2018

Financial Strategies and Initiatives for Preventing Rural Hospital Closure

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This is to certify that the doctoral study by

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Walden University
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Abstract

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Abstract

In the United States, rural hospital closures increased 34% since 2015 due to financial reasons, affecting access to healthcare services in rural communities. For rural hospital leaders, improving the hospital's financial performance is a valuable strategic goal. This multiple case study was designed to explore strategies that rural hospital leaders implement to improve their hospital's financial performance in Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands. The strategic decision-making framework supported the study because top leaders make decisions that affect the organization's health and survival. Fifteen rural hospital leaders who maintain their hospital's financial stability provided hospital documentation and pertinent strategic information from their respective semistructured interviews. Sections of text signifying concepts from collected documentation and transcribed interviews were organized and coded according to research question and interview questions to explore strategies rural hospital leaders implemented to improve their hospital's financial performance. The methods triangulation process encompassed comparing findings from the interview themes and hospital strategic documentation analysis. The key themes that emerged from coded data were rural hospital leaders' decision-making when addressing rural hospital financial performance, developing synergies with external providers and hospitals, creating effective short-term and long-term strategies, and translating success to the entire organization. Implications for social change include the potential to prevent rural hospital closure and ensure access to healthcare services for the communities rural hospitals serve.

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Dedication

My favorite Wilma Rudolph quote is “no matter what accomplishments you make; someone helps you.” I dedicate this doctoral study to my husband, Benjamin Uecker. After Hurricanes Irma and Maria, you lit candles at the table, so I could transcribe interviews and drove me to find internet hotspots to upload my assignments. I dedicate this doctoral study to my family and friends. They understood my temporary absence, gave me space to study and write, and provided me emotional support. I dedicate this doctoral study to my parents, Marina Pennington and Hubert Bailey, and in-laws, Susan and David Uecker, who model hard work and follow through. I dedicate this doctoral study to Sid Pennington who always sent text messages of encouragement. Finally, I dedicate this doctoral study to the memory of my grandparents, Karl Edwards, Laureen Edwards, and Lucille Bailey.

Acknowledgments

Completion of my doctoral study would not have been possible without the support of my doctoral chair, doctoral committee, intensive faculty, peers, study participants, sisters, and mentors. I thank both, Dr. Rivero and Dr. Szostek, for your wisdom, time, and encouragement. I thank Dr. Paluch and Dr. Mayer for their guidance and critical reviews. I thank Dr. Doll and Dr. Chermack for your feedback and advice during the intensive. I am grateful for the e-mails of encouragement from my Walden classmates. I appreciate the study participants for their honesty, insights, and time. I am thankful for my sisters, Asha and Jamila, and mentors, Diane Dixon, EdD, and Dr. Bernard Wheatley, DBA, for their examples of scholarly achievement.

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Section 1: Foundation of the Study

Improving hospital financial performance could be a valuable strategic goal for rural hospital leaders. Although approximately 1,900 rural hospitals became the primary vehicles for rural residents to access necessary medical care, 83 rural hospitals closed from 2010 to 2018 (American Hospital Association, 2016; Bross, Wiygul, & Rushing, 1991; North Carolina Rural Health Research Program, 2018). In 2010, 19.3% of the U.S. population resided in rural communities (U.S. Census Bureau, 2013; U.S. Department of Health and Human Services, 2014). Rural patients accounted for 12% of the total hospitalization in the United States (Hall & Owings, 2014). Since 2010, rural patients had 51 million procedures performed in rural hospitals (Hall & Owings, 2014). The focus of this study was to explore how rural hospital leaders could improve rural hospitals financial performance. The foundation for this study included the background of the business problem, the problem statement, the purpose statement, the nature of the study, the research question, the interview questions, the conceptual framework, the operational definitions, the assumptions, limitations and delimitations, significance of the study, and a comprehensive literature review.

Background of the Problem

Rural hospitals leaders have encountered unique financial challenges (Escarce & Kapur, 2009; Hall & Owings, 2014; Moscovice & Stensland, 2002). In 2010, approximately 1,900 rural hospitals and emergency departments provided primary health care to 59 million people living outside metropolitan statistical areas in the United States (American Hospital Association, 2011; U.S. Census Bureau, 2013; U.S. Department of

Health and Human Services, 2014). Of the rural patients that sought necessary medical care at rural hospitals and rural emergency departments, 7.8% were uninsured, and 52% received medical services through Medicare coverage (Centers for Disease Control and Prevention, 2014; U.S. Department of Health and Human Services, 2014).

In 2014, 10.7% of the U.S. rural population was uninsured, and 42.7% had government healthcare coverage in 2014 (U.S. Census Bureau, 2015). Due to charity and uninsured patients, hospitals and emergency departments struggled financially from limited state and federal reimbursement for services rendered (Simonet, 2009). Uncompensated care became a financial burden for hospitals leaders. The impact of the economic challenges led to rural hospitals to operate at a financial loss (Pugh, 2014). The U.S. government identified strategies to reduce hospitals operating at a loss. One approach adopted by 34 states including the District of Columbia included expanding Medicaid coverage (Carey & Galewitz, 2014; "Current Status of State Medicaid Expansion", 2018).

Problem Statement

Rural hospital leaders balance maintaining hospital financial health and stability while ensuring access to healthcare services within their communities (Countouris, Gilmore, & Yonas, 2014; Spade & Strickland, 2015). Although rural hospitals accounted for 40% of the community hospitals in the United States, rural hospital closures increased 34% since 2015 (North Carolina Rural Health Research Program, 2018). The general business problem was that rural hospital leaders must maintain a positive financial

performance to be a viable entity. The specific business problem was that some rural hospital leaders often lack strategies to improve financial performance.

Purpose Statement

The purpose of this qualitative multiple case study was to explore strategies that rural hospital leaders implement to improve their hospital's financial performance. The targeted population consisted of three rural hospital leaders from Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands who have improved their hospital's financial performance. To discover what strategies rural hospital leaders used to improve hospital financial performance, I interviewed rural hospital leaders. Additionally, I analyzed hospital strategic planning and financial documentation. Exploring successful strategies used by rural hospital leaders can provide other rural hospital leaders with strategic ideas to incorporate into their hospitals. The implications for positive social change include the potential to cultivate the economy, enhance the quality of services delivered, and ensure the presence of rural hospitals.

Nature of the Study

The three research methods are qualitative, quantitative, and mixed methods. The chosen research method for this study was qualitative methodology. The critical attributes of qualitative research are exploring the meaning and gaining an understanding of a problem (Bailey, 2014). Quantitative research entails evaluating the relationships between variables (Wang et al., 2013). With mixed methods research, researchers collect different types of data using qualitative exploration and quantitative examination tactics (Small, 2011). Additionally, a mixed method approach is appropriate when the purpose

of the research is to elicit content and data to explain a phenomenon (Yang & Matthews, 2012). Based on the scholarly statements regarding research methods, the qualitative methodology supported this study more than a quantitative or mixed methods approach because the focus was on gathering rich descriptions of strategies implemented to improve financial performance. The use of quantitative or mixed methods did not support the study because the focus of the study was not to examine relationships between variables or use statistical analysis to explain results. Using the qualitative method for this study enabled me to identify and understand successful strategies used by rural hospital leaders.

For qualitative methods, the three research designs are a case study, phenomenological, and ethnography. The chosen research design was case study design. A case study entails interviewing individuals to understand events associated with a problem (Moll, 2014). The essential characteristic of a case study design is investigating a phenomenon in depth through the decisions made (Yin, 2014). Phenomenological researchers explore events by interviewing participants to understand their lived experiences (Efendi, Chen, Nursalam, Indarwati, & Ulfiana, 2016); however, the focus of the study was not to interview rural residents to understand their lived experiences. Ethnographical researchers study the culture of a group in an area over time (Muecke, 1994), but the focus of the study was not to examine rural hospital leaders over a specified period. Based on the scholarly statements regarding qualitative research designs, the case study design supported this study more than the other qualitative

research designs because the focus of the case study was on using a small population to gather rich descriptions of strategies implemented to improve financial performance.

Research Question

The central qualitative research question was: What strategies do rural hospital leaders implement to improve their hospital's financial performance?

Interview Questions

The interview questions were:

1. What process did you use to improve financial performance?
2. What data did you monitor to alert you there was an issue with financial performance?
3. Who did you involve in the decision-making process?
4. How did you reduce the effects of conflicting interests and limitation of resources?
5. How did you lessen the impact of politics and power in the decision-making process?
6. What strategies have you used to improve your hospital's performance?
7. What data did you capture to review the impact of the changes made?
8. What lessons learned would you want to provide a rural hospital leader who wants to improve financial performance?
9. What else would you like to add that I have not addressed in these interview questions?

Conceptual Framework

The conceptual framework provided conditions in which a business problem exists or does not exist (Yin, 2009). In 1992, Eisenhardt and Zbaracki developed the strategic decision-making framework. Strategic decision-making occurs when top leaders of an organization make decisions that impact the organization's health and survival (Eisenhardt & Zbaracki, 1992). However, these strategic decisions tend to be infrequent.

Researchers use propositions to identify what to focus on within the study (Yin, 2009). Three key concepts for exploring strategic decision-making and financial performance of rural hospitals are (a) bounded rationality, (b) politics, and (c) power (Eisenhardt & Zbaracki, 1992). With strategic decision-making, bounded rationality involves using information and gathering diverse perspectives (Eisenhardt & Zbaracki, 1992). Politics refers to conflicting interests and limited resources whereas power entails control (Eisenhardt & Zbaracki, 1992). The strategic decision-making framework was best suited for this study because random and uncoordinated decisions made by rural hospital leaders were not sufficient for improving hospitals financial performance. Rural hospital leaders must use strategic decision-making to implement more appropriate solutions impacting financial performance (Arbab Kash, Spaulding, Gamm, & Johnson, 2014; Beck & Wiersema, 2013; Martin, Probst, Shah, Chen, & Garr, 2012).

Operational Definitions

Critical access hospital (CAH): A type of rural hospital. CAHs may qualify for special payment provisions under Medicare (Holmes, Pink, & Friedman, 2013).

Medicare-dependent hospital (MDH): A type of rural hospital. MDHs may qualify for special payment provisions under Medicare (Holmes et al., 2013).

PPACA: PPACA is the acronym for Patient Protection Affordable Care Act. The goal of PPACA is to increase Medicaid coverage to low-income U.S. citizens. ACA refers to the final amended version of the PPACA law (Majette, 2011).

Population health: Health outcomes for individuals living in a community (Kindig & Stoddart, 2003).

Rural communities: Rural communities include communities in nonurban areas (Blades et al., 2005).

Rural hospital: Rural hospitals include hospitals in nonmetropolitan areas (Hall & Owings, 2014).

Rural referral center (RRC): A type of rural hospital. RRCs may qualify for special payment provisions under Medicare (Holmes et al., 2013).

Safety net hospitals: Safety net hospitals provide medical services to patients regardless of their ability to pay (Shimizu et al., 2014).

Sole community hospital (SCH): A type of rural hospital. SCHs may qualify for special payment provisions under Medicare (Holmes et al., 2013).

Uncompensated care: The sum of the bad debt and charity care (Coyne, Fry, Murphy, Smith, & Short, 2012).

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions are presumptions and denote reality (Cockburn-Wootten & Cockburn, 2011; Mesel, 2013). Assumptions for this study included that rural hospital leaders answered questions honestly, and rural hospitals reported information accurately. There was also an assumption that rural hospital leaders accurately reported performance of their hospital's strategy.

Limitations

Limitations are potential weaknesses and gaps outside a researcher's control (Dixon, Karniouchina, Rhee, Verma, & Victorino, 2014; Rashid, 2013). Limitations of this study included changes in reimbursement, changes in government regulations, and participants refraining from sharing information. First, changes in reimbursement and government regulations might cause the findings from this doctoral proposal to be irrelevant. Second, the study participants might not have shared strategies that they have found to be best practice.

Delimitations

Delimitations are within the bounds of the research and are what is critical to the study (Cockburn-Wooten & Cockburn, 2011; Krohwinkel-Karlsson & Sjögren, 2008). This study encompassed qualitative interviews with rural hospital leaders. I chose each rural hospital leaders because of their hospital achieving financial performance.

Significance of the Study

Contribution to Business Practice

Because few studies have been on the financial performance of rural hospitals from a leader's perspective, the results of this study might provide valuable information to hospitals in rural communities. Rural hospitals occupy a pivotal role in ensuring access and the quality service to patients. Regardless of rural hospital closures or policy changes, patients will still rely on rural hospitals for their medical treatment. For rural hospital leaders, the topic of improving financial performance might provide strategic ideas to leaders interested in ensuring their hospital remains open. For the community, state, and government agencies, the financial performance of rural hospitals was an issue worth examining (Holmes et al., 2013). A comprehensive evaluation of literature indicates strategic decision-making impacted firm performance, financial performance strategies might require rural hospital leaders to rely less on federal reimbursements, and rural hospital leaders needed to identify internal opportunities to improve financial performance (Holmes et al., 2013; Miller, Burke, & Glick, 1998).

Implications for Social Change

Random and uncoordinated improvements have proven unsuccessful in improving performance (Eisenhardt & Zbaracki, 1992). From this study, a comprehensive list of successful financial strategies and initiatives might be valuable for rural hospital leaders. Rural hospital leaders, community leaders, and researchers can use this research to contribute to social change through the development of strategies to improve rural hospital performance.

The results of this study might have a business, community, and social impact. The business importance of improving rural hospital financial performance might impact rural hospital growth and operational efficiency. The community aspect of improving rural hospital financial performance might affect employment opportunities, as rural hospitals are large employers in the community (American Hospital Association, 2011). The social implication of improving rural hospital financial performance might influence retention of skilled professionals and services to the community.

A Review of the Professional and Academic Literature

The purpose of this literature review was to support the exploration of the research question: What strategies do rural hospital leaders implement to improve their hospital's financial performance? The literature review provides detailed information on the U.S. healthcare system, financial performance, market attributes, and operational characteristics. Organizing the literature review in this manner provides a rich description of the business problem. The literature review begins with a discussion of the conceptual framework, strategic decision-making by Eisenhardt and Zbaracki (1992), and discussion of a contrasting conceptual framework, garbage can theory, by Cohen, March, and Olsen (1972). Next, a summary of the U.S. healthcare system proceeds with a focus on urban hospitals, rural hospitals, and the impact rural hospitals have within the community. Then, the literature review includes the financial performance of rural hospitals, causes for rural hospital closure, and current strategies deployed to improve financial performance in rural hospitals. Besides financial performance, the literature review includes exploration of strategic planning, strategic trends, access to care, and

operational characteristics. The literature review closes with a rich description of the general business problem and potential impact on business and the community.

Online libraries through Walden University Library and Google search engine provided relevant information regarding rural hospital financial performance. The primary literature collected for this review includes peer-reviewed sources, published dissertations, books, government documentation, and other scholarly publications. Newspaper articles, healthcare conference materials, and government websites provided supporting material. I used keywords such as *rural hospitals, safety net hospitals, critical access hospitals, strategic decision-making, financial indicators,* and *hospital financial performance* to find sources. This literature review contained 176 references. Of those 176 references, 157 references were peer-reviewed sources with 147 or 94% less than five years old (2014-2018).

Strategic Decision-making Framework

Rural hospitals provided medical services to 17% of the U.S. population (Balasubramanian & Jones, 2016; U.S. Department of Health and Human Services, 2014). Due to size, patient mix, and economies of scale, rural hospitals tend to rely on government payments and incentives (Ibrahim, Hughes, Thumma, & Dimick, 2016). Since 2010, 83 rural hospitals have closed (North Carolina Rural Health Research Program, 2018). Rural hospital leaders made complex business decisions affecting the hospital they served (da Silva & Roglio, 2015). While making the complex business decisions, hospital leaders have ensured that their decisions do not negatively impact outcomes (Gordon, Demerouti, Bipp, & Blanc, 2015). Furthermore, highly engaged

leaders have made better business decisions when they feel personally accountable for the organization's success and performance (Housseini & Asgari, 2016). To support better business decisions, rural hospital leaders might use strategic decision-making to improve their hospital's financial performance. The strategic decision-making concept developed by Eisenhardt and Zbaracki (1992) represents a supporting conceptual framework, which has explained rural hospital financial performance. The garbage can theory by Cohen et al. (1972) represents a contrasting conceptual framework. The next sections outline strategic decision-making and garbage can theory.

Eisenhardt and Zbaracki (1992) developed the strategic decision-making framework. Strategic decision-making occurs when top leaders of an organization make decisions that impact the organization's health and survival (Eisenhardt & Zbaracki, 1992). According to Eisenhardt and Zbaracki (1992), strategic decision-making tends to be infrequent. Hospital leaders make operational decisions daily and continue to learn from these past operational decisions (Weiner, Balijepally, & Tanniru, 2015). These operational decisions should align with the operational plan (Schubert et al., 2015), which hospital leaders accomplish by using the information to assess performance against goals and objectives identified in the operational plan (Stevens, Xie, & Peng, 2016). Strategic decision-making has been essential because the strategic decision of top leaders impact the overall institution (Eisenhardt & Zbaracki, 1992; Thomas & Ambrosini, 2015). Since Eisenhardt and Zbaracki (1992) developed the strategic decision-making framework, 499 citations exist for this framework. Three key propositions for exploring strategic decision-making and financial performance of rural hospitals are: (a) bounded rationality,

(b) politics, and (c) power (Eisenhardt & Zbaracki, 1992). The next sections include descriptions of the key propositions.

Decision makers have moved from rationality to bounded rationality. Rationality resembles using a firm's resources efficiently to meet intended goals (Ren & Huang, 2018). Bounded rationality resembles having random goals, searching for information haphazardly, and seeking suboptimal solutions (Mu, 2018). When the outcome of a decision is important, leaders make strategic decisions (Robert et al., 2018). Consequently, leaders have moved from rationality to bounded rationality, as their previous experiences influenced their current decision-making (Choudhury, Haq, Khan, & Saddique, 2015; Liu, Lv, Li, & Tang, 2017). Additionally, previous experiences may influence leaders' current performance in important situations (Yu & Lindsay, 2016). In these important situations, the leaders become aware of their behaviors and perceptions during problem-solving (Benson, Hardy, & Eys, 2016). The strategic decision-making process becomes more inclusive as participation in strategic decision-making becomes collaborative between employees within the organization (Kumar & Saha, 2017). As high-performance correlates to increased productivity, an alignment exists between the allocation of the organization's resources and the leader's past performance (Shin & Konrad, 2016). For instance, management might grant more resources to strong performers than low performers to complete a project.

As decisions become more important, bounded rationality resembles strategic management and accountability through a shared objective, systematically researching for information, and analyzing information systematically (Kleibrink et al., 2015). Using

diverse viewpoints enabled organizations to move from rationality to bounded rationality (Budde, Nagler, & Friedli, 2015; White, Pothos, & Busemeyer, 2015). There are several approaches to gathering diverse perspectives in the business setting. Leaders have gathered different perspectives by using a devil's advocate, involving subject matter experts, and encouraging questioning (Connor, 2016; Liu, Fielding-Singh, Iwashyna, & Bhattacharya, 2017). Besides these methods, leaders might crosscheck information gathered before making a decision (Wright et al., 2016). Using different sources to verify the accuracy of the information might be useful in strategic decision-making (Wright et al., 2016). The end goal is to make the best decision using appropriate information available. Although strong recommendations result from diverse viewpoints, leaders must monitor team satisfaction and final acceptance of the business decision made. What limits bounded rationality are hostile environments, high uncertainty, and external factors. Some of these limiting external factors are that the strategic decision-making process takes longer and there may be conflict (Eisenbart, Garbuio, Mascia, & Morandi, 2016).

Within healthcare, rural hospital leaders might make business decisions with incomplete information. As leaders obtain and analyze information, more appropriate solutions become apparent (Garbuio, Lovallo, & Sibony, 2015). These business decisions result from rural hospital leaders using data to drive their decision-making (Cao, Duan, & Li, 2015; Töytäri, Rajala, & Alejandro, 2015). In summary, bounded rationality has enabled leaders to optimize complex decisions through in-depth analysis of people with varied perspectives.

Eisenhardt and Zbaracki (1992) viewed organizations as political systems. Politics influenced a leader's behavior (Marshall, Ambrose, McIvor, & Lamming, 2015). In politics, individuals might behave rationally, whereas organizations do not (Eisenhardt & Zbaracki, 1992). The reason for this difference in behavior is that teams consist of individuals with competing interests and diverse talents (Kimura, 2015). Biases, resulting from roles, titles, and personal ambition, might promote competing interests (Elbanna, Di Benedetto, & Gherib, 2015). When individuals remove their biases in pursuit of the organization's welfare, strategic alignment can occur (Hoyos, 2016). With strategic alignment, leaders have shared goals, which benefit the organization (Cäker & Siverbo, 2014). When the organization's welfare is not a priority, power struggles emerge, allegiances surface, and leaders withhold pertinent information (Chudleigh, 2014; Lane & Hennes, 2017). For rural hospital leaders, the hospital's goals are a priority over an individual's interests. Once rural hospital leaders align their fundamental activities to the organization, the rural hospital leaders have shared goals. With shared goals, rural hospital leaders might assess performance against the organization's strategy. In summary, the organization's goal becomes a priority over personal interests.

The difference between the weak and the strong has been power (Eisenhardt & Zbaracki, 1992). Within the strategic decision-making framework, powerful people have acquired what they want (Eisenhardt & Zbaracki, 1992). This situation has occurred because leaders have created allegiances to ensure their ideas and interests are upheld (Steinbach, Holcomb, Holmes, Devers, & Cannella, 2017). Influential people have used information, resources, and data to enhance their power, position, and ideas (Chown &

Liu, 2015). Furthermore, power might exist in key leadership positions (Tang, 2016). Misalignment in power might hinder strategic decision-making (Stanczyk, Foerstl, Busse, & Blome, 2015). Costanzo and Di Domenico (2014) researched power within the CEO position and the top management team (TMT). The power forces between CEOs and TMTs have impacted strategic decision-making. Consequently, the CEO and the TMT make strategic decisions after a thorough understanding of the issue and discussion of goal alignment (Su, Fan, & Rao-Nicholson, 2017). Politics have also impacted the success of a TMT and the organization's performance (Cheng & Lok, 2015). Another view is that the potential use of power does not mean that leaders have used their power to benefit the organization (Stevens et al., 2016). Rural hospital leaders use data and information to advance the market position and performance of their organization. Furthermore, rural hospital leaders have needed to align resources to meet the organization's strategic objectives. In summary, these approaches are of special importance to rural hospitals that are in financial distress.

Further research has suggested that group tenure, trust, and consensus enhance strategic decision-making (Posthuma, Camelo-Ordaz, García-Cruz, & Sousa-Ginel, 2014). Strategic decision-making involves the use of information to provide a deeper solution to problems. With data, leaders might assess issues and implement changes needed (Biesbroek, Termeer, Klostermann, & Kabat, 2014). Additionally, rural hospital leaders have collaborated, and problem solved together to develop rich solutions (Garbuio, Lovallo, & Sibony, 2015). Often, strategic rigor is a result of consistently analyzing information or data. What results from the constant review of information is a

well-developed solution based on data (Norris, 2015). For rural hospital leaders, strategic decision-making occurs through several approaches such as (a) using data to drive decision-making and (b) placing the organization well-being over personal interests.

The conceptual framework, strategic decision-making, aligns with understanding what strategies rural hospital leaders use to improve their hospital's financial performance. Strategic decision-making is essential in improving hospital's financial performance. Concerning this study, strategic decision-making occurs when rural hospital leaders make decisions that impact the hospital's health and overall survival. These strategic decisions made by rural hospital leaders tend to be infrequent or may occur as the situation arises. With strategic decision-making, rural hospital leaders use information and gather diverse perspectives as part of rationality. Additionally, rural hospital leaders must address politics and power. Arbitrary and uncoordinated decisions made by rural hospital leaders are not sufficient for improving hospitals financial performance. Instead, rural hospital leaders should analyze information and data to identify appropriate solutions (Kowalczyk & Buxmann, 2015). As a result, leaders must use strategic decision-making and data to implement more appropriate solutions impacting financial performance (Arbab Kash et al., 2014; Govindan, Rajendran, Sarkis, & Murugesan, 2015).

Schrettle, Hinz, Scherrer -Rathje, and Friedli (2014) later extend the work of Eisenhardt and Zbaracki (1992) to explain how leaders adjust their firm's strategy as well as how a firm's internal landscape and external environment influences short-term and long-term strategic decisions. Rural hospital leaders face similar financial challenges.

The outcomes achieved through the strategic decision-making process by hospital leaders may vary from leader to leader (Bhansing, Leenders, & Wijnberg, 2015; Thywissen, 2015). Successful leaders' strategic decision-making is methodical, data-driven, factual, and evidence-based. Additionally, a leader's level within the organization and how they respond to information provided may impact strategic decision-making (Daellenbach, Zander, & Thirkell, 2016). For rural hospital leaders, strategic decision-making needs to occur once data has been gathered and analyzed. Once rural hospital leaders gather the data, rural hospital leaders should involve other leaders with diverse business backgrounds in the decision-making process. An example is when rural hospital leaders review their strategic plan to assess performance against goals (Ayers, 2015; Stevens et al., 2016).

Garbage Can Theory

Cohen et al. (1972) developed the garbage can theory. The garbage can theory occurs in a multifaceted, chaotic environment with the organizations referred to as organized anarchies (Cohen et al., 1972). Two key propositions for exploring garbage can theory are (a) organizations as anarchies and (b) decisions as a random confluence of streams (Cohen et al., 1972). Leaders may view some portions of an organization as organized anarchies (Cohen & Karatzimas, 2014; Rudel & Meyfroidt, 2014; Zhu & Kindarto, 2016). Within the organized chaos, there exist three elements: (a) problems to solve, (b) solutions to implement, and (c) resources needed to address the issues. For effective strategic decision-making, aligning the best solution to the problem or having the best-fit individual work on the problem is vital (McGill et al., 2017). In the garbage

can theory, leaders do not align people or resources efficiently (Olsen, 1976). This misalignment is the essence of the garbage can theory. The decision to address a problem or align resources to a problem occurs randomly for leaders. Finally, in the absence of clear target dates, deadlines, and governance, the garbage can theory becomes stronger.

Problems occur both within and outside organizations (Cohen et al., 1972). Additionally, issues are relevant to participants. Participants are individuals with hectic schedules who may pay attention (Cohen et al., 1972). For example, problems may be at the employee, organization, stakeholder, board, or community level. Within the organized anarchy, decisions, relationships, and the attributes by which predispositions exist are random (Steen, Ford, & Verreynne, 2017). Leaders have unpredictable attributes and unclear preferences (Cohen et al., 1972; Paton, 2014). Attributes impact decision-making significantly as problems arise within the organization. Leaders may select a problem to address if it benefits them positively. Conversely, leaders may not choose a problem to address if it benefits them negatively.

Leaders gain knowledge by repetitive experiential learning (Hill, 2017; Saraswat, Bach, Watson, Elliott, & Dominguez, 2017). However, with this approach, leaders spend more time learning. Leaders spend less time problem solving resulting in the leader not being aware of fundamental causes for the business problem. The leader chooses and implements a solution to a business problem with little problem-solving. Consequently, the solutions developed and implemented may not address the business problem.

Frequent or infrequent occasions that require a decision are choice opportunities (Howlett, McConnell, & Perl, 2014). Choice opportunities do not occur in a fluid or

planned manner. Instead, choice opportunities enter an organization randomly or may be avoided (Inamizu, 2015). The leaders select which choice opportunity to address. This situation may have an undesirable impact on the organization as leaders fulfill their personal need before the needs of the organization (Inamizu, 2015). Additionally, the impact of choice opportunities exists when there is no decision maker (Inamizu, 2015).

Leaders respond to business problems by developing solutions (Cohen et al., 1972). In the garbage can theory, solutions are superficial. The solutions do not involve in-depth analysis. The solution may not align with either the problem or results expected. This situation occurs because the resources span several initiatives. The resource assigned to develop solutions specific to the problem may lack the ability or knowledge. The attributes of the leaders who identified the need to address the problem may be personal versus organizationally focused. Additionally, individuals may make decisions yet opt to not resolve problems (Lyndon et al., 2015). As a result, the business problems continue, and issues are left unresolved.

Leaders assign participants to the team to solve problems. Participants support developing solutions to the problems that arise in an organization. The leader may not evaluate the participant's current workload as the participant moves from project to project. Within the garbage can theory, participants are not aware of the priorities, problems, or the need to address the problem. Their leaders move participants into or out of the team environment without thought of any perceived consequences to human-capital management (Bode, Singh, & Rogan, 2015).

The garbage can theory represents a contrasting conceptual framework. The strategic decision-making framework aligns better than the garbage can theory to this study. Random and chance decisions made by rural hospital leaders are not sufficient for improving hospitals financial performance. Strategic decision-making by rural hospital leaders may positively or negatively impact financial performance (Candido & Santos, 2015; Shah, 2015). While rural hospitals may be chaotic environments, rural hospital leaders must identify and implement strategies to improve their hospital's financial performance (Shah, 2015). The decisions made by rural hospital leaders cannot be random. Instead, their decision-making must align with the needs of the hospital. Without the alignment of their decision-making, the rural hospital will not succeed.

United States Healthcare System

Healthcare delivery involves primary prevention, secondary prevention, and tertiary prevention (Collet et al., 2018; Ibáñez-Sanz et al., 2018; Kirk, Terry, Lokuge, & Watterson, 2017). Primary prevention encompasses hindering the development of the disease. Health education classes, vaccinations, and immunizations are an example of primary prevention (Sankaranarayanan, 2015). Secondary prevention includes detecting the presence of the disease. Screenings and lab tests are examples of secondary prevention (FitzGerald, Rorie, & Salem, 2015). Tertiary prevention involves reducing the effects of the disease on the individual (Jacobsen & Andrykowski, 2015). Medicine and treatment are examples of tertiary prevention (Trousselard et al., 2016).

Training, hospitals, public health, and health insurance are four key components of the United States healthcare system. Additionally, each of these key components

impacts the delivery of primary, secondary, and tertiary prevention. At the onset of practicing medicine, there were no requirements for medical education. Admission examinations, medical coursework, board training, and licensure stem from significant improvements to the medical practice. The American Medical Association (AMA) was the professional organization for physicians and standardized medical education (Kim, Curlin, Wolenberg, & Sulmasy, 2014). Due to technology and research, medical training continues to evolve to stay relevant and serve the public (Linde, Caridha, & Kunkler, 2017; Reese, 2018).

Public health encompasses a collaborative approach to protecting and preventing health issues. In 1965, government leaders created public health coverage through Medicaid and Medicare programs (Custer, 2015). The Medicaid program provides health insurance coverage to low-income people (Wright et al., 2018). The Medicare program provides health insurance coverage for those 65 years old or older, people with disabilities, and those with End-Stage Renal Disease (U.S. Centers for Medicare & Medicaid Services, n.d.). In 2014, an essential component of the Affordable Care Act was Medicaid expansion, which expanded coverage to approximately 17 million Americans (Baker & Hunt, 2016). Individuals under 65 with household incomes up to 138% of the federal poverty level (FPL) were eligible for coverage under the federally funded Medicaid expansion (Baker & Hunt, 2016).

In the United States, uncompensated care, which includes charity and bad debt, reached 27.3 billion in 2014 (Rosin, 2015; U.S. Department of Health and Human Services, 2014). Medicaid expansion has impacted rural hospitals. For states that have

not expanded Medicaid, rural hospitals have seen an increase in uninsured patients and decrease in reimbursements for uninsured patients medical costs (Ellison, 2015). For rural hospitals in non-expansion states, the amount of uncompensated care and charity care was higher than in rural hospitals in expansion states (Reiter, Noles, & Pink, 2015). Additionally, the rise of high-deductible plans causes a burden on patients. These high deductible plans require patients to pay upfront and providers to collect payment at the registration process (Rosin, 2015).

As of 2016, there were 4,840 community hospitals in the United States (American Hospital Association, 2018). There are two types of community hospitals: urban hospitals and rural hospitals. There were 3,015 urban hospitals and 1,825 rural hospitals (American Hospital Association, 2018). Urban hospitals reside in metropolitan areas (Hall & Owings, 2014). In the United States, 83% of the United States population lives in urban or metropolitan areas (Centers for Disease Control and Prevention, 2014). Within these urban or metropolitan areas, 88% of the hospitalizations occurred in urban hospitals (Centers for Disease Control and Prevention, 2014). Additionally, 89% of the total hospital days were in urban hospitals (Centers for Disease Control and Prevention, 2014).

Rural hospitals reside in non-metropolitan areas (Hall & Owings, 2014). In the United States, 17% of the United States population lives in rural communities (Centers for Disease Control and Prevention, 2014). Within these rural communities, 12% of the hospitalizations occurred in rural hospitals (Centers for Disease Control and Prevention, 2014). Additionally, 11% of the total hospital days were in rural hospitals (Centers for Disease Control and Prevention, 2014). Rural hospitals provide care while battling

geography, economies of scale, and reduced revenue (Lagrou et al., 2018). There are four types of rural hospitals: critical access hospitals (CAHs), Medicare-dependent hospitals (MDHs), rural reference centers (RRCs), and sole community hospitals (SCHs) (Holmes et al., 2013). The following sections will expound on the types of rural hospitals and safety net hospitals.

CAHs are rural hospitals and may qualify for special payment provisions under Medicare (Holmes et al., 2013; Le, Sánchez, Misono, Saini, & Prabhakar, 2017). CAH eligibility includes the rural hospital must reside in a rural area, have less than 25 beds, and be 35 miles from the nearest hospital (Nelson-Brantley et al., 2018). The Balanced Budget Act of 1997 enabled hospitals meeting the specific criteria to convert to CAHs (James, 2014). Per the Balanced Budget Act of 1997, the reimbursement method for CAHs was 101% of the reasonable costs. Then in 1999, the Balanced Budget Refinement Act of 1999 expanded CAH eligibility enabling geographic reclassification (U.S. Department of Health and Human Services, 2014). From the research of CAHs financial performance, Holmes et al. (2013) discovered hospitals with larger reliance on Medicare have lower profitability due to their patient population served. Conversely, CAHs with higher outpatient volume tend to be more profitable (Holmes et al., 2013). Besides, CAHs with larger populations and market share have better financial performance. Holmes et al. (2013) found the reimbursement method helped the financial performance of CAHs and CAHs tend to have lower financial performance than other rural hospitals.

MDHs are rural hospitals that serve a high proportion of Medicare patients (Holmes et al., 2013). Due to low patient volume, rural MDHs receive additional payments to ensure financial stability (U.S. Centers for Medicare & Medicaid Services, 2014). Although Holmes et al. (2013) reported that hospitals with larger reliance on Medicare, charity care, and uncompensated care might have difficulty financially, Stensland, Gaumer, and Miller (2016) recently found that hospitals benefit from payments from Medicaid, Medicare, and uncompensated care. This phenomenon occurs because of the hospital's payment trends, lack of technology, and low patient volume. Rural MDHs serve communities with low patient volume and provide less technological services. Generally, MDHs have difficulty offsetting low reimbursement, charity care, and uncompensated care with other sources of revenue (Karim, Holmes, & Pink, 2015).

RRCs are acute care rural hospitals that treat high-volume complicated cases (Holmes et al., 2013). RRC eligibility includes the rural hospital must have at least 275 beds, is the primary provider for a geographic area, and has comparable case mix and many discharges to metropolitan hospitals in the same census region (McCue & Nayar, 2009). McCue and Nayar analyzed for-profit RRCs and non-profit RRCs. The authors found non-profit RRCs "achieve a faster receivable collection rate than for-profit RRCs, which more than likely helps contribute to the inflow of cash" (McCue & Nayar, 2009, p. 317). Conversely, non-profit RRCs have longer accounts payable and hold onto the receivables higher than for-profit RRCs (McCue & Nayar, 2009). Additionally, for-profit RRCs have higher cash flow returns because of the financial strategies deployed. These

strategies focus on reducing operating expenses and appropriately maintaining staffing levels (McCue & Nayar, 2009).

Safety-net hospitals provide medical services to patients regardless of their ability to pay and have a high proportion of uninsured, Medicaid-enrolled, or vulnerable patients (Horný et al., 2017; Shimizu et al., 2014). Reiter, Jiang, and Wang (2014) concluded that safety net hospitals have significantly lower margins due to providing healthcare access to a large proportion of uninsured, Medicaid-enrolled and vulnerable patients. However, Sheingold, Zuckerman, and Shartzer (2016) identified specific strategies to reduce financial penalties of safety net hospitals. These plans included policymakers taking careful consideration of how patient socioeconomic status affects hospital readmissions.

SCHs are rural hospitals (Holmes et al., 2013). SCH eligibility includes the hospital must be more than 50 miles from the nearest hospital. SCHs receive reimbursement from a combination of the hospital-specific rate as outlined in the Tax Equity and Fiscal Responsibility (TEFRA) of 1987 and federal-regional diagnosis-related group (DRG). Dumanovsky et al. (2016) investigated the rise of palliative care programs within U.S. hospitals, including sole community hospitals. While palliative care services have increased within the United States, access to palliative care services may be uneven due to geographic location and provider availability barriers (Dumanovsky et al., 2016).

Strategic Planning

Strategic planning begins with understanding an organization's mission, vision, and values (Bazrkar, Iranzadeh, & Farahmand, 2018). Creating an organization's strategy involves an external analysis from scanning the marketplace and internal

analysis from reviewing performance to goals (Wittal, 2018). Scanning the marketplace includes an understanding of a) customer acquisition, profitability, and retention, b) identifying new services, and c) being aware of market share. Implementation of specific goals and ongoing performance measurement occurs next in strategic planning (Brorström, Argento, Grossi, Thomasson, & Almqvist, 2018). With ongoing performance measurement, leaders monitor leading and lagging metrics (Bruns & Poghosyan, 2017). In healthcare, hospital leaders have assessed the healthcare landscape to identify financial strategies to prevent rural hospital closure.

Financial Performance

In 2013, the United States healthcare spending reached $2.9 trillion or $9,255 per person (U.S. Centers for Medicare & Medicaid Services, 2014). As of 2013, the average cost per inpatient day in the United States was $2,013 for state/local government hospitals, $2,413 for non-profit hospitals, and $1,831 for for-profit hospitals (American Hospital Association, 2016). These estimates include the operating and non-operating expenses for United States Community hospitals (American Hospital Association, 2016). Typical expenses include medical costs for a day of inpatient care and the associated volume of outpatient services.

For urban hospitals, healthcare spending is less than rural hospitals due to fixed expenses and patient volume. Rural hospitals provide services according to population need and medical provider responsibility. For rural hospitals, 60% of rural hospitals revenue comes from Medicare, Medicaid, and government payers (American Hospital Association, 2011). Rural hospitals face significant obstacles hindering their ability to

achieve financial performance (Noles, Reiter, Boortz-Marx, & Pink, 2015). The barriers hindering financial performance are (a) reduced revenue due to payer mix, (b) economies of scale and scope due to size, and (c) reduced wasteful utilization (Carey, Burgess, & Young, 2014; McWilliams & Schwartz, 2017). Additionally, economies of scale impact rural hospitals. Rural hospitals overcome economies of scale by affiliating or merging with other institutions, increasing utilization of services, or reducing the services offered only to provide what is essential for the community (Ren, 2017).

As states expand Medicaid, previously uninsured patients may be eligible and retroactively covered for up to 90 days before application. Consequently, hospitals in those states should conduct post-Medicaid scrub. Hospitals will identify patients now covered and reduce the potential for uncompensated care (Rosin, 2015). Besides, there will be a need for face-to-face education for patients to explain medical billing and patient responsibilities (Rosin, 2015). Furthermore, within expansion states, hospitals that serve low-income patients experienced a reduction in uncompensated care (Camilleri, 2017). Chen et al. (2015) cautioned hospitals and provider to consider the growth of specific patient populations on a hospital's uncompensated care. Further support may be needed to reduce financial burdens and improve the availability of resources for growing patient populations (Chen et al., 2015).

While 83 rural hospitals have closed from 2010 through 2018 (North Carolina Rural Health Research Program, 2018), approximately 283 rural hospitals are in danger of closing (Demko, 2015). If the 283 rural hospitals close, this will represent an estimated $10.6 billion loss to the GDP (Ellison, 2015). Reasons for hospital closure are

due to the financial health of the hospital and market characteristics (Kaufman et al., 2015). Issues will continue to increase, as revenue does not offset expenses (Kaufman et al., 2015). Rural hospital closure impacts the community and its residents. From a patient perspective, increased patient financial responsibility is of concern to rural patients who typically have lower incomes (Lee, Jiang, Phillips, & Ohsfeldt, 2014). The impact of these closures on the rural community would be a reduction of 86,000 jobs. Of the 86,000 jobs, 36,000 of those jobs are in the healthcare sector. While not all rural hospitals are facing closure, some rural hospitals have improved their hospital's financial performance. North Sunflower Medical Center in Ruleville, Mississippi experienced a 9.5% increase in revenue and a 42.8% growth in clinic services for FY2013 (Demko, 2015). Hospital leaders attributed the increase to grant funding and increased patient volume (Demko, 2015).

As rural hospital leaders address the financial side of the healthcare system, rural hospital leaders monitor financial measures. Financial measures are of importance for reimbursement, as well as, assessing the overall health of the hospital. By monitoring financial measures, rural hospital leaders will have information and data to determine areas of the operation to improve. The financial strength of a healthcare institution is vital to survival (Gilman et al., 2015). The financial health of an organization will be crucial as organizations reduce the cost of care to maintain profits. Adverse effects of the healthcare reform, such as consolidation of providers to achieve buying power, investments, and market stabilization can impact rural hospitals financial strength. Consequently, rural hospitals and rural hospital leaders will need to understand all the

costs associated with providing patient care and begin removing wasteful activities to control costs.

Hospital executives monitor financial benchmarks and indicators to assess the financial health of their organization. For rural hospital administrators, financial benchmarks serve to provide a reference for comparing groups against one another. Likewise, rural hospital executives use financial indicators to assess the economic state of their organization. Standard financial benchmarks include hospital margins, days of cash on hand, accounts receivable, and the average age of the plant (Ellison, 2015). Typically, financially troubled hospitals lack the financial resources to support infrastructure and operational improvements (Bazzoli, Fareed, & Waters, 2014). Selection of financial indicators involves the ability to measure, the relevance of data collected, and whether the data is meaningful (Pink et al., 2006).

Rural hospital executives monitor financial performance using profitability ratios (Pink et al., 2006). Similarly, Collum, Menachemi, Kilgore, and Weech-Maldonado (2014) used three profitability ratios to measure rural hospital financial performance: total margin, operating margin, and return on assets. Another approach to measuring a hospital's financial performance involves assessing revenue, profitability, cost, utilization, capital structure, and liquidity (Pink et al., 2006). Additionally, another means for evaluating financial performance is to measure peer groups based on net patient revenue, ownership, being a long-term health provider, and being a rural health clinic (Pink, Holmes, Thompson, & Slifkin, 2007). Hospital leaders may choose to compare themselves to one another; however, hospital leaders should only measure

themselves within their peer group for meaningful data (Pink et al., 2007). Because healthcare is a heavily regulated environment, quality is another indicator worth mentioning when evaluating a hospital's financial performance. Researchers suggest that as rural hospitals improve their financial performance, leaders allocate funds for quality improvement initiatives (Pink et al., 2007).

Other strategies cited by hospital leaders to improve their financial performance were a) applying for grant funding, b) introducing a Wellness Center, c) ensuring patients receive care in the most convenient setting, and d) introducing telehealth and patient monitoring through mobile devices. Additionally, some hospitals are exploring new Medicaid payment algorithms for rural hospitals that only have an emergency room and outpatient care.

Government regulations may impact the financial performance of a hospital. Government mandates require that hospitals demonstrate benefit by completing a community health needs assessment (US National Library of Medicine, 2015). The community health needs assessment identifies the needs of a primary service area. Hospitals attempt to match services offered to community needs using the community health needs assessment. Additionally, Blewett, Call, and Marmor (2013) researched the impact of the healthcare reform on the United States Virgin Islands residents. Blewett et al. (2013) utilized information from the Virgin Islands Health Insurance telephone surveys. The researchers administered the survey randomly to the United States Virgin Islands households. From the study, the authors found that the number of uninsured residents increased 4.6%, 24.1% in 2003 and 28.7% in 2009. Besides, the Medicaid caps

had grown as part of the Patient Protection and Affordable Care Act. A segment of the population, adults with or without children, had limited access to affordable healthcare insurance even with the Medicaid cap increase.

Strategic Trends

According to Santilli and Vogenberg (2015), critical healthcare strategic trends include patient engagement, use of technology, and quality measures. A patient engagement strategy, combined with change management and patient education, resulted in a 27% reduction of emergency room usage over a four-year period (Punke, 2015). The strategy included a) cash incentives for members who complete their health risk assessments, b) increased co-pay for emergency room usage, c) decreased co-pay for urgent care, and d) social media to reinforce when to use an emergency room or urgent care. Irizarry, DeVito Dabbs, and Curran (2015) explained that personal factors affect patient engagement and usage of patient portals and electronic/personal health records. Improving usage of patient portals and electronic health records may be achieved through alignment of the patient needs, the provider needs, and functionality (Irizarry et al., 2015).

Gu et al. (2014) researched the impact that the Hospital Readmissions Reduction Program (HRRP) had on rural hospitals who serve vulnerable populations. Rural hospitals may experience excessive readmissions due to the patients they serve. The author recommended that governance for the HRRP program needs to ensure access to care for vulnerable populations. O'Toole, Johnson, Aiello, Kane, and Pape (2016) further explored the Behavioral Model for Vulnerable Populations theoretical framework

with 33 Veterans Health Administration facilities. The authors found that the integration of social supports and services of health into clinical care significantly reduces hospitalization rates for homeless veterans.

Researchers have explored the readiness and adoption of rural hospitals toward telemedicine (Kahn, 2015). Additionally, rural hospitals have used telemedicine, telehealth, and mobile apps to improve patient access (Weinstein et al., 2014). In one instance, researchers examined telemedicine and telephone usage when providing care to acute stroke patients. Researchers explored clinician adoption with telemedicine in rural hospitals (Ray et al., 2017). Concerning telemedicine, exploration of barriers to adoption and strategies to overcome barriers may improve clinical utilization (Ray et al. 2017). Besides telemedicine, researchers have explored other forms of patient monitoring. Telemedicine family conferences enable providers to communicate with rural patients and caregivers, post-discharge (Menon, Stapleton, McVeigh, & Rabinowitz, 2014). With this type of approach, providers have the responsibility to prepare for the telemedicine family conference thoroughly. Another less expensive form of patient monitoring uses smartphones. By using the smartphone monitoring service, clinical staff conducted patient follow-up remotely (Chee, Lowe, & Lim, 2016).

Technology usage in rural hospitals may lead to improved financial performance. For instance, hospitals have used technology to verify insurance coverage when the patient is in the admitting process (Rosin, 2015). There are two benefits from this type of technology. By using these discovery insurance programs, the hospital may accurately determine a patient's insurance status. Likewise, patients are better able to anticipate the

estimated cost for the services. Hospitals use identification verification systems to reduce medical fraud. These systems protect the patient and hospital, as well as reduce the bad debt involved with medical fraud. Technology usage in a rural hospital may also improve patient care. Dose, Holland, Vanderboom, Ingram, and Wild (2015) described how technology might be utilized to enhance communication between providers and rural patients. Utilization of video technology for rural patients and caregivers enabled providers to improve care coordination as patients transitioned from the hospital to home or other care settings. Additionally, physicians utilized video technology to provide on-going follow-up in a lower cost setting.

The relationship between the quality of healthcare a person receives, and the cost of the service provided is complex (Burke & Ryan, 2014). Prior scholars also discovered that the quality of health care received may not accurately indicate the amount paid for the service (De la Torre-Díez, López-Coronado, Vaca, Aguado, & de Castro, 2015). Additionally, the quality of healthcare received by providers varies because variations exist in people, processes, and procedures. Hospital leaders evaluate pay for performance programs, and payers reimburse hospital systems based on these programs. Research suggests that pay for performance programs should account for each hospital situation and socioeconomic status of its patients (Chi et al., 2016).

Hospital leaders and the medical community work together to improve healthcare delivery to meet regulatory mandates and quality standards such as the Institute of Healthcare Improvement's (IHI) Triple Aim efforts (Reiter et al., 2014). IHI Triple Aim includes improving the patient experience, improving population health, and reducing

costs (Reiter et al., 2014). For many hospital leaders, there may be a financial implication or incentive for achieving regulatory mandates or quality standards such as the IHI initiative. On average, the opportunity cost of achieving regulatory mandates and quality standards, such as the IHI initiative, yields $21,550 in personnel and benefits costs (Reiter et al., 2014). To put it in perspective, the opportunity cost of $21,550 is equivalent to a half nurse full-time equivalent. Tactics used by hospital leaders to reduce costs were scheduling meetings during slow periods, improving efficiency, and improving performance (Reiter et al., 2014). Transformational tactics will lead to increased revenue through reimbursement, improved efficiency, enhanced care, and reduced costs.

Current research has found that effective oversight from board members who use accurate information to make decisions yields significant benefits for hospitals (Millar, Freeman, & Mannion, 2015). Hospital boards should set policies to examine board member training, hospital reporting, and quality/safety (Mannion et al., 2014). Tsai et al. 2015 found that there is a relationship between hospital boards, front-line management, and quality of care. When board members and management monitored hospital performance, the hospital provided a higher quality of care to patients and achieved the hospital's objectives (Tsai et al., 2015). Additionally, as hospital boards monitored quality metrics, hospital management was effective in achieving goals and managing hospital operations (Tsai et al., 2015).

Access to Care

Access to healthcare facilities is vital to rural communities (Hung, Casey, Kozhimannil, Karaca-Mandic, & Moscovice, 2018; Kaufmann et al., 2015). Furthermore, understanding factors that hinder healthcare access in rural communities are important. Researchers explored rural hospitals and healthcare access (Mohr et al., 2017). Rural hospitals provide 24/7 care to rural communities (Timonin, Kontsevaya, McKee, & Leon, 2017). For rural residents, the nearest community hospitals are approximately 35 miles from the rural hospitals (Duran, 2012). As rural hospitals close, the distance between the rural communities and local hospitals may impact access to care and needed services (Halverson & Johnson, 2017). Rural hospital closures impact access to care because the patients have increased commute times (Hanson et al., 2015).

Although the distance is not an issue for all rural hospitals, the number of patients served in a rural hospital is less than the number of patients served at a local community hospital. Consequently, rural hospital leaders find it difficult to reduce costs. However, with the CAH program, rural hospitals collect Medicare reimbursements at 101 percent of costs. With the help of the CAH program and using patient-centered care, these rural hospitals are providing care at lower costs as compared to other types of hospitals (Duran, 2012). For low-income minorities living in rural areas, these patients often do not have access to healthcare (Duran, 2012). A study sampled 386 minority residents living in a rural community in Texas found 75% of the minority residents surveyed perceived that they needed access to additional medical care services. The remaining 25% of the minority residents surveyed stated they needed to utilize emergency

department services for primary care needs. Of the 25% of the minority residents surveyed, half of the residents surveyed needed an interpreter while being seen by a provider.

In rural communities, patients with complex social or medical needs may not have access to proper care (Mercer et al., 2017). Rural hospital leaders may decide to survey their patient population and uniquely address patients with complex needs. By doing so, hospital leaders may be able to identify how to improve quality, ensure access to resources, and lower the cost to treat patients with multiple needs (Mercer et al., 2017). Rural hospital leaders' balance fixed resources to ensure that patients with complex needs have adequate medical care and social support. There are two outcomes of the new care model for patients with complex needs. The first outcome is to improve the quality of care, and the second outcome is to reduce cost. Managed care models that encompass medical care and social support for the patients have been able to provide coordinated care efficiently.

Operational Characteristics

Many patients receive healthcare in an environment with fixed resources (Riviello, Letchford, Cook, Waxman, & Gaziano, 2015). For rural hospitals, balancing fixed resources with providing care to patients frequently occurs (Rivello et al., 2015). Rural hospital leaders make decisions as to how to distribute fixed resources with minimal information or data (Rivello, 2015). Analyzing information and data will help rural hospital leaders determine the costs and benefits of allocating fixed resources, improving the quality of care, and exceeding the performance of care (Reiter et al., 2014).

De Harlez and Malagueño (2016) researched the strategic management system in hospitals. The researchers found that hospital leaders should emphasize partnerships and governance to improve hospital performance. With an emphasis on partnerships and governance, hospital leaders will make effective decisions with the use of essential data and information. Additionally, community partnerships are critical to completing the population health assessment and unlocking changes needed for improving population health outcomes (Jorna & Martin, 2014). Coordination of care is vital to ACA (Jorna & Martin, 2014). This coordination of care should extend outside the four walls of the hospital.

Sharing responsibility is essential to improving population health and providing seamless care. Hospital leaders have decided to focus on population health to improve the health of communities (Jorna & Martin, 2014). The Patient Protection and Affordable Care Act (ACA) are two drivers in improving population health (Jorna & Martin, 2014). Hospital leaders recommend essential investments to implement population health strategies (Jorna & Martin, 2014). These significant investments include identifying resources and allocating time to understand population health (Jorna & Martin, 2014).

Population health management utilizes patient information to positively influence financial and clinical outcomes (Hibbard, Greene, Sacks, Overton, & Parrotta, 2016). For rural hospital leaders to make strategic decisions, the rural hospital leaders should understand the population they treat. Hospital leaders collect data to understand patient needs (Nippak, Isaac, Ikeda-Douglas, Marion, & VandenBroek, 2014). Current research

suggests that hospital leaders should collect race, ethnicity, and language (REL) data (Chin, 2015). Consequently, understanding data from the minority population is essential to population health (Gracia et al., 2015). By collecting REL data, hospital leaders, health systems, and governments will be able to determine their patient population and understand where the gaps in access and care exist (Iqbal, Ginsburg, Rochon, Sun, & Narod, 2015). Hospital leaders and health systems should collect REL data to improve three areas: 1) culturally competent care, 2) prevention, and 3) quality of care (Chin, 2015; Gracia et al., 2015; Iqbal et al., 2015).

In a subsequent study, researchers analyzed two years' worth of data, from 2007 to 2009, which shed light on emergency department usage and inpatient length of stays in Canada (Nippak et al., 2014). The goal of the research was to determine characteristics of patients who utilize emergency departments for primary care and inpatient lengths of stay (Nippak et al., 2014). The researchers found that a longer duration of stay in the emergency department correlated to longer inpatient length of stays. Additionally, the researchers found that certain patient characteristics (i.e., complex needs, age, etc.) impact the duration of stay. Subsequent researchers explored access to care and care disparities (Squazzo, 2014). The outcome of the research was that disparities in the type of medical care and quality of care received are still widespread (Squazzo, 2014). Reducing the disparity in medical care is an ethical, social justice, and financial imperative (Squazzo, 2014). Key lessons to address disparities in medical care include (a) gather data, (b) use data to drive decisions, (c) education employees, (d) empower patients, (e) develop culturally competent touch points, and (f) use patient navigators

(Squazzo, 2014). Improving cultural competency involves patient-centered care, technology, access to care, cultural understanding, and leadership buy-in (Squazzo, 2014).

Researchers have explored utilization of healthcare services. Cossette, Frasure-Smith, Vadeboncoeur, McCusker, and Guertin (2015) and Hällfors, Saku, Mäkinen, and Madanat (2018) researched the economic impact of unnecessary emergency room utilization. Cossette et al. (2015) documented an emergency room reduction approach of nursing intervention at discharge and subsequent telephone follow-ups to patients ten days post-discharge. Hällfors et al. (2018) found that providing phone consultation services reduced emergency room utilization, the financial burden on hospitals, and waiting time for patients. While these authors explored the financial aspects of healthcare, the authors identified that improving utilization of services consumed by patients significantly impacts hospital finances.

In a subsequent study, usage of the emergency department for unnecessary services might increase uncompensated costs and raise the hospital's financial burden (Simonet, 2009). Methods, such as triaging patients to reduce the bottlenecks, has helped the flow and improve efficiency in emergency departments (Simonet, 2009). Hospital providers might encourage patients to use walk-in clinics as another option for receiving medical care (Simonet, 2009). The walk-in clinics provided access to relatively quick care. However, the issue of uninsured patients seeking and needing care has remained unaddressed. Hospital leaders might work with providers and clinical staff to determine

ways to remove waste in the emergency department. By doing this, patients have benefited from improved access and quality of care.

For many rural hospitals, the waiting room was often an area of opportunity. The adverse effect of the waiting room was undue waiting before moving to the operating room (Testi & Tànfani, 2009). Researchers developed an operation room blocked time model to support time allocation in the operating room (Testi & Tànfani, 2009). With the model, researchers analyzed various patient attributes, such as subspecialty, day of the week, status, expected length of stay (ELOS), and expected operating time (EOT). The model appeared to be most effective for determining time allocation in the operating room.

Nurses tend to be the first provider patients see when obtaining care. Additionally, nursing roles tend to be team-oriented, highly involved, and compassionate (Smolowitz et al., 2015). Community-based health workers support patients within their communities (Kim et al., 2016). Their two main responsibilities include patient education and case management (Kim et al., 2016). Kim et al. (2016) researched vulnerable populations and found vulnerable populations include patients who tend to have poor health and limited access to medical care. Involvement by the community-based health workers in patient care appears to be of significance and cost-effective for vulnerable populations. A possible recommendation is that healthcare leaders work with community-based health workers to improve health outcomes for patients in their community. Similarly, Dawson, Nkowane, and Whelan (2015) found that collaboration among nurses, midwives, and other providers impacted healthcare and patient outcomes.

Additionally, the authors found that education and training prepared nurses and midwives for providing care for vulnerable populations. The authors suggested that hospital leaders should identify governance and training strategies to support nurses and midwives.

In rural communities, rural hospitals employ nurse practitioner and physician assistant to provide care to residents (Hooker & Muchow, 2015). Under the Rural Health Clinic program, rural hospitals employ nurse practitioners and physician assistants to enhance outpatient care services. The purpose of the Rural Health Clinic program is to increase access to primary care services for rural residents covered by Medicare and Medicaid. An essential element of the Rural Health Clinic program is to utilize a team approach when treating patients. This team approach takes the shape of a physician working with non-physician practitioners. Non-physician practitioners include nurse practitioners, physician assistants, and clinic nurse midwives. These non-physician practitioners must be staffed 50% of the time in the hospital. Additionally, rural health clinics must provide outpatient care and basic laboratory services. One main advantage of rural health clinics is reimbursement rates for Medicaid and Medicare services. Medicare reimbursement follows reasonable costs, and Medicaid reimbursement follows prospective payment system.

Clinician decision-making within palliative care consult services has impacted rural hospitals (Durie & Tanksley-Bowe, 2018). Rural hospitals lack the resources to provide palliative care consult services (Durie & Tanksley-Bowe, 2018). The researchers recommended incorporating technology to provide patients with palliative care consult services using telemedicine (Durie & Tanksley-Bowe, 2018). Another type of decision-

making involving patients has occurred in hospitals (McAdams, McPherson, Batra, & Gerelmaa, 2014). Shared decision-making has occurred between providers and patients. Rural hospital primary care providers have offered patients information and recommended treatment options for patient care. As a result, patients are empowered to own their health and make decisions for their care. Additionally, hospital leaders have coordinated resources to address care for children (Yang et al., 2015). Researchers evaluated the cost, effectiveness, and return on investment for providing telephone consultations to providers of injured children in rural emergency departments (Yang et al., 2015). By making these telephone consultations, the outcomes of injured children receiving care in rural emergency departments improved. For rural hospital leaders, utilization of technology to improve outcomes of a specific patient population may be a strategy impacting quality measures, such as re-admissions. Additionally, utilizing technology to improve access to care and outcomes might affect the hospital financially with additional reimbursement.

Usage of clinical guidelines does not guarantee accuracy. Certain factors, such as inconsistent use of guidelines and medical errors, might affect clinical decision-making even with the usage of established clinical guidelines (McAdams et al., 2014). Standards of care help clinician provided quality care (Glance, 2011). Clinical information systems and monitoring patient outcome data have helped identify medical errors. By addressing these medical errors, patient outcomes have improved, and patients have perceived efficiencies in care. Efficiencies in care might be in the forms of shorter hospital stays, reduced errors, and reduced lawsuits. Kitchenman (2013) researched how a group of

New Jersey hospitals improved overall efficiency. The New Jersey hospitals were able to improve efficiencies without increasing hospital beds or expanding (Kitchenman, 2013). The hospitals identified bottlenecks causing patient delays, overcrowding, and low patient satisfaction (Kitchenman, 2013). The hospital estimated that there was a potential to save $8 million per year by improving process flow, developing patient criteria, and addressing patient motion (Kitchenman, 2013).

Transition

The literature review regarding strategies rural hospital leaders implement to improve their hospital's financial performance revealed that the general business problem has multiple causes. Solutions have existed to address the general business problem. State departments, federal entities, and rural hospitals have enacted solutions such as expanding Medicaid, improving operations and identifying indicators for unfavorable financial performance. However, rural hospital closures and financial problems have continued at the expense of the rural hospital, rural hospital employees, and surrounding the rural community. The problem statement and purpose statement supported the exploration of strategies rural hospital leaders implement to improve their hospital's financial performance. Besides, the conceptual framework, strategic decision-making, helped explore the effect of bounded rationality, politics, and power on a hospital leader's ability to develop strategies to improve financial performance.

Section 2 included a description of the study, the role as a researcher, participants, research method and design, population and sampling, ethical research, data collection instruments and technique, data organization, data analysis, reliability, and validity. The

purpose of Section 2 was to provide a rich description of the study, an explanation of how the interviewer will conduct the interviews, and justification of using qualitative method multiple case study design to explore strategies rural hospital leaders implemented to improve financial performance.

Section 3 included a presentation of findings, application of rural hospitals, implications for social change, and recommendations for action and future research. The purpose of Section 3 was to provide an analysis of the interviews and strategic documentation review, as well as, summarize the implications of this study to business, rural hospitals, and rural communities.

Section 2: The Project

The purpose of this qualitative multiple case study was to explore strategies rural hospital leaders implemented to improve their hospital's financial performance. Section 1 provided a background of the problem, the purpose of the study, and a review of the literature on rural hospitals and strategic decision-making. The primary research question was: What strategies do rural hospital leaders implement to improve their hospital's financial performance? Section 2 includes the purpose statement, the role of the researcher, participants, research method and design, population and sampling, ethical research, data collection, data analysis technique, credibility, transferability, confirmability, and dependability.

Purpose Statement

The purpose of this qualitative multiple case study was to explore strategies that rural hospital leaders implement to improve their hospital's financial performance. The targeted population consisted of rural hospital leaders. The specific population consisted of three rural hospital leaders from Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands, who have improved their hospital's financial performance. To discover what strategies rural hospital leaders used to improve hospital financial performance, I interviewed rural hospital leaders. Additionally, I analyzed hospital strategic planning and financial documentation. Exploring successful strategies used by rural hospital leaders can provide other rural hospital leaders with strategic ideas to incorporate into their hospitals. The implications for positive social change included

the potential to cultivate the economy, enhance the quality of services delivered, and ensure the presence of rural hospitals.

Role of the Researcher

A qualitative researcher is someone who inquires without prejudice or personal bias (Seidman, 2013). As a researcher, my role in the qualitative case study was to collect, analyze, and interpret information from rural hospital leaders without bias. A qualitative researcher is also someone who investigates a phenomenon in depth (Nijmeijer, Huijsman, & Fabbricotti, 2014). Similarly, Bailey (2014) described the role of a qualitative researcher as someone who explores the meaning of an event to gain understanding. An inquiry is a form of interviewing (Seidman, 2013). By interviewing study participants, I explored the strategies rural hospital leaders implemented to improve financial performance.

Since March 2013, my employment responsibilities have included managing process improvement, project management, strategy, and research projects. I have read healthcare articles and have attended healthcare conferences to stay current in my discipline. During the duration of my DBA coursework, I have lived in St. Thomas, Virgin Islands and volunteered at a local hospital in St. Thomas, Virgin Islands.

The Belmont Report, written in 1979, outlines ethical standards for research and researchers (Greaney et al., 2012). These guidelines assist researchers in protecting a human subject from harm or resolving ethical issues that may surface during research. The guidelines within the Belmont Report are (a) respect for persons, (b) beneficence, and (c) justice. Throughout the research process, I followed the basic ethical standards as

outlined in the Belmont Report. Following basic ethical standards included asking for consent before conducting the interview and protecting the identity of study participants by using coding. Greaney et al. (2012) suggested that a researcher should state any conflict of interest. There were no conflicts of interest impacting my ability to perform this study. To mitigate personal bias towards a business problem, researchers have used methods triangulation to gather relevant information from multiple sources for research purposes (Oleinik, 2011). For this study, I gathered relevant information from interviews about strategic decision making and financial documentation from publicly available documents to explore strategies rural hospital leaders implemented to improve financial performance.

The interview protocol included scripting to introduce the interview, list the questions to ask during the interview and specify member checking. Researchers have used scripting to mitigate bias and reduce viewing data through a personal lens (Donfouet, Makaudze, Mahieu, & Malin, 2011). Additionally, researchers have used member checking to validate the study participant's statements derived from the interview (Harvey, 2015). For qualitative research, the rationale for the interview protocol serves as a guide to the researcher and ensure consistency (Jacob & Furgerson, 2012). An effective interview protocol has enabled researchers to obtain critical information from study participants (Jacob & Furgerson, 2012). However, having an effective interview protocol does not guarantee a successful interview (Jacob & Furgerson, 2012). The researcher might make a connection with the study participant and listen intently to the interview (Jacob & Furgerson, 2012). I developed an interview

protocol (Appendix D) with scripting, listened carefully during the interviews, and used member checking to validate interview responses. With method triangulation and using a case study interview protocol, I was able to mitigate bias and view data from multiple sources enabling me to provide a rich description of the study.

Participants

Researchers establish criteria for selecting study participants based on the study's research question (Kieft, de Brouwer, Francke, & Delnoij, 2014). Purposively sampling researchers (Nijmeijer et al., 2014) recommend selecting and interviewing participants based on established criteria. The established criteria for this study included rural hospital leaders from Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands who have improved their hospital's financial performance. The researcher must devise a plan to gain access to the target population (Moll, 2014). My strategy to gain access to the study participants included contacting the study participants, based on established criteria, using a mailed letter (Appendix B). I obtained the names of the study participants and addresses of the hospital from the hospital directory. Before the interview, the researcher may send each participant a consent form to sign (Siddiqui et al., 2014). Once the study participant agreed to participate in the study, I sent the informed consent form listing the Institutional Review Board (IRB) number (04-04-17-0424939) for this study.

Researchers establish working relationships with study participants by sharing their expertise and listening to the study participants during interviews (Marshall & Rossman, 2016). To develop relationships with the study participants, I encouraged

study participants to share their expertise and knowledge. Additionally, I attentively listened as they responded to the interview questions. Furthermore, qualitative researchers choose study participants that align with the purpose of the research and research question (Suri, 2011). The research question was: What strategies do rural hospital leaders implement to improve their hospital's financial performance? The eligibility criteria for study participants included hospital leaders in Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands who have implemented successful strategies to improve hospital financial performance.

Research Method and Design

Research Method

The three research methods used in business research are qualitative, quantitative, and mixed methods. For this study, I chose the qualitative methodology. The key attributes of qualitative research are exploring the meaning and gaining understanding (Bailey, 2014). Researchers use qualitative research to explore a phenomenon and understand what caused the events (Patton, 2002). Furthermore, researchers acquire and interpret data to explore real-world problems using qualitative research (Meyer & Ward, 2014). Quantitative research entails evaluating the relationships between variables (Wang et al., 2013). Additionally, quantitative research includes using data to examine relationships, test hypotheses, and model scenarios (Jacobs, Weiner, Reeve, Hofmann, Christian, & Weinberger, 2015). Researchers using a mixed methods research approach collect data by using both qualitative exploration and quantitative examination tactics (Small, 2011). Additionally, the mixed method approach is appropriate when the purpose

of the research is to draw upon content and data to explain a phenomenon (Yang & Matthews, 2012). Based on the scholarly statements regarding research methods, the qualitative methodology supported this study better than a quantitative or mixed methods approach because the focus was on gathering rich descriptions of strategies implemented to improve financial performance. The use of quantitative or mixed methods did not support the study because the focus of the study was not to examine relationships between variables or use statistical analysis to explain results. Using the qualitative method for this study enabled me to identify and understand successful strategies used by rural hospital leaders.

Research Design

For qualitative methods, the three primary research designs are a case study, phenomenology, and ethnography. For this study, I chose a case study design. The essential characteristic of a case study design was exploring a phenomenon in depth through the decisions made (Yin, 2014). A case study entails interviewing individuals to understand a problem more thoroughly (Moll, 2014)

Ethnography or phenomenology designs were not appropriate for this study. Ethnography involves studying a group in an area over a given period (Muecke, 1994). Researchers use ethnography design to understand a point of view of a target population living in a specific situation (Larsen, Larsen, & Birkelund, 2014). However, the focus of the study was not to study rural hospital leaders over a given period. With the phenomenological design, researchers explored an event by interviewing participants to understand their lived experiences (Wagstaff & Williams, 2014). A researcher uses a

phenomenological design to understand the lived experiences of the target population (Hudson, Duncan, Pattison, & Shaw, 2015). The focus of the study was not to interview rural hospital leaders to understand their lived experiences. Based on the scholarly statements regarding qualitative research designs, the case study design supported this study more than ethnography or phenomenological design. The focus of my case study was on using a small population to gather rich descriptions and a better understanding of strategies implemented by rural hospital leaders to improve financial performance.

To ensure data saturation in this study, I interviewed three study participants per hospital. However, when data saturation did not occur, then I continued interviewing study participants until no new information emerged. The study participants included three rural hospital leaders each from Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands. Researchers collected information to obtain themes and ceased sampling due to futility as no new themes emerge (Tran, Porcher, & Falissard, 2016). Data saturation occurred when no new or pertinent information surfaces from research (Saumure & Given, 2008). Additionally, data saturation occurred when no new themes emerge (Green, James, Latter, Sutcliffe, & Fader, 2014).

Population and Sampling

I used purposeful sampling to select study participants who met the eligibility criteria and experienced the phenomena. I interviewed three rural hospital leaders per hospital who have implemented successful strategies to improve hospital financial performance. In qualitative research, researchers used purposeful sampling to identify

and select study participants or cases that directly aligned with the phenomenon (Palinkas et al., 2013). Additionally, researchers used purposeful sampling to obtain participants from the target population (Ozcan, Karatas, & Çaglar, 2014).

I interviewed three study participants per hospital for this study. For qualitative research case study design, a small number of participants or cases might yield rich descriptions of a problem to explore (Patton, 2002). Furthermore, the number of study participants should satisfy the research goal (Hum, 2015). The study participants included three rural hospital leaders per hospital in Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands who have implemented successful strategies to improve hospital financial performance. The study participants met the eligibility criteria and aligned with the research question: what strategies do rural hospital leaders implement to improve their hospital's financial performance?

I interviewed three hospital leaders per rural hospital to ensure theoretical saturation. Reaching theoretical saturation occurred when no new information was gained from interviews (Siddiqui et al., 2014). Additionally, reaching theoretical saturation took on an iterative approach where data collection and analysis coincide (Potter, Mills, Cawthorn, Donovan, & Blazeby, 2014).

I selected rural hospital leaders who have successfully implemented strategies that have improved their hospital's financial performance and interviewed these selected rural hospital leaders to understand what strategies they used. The interviews were in person and at the hospital site. Interview discussions should occur in the setting where the phenomenon occurred to ensure participants do not have factors preventing them from

participating. The interview environment was critical (Seymour et al., 2015). The researcher might use the interview setting to complete observations and observe the situation where the phenomenon occurs (Seymour et al., 2015).

Ethical Research

Establishing relationships was crucial to developing trust (Patton, 2002). Researchers might establish trust and credibility with study participants by using consent forms (Dove, Avard, Black, & Knoppers, 2013). The rural hospital leaders received a letter explaining the purpose of the study and requesting participation in the study (see Appendix B). Included with the letter was an informed consent form. The informed consent form provided details about this doctoral study, summarized the study participant's rights, and outlined the confidentiality agreement. Dove et al. (2013) suggested that obtaining consent forms before an interview is best practice for ethical research. The written confirmation from the study participant after reading the consent form indicated a willingness of the rural hospital leader to participate in the study voluntarily and willingness for the researcher to publish results of this research as part of my doctoral study. The consent form contained the procedure for withdrawing from the study. According to the consent form, participants might leave the study at any time by notifying the researcher (Tam et al., 2015).

Busby and Yoshida 2015 stated researchers might improve response rate by providing incentives. There were no incentives for interview participation to improve response rate. For participating in the study, study participants received a summary of the findings. I will store all interview transcripts, consent forms, and hospital

documentation in a locked safe for five years and will destroy the materials at the end of the five years. The identity of each study participant and the rural hospital remained confidential. A numeric identification number represented the study participants (Millar, Reid, & Porter, 2013). Before the interview, each study participant had a numeric code (Carter, Murphy, Payne, & Bryant-Lukosius, 2014). For this study, a numeric identification number represented a rural hospital, and participant coding consisted of the word "Participant" followed by a number from 1 to 6 (i.e., Participant 1, Participant 2, etc.). During the analysis stage of the doctoral study, I referred to each participant by code. By coding each study participant, this approach protected the names of study participants and rural hospitals. Furthermore, I kept the names of study participants and rural hospital confidential.

The written acceptance after reading the informed consent form indicated a willingness to participate in the study and willingness for me to publish results of this research as part of my doctoral study. Additionally, the informed consent form indicated participation was voluntary, and participants might leave the study if desired. The role of the researcher is to keep the community partner and study participant information confidential. I kept all informed consent forms secure and ensured the participant's identity remained confidential.

Data Collection Instruments

Researchers might serve as the principal data collection instrument (Seidman, 2013). For this study, I served as the primary data collection instrument. I asked the study participants open-ended questions (see Appendix C) and recorded the

semistructured interviews. Researchers have used semistructured interviews to explore beliefs within a phenomenon (Sahin, Ayar, Adiguzel, 2014). Furthermore, a researcher might suggest using semistructured interviews to understand a phenomenon (Jacobson, Wasserman, Wu, & Lauer (2015). My data collection process included using the interview protocol and interview questions (see Appendix D). The interview protocol included scripting before, during, and after the interview. For qualitative studies, researchers used the interview protocol as a guide and to ensure consistency (Jacob & Furgerson, 2012). A researcher might obtain essential information from study participants with an effective interview protocol (Jacob & Furgerson, 2012). In addition to the interview, I reviewed publicly available hospital documentation. The goal of the interview and documentation review is to collect data (Patton, 2002). The open-ended questions provide details specific to the study (Seidman, 2013). Using open-ended questions prompted rural hospital leaders to share strategies that improved hospital financial performance. These strategies might be significant and be of use to other rural hospital leaders.

In research, study participant credibility and participation improved with member checking (Harvey, 2015). I used member checking to enhance the reliability and validity of the data collection process for this study. I e-mailed the study participant the interpretation of the interview and hospital documentation to review following the interview. A researcher might utilize transcript review to ensure written recording of interviews were accurate (Schroll, Kjærgaard, & Midtgaard, 2013). Ali, Moghadam, and Fayaz-Bakhsh (2014) utilized this technique by ensuring two individuals analyze the

interview transcripts for accuracy. The study participant reviewed the information and provided feedback on the accuracy of the interview interpretation and initial findings. Even with member checking, a researcher might conduct follow-up interviews with study participants as needed (Goldblatt, Karnieli-Miller, & Neumann, 2011).

Data Collection Technique

Having a consistent process was instrumental in ensuring information was reliable and valid (Patton, 2002). I conducted open-ended interviews using semistructured interview questions with three rural hospital leaders per hospital in Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands. I asked open-ended questions. The secondary data collection occurred through audio recordings of the interviews. The transcription of audio recordings and analysis of the hospital documentation revealed trends and augmented my understanding of successful financial strategy results.

I conducted the open-ended interviews in person and at the hospital site. Researchers have used semistructured interviews to elicit information about a phenomenon from study participants (Park & Slater, 2014). The advantages of conducting semistructured interviews were the ability to ask questions based on the participant's response and capacity to gather participant's perspectives freely (Meo, 2010). The disadvantages of conducting semistructured interviews were time and resource availability (Carduff, Murray, & Kendall, 2015).

Upon completing an interview, I listened to the audio recording and transcribed the interview. Timely processing of an interview ensured the accuracy of information

(Schroll et al., 2013). Additionally, documenting the exact words used by the interviewee ensured reliability and validity (Ali et al., 2014). Member checking ensures data was reliable and valid (Harvey, 2015). Post interviews, I requested that the study participants review the interpretation of the interview and provide feedback for accuracy. Each study participants reviewed the interview interpretation and provided feedback.

Data Organization Technique

Rantala and Hellström (2001) described organizing interview data to support the researcher with providing a meaningful interpretation of the data. For this study, I tracked interview information and logged hospital documentation received in a spreadsheet on a password-protected computer. This process was the first step in analyzing the interview themes or hospital strategic financial plans. Additionally, I took notes during the interviews and examined hospital strategic financial plans. Within my proposal log, I organized the data according to study participant, type of information received, date received/collected, the location of the information, and brief comments. The identity of study participants and the rural hospital remained confidential. Assignments of numeric codes for the study participants occurred before the interview. The numeric codes protected the identity of the study participants and hospitals. For five years following the study approval, the information from the interviews will reside on a secured/password-protected laptop and a flash drive placed in a secured safe. After five years, I will discard the study information on the secured/password-protected laptop and a flash drive (Walden University Center for Research Quality, 2014).

Data Analysis

Triangulation encompassed combining data sources to explore a phenomenon (Denzin, 1989). Furthermore, researchers used triangulation methods to enhance the analysis of a business problem (Cronin, 2014). There are four types of triangulation: methods triangulation, triangulation of sources, analyst triangulation, and theory/perspective triangulation (Denzin, 1978; Patton, 1999). For this study, I used methods triangulation. Besides the interpreted interviews, I used information from publicly available hospital documentation. The methods triangulation process for this qualitative case study encompassed both interview themes and hospital documentation analysis. Additionally, the methods triangulation process included a comparison of findings from various data sources to provide a deeper understanding of a phenomenon (Denzin, 1978; Patton, 1999).

For the data analysis, each participant received a unique code for the interviews. The code protected the identity of the study participant. In qualitative case study research, a researcher used participant-coding techniques to protect the study participant's identity and maintain confidentiality (Yin, 2009). Then, during the analysis portion, I coded the interview responses and themed the interview responses (Yin, 2009). The product of the data analysis was a mind map detailing how the themes correlate to literature and the conceptual framework. A mind map was a visual representation and collection of ideas categorized into themes (Hsieh, Huang, Luh, Liu, & Ma, 2013). The mind map represented the themes from the interview and documentation (Budd, 2004).

Case study design was a process that includes interviewing study participants, transcribing the notes, coding, and theming responses (DeLyser et al., 2013). For this study, I developed interview questions to explore the research question for this qualitative case study: What strategies do rural hospital leaders implement to improve their hospital's financial performance? During the interviews, the study participants shared insights into strategies that may improve financial performance. The hospital documentation review revealed strategies implemented and impact. I aligned the data collected, themes that emerged, and analysis to the conceptual framework, strategic decision-making (Eisenhardt & Zbaracki, 1992) selected for this study.

Reliability and Validity

Reliability

In qualitative research, researchers focused on dependability rather than reliability (Denzin & Lincoln, 2017; Marshall & Rossman, 2016). Qualitative researchers aimed to confirm their research with dependability techniques. Dependability involved the researcher keeping account of the research environment (Valizadeh et al., 2012). Confirmability consisted of member checking results with others (Valizadeh et al., 2012). Post interviews, I requested that the study participants review the interpretation of the interview and provide feedback for accuracy. The study participants reviewed the interview interpretation and provided feedback for accuracy. The advantages of member checking include the study participant reviews the interview transcript for accuracy and the researcher allows the participant to confirm the initial findings (Valizadeh et al., 2012). The disadvantages of member checking include the time for transcribing the

interview, sharing the transcribed notes with the participant, and awaiting feedback from the participant on the accuracy of information (White, Oelke, & Frieson, 2012).

Validity

In quantitative research, researchers identified and implemented measures to ensure credibility and transferability (Denzin & Lincoln, 2017; Marshall & Rossman, 2016). Credibility involved the researcher describing the phenomena from the perspective of the study participant (Houghton, Casey, Shaw, & Murphy, 2013). Transferability involved generalizing the research results for other settings (Lincoln & Guba, 1985). I used transcript review and focused observation during the interview to address credibility. The advantages of transcript review were the researcher transcribed the interview using the words of the study participant and the transcription accurately reflected statements made by the study participant (Lincoln & Guba, 1985). Time was also a critical disadvantage for transcript review (White et al., 2012). With transferability, the researcher described the research and assumptions (Lincoln & Guba, 1985) thoroughly. I accurately described the research to enhance transferability.

To achieve data saturation in this study, I interviewed three study participants per hospital. The study participants included three rural hospital leaders each from Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands. Data saturation occurred when no new or pertinent information surfaces from research (Given, 2008). Additionally, data saturation occurred when no new themes emerge (Green et al., 2014).

Transition and Summary

Section 2 included the purpose statement, the role of the researcher, participants, research method and design, population and sampling, ethical research, data collection, data analysis technique, credibility, transferability, confirmability, and dependability. The goal of this qualitative method case study design was to collect data from successful Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands rural hospital leaders on strategies implemented to improve hospital financial performance. According to Patton (2002), reliability and validity are essential in qualitative research. For this study, ensuring the reliability and validity of information was fundamental to the qualitative research. Informed consents and interview transcripts were password protected and kept for five years following the research.

Section 3 included an overview, the presentation of findings, applications to professional practice, implications for social change, recommendations for actions and further research, reflections, and conclusion.

Section 3: Application to Professional Practice and Implications for Change

Introduction

In this section, I present the findings from this qualitative multiple case study of strategies rural hospital leaders implement to improve hospital financial performance in Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands. The analysis of the qualitative multiple case study data and review of hospital strategic documentation supported the identification of four key themes: (a) the need for rural hospital leaders to use strategic decision-making when addressing rural hospital financial performance, (b) developing synergies with external providers and hospitals, (c) creating effective short-term and long-term strategies, and (d) translating success to the entire organization. Section 3 includes an introduction, the presentation of findings, applications to professional practice, implications for social change, recommendations for actions and further research, reflections, and a conclusion.

Presentation of the Findings

I conducted a qualitative multiple case study of strategies rural hospital leaders implement to improve their hospital's financial performance in Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands. The central qualitative research question was: What strategies do rural hospital leaders implement to improve their hospital's financial performance? Exploration of the interview questions supported the rich exploration of rural hospital leaders' descriptions of the problem of financial performance. All 15 study participants answered the nine interview questions included in the case study protocol. I also reviewed supportive hospital documentation. The

secondary data collection occurred through audio recordings of the interviews. After the interview, the study participants reviewed, provided corrections, and approved their interview transcripts. The transcription of audio recordings and analysis of the hospital documentation revealed themes and augmented my understanding of successful financial strategy results.

Four themes evolved from this study. From the analysis of the central qualitative research question, two themes emerged. Additionally, from the analysis of the relationship between the conceptual framework and the study participant insights of the business problem for improving hospital financial performance, two themes emerged. The themes are:

1. The need for rural hospital leaders to use strategic decision-making when addressing rural hospital financial performance
2. Developing synergies with external providers and hospitals
3. Creating effective short-term and long-term strategies
4. Translating success to the entire organization

Responses from interview participants and review of strategic documentation aligned to Themes 1 and 4. Additionally, Themes 1 and 4 affirmed information described in the literature review. Themes 2 and 3 helped describe the financial strategies used by rural hospital leaders to improve their hospital's financial performance, lessons learned during the journey, and insights on rural healthcare.

Theme 1: The Need for Rural Hospital Leaders to Use Strategic Decision-Making When Addressing Rural Hospital Financial Performance

The conceptual framework, strategic decision-making, supported this qualitative multiple case study on what strategies rural hospital leaders in Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands implemented to improve their hospital's financial performance. Strategic decision-making occurs when top leaders of an organization make infrequent decisions that impact the organization's health and survival (Eisenhardt & Zbaracki, 1992). I reviewed all interview transcripts and hospital documentation to discover the presence of strategic decision-making. Additionally, I focused on exploring strategic decision-making and financial performance of rural hospitals concerning bounded rationality, politics, and power. Exploration of the conceptual framework occurred through analysis of study participant responses to interview questions (4 and 5) and hospital strategic documentation (see Figure 1).

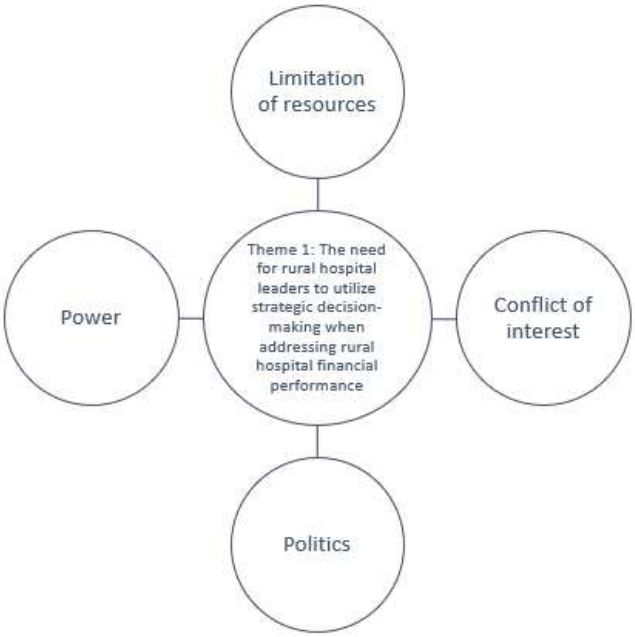

Figure 1. Theme 1: The need for rural hospital leaders to use strategic decision-making when addressing rural hospital financial performance.

With strategic decision-making, a leader's strategic actions shape an organization's current performance and future development opportunities (Wu, Wu, Tasia, & Li, 2017). Rural hospitals are relevant to the communities that they serve. Consequently, the strategic actions of rural hospital leaders must lead to achieving financial performance and future growth. With strategic decision-making, rural hospital leaders use data to drive their strategic decisions, monitor data to proactively navigate business changes, and gather internal and external perspectives to ensure current needs are met and outline future opportunities. Rural hospital leaders prioritize goals and assign resources based on applicability to the strategic plan.

Participants 1 through 15 acknowledged the relevance of a rural hospital within a community. Participant 1 stated, "the rural hospital must become the economic engine for health and growth to the community." Rural hospitals tend to be the largest employer in the rural community (Participant 12). Participant 3 further described the theme in the following manner:

> Rural hospitals help provide preventive services even though rural hospitals are not reimbursed for those preventative services. It is essential to ensure those preventative services are provided because rural hospitals do not want patients visiting the highest cost areas like the ER to receive care.

Participant 5 elaborated on the relevance of rural hospitals stating that rural hospitals must always do what is best for the community and make sure that necessary services are available for the community.

Rural hospitals are relevant to the communities they serve, as rural hospitals market the services they provide to the community and "playoff those services provided" (Participant 4). Participant 7 described that rural hospitals should understand their role and confirm their impact to the community. Through confirmation of their effect on the community, rural hospitals demonstrate how hospitals support the community through the services they provide patients, the residents they employ, and outreach efforts within the community. Furthermore, it is essential to recognize and change the narrative if the community does not think "you (the hospital) are relevant" (Participant 4). A suggestion is for rural hospitals to establish their vision, understand what is occurring outside the organization, and reinforce the impact of their organization to the local community (Participant 7). Providing the residents with a community benefit analysis (see Document 5 in Appendix C) is an example of disseminating information on the hospital's impact on the community. Nonprofit hospitals document the community benefit provided to the communities they serve to receive non-profit, tax-exempt status (James, 2016; Young, Flaherty, Zepeda, Singh, & Rosen Cramer, 2018). Based on obtaining tax-exempt status, nonprofits were able to provide care and community benefit to the populations they serve (Worthy & Anderson, 2016).

Although literature has been written on the negative impact of rural hospital closure on a community, Participants 1 through 15 reiterated the negative consequences

of rural hospital closure. Participant 3 reported that when a rural hospital closes, the community suffers from needed services that are no longer available. The consequences of rural hospital closure leave a void in the community. To prevent rural hospital closure, rural hospital leaders try to maintain positive financial performance. As rural hospital leaders devise strategies to maintain positive financial performance, the rural hospital leaders try not to put the hospital into financial difficulty knowingly (Participant 13). In addition to ensuring positive financial performance, rural hospital leaders want to ensure access to quality care. Participant 10 reported that rural hospital leaders do not want to hinder the hospital's ability to serve the patient.

Addressing politics and power was a key element of using strategic decision-making when addressing rural hospital financial performance. Politics helps influence leaders (Marshall & Rossman, 2016). Additionally, influential people use information, resources, and data to enhance their power, position, and ideas (Chown & Liu, 2015). From the study participant responses, rural hospital leaders reduced politics and power in various ways to benefit the organization. Prioritizing initiatives enabled rural hospital leaders to focus on strategies that align with improving the hospital's financial performance (Participants 1 & 3). Aligning actions to the strategic plan reinforced the rural hospital leader's attempt to ensure prioritization of significant initiatives benefiting the organization (Participants 2, 7, 13, & 15). Staying on top of healthcare trends ensures that rural hospital leaders understand changes that may impact their organizations (Participant 1). Participants 1 and 9 further elaborated to keep a patient-centered ethos by keeping the patient and community needs front and center. Additionally, rural hospital

leaders use data to drive decision making, use the core strengths of the organization to improve financial performance, establish team goals for them to meet collectively, and communicate openly with challenges facing the organization (Participants 4, 8, & 14). As rural hospital leaders work together to improve the hospital's financial performance, they can break down unintended silos, gain alignment from their staff, and help their teams understand the strategy (Participants 2, 4, 7, & 8). Furthermore, as the CEO drives and facilitates forward progress, the administrative staff can maintain close relationships with their staff, frequently communicate on the status of goals, and drive decision making to those impacted (Participants 3, 14, & 15). The net effect of rural hospital leaders addressing politics and power was that the organizations became more aligned (Participant 7).

Minimizing conflicting interests was another critical element of using strategic decision-making when addressing rural hospital financial performance. Institutions are comprised of individuals with conflicting interests (Eisenhardt & Zbaracki, 1992). Study participants responded on how leaders could reduce the impact of conflicting interest by providing examples from their organization. Prioritization was again used by rural hospital leaders to manage conflicting interests (Participants 3, 8, 9, 10, & 13). Using data to drive decision-making and helping staff focus on the right goals to improve the hospital's financial performance was elaborated by Participants 10, 11, 12, and 14. Communicating to staff by providing educational retreats, getting input from staff, and making collaborative decisions were all ways that rural hospital leaders reduced the impact of conflicting interests (Participants 1, 2, 4, & 13). Additionally, allowing those

who were impacted to be part of the decision-making enabled the hospitals to identify appropriate initiatives to manage care and improve financial performance (Participants 1, 2, 5, 6, & 7).

Reducing limitation of resources was another critical element of using strategic decision-making when addressing rural hospital financial performance. In rural hospitals, resources are often limited. Within the strategic decision-making framework, allocation of resources depends on a leader's past performance (Papadakis et al., 1998). The study participants provided examples of how to reduce the impact of limitation of resources from their perspective. Resources consist of people, time, and money. For limitation of resources concerning people, the interviewed rural hospital leaders tended to wear multiple hats, were creative with maximizing staffing positions, and sought grant funding opportunities to evaluate hospital operations and staffing (Participants 7, 10, 12, & 14). For limitation of resources concerning time, the rural hospital leaders set priorities to manage their time, documented justification for prioritization, and identified factors based on information to move the organization to the future state (Participants 2, 6, 7, 8, & 9). For limitations of resources concerning money, the rural hospital leaders identified strategies which had a financial impact to the organization, understood hospital expenses, and examined the benefit of capital expenditures to the hospital (Participants 7 & 9).

Theme 2: Developing Synergies with External Providers and Hospitals

Through partnerships, organizations achieve intended results (Nurmala, de Leeuw, & Dullaert, 2017). The rural hospital leaders explained that affiliations and mergers are not the only alternatives to ensuring survival. As healthcare reimbursement

shifts to population health management, rural hospital leaders must identify ways to reduce cost, while improving financial performance. Partnerships include identifying external providers or hospitals that can provide a tangible benefit to the rural hospital. Establishing critical partnerships with external providers and hospitals may help rural hospitals reduce cost, ensure patients do not leave the community to seek care, and improve the rural hospitals' financial performance (see Figure 2).

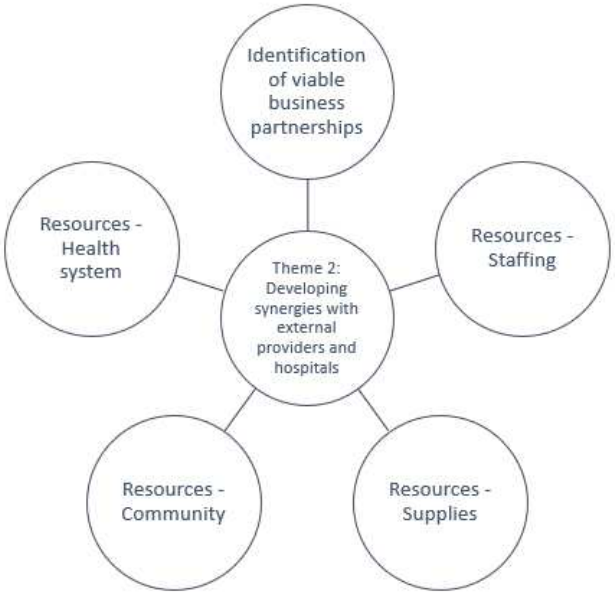

Figure 2. Theme 2: Developing synergies with external providers and hospitals.

Identification of viable business partnerships was an essential component of developing synergies with external providers and hospitals. As business leaders seek new partnerships to enhance their business, business leaders identify vital characteristics of future partners (Wiener, Hoßbach, & Saunders, 2018). Participant 2 shared that it was important for their site to identify new relationships that the rural hospital could count on

for support. Participant 13 elaborated that their site sought mutually beneficial partners while improving the hospital's financial performance.

Elevating resources was another essential component of developing synergies with external providers and hospitals. Resources can be staffing, supplies, community, and a health system. For staffing, Participant 10 shared that their hospital partners with a medical graduate program and sponsors a preceptor program. Additionally, Participant 11 elaborated that the leadership team refreshes staff by attracting physician assistants, physicians, and nurses to work at the rural hospital. Furthermore, Participant 13 described how their hospital maintains stable relationships with medical staff to ensure utilization of hospital services. Concerning supplies, Participants 1 and 10 expressed how their hospitals' affiliate with other hospital group purchasing organizations to lower the cost of supplies needed. With the community, Participant 2 suggested that lobbying within the community may help improve the hospital's financial performance. Additionally, Participant 6 described that rural hospital leaders need to identify partners to support the hospital with meeting the needs of the community:

> There is no bailout for hospitals. There are no patients in any geography that will accept taxpayer dollars to save hospitals like what happened with the banks. The hospital will close if it is not being used. If the hospital is not providing services to meet the needs of the community, they will die on the vine and close.

With other health systems, Participant 8 suggested to reach out to other CAHs to understand how they manage their services lines, control cost, and make a profit. Participant 3 discussed forming an accountable care organization to improve the

hospital's financial performance. Participant 7 shared that their hospital brings external systems into view the healthcare delivery system as a step in establishing a partnership. Participant 13 discussed their hospital's attempts to affiliate with a large tertiary health system to drive down cost.

Theme 3: Creating Effective Short-Term and Long-Term Strategies

Hospital leaders adopt new alternatives for improving their organization's health and ensuring its survival (Aslan, Çınarb, & Özenc, 2014). Rural hospital leaders explained that identification of short-term and long-term strategies provides a foundation for the organization. Delineating between short-term and long-term helps staff see a progression towards future development and growth of the hospital. Additionally, the strategies used by rural hospital leaders to improve their financial performance focused on quality, utilization, expenses, revenue, safety, satisfaction, talent, and technology. Fifteen study participants elaborated on the process used to improve the hospital's financial performance, identified individuals involved in the decision-making, described the data monitored to alert when there was an issue with financial performance, defined the data monitored to signify the impact of the changes made, and shared the short-term and long-term strategies used to improve the hospital's financial performance (see Figure 3).

Figure 3. Theme 3: Creating effective short-term and long-term strategies.

Understanding the process used by rural hospital leaders to improve the hospital's financial performance was the first tenet of creating effective short-term and long-term strategies. The output from the rural hospital's strategic planning sessions resembled a strategic plan with defined initiatives. Participants 1, 2, and 3 shared that from the strategic planning process and review of the hospital's dashboard the cost reduction plan tied to revenue enhancing initiatives emerged. Additionally, Participants 1, 2, and 3 shared that during the strategic planning session the individuals were broken into four teams. The first team focused on third-party service providers and denial management. The second team focused on charity care and late charges. The third team focused on compliance. The fourth team focused on self-pay early out and accounts receivable clean-up. Participants 4, 5, and 6 elaborated that the strategic planning process encompassed usage of the SWOT (strengths, weaknesses, opportunities, and threats), external market analysis, review of the hospital's past financial performance, continuous

improvement initiatives, and covered lives data. Participants 7, 8, and 9 described that from the strategic planning process and review of the staff survey results identifying the top 3-4 improvement areas for the organization, financial assessment of the organization, SWOT (strengths, weaknesses, opportunities, and threats), and progression towards the strategic turnaround plan emerged. Participants 10 and 11 shared that the strategic planning process encompassed being conservative with spending and movement towards becoming a CAH. Participant 12 elaborated that the strategic planning process assessed services that were revenue drivers as well as others that provided community benefit. Participants 13, 14, and 15 described that the strategic plan emerged from analysis of the SWOT and market analysis.

Identifying individuals involved in the decision-making was the second tenet of creating effective short-term and long-term strategies. The senior leadership team and board were common groups involved in developing the strategic plan for the rural hospital. Participants 1, 2, and 3 stated that the executive team, finance team, directors, managers, clinical leaders, lean, and board were involved in developing the strategic plan. Participants 4, 5, and 6 elaborated that a consultant facilitated the strategic planning session including the executive team, executive medical committee, community officials, and board. Participants 7, 8, and 9 described that the hospital employees, medical staff, leadership team, community, local CAHs, external primary care physicians, and board were involved in developing the strategic plan. Participants 10 and 11 shared that the senior leadership team, clinic manager, and board were involved in developing the strategic plan. Participant 12 stated that the entire hospital helped to create the strategic

plan. Participants 13, 14, and 15 elaborated that the administrative team and board were involved in developing the strategic plan.

Monitoring data to alert when there was an issue with the financial performance was the third tenet of creating effective short-term and long-term strategies. Participants 1 through 15 provided lagging indicators that they regularly monitored to alert them there was an issue with financial performance. Lagging indicators represent information that follows an event (Lingard, Hallowell, Salas, & Pirzadeh, 2017). Financial dashboards and financial reports (balance sheet and deterioration of the balance sheet) are the compilation of the indicators for the rural hospital leader and board view. The lagging indicators included targets to the strategic plan, volumes, earnings before interest, depreciation and amortization (EBIDA), debt service coverage, days cash on hand, days in Accounts Receivable, patient volumes, days in Accounts Payable, admissions, productivity, inpatient days, surgical outpatient or inpatient days, procedures, swing beds days, equipment usage, supplies, collections, discharge but not final billed, operating margin, cash flow, debt to capitalization, and capital spending, reimbursements, hospital costs, revenue, transfers, and daily census.

Monitoring data to signify the impact of the changes made was the fourth tenet of creating effective short-term and long-term strategies. Participants 1 through 15 provided lagging indicators that they capture to measure the impact of strategies implemented to improve rural hospital financial performance. Similarly, financial dashboards and financial reports are the compilation of the indicators for rural hospital leader and board view. The lagging indicators included admissions data, balanced score card, community

health needs assessment, departmental income statements, volume, patient census, expenses, days of cash on hand, operating margin, market share, surgical cases, utilization, statistical reports, production reports, quality (readmission rates and hospital acquired infections), revenue per adjusted day, expense per adjusted day, gross charges, net patient revenue, cash collections, discharged but not final billed (DNFB), operating expenses, and average length of stay (ALOS).

For three study participants, there was discussion on leading indicators such as variances to budget or forecast that was captured or monitored (Participants 2, 12, and 14). Leading indicators represent information that precedes events (Raben, Bogh, Viskum, Mikkelsen, & Hollnagel, 2018). Reviewing variances to budget is common for rural hospital leaders because rural hospital leaders know their staffing, budgets, and expenses (Participant 2). According to Participant 12, "monthly variance reports and monthly budget reviews help me keep my finger on the pulse and our hospital's financial performance." Another example of reviewing variances is providing each manager with a variance report and requiring each manager to explain the variances by month (Participant 14).

Identification of short-term and long-term strategies used to improve the hospital's financial performance was the final tenet. The study participants described successful short-term and long-term strategies used to improve their hospital's financial performance. Short-term strategies include planned changes that are expected to deliver results within one year (Brinkmann, Ulmer, & Mattfeld, 2015). Long-term strategies

include planned changes that take longer than one year to deliver results (Brinkmann et al., 2015).

Short-term strategies developed by the study participants varied by site; however, the short-term strategies focused on improving rural hospital financial performance. Participants 1, 2, and 3 developed short-term strategies focused on understanding the community served, margin improvements, reducing positions through attrition, and renegotiating supplier contracts. Participants 4, 5, and 6 created short-term strategies focused on ensuring patients treat locally, attract physicians to the rural hospital, cut costs, improve employee engagement, improve volume, and modify reimbursement contracts. Participants 7, 8, and 9 established short-term strategies focused on delivering world-class care, market hospital services to local communities, encourage utilization of hospital services by external physicians, strengthen core inpatient services, establish satellite clinics, telemedicine, renegotiate contracts, and enhance supply chain. Participants 10 and 11 developed short-term strategies focused on encouraging referral patterns by external providers to the rural hospital. Participant 12 created short-term strategies focused on increasing volume of hospital revenue-generating services. Participants 13, 14, and 15 established short-term strategies focused on bringing in needed specialties, hospital obtaining ancillary services, and monitoring expenses.

Long-term strategies developed by the study participants focused on technology, data and analytics, and improving rural hospital financial performance. Technological long-term strategies included technology investments and electronic health records. Data and analytical long-term strategies included cost accounting systems and decision

support. Financial long-term strategies included addressing revenue cycle, identification of new rural hospital services, capital infusion to improve the rural hospital infrastructure, foundation and charity support, and monitoring the effects of potential joint ventures.

A thorough examination of the documentation provided by the study sites and community health needs assessment information from the internet (Documents 1-7) provided clarity on the study sites strategic areas of focus (see Table 1).

Table 1

Summary of Study Sites Strategic Areas of Focus

Focus area	Descriptions
Quality/Safety	Enhance quality outcomes and patient safety, achieve excellent outcomes in quality
Utilization	Restore core inpatient services, expand pharmacy use, expand rehab services, implement satellite clinics, expand pain management, achieve thoughtful growth in services
Expenses/Revenue	Financial performances, facilities and capital improvements, achieve financial viability through improved access
Satisfaction	Improve customer satisfaction, provide an excellent experience and service to patients, create a culture of staff satisfaction and engagement to achieve high performance, patient satisfaction
Technology	Information technology (IT), integrate IT systems, expand telehealth
Talent	Physician manpower, hospital manpower, workforce/continued availability of local physicians,

Theme 4: Translating Success to the Entire Organization

Engaging all levels of the organization while communicating future strategy ensures success (Appelbaum et al., 2017). As rural hospital leaders set the strategic course for the organization, translating the strategy to ensure success becomes vital. The rural hospital staff needs to understand how their actions lead to successfully achieving

the desired goals within the strategic plan. Eight study participants elaborated on employee motivation, how rural hospital staff involvement with developing the strategic plan creates ownership, communicating the strategy ensures staff buy-in and transparency (see Figure 4).

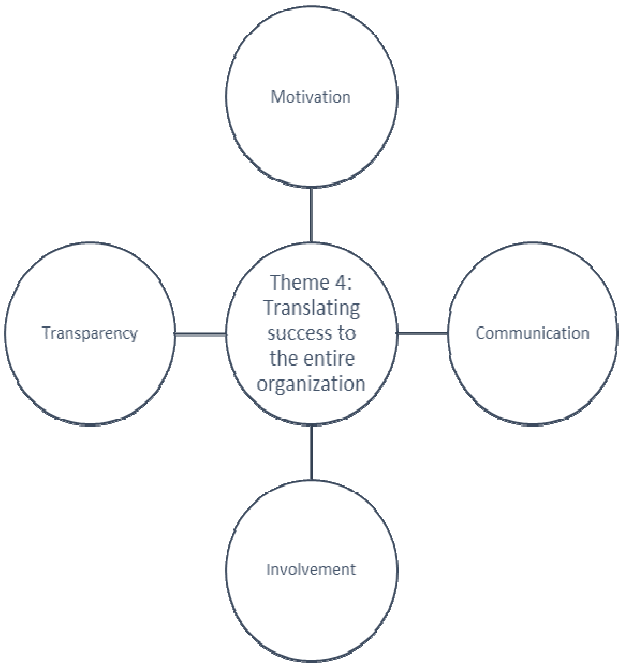

Figure 4. Theme 4: Translating success to the entire organization.

Employee motivation was a tenet of translating success to the entire organization. Anitha (2014) described employee motivation as the degree employees are compelled to meet the needs of their organization. Participant 6 provided that the purpose of their rural health system was to understand best practices from other rural hospitals and incorporate those best practices within their rural hospital. Participant 1 reported that "the rural hospital must become the economic engine for health and growth for the rural community." Additionally, Participant 1 shared rural hospital employees must be aware that "patients attach your service and capability to your institution."

Staff involvement was a tenet of translating success to the entire organization. In setting the strategic plan, staff involvement creates ownership. Employees are essential to achieving organizational goals (Fiaz, Su, Amir, & Saqib, 2017). As a result, leaders include staff to achieve organizational goals (Fiaz et al., 2017). As rural hospital leaders define and communicate the organization's purpose, employees must be involved in the execution of goals. Participant 1 shared that rural hospital leaders should find ways for the staff to contribute to the plan in their own ways. Also, Participant 7 observed that organizations achieve goals and grow the organization by involving their staff. Participants 9 and 14 discussed that they work with their staff to manage expenses and turnaround struggling departments.

Transparency was a tenet of translating success to the entire organization. Leaders leverage transparency to achieve competitive advantage over their competitors (Merlo, Eisingerich, Auh, & Levstek, 2018). Participant 1 discussed that the hospital must be the economic engine for health and growth in the community. To realize the competitive advantage, rural hospital leaders need to be transparent when it comes to progress towards hospital goals (Participant 7). The rural hospital is often the largest employer in rural communities and significantly contributes to the rural community's local economy (Ricketts, 2000). Transparency in hospital metrics enables staff to understand how the organization is performing.

Communication was a tenet of translating success to the entire organization. Communicating the strategic plan and associated actions are essential to the development of the strategic plan (De Salas & Huxley, 2014). Communicating the strategic plan to

staff ensures staff buy-in. Translating the organization's mission and strategy so that everyone understands is essential (Participant 8). Participant 2 shared that communicating with the rural hospital staff on a regular basis about goals, understanding goal progress, and identifying course correction helps ensure rural hospital staff acceptance. Also, daily huddles were used by Participant 3's organization to communicate business information to staff.

Applications to Professional Practice

The purpose of this qualitative multiple case study was to explore what strategies rural hospital leaders in Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands implemented to improve their hospital's financial performance. Study participant interview responses, publicly available hospital documentation, strategic plans, and literature review findings illustrate the magnitude, aspects, and potential outcomes contributing to rural hospital closure. Study participant interview responses on rural hospital closure support the statements in the literature review that rural hospital closure and adverse financial performance are problems of business, community, and social significance.

In addition to validating the business problem of rural hospital closure, the study findings highlight potential strategies for improving rural hospital financial performance. Study findings suggest that strategies need to address the short-term and long-term needs of the rural hospital. Study participants expressed their strategies used to improve the rural hospital's financial performance by categorizing strategies as short-term or long-term.

Study findings suggest the need for inclusion of administrative teams, board, hospital staff, and the community in the strategic decision-making process. As rural hospital leaders monitor financial information, making this information available for the various groups keeps them informed on hospital operations. Engaging these groups in the development of the strategic plan ensures these groups are bought into the success of the organization and are accountable for the organization's outcomes.

For rural hospital leaders, the quest to improve financial performance includes the development of a short-term and long-term strategic framework which addresses components of quality, utilization, expenses, revenue, safety, satisfaction, talent, and technology. Study participants advocated that addressing these components will affect a hospital's financial performance. Results from this study highlight the need for preemptive tactics to prevent rural hospital closure and identification of short-term and long-term strategies to support the implementation of strategies for improving a hospital's financial performance.

Implications for Social Change

Rural hospitals accounted for 40% of the community hospitals in the United States. North Carolina Rural Health Research Program (2018) estimated that 83 rural hospitals have closed since 2010 in the United States. Both Spade and Strickland (2015) and Countouris, Gilmore, and Yonas (2014) noted that rural hospital leaders balance future planning while ensuring current access and healthcare within their communities. For federal, state, and local programs, the development of a financial assessment tool that monitors the organization's financial health and stability, as well as, signals any financial

distress of rural hospitals before closure happens may support government entities as well as rural hospital leaders (Holmes, Kaufman, Pink, 2017).

Because rural hospitals occupy a pivotal role in providing quality care and service to patients, the study findings might offer strategic ideas to rural hospital leaders interested in ensuring their hospital remains open. Regardless of the threat of rural hospital closures or policy changes, patients will still rely on rural hospitals for their medical treatment. The study findings address the business, community, and social impact. The business importance of improving rural hospital financial performance affects the services currently provided by the rural hospital and potential future growth. The community aspect of improving rural hospital financial performance affect employment opportunities as rural hospitals are large employers in the community and recruitment of clinical staff. The social implication of improving rural hospital financial performance affect retention of skilled professionals and service to the community.

Recommendations for Action

By examining study participant responses and case study documentation, I identified multiple themes on the perception of the business problem of rural hospital closure and strategies believed to improve rural hospital financial performance. The synthesis of themes 2 and 3 supported the identification of recommended action the rural hospital leader should consider for improving rural hospital financial performance. Rural hospitals encompass 40% of the community hospitals in the United States. The effective implementation of strategies to improve rural hospital financial performance requires the efforts of a rural ecosystem consisting of hospital leaders in tandem with the hospital

staff, the board, and the community. Recommendations from this study might further support the actions of those within this rural ecosystem.

First, rural hospital leaders should promote proactive approaches to prevent rural hospital closure by monitoring the organizational health on a routine basis. Rather than relying on lagging indicators of financial distress, rural hospital leaders should frequently monitor financial data with the use of financial dashboards. Rural hospital leaders working to deploy financial dashboards to aid in the real-time monitoring of their organizational health may be in a better vantage to improve their hospital's financial performance.

Second, rural hospital leaders should work to concentrate efforts to improve the hospital's financial performance by focusing on short-term and long-term strategies to improve hospital financial performance. A framework to support rural hospital leaders implement strategies to improve hospital financial performance may align with quality, utilization, expenses, revenue, safety, satisfaction, talent, and technology tactics. As rural hospital leaders work to develop annual strategic plans with the board and staff, the rural hospital leaders can ensure that tactics align with both short-term and long-term needs of the organization.

Results and recommendations from this study are of significance to the rural hospital leader seeking to improve their hospital's financial performance. Using multiple methods of communication will increase the opportunity for rural hospital leaders to access the information in this study. The study participants will receive an overview of the study findings and recommendations for future action. Additionally, I will pursue

opportunities to publish an article based on my study findings and present the study findings at a professional conference.

Recommendations for Further Research

I used purposeful sampling to select rural hospital leaders in Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands who met the eligibility criteria and experienced the phenomena. I examined publicly available hospital documentation and strategic reports as the basis for the study of the problem of rural hospital financial performance. I analyzed the coded data from the open-ended semi-structured interviews with study participants and hospital strategic documentation provided by the study participants. These details allowed me to gather a rich understanding of the business problem and identify strategies that may prove effective for improving rural hospital financial performance. Conducting further research that goes beyond the target population of this study might lead to additional insight regarding strategies necessary for reducing the business problem affecting rural hospitals, rural communities, and patients.

The first recommendation for further research includes the exploration of rural hospital leader responses to the business problem of changes in reimbursement. Researchers could utilize a qualitative approach like that used in this study to detect strategies for improving rural hospital performance concerning changes in reimbursement. Alternatively, researchers could use the study findings to develop a survey that gathers rural hospital leader actions used to ensure positive financial

performance with changes in reimbursement. This survey tool could also gather types of data rural hospital leaders would have to monitor and the frequency of tracking the data.

The second recommendation for further research includes the exploration of rural hospital leader responses to the business problem when the rural hospital closes and converts to an alternative healthcare facility. Researchers could utilize a qualitative approach like that used in this study to detect strategies for improving rural hospital performance post-conversion. Additional studies may warrant researchers to identify strategic factors that would influence hospital closure followed by conversion.

The final recommendation for further research includes the exploration of rural hospital leader responses to the business problem of inability to share valuable insights and knowledge. As noted by some study participants, sharing valuable insights and knowledge about preventing rural hospital closure can lead to rural hospital leaders building a deeper understanding of potential strategies that can be implemented to improve their hospital's financial performance. Strategies identified by rural hospital leader may be best practice and serve to support other rural hospital leaders facing imminent danger of rural hospital closure.

Reflections

The goal of completing the multiple case study was to gain experience and develop my skill as a qualitative researcher while exploring a topic of importance to rural hospital leaders. Having the opportunity to engage with study participants openly provided the environment for exploration of strategies implemented to improve rural

hospital performance. While remaining mindful of my personal biases, I captured and represented the viewpoints of the study participants in an unbiased way.

Before starting the data collection for the study, I documented a personal bias that the identification of strategies for improving rural hospital financial performance is possible. The study participants acknowledged the existence of rural hospital closures due to unfavorable financial performance, and some study participants expressed the view that solutions to improve a hospital's financial performance are present. My assessment of the study participants' interview responses and strategic documentation required a reexamination of my personal bias that rural hospital leaders have strategies to improve their financial performance. Completing the study resulted in an outlook that efforts to improve a rural hospital's financial performance require the implementation of short-term and long-term initiatives designed to address quality, utilization, expenses, revenue, safety, satisfaction, talent, and technology focus areas.

Prior studies of rural hospital closure have focused on the development of a financial assessment tool that may signal financial distress of rural hospitals before closure happens (Holmes, Kaufman, Pink, 2017). Completing the qualitative multiple case study allowed direct access to rural hospital leaders who have oversight and responsibility for hospital operations in Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands. Additionally, conducting the study supported the exploration of strategies used by rural hospital leaders to improve their hospital's financial performance. Direct observations further validated content from peer-reviewed documentation describing the reality and consequences of rural hospital

closure. From the analysis of study participant interview response and hospital strategic documentation, I was able to identify short-term and long-term strategies, which might be useful for rural hospital leaders seeking to improve their hospital's financial performance.

Conclusion

Conducting the qualitative multiple case study supported the exploration of identifying strategies rural hospital leaders implement to improve hospital's financial performance in Arizona, Georgia, Illinois, Oklahoma, Pennsylvania, and the United States Virgin Islands. I used information collected from hospital strategic documentation and interviews to examine how rural hospital leaders perceive the business problem of an institution's struggling financial performance and describe strategies used by successful rural hospital leaders. Using the case study protocol supported the study reliability. Analyzing multiple data sources and conducting member checking contributed to the credibility of the study findings. The rich description of the study sample population supported transferability of the study findings.

Analyzing the study participants' interview responses supported the development of themes. I mapped the study findings to a framework to illustrate the strategies rural hospital leaders can implement to improve their hospital's financial performance. The framework also demonstrated the importance of quality, utilization, expenses, revenue, safety, satisfaction, talent, and technology within the context of short-term and long-term strategies.

The study findings aligned with the results of the literature review and further supported the depiction of rural hospital closure as a business problem that adversely

affects not only the rural hospital but also the community that the rural hospital serves. A significant recommendation resulting from the study is the need for rural hospital leaders to implement proactive strategies to combat rural hospital closure. Another proposal is the need for the collection and sharing of knowledge among rural hospital leaders. This approach will aid rural hospital leaders who want to overcome rural hospital closure by tapping into a peer network of rural hospital leaders who have the knowledge needed. Implementation of the recommendations from this study might permit rural hospital leaders to control their hospital's financial performance and guarantee that services will be available for the community they serve.

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Appendix A: Letter of Cooperation

[INSERT COMMUNITY RESEARCH PARTNER NAME]

[CONTACT INFORMATION]

[INSERT DATE]

Dear Chinue Uecker,

Based on my review of your research proposal, I give permission for you to conduct the study entitled "Financial Strategies and Initiatives for Preventing Rural Hospital Closure" within the [INSERT COMMUNITY RESEARCH PARTNER NAME]. As part of this study, I authorize you to interview hospital leaders, collect hospital strategic documentation, conduct member checking, and disseminate results. Individuals' participation will be voluntary and at their own discretion.

We understand that our organization's responsibilities include: approve your access to hospital leaders and schedule a room to conduct the interviews. We reserve the right to withdraw from the study at any time if our circumstances change. The student will be responsible for complying with our site's research policies and requirements, including [INSERT REQUIREMENTS].

I understand that the student will not be naming our organization in the doctoral project report that is published in Proquest.

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

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

Sincerely,

[AUTHORIZATION OFFICIAL]

[CONTACT INFORMATION]

Appendix B: Participant Letter

[INSERT DATE]

Dear [INSERT NAME]:

My name is Chinue Uecker and I am a Doctor of Business Administration (DBA) candidate at Walden University. I am conducting a doctoral study entitled "Financial Strategies and Initiatives for Preventing Rural Hospital Closure". The purpose of this doctoral study will be to explore strategies rural hospital leaders implemented to improve financial performance. This study is intended to explore the following question: what strategies do rural hospital leaders implement to improve their hospital's financial performance?

Based on your professional experience with improving hospital financial performance, I would like to interview you face to face to gather information about strategies implemented at your hospital to improve financial performance. The interview will require approximately 60 minutes of your time and the post interview review of information will require 30 minutes of your time. In addition, I welcome any hospital documentation that you feel may supplement the interview and provide additional details on rural hospital financial strategies. I understand that participating in the interview and/or providing any hospital documentation is strictly voluntary.

Your participation is voluntary. The information you provide will help ensure that I gather data from knowledgeable rural hospital leaders in [INSERT STATE]. If you decide to participate in this doctoral study, I will send you an informed consent form for

you to review and retain. The informed consent form provides details about this doctoral study, summarizes the participant's rights, and outlines the confidentiality agreement.

Please respond to this e-mail indicating your intent to participate by [INSERT DATE]. Thank you in advance for your time and consideration. If you have any questions, I may be reached me at [redacted]

Sincerely,

Chinue Uecker

Appendix C: Case Study Documentation

Document Identification	Description
Document 1	Strategic Plan
Document 2	Strategic Plan
Document 3	Strategic Plan
Document 4	Strategic Initiatives
Document 5	Community Benefit Summary
Document 6	Strategic Plan
Document 7	Community Health Needs Assessment

Appendix D: Case Study Protocol

Case Study Protocol	
What you will do	What you will say—script
Introduce the interview.	Ms. /Mrs. /Mr. _____. Thank you for volunteering to participate in this interview. The purpose of this qualitative case study is to explore strategies rural hospital leaders implemented to improve financial performance. I would like to begin by asking you the interview questions. Interview information shared will remain confidential. I will give each study participant a code. You may skip a question if you do not feel comfortable answering the question.
Set the stage for the interview	The interview will last approximately 60 minutes. During the interview, I will record and take notes. Do you have any questions or concerns? Is this process acceptable with you?
Watch for non-verbal cues, paraphrase as needed, and ask follow-up probing questions	1. What process did you use to improve financial performance?
	2. What data did you monitor to alert you there was an issue with financial performance?
	3. Who was involved in the decision-making process?
	4. How did you reduce the effects of conflicting interests and limitation of resources?
	5. How did you reduce the effects of politics and power in the decision-making process?
	6. What strategies have you used to improve your hospital's performance?
	7. What data did you capture to monitor the impact of the changes made?
	8. What lessons learned would you want to provide a rural hospital leader who wants to improve financial performance?
	9. What else would you like to add that I have not addressed in these interview questions?
Wrap up interview	Thank you for participating in this interview. I value your input. I will send you a copy of the transcribed interview for your review. If the transcription is not accurate, please let me know so that I can correct the information.

Follow–up Member Checking Interview	
Share a copy of the synthesis for each individual question In the e-mail, ask did I miss anything? Or, what would you like to add?	Ms. /Mrs. /Mr. _____. Enclosed is the interpretation of the interview for your review. By _____, please review and respond via e-mail stating whether the interpretation is correct, or changes are needed. Thank you for your time.
	1. What process did you use to improve financial performance?
	2. What data did you monitor to alert you there was an issue with financial performance?
	3. Who was involved in the decision-making process?
	4. How did you reduce the effects of conflicting interests and limitation of resources?
	5. How did you reduce the effects of politics and power in the decision-making process?
	6. What strategies have you used to improve your hospital's performance?
	7. What data did you capture to monitor the impact of the changes made?
	8. What lessons learned would you want to provide a rural hospital leader who wants to improve financial performance?
	9. What else would you like to add that I have not addressed in these interview questions?