualized the study from defined terms, establishes why one the selected method is appropriate, and others are not;

finally, to stipulate a reference point for interpretation of findings. The literature review shows an increase of regulations and governance in healthcare reimbursement over the last century, demonstrating the ongoing reform changes physician-led primary care practice leader's strategies to adapt and evolve to sustain a medical practice longer than 5 years.

Review content also includes healthcare reform perceptions as well as evolving organization models for the delivery of primary care, barriers to healthcare reform and ways to manage the barriers. A gap exists in the literature on geographical data as well as what strategies physician-led primary care practice leaders use to sustain their practices.

The central theme is an uncertainty of how PPACA will affect physician-led primary care practices, and how to use strategies to mitigate the barriers of sustaining physician-led primary care practices. I discovered deficiencies in strategies leaders use to manage a physician-led primary care practice in the 2010s. I revealed a scarcity of information on the amount of time a physician has been in practice before they experience financial problems. Evidence revealed some physician-led primary care practice leaders are trying to adapt and continue their primary care medical practices. Even with the perceptions of governmental regulatory burdens, and uncertainty of reimbursement. Others are joining larger health systems they feel are equipped to address the uncertainty of the reform. The literature review concludes with a description of the general problem that some physician-led primary care practices are facing sustainability challenges.

Transition

Section 1 focused on the foundation of the study. This section began with an introduction to the study relevant to (a) the problem and purpose statements, (b) the nature of the study, (c) and the overarching research question of: What strategies do physician-led primary care practice leaders use to sustain a medical practice longer than 5 years? Section 1 also includes (a) the conceptual framework, (b) operational definitions (c) assumptions, limitations, and delimitations, (d) significance of the study, and (e) concluded with a synthesized review of the scholarly literature.

Section 2 presents the project. Section 2 begins with (a) restatement of the purpose statement, (b) the role of the researcher, (c) participants, (e) research method and design, and (f) population and sampling. Section 2 also focuses on ethical and reliability considerations including (a) ethical research, (b) data collection instruments and techniques, (c) data organization, and analysis, (d) reliability and validity. Section 2 concludes with a transition and summary.

Section 3 consists of the application for professional practice and the implications for social change. Including, (a) the presentation of the findings, (b) applications to professional practice, (c) implications for social change, (d) recommendations for action, and further research, (e) and reflections. Section 3 ends with a summary and study conclusion.

Section 2: The Project

The objective of this qualitative multiple case study was to explore strategies physician-led primary care practice leaders use to sustain a medical practice longer than 5 years. Exploration consisted of various components of a physician-led primary care practice such as organizational design and reimbursement. Section 2 includes a restatement of the purpose statement, the role of the researcher, participants, research method and design, population and sampling, ethical research, a data collection plan, and the data analysis procedures.

Purpose Statement

The purpose of this qualitative multiple case study was to explore strategies physician-led primary care practice leaders use to sustain a medical practice longer than 5 years. The target population consisted of physician-led primary care practice leaders or practice managers who have sustained a profitable medical practice longer than 5 years in southern Indiana. I conducted multiple meetings with physician leaders or practice managers to identify an accurate view of strategies used to sustain a medical practice longer than 5 years. I also examined company policies and procedures as well as government statistics to triangulate the findings. The selected population was appropriate for this study because of its history of sustaining a profitable medical practice in the current environment. The implication for a positive social change is the possible increase of sustainable primary care medical practices, which may lead to an increase of patient access to PCPs.

Role of the Researcher

My role as the researcher was to perform a qualitative case study to explore what strategies physician-led primary care practice leaders use to sustain a medical practice longer than 5 years in the state of Indiana. The principal role of a researcher is to collect data to assess a phenomenon (Marshall & Rossman, 2014). I selected participants through the American Medical Association member directory. Next, I ensured the participants were appropriate for the study by confirming they are a physician leader or practice manager who has sustained a physician-led primary care practice longer than 5 years. I then conducted semistructured interviews, gathered other relevant data, and analyzed and triangulated the data to increase validity.

Qualitative research is an interpretive inquiry; therefore, the role of the researcher is to identify biases, values, socioeconomic status, history, and culture as these may alter their interpretation (Benner, 1994). My spouse is a family practice MD working in a hospital setting. Because I am linked closer to a hospital setting, I chose to study physician-led primary care practices to reduce bias. I did not have any prior contact with participants before IRB approval.

My role as a researcher is to deliver basic ethical principles as described in the Belmont Report. The ethical principles include the respect for participants, beneficence, and justice and proper applications of informed consent, assessment of risk and benefits, and selection of subjects (Aggarwal, & Gurnani, 2014). Prior to this study, I have never collected data on strategies used to sustain a physician-led primary care practice. I have had no previous relationship with the participants. I also applied basic ethical principles

as described in the Belmont Report protocol by following the interview protocol that I have created, which includes but is not limited to informed consent, respect, and requirements (Appendix A).

Some researchers find it difficult to set aside their biases; as a result, they do not ask questions about historical, cultural, or geographically defined social phenomena (Nelson, Onwuegbuzie, Wines, & Frels, 2013). I mitigated biases by using semistructured interviews and an interview protocol (Appendix A). Because of my knowledge of medical practices, I conducted semistructured interviews to obtain a complete view of the participant's perspectives while viewing data from a conceptual lens that some physician leaders lack strategies to sustain a primary care practice longer than 5 years. A case study protocol is a procedural outline to increase reliability by keeping the study focused (Marshall & Rossman, 2014). The interview protocol (Appendix A) was used as a procedural guide throughout the study to assist in remaining focused. I also conducted member checking to verify I captured what the contributors were trying to say.

Participants

I discovered three factors for determining the eligibility criteria for participants for this study. First, participants are the owner or manager of a physician-led primary care medical practice. Second, the owner or manager is located in southern Indiana. Third, the business owner has been operating as the owner or manager for 5 years or longer. When creating an eligibility criterion, a researcher must consider the overall goal of the research (Kim et al., 2015). Whiting et al. (2016) stated the importance of

determining if the eligibility criteria align with the overarching research question. The eligibility criterion is based on the belief the participants possessed relevant insights of their experience of managing a physician-led primary care practice for over 5 years. Srikanthan et al. (2016) discovered eligibility criteria may make a study less generalizable. Scholars demonstrated the importance for a study to be generalizable, yet a study is desired to have succinct and accurate findings.

The strategy to gain access to participants was through personal and professional relationships. I called PCPs to invite them to participate in the study. I then followed up with an e-mail to ensure participation and described their rights as a participant. I also provided an explanation of the goals of the study and how the member would aid in assistance of exploring how physician-led primary care practice leaders sustain a medical practice longer than 5 years

Research Method and Design

I investigated qualitative, quantitative, and mixed method methodologies to determine which method would be the most suitable for this study. The research and method design section begins by including a discussion of the research method and design chosen for the doctoral study, followed by a justification as to why it was the appropriate method. The focus then shifts to the research design and its applicability.

Research Method

I selected a qualitative case study research design. Qualitative research answers a central question and associated subquestions (Moustakas, 1994). Qualitative research is considered exploratory, flexible, data driven, and context sensitive (Gioia, Corley, &

Hamilton, 2013). Qualitative research is an empirical investigation used to retrieve data from a variety of sources such as interviews, observations, design efforts, interventions, and archival materials (Macfarlane et al., 2015). The selected method was appropriate because using a qualitative methodology allowed the fluidity needed to explore what strategies physician-led primary care practice leaders use a variety of sources.

Quantitative researchers create hypotheses and test predefined variables to determine statistical significance (Babones, 2015). Hannigan and Lynch (2013) stated that conventional techniques used in a quantitative method are descriptive statistics, correlation, regression, hypothesis tests and survival analysis, yet quantitative studies can have insufficient information. A quantitative methodology allows a researcher to measure specific data points; for example, Takuma et al. (2013) identified spleen stiffness by radiation using quantitative data. A quantitative method was not appropriate for this study because I explored a phenomenon and did not consider correlations between dependent and independent variables.

Makrakis and Kostoulas-Makrakis (2015) ascertained that mixed methodology is a complementary integration of qualitative and quantitative data through a transformative process, which involves collecting data in a process where data gathered in one phase contributes to data collected in the next. McKim (2015) stated that mixed methods research typically displays statistics by themes and side-by-side comparisons to connect findings with explanatory sequential, exploratory sequential, and intervention designs. Frels and Onwuegbuzie (2013) identified mixed methods as the combination of two independent components of quantitative and qualitative data, which also involves the

integration, connection, and embedding of the two data components. Strategies to sustain a physician-led primary care practice longer than 5 years are not a phenomenon, which requires a mix of quantitative and qualitative data. Therefore, a mixed methodology was not appropriate for this study.

Research Design

I selected a multiple case study design for this study. Moustakas (1994) specified that some qualitative designs include phenomenology, case study, and narrative. Case studies have an advantage over other quantitative methods because researchers can answer how or why something worked, as opposed to other methods such as true experiments, which are limited to whether something works (Yin, 2014). Multiple case studies can mitigate validity and generalization issues with the use of triangulation, rival explanations, and logic models (Yin, 2013). For example, Nguyen and Bosch (2012) used a multiple case study to identify leverage points for sustainability. I chose a multiple case design to provide a real-world context and a deeper understanding of the topic, resulting in new learning about the strategies physician-led primary care practice leaders use to sustain their medical practices longer than 5 years.

I established a phenomenological design inappropriate for this study. Phenomenology starts with induction to generate ideas, insights, or questions from experience, then a researcher explores and deduces data with scrutiny and concludes with verification (Moustakas, 1994). Phenomenology focuses on a unique lived experience (Gee, Loewenthal, & Cayne, 2013). The phenomenology design allows a researcher to collect data only through interviews (Peters, & Halcomb, 2015); however, collecting data

only through interviews would not have met the extent of data collection desired for this study.

Although Moustakas (1994) described a narrative design as a principal qualitative method, it was not applicable for this study. Moustakas described a narrative design as gathering stories from two or more individuals and sharing the stories chronologically. A narrative approach is appropriate when a researcher desires to tell a chronological story. For example, Bhatia et al. (2015) used to a narrative design to describe a recent advance in treatment for older people with substance use problems, and Locock et al. (2014) used a narrative design to archive patient experience. However, collecting stories was not the desired content for this study, meaning a narrative design was unsuitable.

Data saturation occurs when data is superfluous (Marshall, et al. 2013). I saturated and triangulated data to be certain the findings were accurate. The goal of this study was to discover strategies physician-led primary care practice leaders use to sustain their medical practice longer than 5 years.

Population and Sampling

The study involved a purposeful sampling of participants who are physician-led primary care practice leaders or managers involved in sustaining a physician-led primary care medical practice 5 years or longer in southern Indiana. Yin (2014) found that purposeful sampling aids in selecting participants. Purposeful sampling allows a researcher to contextualize findings from fieldwork to find knowledgeable contributors (Poulis, Poulis, & Plakoyiannaki, 2013). Elo et al. (2014) determined that a purposeful selection of participants could aid in reaching a population with a wealth of experience

with a phenomenon. Therefore, I used a purposeful selection of participants for this study.

I interviewed three physician-led primary care practice leaders and managers until data saturation occurred. Data saturation is appropriate for qualitative research that has interviews as the primary data source (Marshall, et al. 2013). Data saturation transpires when no new concepts emerge (Houghton et al., 2013). I saturated data and triangulated the research to be confident in my findings. Triangulation uses more than one type of data to confirm discoveries and increase validity (Yin, 2014). I interviewed participants until I reached saturation, which occurred when the same themes continued to appear.

The participants selected for this study met the criteria of being a physician leader or practice manager involved in sustaining a physician-led primary care medical practice for 5 years or longer in southern Indiana. The participants were selected on the assumption that they had a working knowledge of managing a physician-led primary care medical practice. I conducted multiple meetings with physician leaders or practice managers to identify an accurate view of strategies used to sustain a medical practice longer than 5 years.

The prospective participants received a letter to inquire if they were interested in participating the study. I then called to follow up and explain why participation is needed. If a prospective contributor was interested, I sent an informed consent form and ask to schedule a meeting. I conducted interviews in person or via a recorded video chat program (e.g. Skype, Facetime). The participants chose a location that was most comfortable for them.

Ethical Research

This qualitative multiple case study incorporated the processes necessary for the Internal Review Board (IRB) approval and general ethical considerations. The considerations include certification of recruitment, procedures promoting voluntary, and noncoerced participation. Yin (2014) stated the importance of obtaining informed consent before a study begins. Informed consent is widely accepted and a standard requirement for legal, ethical, and regulatory research (Grady, 2015). I used an informed consent form to notify the participants of the purpose of the study and obtain their signature in agreeing to participate.

All participants were over the age of 18. Participants were physician leaders or practice managers involved in sustaining a physician-led primary care medical practice. The risk of participating in the study was minimal, and I ensured anonymity of the participants. Additionally, members could withdraw from the study at any time until after I collected all data. A participant could withdraw from the study freely and could do so verbally or by emailing me. If a participant decided to withdraw during an interview, I would have disregarded all data from that participant.

Researchers widely use financial incentives when conducting research; however, Giles et al. (2015) discovered ethical concerns with coercion, personal responsibility, and can be unintended consequences. To mitigate ethical concerns, I did not offer financial incentives for participating in the study. The incentives include understanding themes within a participant's physician-led primary care practice and contributing the knowledge of strategies on how to sustain a physician-led primary care practice.

In accordance with Walden University's Research Center, I maintained all electronic data with password-protected files, and the hard data collected will be conserved in a locked safe for 5 years. I will destroy all data after 5 years to protect the confidentiality of the participants. Moreover, I did not collect any data until approval from Walden University's IRB board had approved the study. Finally, I protected the participants and organizations confidentiality by numerically coding the participants and organizations (e.g., Participant 1, Participant 2, and Participant 3).

Data Collection Instruments

I was the primary instrument for data collection. The data collection process included a review semistructured interviews, company policies and procedures, and government statistics. Yin (2014) described four types of data collection methods for qualitative research: interview, observation, collection, and feeling. Using several types of data allows a researcher to triangulate the data increasing the reliability and validity of a study (Shaw, 2013). Marshall and Rossman (2014) established the use of triangulation in a case study gives a more accurate, objective, and neutral representation of findings. Semistructured interviews utilize open-ended questions to provide structure while allowing participants to divulge pertinent data (Chan, Fung, and Chien, 2013). Campbell, Quincy, Osserman, and Pedersen (2013) stated that semistructured interviews are often the empirical backbone of qualitative studies. For example, Serafini, Lake, and Long (2015) used semistructured interviews to conduct face-to-face, online chat, and telephone interviews.

I used an interview protocol (Appendix A) to explore strategies physician leaders or practice managers use to sustain a physician-led primary care practice. An interview protocol is a procedural outline to increase reliability, by ensuring data collection, analysis, and reporting remains focused (Marshall & Rossman, 2014; Yin, 2014). Gioia et al. (2013) revealed the importance in attention to detail when creating an interview protocol is to ensure; the protocol is thorough, no leading questions, and is focused. Based on Yin's (2014) case study protocol, I have prepared an interview protocol. The interview protocol (Appendix A) includes (a) an overview of the case study; (b) a description of the data collection procedures; (c) the interview questions and (d) a summary of the data analysis techniques to be used.

I enhanced the reliability and validity of the data collection process through member checking, and methodological triangulation. After I transcribed the interviews, I synthesized the data. Next, I conducted a member checking interview to review data collected. Member checking ensures a researcher captures what a participant is trying to convey (Marshall & Rossman, 2014). Mazor et. al., (2013) found reviewing data collected assists in accurately capturing data. I used interviews, company's policies and procedures as well as government statistics to methodologically triangulate data. Triangulation increases the reliability and validity of qualitative research (Yin, 2014).

Data Collection Technique

I developed semistructured interview questions to explore strategies physician-led primary care practice leaders and managers use to sustain their practice. I selected a data collection technique that contains semistructured interviews using open-ended questions.

This approach allows participants to openly express their outlooks, and direction to the dialogue (Campbell et al., 2013).

The interview process included collecting pertinent documents (e.g., archival documents) from each participant. The interview sessions were electronically recorded and then transcribed. I also utilized a field log during the interview process. The advantage of using Internet video chat (e.g. Skype, Face time) is accessibility to participants. A potential disadvantage is not viewing a participant's entire body limiting the ability to observe the contributors body language completely.

I used member checking to ensure I captured what the participant was attempting to portray. Member checking allows follow up questions or expansion to ensure data saturation (Cope, 2014). Caretta (2016) discovered member checking was an important tool for researchers to use because it enables participants to confirm or clarify data collected. Forber-Pratt (2015) used member checking to ensure their qualitative study was legitimate, reliable, and valid.

Data Organization Technique

Yin (2014) revealed data organization crucial when conducting research to increase the reliability and validity of a study. I used Microsoft Word to transcribe the audio recordings. Then, I used NVivo to assist in organizing and analyzing data. NVivo is applicable for qualitative data analysis (Edwards-Jones, 2014). Straus et. al., (2013) used NVivo to aid in analyzing their qualitative study consisting of two health centers. Cameron, Naglie, Silver, and Gignac (2013) used the NVivo to assist in coding the data from their qualitative study. As required by Walden University, I secured all electronic

data and will keep the data for 5 years by using password-protected documents. To further protect the anonymity of the participants, I created a secured folder titled Doctoral Study Data with associated subfolders titled Participant 1, Participant 2, and Participant 3. The member folders contain participant's data as well as their informed consent. I secured all hard data copies in a locked safe in which only I have access. After 5 years I will destroy all data.

Data Analysis

Methodological triangulation was chosen for the data analysis process. I applied triangulation by comparing semistructured interviews, company's policies and procedures as well as government statistics. Data analysis is an essential to interpret data, facilitate the generation of descriptions, categories, explanations and typologies (Keenan, van Teijlingen, & Pitchforth, 2015). Methodological triangulation involves two or more sets of data from the same methodology to reach deeper findings (Heale & Forbes, 2013; Yin, 2014). Triangulation is used as a crosscheck and to validate results (Shaw, 2013). I structured the interview questions using significant phrases to explore *how, why,* and *what* participating physician-led primary care practice leaders use strategies to sustain a physician-led primary care medical practice longer than 5 years.

After the collection of data, I triangulated the data from semistructured interviews, company's policies and procedures as well as government statistics utilizing the Framework Method for data analysis. The Framework Method had been used over 25 years in qualitative health research (Keenan, van Teijlingen, & Pitchforth, 2015). The data analysis procedure included seven stages: Stage 1, Transcription; Stage 2,

Familiarization with the interview; Stage 3, Coding; Stage 4, Developing a working analytical framework; Stage 5, Applying the analytical framework; Stage 6, Charting data into the framework matrix, Stage 7 Interpreting the data.

After transcribing interviews into a Word document, I read transcriptions and familiarize myself with the interviews. I then conducted a member checking interview with participants to ensure the data is accurate and conveys what the contributor wanted to say. I proceeded to Stage 3 of the data analysis and utilize NVivo to code the data for this study. Keenan van Teijlingen, and Pitchforth (2015) found data analysis software assists in managing and analyzing data. NVivo is a Qualitative Data Analysis (QDA) software package that allows researchers to code and discover relevant themes (Hilal, & Alabri, 2013). NVivio allowed me to create an analytical framework and apply it to the study. After themes emerge, I moved to Stage 6 and charted data into a framework Matrix. Qualitative data can be abundant and is important to chart the data to have an overall view (Keenan et. al, 2015). I concluded with Stage 7 of the data analysis and interpreted the data.

I designed an interview protocol (Appendix B) to guide the collection of data to find strategies that physician-led primary care practice managers use to sustain their practices longer than 5 years. Data analysis is a systematic search of patterns to render a full understanding of the phenomenon under investigation (Keenan, van Teijlingen, & Pitchforth, 2015). The complex adaptive systems (CAS) theory embodies an organizational loop or learning and redesign, including the organization, interactions, random events, adaptation, and evolution (Dann, & Barclay, 2006). By using the CAS

approach, I explored strategies used by physician-led primary care practice leaders to sustain their business. I used methodological triangulation using the participants' semistructured interviews, company's policies and procedures as well as government statistics to see similarities, differences, or similar yet inconsistencies.

Reliability and Validity

Historically qualitative research has been considered soft science (Cope, 2014). Therefore, a researcher must use reliability and validity to demonstrate the trustworthiness of the research. Dependability, credibility, transferability, and confirmability is a form of criteria to assess the reliability of qualitative research (Houghton, Casey, Shaw, and Murphy, 2013; Cope, 2014; Elo, Kääriäinen, Kanste, Pölkki, Utriainen, & Kyngäs, 2014). Qualitative data is not inferior to quantitative data, and I used dependability, credibility, confirmability and data saturation to justify the reliability and validity of the study.

Dependability

Dependability refers to how stable data is in qualitative research, and dependability is synonymous with reliability (Houghton, Casey, Shaw, and Murphy, 2013; Cope, 2014). I addressed dependability through member checking, member checking, and an audit trail. I followed an interview protocol (Appendix B) for the interviews, conduct and collect documents from the participants. Marshall and Rossman (2014) deemed a case study protocol necessary to increase reliability and credibility.

After I transcribed the interviews, I synthesized the data and conducted a member checking interview. Member checking is when a researcher collects and synthesizes data,

and then reviews the transcript and synthesis with the participant to ensure their view was captured correctly (Cope, 2014). Transcript reviews increase the reliability and validity by allowing interviewees to review a transcript to verify its exactitude (Berger, 2015). Houton et al., found an audit trail allows other researchers to understand the interpretive judgements made to assess the findings. NVivo records the decisions made in the analysis phase of the study. I presented the findings as an illustration in the final research report.

Credibility

Credibility refers to the truth of the data in relation to the participant's views and the researcher's interpretation (Cope, 2014; Houghton, Casey, Shaw, & Murphy, 2013). I ensured credibility through member checking, data saturation, and methodological triangulation. Member checking and data saturation are important steps in qualitative research (Cope, 2014). Yin (2014) emphasized the importance of triangulation, stating triangulation uses more than one type of data to confirm discoveries to increase validity and reliability. I used methodological triangulation to triangulate participants' semistructured interviews, company's policies and procedures as well as government statistics. Using methodological triangulation allowed me to account for similarities, dissimilarities, or similar yet inconsistencies.

Transferability

Transferability is one of the most common measures of reliability and validity (Elo et al., 2014). Transferability refers to the ability to transfer the data in the study to future similar studies (Cope, 2014; Houghton, Casey, Shaw, & Murphy, 2013). Cope

stated researchers must provide sufficient information, so readers can assess the findings concerning their work. I addressed transferability in relation to the reader and future research by using thick descriptions. However, prospective authors must make an informed decision if the data is acceptable or not to transfer to their study.

Confirmability

Confirmability is closely related to dependability with the goal of ensuring the data is accurate (Houghton, Casey, Shaw, and Murphy, 2013). I addressed confirmability similarly to dependability with an audit trail. In addition, I used methodological triangulation on the data collected to confirm findings. An audit trail allows scholars to understand how a researcher has interpreted the data collected and allows them to draw their conclusions (Cope, 2014). I used NVivo software which can record an audit trail. I present the audit trail at the end of the study.

Triangulation assists in the confirmation of findings (Heale & Forbes, 2013; Yin, 2014). Triangulation occurs when a researcher uses multiple types of data to confirm results (Cope, 2014). Triangulating data assisted me in exploring the data to find similarities, dissimilarities, or similar yet inconsistencies.

Data Saturation

Marshall, Cardon, Poddar, and Fontenot (2013) found no set rules to justify sample size but stated data saturation is essential when conducting qualitative research. Houghton, Casey, Shaw, and Murphy (2013) found data saturation occurs when there is a lack of new themes arising in the data collected. Cope (2014) stated data saturation

occurs when there has been a full exploration of the data. I ensured data saturation by exploring the data collecting enough until no new themes arrive.

Transition and Summary

Section 2 focused on the role of the researcher and how and why a method and design was selected. Section 2 discussed the ethical considerations, data collection instruments, techniques, organization, and analysis. Finishing with the reliability and validity techniques selected for the qualitative multiple case study design. Section 3 consists of the application to professional practice and the implications for change that include, but is not limited to, presentation of the findings, implications for social change, and recommendations.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative multiple case study was to explore strategies physician-led primary care practice leaders use to sustain a medical practice longer than 5 years. In this study, I conducted three semistructured interview and triangulated data with the company's policies and procedures as well as government statistics. Participants consisted of physician-led primary care practice leaders from three different medical practices. Three themes emerged: (1) patient engagement, (2) relationship development and retention, and (3) adaptation and innovation. All participants stressed the importance of patient engagement as a primary strategy. All participants stated the importance of healthy internal and external relationships. One participant stressed the importance of internal relationships more than the others. Most participants stated flexibility was important to sustain their practice, while all participants felt the ability to adapt and innovate was secondary to patient commitment.

Exploring strategies to sustain a physician-led primary care medical practice may add value to the participants' business. Participants and readers can use this study to contribute to their practice, allowing them to address issues and enhance positive fixtures. In addition, the results of this study may contribute to a positive social change by reducing the shortage of small business primary care practices, allowing more patients to access PCPs.

Presentation of the Findings

The overarching research question for this study was: What strategies do physician-led primary care practice leaders use to sustain a medical practice longer than 5 years? I discovered three themes which emerged from the use of triangulation and coding: (1) patient engagement, (2) relationship development and retention, and (3) adaptation and innovation. The following open-ended semistructured interview questions were asked to answer the overarching research question:

1. Please describe in detail any business training you have had that has assisted you in building strategies to sustain your medical practice.
2. What strategies have you revealed of specific importance in sustaining your medical practice longer than 5 years?
3. What relationships have given you the ability to innovate?
4. What internal interactions, such as employee turnover, discrimination, and recruitment, resulted in a noteworthy event affecting the sustainability of your medical practice?
5. What strategies were used to adapt your medical practice to align with PPACA?
6. Please describe in detail any external interactions other than PPACA that significantly affected your medical practice.
7. What strategies do you use to manage unexpected events requiring adaptations in your medical practice?
8. How are innovations or process improvements used in supporting adaptation and sustainability?

9. Please describe in detail the strategies you have used to sustain your medical practice longer than 5 years.
10. Please describe in detail anything else pertinent to the strategies used to sustain your medical practice longer than 5 years that have not yet been addressed.

Participants and their businesses. I searched the American Medical Association directory for physician-led primary care medical practices that had been in operation for at least 5 years in southern Indiana. I called physician-led primary care practice leaders to invite them to participate in the study and followed up with emails and phone calls to ensure participation and describe their rights. I also explained how the participants would assist with the goal of the study to determine how physician-led primary care practice leaders sustain a medical practice longer than 5 years.

All three physician-led primary care practice physicians are board certified. One participant has been in practice more than 15 years, another more than 35 years, and the final member has been in practice more than 40 years, as confirmed on the Indiana Professional Licensing Agency Website. All three contributors have conducted academic research in the medical field.

Before the interviews, I reviewed the informed consent form with the participants. The owners then signed the form, and I scheduled interviews. The meetings took place in various physician offices that were most accommodating to each participant. I briefly reviewed the informed consent form, stating the interview will be recorded, voluntary, confidential, and the participant may stop at any time. After the participants verbally consented again, I asked each participant 10 open-ended questions, following the pre-

established interview protocol (Appendix A). All three participants answered all 10 questions. After concluding the interview, I set up member checking interviews and asked each participant for supporting documents. All three participants directed me to the Indiana State Professional Licensing Agency and provided me with company policy and procedure documentation. In closing, I thanked the participants for their assistance with my doctoral study.

Following data collection, I analyzed using the framework method. Keenan, Van Teijlingen, and Pitchforth (2015) stated the framework method has been used over 25 years in qualitative health research. Stage 1 is transcription, Stage 2 is familiarization with the interview, Stage 3 is coding, Stage 4 is developing a working analytical framework, Stage 5 is applying the analytical framework, Stage 6 is charting data into the framework matrix, and Stage 7 is interpreting the data.

I transcribed the interviews, which allowed me to familiarize myself and synthesized the interviews. I presented the findings to the participant within five business days for member checking. Marshall & Rossman (2014) stated that member checking ensures a researcher captures what a participant is trying to convey. Each participant confirmed I had captured what each participant had described. No participant had any additions to the synthesized transcriptions.

I proceeded to Stage 3 of data analysis and used NVivo to code the data. NVivio allowed me to create an analytical framework to apply to the study. After themes emerged, I moved to Stage 6 and charted data into a framework matrix. I concluded with Stage 7 of the data analysis and interpreted the data.

As previously stated, three themes emerged from the use of triangulation and coding: (1) patient engagement, (2) relationship development and retention, and (3) adaptation and innovation. From the findings, I identified strategies physician-led primary care practice leaders use to sustain their practices longer than 5 years.

Emerging Theme 1: Patient Engagement

The first theme that emerged was the importance of patient engagement. Theme 1 relates to the CAS theory. Dann and Barclay (2006) stated that one of the five key constructs of the CAS theory are interactions with others. Basole et al. (2013) noted that the CAS could take into account contextual factors such as multiple perspectives that broaden the understanding of others. Theme 1 had three minor themes: commitment to patients, discussing personal issues, and follow-up appointment.

Commitment to patients. During the interview process, all participants stated the importance of a commitment to the patient.

- Doc has a real genuine interest in patients' health which not all physicians have. Then the right staff to support them can help take really good care of the patients. Listen if you take good care of the patients they take really good care of you. (P1)
- I don't think if a person doesn't want to care for someone else they couldn't be a physician for too long because of the demands of the job. But then again it is really easy, it's a natural instinct to want to care for someone else and when we see the positive effects from what we do. Having said that there are some people more focused on the scientific information the outcome and the statistics they don't have or don't want to have the social skills to interact with people. Which

is less than a science and more of an art form. I don't know if it is being passionate or dedicated. (P2)

- "Most importantly you need to do your best to care for the patient" (P3).

These findings confirmed the literature I found. PPACA is attempting to address commitment to patients by changing the reimbursement from a volume-based system to a value-based system. Henderson, Princell, and Martin (2012) ascertained a Patient Centered Medical Home (PCMH) is an efficient way of restructuring the health care system to improve health care outcomes. A strategy for practice leaders is to focus on the quality of care rather than the volume of patients, because patients' needs are now shaping all relevant interactions within the health care system. The shift in value over volume requires physicians to adapt and allows the emergence of different solutions for individuals and communities.

Personal engagement. Only one participant discussed the importance of personal engagement; however, I felt it pertinent because it was the central theme throughout their interview. P1 emphasized the importance of knowing how a patient is doing not only physically, but mentally:

> You cannot succeed in primary care if you do not talk and listen to the patient. One is financial, certainly. The other is just feeling really good at the end of the day about the people you helped, and I mean help them speak to their life, I mean help them with their problems. You have a patient who comes in here with a stomach ache. Well, we are going to work on that stomachache but what is leading to that stomachache?

Personal engagement is an extension of the commitment to patients. This reiterates the confirmation of the importance of a value-based system. It also extends the knowledge that connecting with a patient and being passionate about an individual's work is important for success.

Follow up appointments. All participants stated the importance of follow up appointments.

- A patient comes back in hopefully a week or 2 follow up and then the doctor follows up and addresses it. But maybe something should have been done the next day or 2 days. It's a matter of the doctor taking the time. (P1)
- "Reaching out to patients and family to make sure they are satisfied and comfortable with what we are doing for them, and hoping the good outcomes provide us with more of their referrals" (P2).
- "It is important to have patients come back to make sure their treatment is going well. This is a part of taking care of the patient and patient satisfaction" (P3).

There is an abundance of literature confirming the importance of follow up appointments. Wilson, McNeal, and Blackett (2015) discussed the importance of follow up appointments for better health outcomes and stated the topic has been underexplored. Meiklejohn, Mimery, Martin, et al. (2016) found patient outcomes occurred when a general practitioner follows up with patients and has a good relationship with them. Literature not only confirms the importance of follow up appointments for the patient's outcome but ties it to patient engagement.

Table 1

Patient Engagement

Strategy	# of participants offering strategy	Total Percentage
Commitment to patients	3	100%
Personal engagement	1	33%
Follow up appointment	3	100%

Emerging Theme 2: Relationship Development and Retention

Relationship development and retention was also an important theme. Even though participant engagement was Theme 1 and all participants agreed patient engagement is the primary strategy, this derived from relationship development and retention. Theme 2 had four minor themes: patient relationships, private insurance relationships, hospital affiliation, internal relationships. Theme 2 relates to the CAS theory in that a key construct of the CAS theory is interactions with others (Dann & Barclay, 2006). Basole et al. (2013) echoed the importance of interactions to having a greater understanding of others allowing companies to adapt and evolve.

Private insurance relationships. Two-thirds of participants noted the importance of billing.

- Well maintaining a good relationship with better paying insurance and making sure that we have some kind of priority of scheduling those patients while also keep the door open for new patients. Running a close audit on monthly expenses and reimbursements from the insurance company. (P2)
- P3 stated, “I hired an outside company that handles all of the billing. I don’t want anything to do with that. It is a headache.”

I did not find any supporting literature that stated maintaining a good relationship with payers was important. This may have extended knowledge on the topic of sustaining a physician-led primary care medical practice. I found literature to support the knowledge of billing related issues. The Payment Advisory Commission (2014) found providers have begun retainer-based practices (concierge) to simplify the administration. PPACA has tried to address this by transforming primary care practices into collaborative models such as PCMH and ACO, but the effectiveness in cost containment and quality improvement is unclear (Wilensky, 2014). P1 & P2, both bill in-house, while P3 hired an outside agency.

Hospital affiliation. Two-thirds of the participants stated the importance of hospital affiliation.

- P1 stated, “Doc has a great relationship with the hospital. Doc is on a couple of boards. We are not employed by the hospital they understand how valuable he is to them. They definitely value his opinion.”
- P3 stated, “Staying in good standing with the hospital is important. By maintaining good relationships, I keep my privileges and get patient recommendations.”

I did not find any literature that stated staying in good relations with a hospital can help sustain a physician-led primary care practice. This may be extended knowledge of the phenomenon. However, it does relate to the CAS system theory’s emphasis on the importance of interactions within an organization (Dann & Barclay, 2006).

Internal relationships. All three participants discussed the importance of conflict resolution within their practices.

- Staff doesn’t always get along. You really need someone to be in charge of the staff who is actually in the office every day; I am not saying a manager that is across town and have 3 or 6 or 55 offices that they are the manager of that isn’t going to work and unfortunately it has to be a special person. I am in the middle of 7 kids - I grew up being a diplomat. I keep the peace, everyone chill. (P1)
- It is a very demanding field people get tired and overextended and frustrated and we try and make sure those issues stay in the back office and we smooth things out before we interact and handle the patients. (P2)
- “Conflict resolution is important. We try and keep the morale of our staff together with an office lunch every month” (P3).

I did not originally review literature on conflict resolution as a strategy to sustain a physician-led primary care medical practice. However, many scholars have discussed the importance of conflict resolution in small businesses. Fisher (2016) stated that conflicts are a fact of human existence and recommended a third-party consultation to ease a workspace.

Employee retention. All three participants noted the importance of employee retention.

- We do see a lot of people during the day but we have a great support staff and because we are self-employed this is really money coming out of our pockets, but it’s the only real way to take good care of the patients and not have the ball drop

as it drops so frequently anymore . . . but my thing is we pay them well we pay them twice as much. (P1)

- P2 stated, "The most important would be of recruiting physician providers and the longevity of the working for the company. I have had a problem with employee turnover with the providers."
- P3 stated, "Having a great staff makes a world of a difference, I am able to trust my staff to get the job done."

Employee retention was not originally a strategy that was found to sustain a physician-led primary care medical practice. However, there is an abundance of literature that confirms employee retention as a strategy to sustain a small business. Achtenhagen, Melin, and Naldi (2013) discuss the importance of adapting and evolving as a strategy to add coherence between leadership and employee commitment to shaping a company.

Table 2

Relationship Development and Retention Strategies

Strategy	# of participants offering strategy	Total Percentage
Patient Relationship	3	100%
Private Insurance Relationships	2	67%
Hospital Affiliation	2	67%
Internal Relationships	3	100%

Emerging Theme 3: Adaptation and Innovation

Theme 3, adaptation and innovation had four minor themes: continuing medical education, continual business education, bringing work home, electronic health records.

Adaptation and innovation directly correlated with the CAS theory, which is an organizational loop of learning and redesign (Dann & Barclay, 2006). Achtenhagen, Melin, and Naldi (2013) discussed the importance of adapting and renewing a business model to add value to a company.

Continual Medical Education (CME). All physician offices utilized board-certified physicians. All participants discussed the importance of CME. CME is a requirement to remain board-certified.

- (From P1) It's the desire to work and to continue to get new equipment learn new procedures keep up with the latest and greatest.
- (From P2) Trying to stay up-to-date with the newest treatments options services technology.
- (From P3) Physicians are required to do CMEs to keep their board-certification, because it is important. Medicine changes and evolves, and it is important to be current in medicine for the best health outcome of the patients.

Literature confirms the findings of this study. The purpose of CME is to create a competent licensing population. The American Board of Internal Medicine (2017) requires 100 hours of CME to remain board-certified. CMEs can help physicians stay up to date on new procedures adding value to a patient's care. It also keeps them up to date on how to use systems such as EHR systems.

Continual Business Education. 100% of participants discussed the importance of continual business education.

- (From P1) I am usually at the office evenings weekends and take paperwork home, I will pick up business magazines to keep up with business.
- (From P2) I haven't had any formal business training other than a few guidance tips from other business managers. I feel it is important to continue to learn because business is always changing, for example, EHR requirements
- (From P3) You need to learn about business now, they have great MBA programs for doctors. It is also important to have a great front desk manager.

Originally, I did not find literature describing the importance of continual business education as a factor to sustain a physician-led primary care medical practice. This may be a contribution to existing literature.

Electronic Health Records. All participants stated the importance of switching to an EHR system.

- (From P1) When it comes to switching to EHR, I put it off until I had to take the big leap so I would still get the incentive payments for Medicare it came in 4 years. The first year was the first big chunk of change. To put the computers in and jump through all the hoops and passed the meaningful use. I just made sure I maximize the money I could get. I didn't do it the year before I did it in 2012 to make sure I could still get the biggest check you know to pay for the system. Because we weren't in any hurry and quite frankly I am not speaking for anyone but myself there are a few areas where it's very nice to be on EHR but it is expensive. I hired a full-time scribe for Doc, first of all, he can't type and second

of all he isn't going to stare at the computer, and the patient wouldn't like that either. Even if he did type I wouldn't expect him to sit in a room and type.

- (From P2) Well the big thing now is the adaptation of electronic health records to practice flow and with that comes the use of electronic billing and ordering for prescriptions and services. That also has its own included ways of making sure the billing is consistent with the services provided and meet the required qualifications to reach the level of billing or not.
- (From P3) There was a learning curve when electronic health records became mandatory, we had to learn and work together. It is more efficient now. But we also need to remember how to do everything manually because sometimes systems go down.

The use of EHR systems as a sustainable strategy is confirmed through literature. Boons and Ludeke-Freund (2013) stated one way to sustain a medical practice is by using sustainable technologies. Delisle (2013) found EHR systems create an effective coordination automating processes of the exchange of information and increased access to data. Casalino et al. (2013) stated the importance of HIT for improving care in smaller practices.

Literature also confirms some of the barriers of EHR systems. The reviewed literature stated a barrier to adapting to healthcare reform is the ability to navigate increasingly complex EHR (Blumenthal et al., 2012; Delisle, 2013). Moreover, addressing problems of an EHR system falling offline (Kellog, 2013). Although scholars discovered barriers to the implementation of an EHR system, Schoen et al. (2013),

revealed the performance feedback from information systems provides a strong incentive and engages physicians to commence changes.

Table 3

Strategies to Adapt and Innovate

Strategy	# of participants offering strategy	Total Percentage
Continual Medical Education	3	100%
Continual Business Education	3	100%
Electronic Health Records	3	100%

Applications to Professional Practice

The purpose of this qualitative multiple case study was to explore strategies physician-led primary care practice leaders use to sustain a medical practice longer than 5 years. The results of the study revealed three thematic strategies participants used to sustain their physician-led primary care medical practices longer than 5 years. The data of the study can assist physician-led primary care practice leaders. It may be transferable to any physician-led medical practice. I discovered three major themes (1) patient engagement, (2) relationship development and retention, and (3) adaptation and innovation. I revealed three minor themes associated with each major theme. Theme 1, patient engagement had three minor themes:

- commitment to patients
- discussing personal issues
- follow-up appointment.

Theme 2, relationship development and retention had four minor themes:

- patient relationships
- private insurance relationships
- hospital affiliation
- internal relationships

Theme 3, adaptation and innovation had four minor themes:

- continuing medical education
- continual business education
- bringing work home
- electronic health records.

Physician-led primary care practice leaders are constantly adapting to regulation changes. Effecting significant change within physician-led primary care medical practice may meet some resistance.

Implications for Social Change

The shortage of primary care physicians leads to an improper access to primary care physicians. Primary healthcare is typically the first contact with a healthcare system (Buykx et al., 2012). Berry, Beckham, Dettman, and Mead (2014) have acknowledged a growing need for patient-centered access to primary care services. The loss of such access diminishes healthcare and offers poorer health outcomes particularly in remote or rural communities. The results of this study may contribute to a positive social change by reducing the shortage of small business primary care practices, allowing more patients to access primary care. Healthcare leaders can benefit from an understanding of strategies to sustain a physician-led primary care medical practice.

If a physician-led primary care practice leader chooses to implement the strategies recommended in this study about sustaining their company longer than 5 years, it may result in more profitability, employee retention, and overall happiness. In addition, physicians may choose to become a primary care physician after they are aware of successful strategies to operate a physician-led primary care practice. Adopting these strategies may increase access to primary care physicians. With access to care citizens may have the opportunity to increase the longevity of their lives, which may allow them to have a feeling of more worth and dignity.

Recommendations for Action

All primary care medical practice leaders should view strategies to sustain their practice important since there has been a steady decline primary care practices since 2008 (Peterson, Baxley, Jaén, & Phillips, 2015). Results from this study provide physician-led primary care practice leaders with strategies to sustain their medical practice. Successful strategies used by the participants included (1) patient engagement, (2) relationship development and retention, and (3) adaptation and innovation.

The first recommendation is to foster the love of one's work and engage with patients. I found the participants all truly cared about their patients and patient engagement. Some strategies that may be beneficial are connecting with patients by discussing personal issues and conducting a follow-up appointment. Moreover, I recommend physician-led primary care practice leaders use surveys to monitor patient satisfaction and engagement. Leader's may then adapt and evolve to the responses to patient interactions.

The second recommendation is to focus on relationship development and retention. One can accomplish this by again focusing on the importance of patient relationships. Fostering healthy relationships with private insurance to maximize profits. Join a board at the affiliated hospital and maintain a mutually beneficial relationship. Finally, to focus on internal relationships. Physician-led primary care practice leaders can monitor the progress of said relationships with a survey. Allowing them to adapt and evolve with the results of their study.

The final recommendation is to continue to learn. As mentioned throughout the study the healthcare industry is constantly evolving. I discovered it essential to continue medical education, continue business education, and to stay up-to-date with the latest trends in medicine, such as electronic healthcare records.

The study is not limited to physician-led primary care practice leaders. Other business owners providing care to patients may view the findings in this study useful as well. I will disseminate the results of the study through the primary care industry in conferences, scholarly journals, and business consulting. I will provide participants with the study results.

Recommendations for Further Research

The limitations of this multiple case study make space for further research, particularly geographical transferability. I recommend exploring additional geographic locations other than southern Indiana. Exploring other regions could add rich data to expand this study. Another topic worth exploring is what strategies do small business primary care practice leaders use to sustain their physician-led primary care medical

practices in rural areas versus urban areas. Or conducting a comparative analysis of hospitals and primary care practices.

All three participants discussed an increase in regulations on how the office practices medicine. Researchers should study the impact of government regulation on the primary care physician to determine if changes are necessary to sustain primary care in the United States.

Reflections

The DBA Doctoral Study process was extremely challenging yet worthwhile. I met people in the industry and have become an expert in healthcare management. I discovered it difficult to get participants than I thought it would be, this is understandable because physician offices are often bustling. I noticed some participants had fears with divulging private information. I also discovered the fear of not answering the questions appropriately. However, the participants that participated in the study reminded me the importance of humility and helping others.

I am satisfied I did not have any relationship with participants before I interviewed them. I would not discuss the questions with the interviewees before interviewing this assisted me in bias reduction and sharing preconceived ideas. I understand the importance of open-ended questions. It helped me reduce an outcome-based on preconceived ideas.

The physician-led primary care practice leaders were inspirational - this surprised me. I was surprised how important leaders found it to love their craft, and to have a genuine care for their patients. I had a preconception that managing a physician-led

primary care practice was more scientific, rather the fluidity and loving what you do and the people around you.

I matured academically, and I now understand different research methods and how they apply at a different level. I learned how to align a study, and why the important of alignment. My interview skills and confidence increased by having a great understanding of the topic I was researching. The DBA process has been long and emotional, and my thinking has changed. I now believe anything is attainable, by looking within, love, and persistence.

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Appendix A: Interview Protocol

Table A1

Interview Protocol

What you will do	What you will say—script
Introduce the interview and set the stage—The interview may be over a meal, coffee or participants in office. Before the interview I will schedule a location that makes the participant most comfortable.	Script: Good X (morning, afternoon, evening) Participant, it is great to have you with me here today, thank you for your time. I am eager to hear the strategies you have used to sustain a medical practice longer than 5 years. I would like to remind you that as we had discussed before this interview will be recorded. Are you still ok with that? Great. I would also like to remind you that you may stop the interview process at any time if you feel uncomfortable at all by telling me you would like to stop the interview. In addition, I will be protecting your anonymity by labeling you and your company as Participant X. I have a field log and I will have it here to take notes on what you are saying. Are you still comfortable with that? Also, I will keep the documents for 5 years in a secure location and will destroy them after said time. Today I will be asking you the overarching research question: What strategies do physician-led primary care practice leaders use to sustain a medical practice longer than 5 years? Followed by associated sub-questions. I will then ask you to schedule a follow-up interview to check that I have captured what you are saying. Does everything sound good? Fantastic. Let's start.
• Ask interview questions • Watch for nonverbal queues • Use a field log to take notes. • Paraphrase as needed • Ask follow-up probing questions to get more in-depth information	1. Please describe in detail any business training you have had that has assisted you in building strategies to sustain your medical practice.
	2. What strategies have you found of specific importance in sustaining your medical practice longer than 5 years?
	3. What relationships have given you the ability to innovate?
	4. What internal interactions, such as employee turnover, discrimination, and recruitment, resulted in a noteworthy event affecting the sustainability of your medical practice?
	5. What strategies were used to adapt your medical practice to align with PPACA?
	6. Please describe in detail any external interactions other than PPACA that significantly affected your medical practice.
	7. What strategies do you use to manage unexpected events requiring adaptations in your medical practice?
	8. How are innovations or process improvements used in supporting adaptation and sustainability?
	9. Please describe in detail the strategies you have used to sustain your medical practice longer than 5 years.
	10. Please describe in detail anything else pertinent to the strategies used to sustain your medical practice longer than 5 years that have not yet been addressed.
Wrap up interview thanking participant	Script: Thank you so much for your time Participant. I am very grateful you took the time to help me in this process.

(table continues)

What you will do	What you will say—script
Schedule follow-up member checking interview	Script: I would now love to schedule a member checking interview as discussed. When would be a good time and location for you?
	Follow–up Member Checking Interview
Introduce follow-up interview and set the stage	Script: It is so great to see you again. Thank you again for your time. I have reviewed and interpreted the interview transcriptions. The purpose of meeting again is to ensure I have captured what you were trying to portray. I will now be providing you with a copy of the synthesis.
• Share a copy of the succinct synthesis for each question • Bring in probing questions related to other information that you may have found • Walk through each question, read the interpretation and ask: • Did I miss anything? Or, What would you like to add? • Wrap up interview thanking participant	Script: I would like to go over the questions and interpretation represents the answer or if there is any additional information.
	1. Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
	2. Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
	3. Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
	4. Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
	5. Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
	6. Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
	7. Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
	8. Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
	9. Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
	10. Question and succinct synthesis of the interpretation—perhaps one paragraph or as needed
Introduce follow-up interview and set the stage	Script: Thank you again for your time. I truly appreciate your assistance with my Doctoral Study.

Appendix B: Participant Recruitment Letter

Date: [Insert Date]

Re: Request to Participate in a Research Study

Dear [Recipient]:

My name is Ashley Polidori, I am a doctoral candidate at Walden University pursing the degree of a Doctor of Business Administration (DBA). I am conducting a qualitative research study to explore what strategies do physician-led primary care practice leaders use to sustain a medical practice longer than 5 years. I am focusing my research on physician-led primary care practices in southern Indiana. I wish to interview primary care practice leaders who meet the following criteria:

- All participants must be over the age of 18, and not associated with a protected class.
- Physician-led primary care practice leader who has been in business 5 years or longer, and;
- Primary care practice located in southern Indiana or the surrounding area.

Conducting face-to-face interviews with physician-led primary care practice leaders may provide insight for the research study. Once the study has been completed I will share the results of my findings with participants, other physician-led primary care practice leaders, and scholars. If you meet the qualifications and would like to participate in the study, please contact me at [redacted] or [redacted]. Thank you for taking the time to consider this opportunity.

Kind Regards,

Ashley Polidori
Doctoral Candidate,
Walden University