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Leadership Strategies for Implementing Quality Improvement Initiatives in Primary Care Facilities

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This is to certify that the doctoral study by

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Abstract

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Doctoral Study Submitted in Partial Fulfillment

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Abstract

Health care spending accounts for 17.7% of the gross domestic product in the United States, and it is expected to continue rising at an annual rate of 5.3%. Despite high costs, health care quality lags behind other high-income countries; yet, over 70% of change initiatives fail. The purpose of this multiple case study was to explore strategies primary care leaders use for implementing quality improvement initiatives to improve patient outcomes and reduce waste in primary care facilities. The target population consisted of 3 health care leaders of 3 primary care facilities in southern California who successfully implemented quality improvement initiatives. The conceptual framework for this study was Kotter's 8-step of change management. Data were collected through face-to-face semistructured interviews with senior health care managers, document review, and quality reports. Member checking of interview transcripts strengthened the credibility of the findings. Data analysis included Yin's 5-phase process, which consisted of compiling, disassembling, reassembling, interpreting, and concluding the data. Themes emerged from the use of methodological triangulation of data. The themes included communication, leadership support, inclusive decision-making, and employee recognition. The implications of the findings of this study for positive social change include assisting primary care leaders in improving strategies for implementing quality improvement initiatives to increase efficiency, reduce health care cost, and improve patient and community health.

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Dedication

I would like to dedicate this study to my entire family for their love, support, and encouragement throughout this journey. First, I dedicate this accomplishment to my amazing wife, Maegan, for exhibiting tireless patience and understanding while I have been pursuing my personal and professional goals. I also dedicate this study to my parents, Luz and Jose, because they have always been my source of inspiration. Whatever I am today is because of the values and morals they instilled in me during my upbringing. Lastly, I want to dedicate this doctoral study to my mentor and friend, Indira, who has been in my life for the last 15 years. She continues to challenge and push me every day to achieve my full potential.

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Section 1: Foundation of the Study

Section 1 includes a discussion of the background of the problem, the purpose of the study, the research questions, the significance of the study, the nature of the study, operational definitions of terms, and a comprehensive literature review.

Background of the Problem

The United States spent 17.7% of gross domestic product (GDP) or $3 trillion in health care expenses in 2014. Health care costs will continue to rise at a 5.3% rate per year, and it is expected to reach a total of 19.6% of the GDP by 2024 (Lee et al., 2016; Martin, Hartman, Benson, & Catlin, 2016). The *iron triangle* guides the economics of health care in the United States, and cost, quality, and care comprise each side of the triangle (Riggs, 2015). Change initiatives in health care focus on addressing all sides by improving quality and care while decreasing cost; however, a high percentage of those change initiatives fail (Donnelly, 2017; Longenecker & Longenecker, 2014; Silver et al., 2016). This high rate of failure in change initiatives suggests the need for research on quality improvement initiatives in primary care facilities.

Factors such as poor implementation planning, failure to create buy-in, and ineffective leadership affect implementation of quality improvement initiatives in primary care facilities (Longenecker & Longenecker, 2014). In 2014, primary care visits surpassed 461 million and accounted for 52% of the total visits to health care facilities in the United States (Center for Disease Control and Prevention, 2016). Lee et al. (2016) explained that health care cost is directly related to quality. Therefore, primary care facilities can reduce the overall cost of health care through quality improvement

initiatives. The findings of this study will contribute to professional practice by offering senior health care leaders' strategies to successfully manage change and implement quality improvement initiatives that reduce waste and improve patient outcomes in primary care facilities.

Problem Statement

Health care quality in the United States is deeply flawed and lags behind other high-income countries (Avendano & Kawachi, 2014). Improving quality of care is a priority in primary care; however, up to 70% of organizational change initiatives fail (Donnelly, 2017; Silver et al., 2016). The general business problem is the inability of leaders to successfully implement quality improvement initiatives to improve patient outcomes and reduce waste in primary care facilities. The specific business problem is that some leaders of primary care facilities lack strategies for implementing quality improvement initiatives to improve patient outcomes and reduce waste.

Purpose Statement

The purpose of this qualitative multiple case study was to explore strategies primary care leaders use for implementing quality improvement initiatives to improve patient outcomes and reduce waste in primary care facilities. The target population consisted of health care leaders of three primary care facilities in Southern California who successfully implemented quality improvement initiatives. The implications for positive social change include the potential to develop strategies that primary care leaders may use to implement quality improvement initiatives to increase efficiency, reduce health care cost, and improve patients and community health.

Nature of the Study

Using a qualitative research method for this study provided me the opportunity to explore strategies primary care leaders use to implement quality improvement initiatives in primary care facilities. Researchers use qualitative methods when they need an extensive understanding of consumer attitudes, behavior and motivations (Barnham, 2015). Qualitative research manifests participants' experiences through observation and interviews (Yin, 2017). Therefore, it is appropriate that I used this method of research for the study. I rejected a quantitative approach because I did not plan to test a hypothesis. According to Park and Park (2016) and Barnham (2015), quantitative research describes occurrences based on numerical data and hypothesis generation and testing. In addition, mixed methods research includes a quantitative element, which made this method of research also inappropriate for the study.

Barnham (2015) explained several types of qualitative research designs, and for this study, I considered: a) ethnographic, b) phenomenological, and c) case study. An ethnographic study was not appropriate for this study because it focuses on exploring the culture of a group within their specific environment (Renedo & Marston, 2015), and that was not the intent of this study. I also rejected a phenomenological design because the intention was not to inquire about people's perspective of a situation. Tumele (2015) utilized case study design to explore in detail a program, event, or process and develop historical explanations that can be generalized to explain other events. A case study was appropriate for this study because it allowed me to explore successful strategies utilized

by primary care leaders during the implementation of quality improvement initiatives in primary care facilities.

Research Question

What strategies do some primary care leaders use for implementing quality improvement initiatives to improve patient outcomes and reduce waste in primary care facilities?

Interview Questions

1. What has been your experience with implementing quality improvement initiatives?
2. What role did you play in the implementation of the quality improvement initiatives?
3. How did you communicate the change vision to employees?
4. Who was involved in the planning process for the quality improvement initiatives?
5. What steps did you follow when implementing the quality improvement initiatives?
6. What successful strategies did you use to implement quality improvement initiatives?
7. What strategies failed to meet the intended results, and why they were not successful in your opinion?
8. How did you overcome the challenges posed by those failed strategies?
9. What other comments or additional information would you like to add regarding

strategies used to implement primary care transformation initiatives?

Conceptual Framework

According to Williamsson, Eriksson, and Dellve (2016), primary care leaders must consider various essential steps to implement successful change in an organization. Kotter's (1995) eight-step process developed in 1995 is well-known for successful change management and organizational transformation (Burden, 2016; Pollack & Pollack, 2015); therefore, it offered the appropriate framing for this qualitative study. Kotter's process provided a conceptual structure to explore leadership strategies for implementing quality improvement initiatives because successful changes in clinical practice must be adaptable and dynamic (Burden, 2016). Kotter's process framework may assist primary care leaders in using a systematic and strategic approach to implement organizational change by connecting with people's emotions and enabling employees to identify solutions to possible problems (Burden, 2016).

Operational Definitions

Primary care: Primary care is a patient's first level of care and entry point into the health care system (Amisi & Downing, 2017; Greenfield, Foley, & Majeed, 2016).

Quality improvement initiative: Quality improvement initiative is the series of efforts by health care employees to make changes focused on better patient outcomes, waste reduction, improved performance, and employee development (Gauld et al., 2014; Pendharkar et al., 2016).

Assumptions, Limitations, and Delimitations

Researchers strive for high quality research reporting. Acknowledging assumptions and limitations to interpreting findings appropriately enhances the credibility of the study (Cope, 2014b; Kirkwood & Price, 2013). Delimitations establish boundaries for the study (Welch, 2014). I outline the assumptions, limitations, and delimitations of this study in the following subsections.

Assumptions

An assumption refers to something the researcher is unable to confirm but assumes to be true (Nkwake & Morrow, 2016). To adhere to the confidentiality requirements established on the consent form, I assumed that participants' responses to the questions were honest and accurate. In addition, I assumed that participants possessed the knowledge to answer the questions of the study.

Limitations

According to Dennison, Morrison, Conway, and Yardley (2013) and Helmich, Boerebach, Arah, and Lingard (2015), limitations influence the strength of the study because they are weaknesses that researchers cannot control. The first limitation identified in this study was that the sample size of three organizations might not represent organizations in other regions. Another limitation was the participants' personal biases regarding success or failure of quality improvement initiatives. The third limitation was that the results might not transfer to other industries.

Delimitations

Factors that define the scope of the study and establish boundaries are delimitations (Welch, 2014). For this study, there were three areas of delimitations including the environment, the target population, and the geographical location. The purpose of this study was to explore quality improvement initiatives implemented by primary care leaders; therefore, the questions only addressed the initiatives for the implementation and not other administrative requirements in primary care. The sample population possessed specific knowledge on the topic. The study did not include other personnel of the organizations. The geographic location of the study was Southern California.

Significance of the Study

Contribution to Business Practice

According to Kaplan and Witkowski (2014), there are inefficiencies in the health care industry that contribute to waste and the increasing costs of health care, which equaled $3.2 trillion or 17.8% of the gross domestic product in 2015 (Centers for Medicare and Medicaid Services, 2017). This study is of value to business practices because it could provide information for primary care leaders to reduce waste and address the escalating costs of care while improving health outcomes. In addition, the contributions to the professional application are strategies that are successful in implementing quality improvement initiatives in primary care facilities from the perspective of other primary care leaders.

Implications for Social Change

The implications for positive social change include the potential for primary care leaders to apply successful strategies for implementing quality improvement initiatives and the possible application of these strategies to quality improvement initiatives in other specialties of health care. Swensen, Dilling, Mc Carty, Bolton, and Harper (2013) stated that quality care has negligible waste from inefficiencies, overuse, and preventable harm; therefore, implementation of quality improvement initiatives aligns with the best interest of the patients in any facility. Additionally, improving primary care practice benefits the community by providing access to affordable care to those in need.

A Review of the Professional and Academic Literature

In this qualitative multiple case study, I explored strategies primary care leaders use to implement quality improvement initiatives to increase patient outcomes and reduce waste in primary care facilities. The population consisted of senior health care managers from three primary care facilities located in Southern California, who successfully implemented quality improvement initiatives in their respective organizations. To identify the literature on quality improvement initiatives in primary care, I conducted searches in the Walden Library and Google Scholar for specific keywords connected to the challenges health care managers face in implementing quality improvements.

The keywords used in searching for articles included *quality improvement, waste, total quality management, problem-solving methodologies* and *quality improvement training*. I also focused on the specific industry of study by searching *healthcare*, *health care,* and *primary care*. The resources found included books, dissertations, and peer-

reviewed journal articles. The databases that I accessed in collecting this literature were health-related databases and business databases including ProQuest Thesis, ProQuest, ABI/INFORM Complete, CINAHL Plus with full text, EBSCOhost, MEDLINE, SAGE Publications, Science Direct, Health Science, Emerald Management Journals, and Dissertations. There are 93 sources in the literature review section, and 96% of those sources were peer-reviewed and published within 5 years of the anticipated graduation date.

The literature review consists of five main subsections: (a) the conceptual framework, (b) high reliability in health care (c) quality in primary care, (d) quality improvement strategies, and (e) quality improvement challenges in primary care. The conceptual framework for this study was Kotter's eight-step process for implementing change model. The first subsection includes a synthesis of previous research based on Kotter's model. The articles that I reviewed focused on how different health care sectors, including primary care, have been able to apply Kotter's model to quality improvement initiatives. Also, the articles are historical and based on continuous quality improvement.

The second subsection of the literature review is an overview of the concept of high reliability in health care. The third subsection on quality comprises information on high reliability organizations, quality in health care, quality indicators, and the Healthcare Effectiveness Data and Information Set (HEDIS) measures. The fourth subsection includes a summary of the existing research on the different strategies for implementation of quality improvement initiatives. The last subsection is a summary of various challenges of implementing change initiatives in primary care facilities.

Application to the Applied Business Problem

Conceptual Framework

I applied Kotter's eight-step model of implementing change to analyze the literature. Kotter's model is used widely for implementing and sustaining change (Hughes, 2016; Pollack & Pollack, 2015). In this section, I describe the model in detail and discuss recent studies focused on change management in health care settings. The eight-step process includes: (a) developing a sense of urgency, (b) creating a guiding coalition, (c) developing a vision and strategy, (d) communicating the change vision, (e) empowering broad-based change, (f) generating short-term wins, (g) consolidating gains and producing more change, and (h) cultivating a culture of change.

The first step in Kotter's model is to create a sense of urgency. A concerted effort in the organization is necessary to propel staff motivation and carry out changes (Kotter, 1995). Kotter (1995) described the importance of leadership engagement in driving a successful change management initiative. At least 75% of the organization's leadership must buy-in for change to be prosperous (Kotter, 1995). In primary care facilities, focusing on quality improvement efforts in areas aligned with patients' interests create leadership and personnel buy-in, which has a positive impact on the organizational bottom line.

In the first step of the model, Kotter (1995) described how the leader allows for complacency where employees desist from status quo and resistance to change. Schwaninger and Scheef (2016) found that employees must feel like they are part of the change and understand why it is necessary for successful change management. This first

step is a stage where every person coaches, mentors, and provides feedback to the team to overcome the existing barriers. Sharing information promptly and providing evidence on why change is important in improving quality and reducing waste also alleviates some barriers (Höög, Lysholm, Garvare, Weinehall, & Nyström, 2016). Leaders can increase urgency by mitigating anxiety and stress and ensuring staff members understand the evidence supporting the need for change.

Kotter (1995) emphasized the importance of leadership engagement to achieve most of the elements identified in the management processes. Allahverdyan and Galstyan (2016) described how leaders could make decisions without seeking team opinion in an autocratic leadership culture, especially where there is an emergency and decisions need to happen quickly. However, primary care leaders must embrace a collective leadership culture when aiming at improving the health care quality and reducing waste (Eckert, West, Altman, Steward, & Pasmore, 2014). This cultural shift drives staff members to respond positively to the vision of the organization and help achieve high quality care.

Traditionally, leaders focused more on oversight and inspection of practices and behavior with an aim to find fault where there was little or no guidance on how to improve. Pearce (2015) found that leaders with an authoritarian or hierarchical approach felt responsible for overseeing lower level employees ensuring that they carried out their roles in the right way. The view was that there was no need for motivation and incentives to achieve higher performance. However, Scott, Jiang, Wildman, and Griffith (2018) found that hierarchical structures do not match current expectations of highly skilled

employees nor do they facilitate the development of innovative solutions. By creating the right urgency and buy in, employees increase their motivation toward embracing and implementing the needed change.

Kotter (1995) explained how promoting urgency involves using visuals to show what may happen to the organization if change does not occur. Silver et al. (2016) referred to this concept as visual management. The attributes of visual management include transparency, simplicity, and being actionable. Silver et al. (2016) recommended using process control and performance boards to facilitate visual presentations. Primary care leaders could create a higher sense of urgency by using process control and performance boards as tools to communicate potential crises or areas of opportunity.

The second step in Kotter's model is forming a guiding coalition. Kotter (1995) explained that leaders are the focus of the team, which also applies to primary care facilities and other health care organizations. The leadership should be visible in supporting the people within the organization (Silver et al., 2016). Leading by example is a technique leaders can utilize to convince employees of the need to change.

Leading staff is a challenging task in the health care industry. Mount and Anderson (2015) described how leaders are responsible for employees who work in challenging environments, and leaders' response to change management could turn into a defining leadership trait. Suthar, Roy, Call, Besser, and Davis (2014) explained that primary care workers must deliver critical health care services where implementation of complex, longitudinal care interventions occur even if in remote locations. Other leadership tasks include shifting the nonphysician operations of health practitioners to

achieve higher results (Delmatoff & Lazarus, 2014). Leading by example is an approach that must reach the primary care employees for successful implementation of change.

Primary care leaders are responsible for making sure that complex care is available. However, staffing shortage is a common challenge in delivering quality of care. Drupsteen, van der Vaart, and Van Donk (2016) argued that leadership should have the right people and sufficient trust to improve the decision-making process. Kotter (1995) suggested that employees form a coalition where they can help each other undertake challenging tasks. Forming a coalition in primary care will help in the change management process.

Kotter (1995) explained that failure in the second step often relates to underestimating the power of the coalition. Sometimes the team members expect executive staff to lead the efforts instead of key line leaders. Kotter also attributed failure to lack of teamwork exposure by leaders, which also creates supervision challenges. Team members must come together to develop a shared commitment to excellence.

Employee supervision is a strategy highly studied and referenced in quality improvement. Drupsteen et al. (2016) described the importance of employee supervision for the successful implementation of change. In health care, the most commonly used terms to refer to supervision include clinical supervision, managerial supervision, supportive supervision or supervision (Ginter, Swayne, & Duncan, 2018). Ginter et al. (2018) stated that the approach makes a difference in the term used. Leaders provide support and appropriate guidance with an aim to help staff become more knowledgeable, competent, and efficient.

Mbamalu and Whiteman (2014) explained that by forming a powerful coalition, the leader does not need to supervise the team as each member works to ensure the others excel. In a coalition, the employees avoid traditional hierarchies and work as a team where they can build on urgency and momentum in accepting change (Moraros, Lemstra, & Nwankwo, 2016). Having the right people, developing a common goal, and creating trust are vital for building a coalition. A powerful coalition is essential in establishing a team as well as engaging all primary health care stakeholders in implementing innovative change.

Creating a vision and a strategy for change is the third step in Kotter's model. Kotter (1995) explained that the vision must clarify the direction in which the organization is moving. Leaders must be able to communicate the vision in 3 to 5 minutes, and the vision should go beyond the 5-year plan of the organization (Kotter, 1995). In primary care, a vision to improve quality and reduce waste can lead to high reliability, which also builds a positive organizational reputation.

Driving out waste reduces costs. However, in some instances, leaders view quality improvement as a response to required external accreditation and regulatory agencies (Gassman & Thompson, 2017). Many groups benefit from quality improvement and waste reduction including the patient, employer, and the insurer. In America's health care system, insurances reimburse according to the prospect of underused care, inefficiency, defection, and overuse (Mount & Anderson, 2015). Therefore, a coalition of the primary care workers that build a sustainable vision is necessary to maximize reimbursement opportunities.

Primary care leaders must avoid trade-offs between productivity and quality as a right means of removing waste in health care quality because waste and cost differ. For instance, unplanned removing of workers or increasing workload would reduce cost but to erode quality. A systematic removal would add value, as it would streamline the processes to cut costs. Ginter et al. (2018) described how health care leaders have the responsibility to reduce process inefficiencies. Fleming et al. (2017) explained the need to control the underuse or overuse of resources by reducing inefficiency and defective care. Reducing waste is accomplished by streamlining processes to drive away variations and yield return on investment, which is decided upon when developing the right strategy and a vision.

The vision and strategy identification establish a collective leadership culture within the primary care facility as it identifies a shared sense of direction for change in quality development. Leaders face controversies and confusion during the implementation of change (Kotter, 1995). Leaders should be prepared with backup strategies to resolve such issues (Conway-Orgel & Edlund, 2015). For example, primary care leaders must identify the existing gap in training for quality development. Viryansky, Semenov, and Shaposhnikov (2017) described how quality training is essential for formulation and solution of topical problems related to quality. Training provides support and appropriate guidance with an aim to help staff become knowledgeable, more competent, and effective in their work. A clear vision helps motivate health care workers to take the right training and make an effort in the right direction.

The fourth step in Kotter's model is to communicate the vision. Kotter (1995) explained that leaders must identify the means of communicating the vision to the team members more frequently to ensure it is fresh in the minds of the implementers. Osatuke and Yanchus (2014) described how the leader's role is critical because leaders can motivate staff to attain the desired results by using the right communication channel to present a compelling vision. Primary care leadership should communicate the change vision effectively due to its importance in guiding the coalition and promoting organizational understanding.

The communication strategy sets up the basis to gain commitment from the staff as well as the leadership in embracing the new direction. According to Kotter (1995), leaders must use all the available means of communication to capture the attention of staff effectively on the need for change. The leadership makes sure that there is adequate communication so that all the stakeholders understand the reasons for the change and agree to commit to achieving it (Kotter, 1995). For an organization to perform maximally, staff members should have a better understanding and common direction to achieve desired goals.

Efficient communication and clear information flow across organizational boundaries characterize quality improvement and reduction in waste. Pollack and Pollack (2015) suggested developing a relationship with the communications department to increase the visibility of the program and use all available channels to deliver the message. Efficient communication and staff motivation to participate in decision-making have a positive effect on the working environment, which improves staff's overall well-

being (Eckert et al., 2014). Honest and direct expression of the reason to implement change is imperative to improve staff buy-in. By adopting effective communication strategy, primary care employees can understand the message clearly and avoid confusion and alienation of some groups.

Matos Marques Simoes and Esposito (2014) also added that communication is a relevant dimension to implement organizational change successfully. Leaders can communicate the change vision through simplified methods and increased repetition because some stakeholders do not embrace change. Due to high suspicion among team leaders and staff, leaders must convince them that future target would present a better environment than the current one. Lame, Jouini, and Stal-Le Cardinal (2017) suggested using two ways to communicate the vision. The first approach is where the leadership needs to let other stakeholders contribute to the change effort. The second approach is where the other stakeholders should also be allowed to offer suggestions on implementation processes by having open communication and feedback. The continued communication is helpful in supporting those involved in undertaking the needed actions.

Researchers found different methods of communication that change vision in a primary care organization. Using organizational vehicles such as the intranet, informal setting, written communication, large group meetings and email communication to get the message out is particularly effective (Lame et al., 2017). Another method presented by Crouzet, Parker, and Pathak (2014) is using metaphors to explain why the change is important. The intent is to ensure that the change vision becomes parts of everyday activity in a way that it shows their daily operations and promotes existing processes.

Lame et al. (2017) explained how the vision should follow the principles of efficiency, innovative thinking, budget conservation, and honesty. The leadership should be the role model in vision implementation.

The next and fifth step in Kotter's model is empowering broad-based change. Lv and Zhang (2017) found that effective leaders establish a collective leadership culture that empowers staff in the primary care facility. When staff is empowered, they can develop autonomy, which builds trust to complete what they were charged to accomplish (Conway-Orgel & Edlund, 2015; Pollack & Pollack, 2015). Lv and Zhang established how collective leadership culture ensures the continual delivery of quality.

A significant piece of empowerment is to provide primary care workers needed training to adopt change. Hughes (2016) described how employees could get the necessary tools to assess the planning and implementation and conduct self-evaluation of the change process. Longenecker and Longenecker (2014) explained that without employee empowerment, health care quality initiatives fail. On the contrary, through empowerment, primary care organizations can achieve the set goals as clinical administrative staff and health care providers can conduct and use their individual evaluation to improve quality and reduce waste.

When leaders empower the team members to be leaders in their own capacity, they improve program implementation and strengthen the change process as it builds local capacity for strategic planning. Fetterman, Kaftarian, and Wandersman (2015) described how strategic planning with empowered teams is more systematic, quality implemented, self-evaluated. It also enables continuous use of information for quality

improvement. According to Pearce (2015), staff members need to be trained to empower other staff to change, and training must focus on new attitude, skills, and behavior, which will embrace change. Leaders need to be engaged in all levels of decision-making processes to feel like part of the change process.

Kotter (1995) suggested that removing obstacles allow employees to take action within the broad parameters of the vision. Leadership in primary care should have an accurate understanding of the barriers that hinder implementation of change. It is an important factor as it helps select a guiding teamwork whose members are from diverse organizational backgrounds characterized by different expertise, credibility, and position (D'Innocenzo, Mathieu, & Kukenberger, 2016; Mathieu, Tannenbaum, Donsbach, & Alliger, 2014). The team to implement change should know how the organization operates and improve the communication with other stakeholders including other nurses, physician, and support staff. Empowerment helps to align the reward system, procedures, structures, organizational processes, and effort to implement the change vision.

Generating short-term wins is the sixth step in Kotter's model of change management. Burden (2016) explained that although some quality improvements may be short-term achievements, they help form the foundation of long-term goals. In implementing the short-term goals, the leadership can get the information needed on the viability of new ideas. Audit and feedback methods are effective in offering support interventions for sustainable quality improvement. Feedback from different levels across the organization is necessary to ensure personnel is responding to the changes (Eckert et al., 2014; Lewis et al., 2015). Feedback includes both positive and negative responses as

they help in motivating the teams. Mount and Anderson (2015) described how it is possible to correct methods and strategies used in implementing change by reading the negative feedback. When having a long-term implementation of a vision, the leader can use the feedback in the short term to understand how the implementation is moving to achieve the intended goal.

The seventh step in Kotter's model is consolidating gains and producing more change. In primary care environments, change implementation can be a long endeavor, which is marked by lengthy processes. Pollack and Pollack (2015) stated that leaders need to be capable of running multiple change initiatives simultaneously. By establishing a collective leadership culture, all levels of staff and primary care workers get a clear understanding of their joint mission and deliver continual quality improvement (Lv & Zhang, 2017). Practices must be grounded in the organization's culture for successful change implementation (Kotter, 1995). In a primary care organization, culture establishes shared values among the team, which can powerfully influence health care workers behavior even if the team's membership or leadership changes (Eckert et al., 2014). Therefore, it is imperative to maintain the quality of patient care above many other organizational aims.

The eighth and last step in Kotter's change management model is cultivating a culture of change. In this step, there is the articulation of how the organization will achieve success especially in developing the right environment for ensuring leadership development and succession planning (Kotter, 1995). Kotter (1995) established the importance of the new changes to be well established to become sustainable and part the

organizational culture. Culture is concerned with behaviors and norms as well as shared values (Waterworth et al., 2016). As social forces, they help cement the change implementation where every individual contributes to the organizational goal. It is not a simple task to guide the change, but a strong organizational culture helps guide coalition especially for long-term success.

Reward and recognition policies should incentivize good leadership shown by informal leaders. Leaders must modify reward plans to encourage adoption of the new values and norms, supplemented development, and training practices characterized by competencies and skills related to the implementation of changes (Hughes, 2016; Waterworth et al., 2016). When primary care organizations have a strong leadership culture to consolidate the gains, then they can continue to produce additional and continuous change (Lv & Zhang, 2017). Additionally, continuous improvement goes a long way in achieving reduced waste as all needed changes are implemented to reduce resource wastefulness.

High Reliability in Health Care

Pressure from government agencies, health insurance companies, and health care consumers to improve quality outcomes and reduce waste in health care organizations will continue to drive health care leaders to seek zero harm. According to Tolk, Cantu, and Beruvides (2015), the concept of a high reliability organization (HRO) surfaced in 1981. HROs operate in hazardous environments and use work practices and behavioral procedures to attain excellence and maintain safety (Tolk et al., 2015). Industries like air traffic control, aircraft carriers, and nuclear power plants continue to operate in dangerous

conditions with nearly error-free outcomes (Tolk et al., 2015). Chassin and Loeb (2013) argued that primary care facilities could also achieve high reliability by engaging in change initiatives to improve quality. However, primary care leaders face challenges in pursuing high reliability because a high percentage of the change initiatives in health care organizations fail.

Chassin and Loeb (2013) explained that primary care organizations seeking high reliability must engage in three domains. The three domains are leadership commitment, a culture of safety, and robust process improvement (Chassin & Loeb, 2013). Vogus and Iacobucci explained the connection of high reliability with increasing quality in health care organizations. As organizations seek to deliver failure-free health care services through leadership commitment, a culture of safety, and process improvement, quality will increase (Griffith, 2015). Vogus and Iacobucci (2016) described the limited success in improving quality, and primary care facilities are not exempt from sharing those limitations.

Quality in Primary Care

Primary care refers to the care for patients by physicians who received formal training and possess the necessary skills for first contact and care for patients (Amisi & Downing, 2017). Primary care includes disease prevention, health care maintenance, health promotion, patient education, identification and treatment of chronic and acute diseases in diverse health care conditions (Allenby et al., 2016). This type of care is managed by a personal physician in collaboration with other health care professionals and can utilize consultations and referrals when appropriate (Van Loenen, Faber, Westert, &

Van Den Berg, 2016). Primary care encourages efficient physician-patient communication and inspires the role of the patient as a partner in health care (Kelley, Kraft-Todd, Schapira, Kossowsky, & Riess, 2014). Since primary care provides an entry point into the health care system, improvement of quality and waste reduction contributes to improving the value of health care.

Primary care is a critical tool in reaching objectives constituting the value of the overall health care system as it provides a logical basis for an efficient system. Lee et al. (2016) acknowledged that objectives constituting value in health care include the high quality of care, patient satisfaction, and the effective use of resources in the health care setting. Primary care respects the immediate needs of patients and the sense of responsibility and competence of first contact health care professionals (Fleiszer, Semenic, Ritchie, Richer, & Denis, 2015). Edwards, Bitton, Hong, and Landon (2014) described an efficient health care system as one that involves balancing of patient needs, economic concerns, and environmental costs. It is the core responsibility of the health care practitioners and facilities to provide patients with efficient, appropriate, and humane care.

Quality in primary care refers to providing the right attention to patients at the right time while aiming at the best possible patient outcome and keeping the patient safe from any hazards or harm (Silver et al., 2016; Van Loenen et al., 2016). The primary concern of high quality care should be characterized by the ease of accessibility of services for all while addressing the health needs of patients, provision of widespread services to meet patient needs, and services centered toward the patient rather than the

disease (Bodenheimer, Ghorob, Willard-Grace, Grumbach, & Care, 2014). Additionally, quality care ensures coordination of care for individual patients with a holistic approach integrating psychological, biomedical, and social dimensions as well as a focus on prevention of diseases, promotion of health, and management of established health problems (Abrams et al., 2015; Bodenheimer et al., 2014). Quality improvement in primary care provides an opportunity to focus the care to meet the patient needs.

The World Health Organization (WHO) calls on all countries to strengthen primary health care systems, improve the effectiveness of health care overall, provide better public health, keep health care costs at manageable levels, and provide equality for all to access the appropriate health care while ensuring sustainability of the health care systems (Simou, Pliatsika, Koutsogeorgou, & Roumeliotou, 2015). van den Driessen Mareeuw et al. (2017) reiterated WHO's six dimensions of quality in primary care, and they include care being effective, efficient, accessible, patient-centered, equitable and safe. Simou et al. (2015) explained that to assess performance, WHO implemented quality health indicators of health services. Harris, Green, et al. (2015) described how improvement in the quality of care enhances accountability of managers and health care practitioners, provides resource efficiency, identification, and minimization of medical errors, while maximizing the use of adequate care, improving patient outcomes, and aligning care to specific patient needs. In fact, quality improvement in health care is the core mandate of health care settings (Sibthorpe et al., 2017). Understanding the quality indicators will assist primary care leaders in improving overall quality and maximizing reimbursement opportunities.

Quality Indicators. Indicators are measurable items used as building blocks in the assessment of care. A performance evaluation is fundamental to improvement in the value of primary care and the overall health care (Young, Roberts, & Holden, 2017). Quality health indicators that assess primary care system performance focus on evaluating access, continuity of care, and holistic approach to care with a family and community-based orientation and coordination (Saust, Monrad, Hansen, Arpi, & Bjerrum, 2016; Simou et al., 2015). Therefore, the quality indicators are in reaction to the multidimensional needs of patients and vital in gauging performance in primary care settings.

Leading organizations around the world, such as WHO, the Organisation for Economic Co-operation and Development (OECD), and the Agency for Healthcare Research and Quality (AHRQ) developed and implemented systems to monitor health and quality health indicators to assess the performance of health services provided at regional, national, and international level (Pavlič, Sever, Klemenc-Ketiš, & Švab, 2015; Simou et al., 2015; van den Driessen Mareeuw et al., 2017). Simou et al. (2015) described how the 2007 National Healthcare Quality Report published 41 indicators for primary care. However, the Practice Partner Research Network (PPRNet) comprises the most useful data for primary care by utilizing an electronic medical record tool named the Accelerating the Translation of Research into Practice (A-TRIP) (Simou et al., 2015). Both systems allow monitoring of quality measures by different agencies or stakeholders of primary care practices.

Prevention quality indicators are a set of quality procedures used in the identification of potential problems in the health care setting, following movements over time, and ascertaining differences across sections, providers, and communities (Manzoli et al., 2014). Primary care focuses on services in preventive care that are helpful for persons to manage chronic illnesses or stay healthy as a result of disease prevention services (Grace et al., 2014). The prevention quality indicators use admission data from health care settings to evaluate instances where preventive services or better management of chronic illnesses could prevent admission cases (Manzoli et al., 2014; Van Loenen et al., 2016). For example, inpatient data could provide admission information for instances where better outpatient services could avoid ambulatory situations. A diabetic patient may be admitted as a result of complications from poor illness monitoring or not getting the necessary education for self-management of the condition. The prevention quality indicators would capture the admission and report the data to different stakeholders.

Several factors contribute to the hospitalization of patients, including lack of observance of the patient treatment regimen and environmental factors. However, prevention quality indicators offer a starting point to evaluate the value of structural aspects of services within communities (Van Den Driessen Mareeuw et al., 2017). Manzoli et al. (2014) explained that prevention quality indicators provide a clear picture of health care by identifying the needs that have not been met, checking how problems are being circumvented in outpatient settings, considering access to health care, and relating the performance of local health care systems within the communities. Prevention quality indicators also represent the present conditions of the health care system and pay

particular interest in the ambulatory care, such as the prevention of both chronic diseases and acute illnesses (Manzoli et al., 2014; van den Driessen Mareeuw et al., 2017). Prevention quality indicators are appreciated when calculated at the area or population levels to offer evidence about the possible problems within the community requiring further investigation.

The prevention quality indicators are used in preventing medical difficulties for both, acute ailments, and chronic conditions. Rinke et al. (2015) assessed how the indicators allow comparisons between different areas or regions over time, and they reflect on the quality of care provided in the community. Rinke et al. (2015) also explained how prevention quality indicators possess several strengths, but data users must exercise care when applying these quality indicators because variances in indicators may not clarify some disparities across regions. For example, the association between prevention quality indicators and the socioeconomic status is complex and makes it difficult to determine the quantity of the observed associations relating to access of care issues and other patient features distinct to the quality of care (Rinke et al., 2015). Primary care leaders must use prevention quality indicators with caution to establish disparities among regions.

HEDIS Measures. HEDIS refers to a set of standardized performance measures put in place by National Committee for Quality Assurance (NCQA) allowing comparison across health care settings (Trivedi, Wilson, Charlton, & Kizer, 2016). It is an instrument used by the majority of America's health care entities to quantify the performance on critical dimensions of care. Health plans use HEDIS to identify areas that need

improvement in health care (Hu, Schreiber, Jordan, George, & Nerenz, 2018). The crucial health issues measured by HEDIS include the use of medication in asthma, control of high blood pressure, screening of breast cancer, and management of antidepressant medication among others (Hu et al., 2018; Trivedi et al., 2016). Therefore, health care stakeholders utilize the HEDIS measures for various purposes, including reimbursement and quality improvement.

Health care plans use data from HEDIS and their results to improve quality of care and ensure quality in primary care (Trivedi et al., 2016). As states and the national government move toward a health care sector focused on quality, HEDIS rates become more significant for health care plans and individual service providers (Harris, Ellerby, et al., 2015; Robst, Rost, & Marshall, 2013). The purchasers of health care services make use of these scores in the evaluation of health insurance industries and primary health care settings in making their medical decisions. The rates, therefore, act as the foundation for profiling of primary care physician as well as the choice of incentive programs.

DeVoe et al. (2015) explained how calculations for HEDIS rates derive from hybrid or administrative data. Claims or encounters data submitted to the health care plans comprises the administrative statistics, and the measures in this category include annual chlamydia screening, annual mammogram, annual Pap test among others (DeVoe et al., 2015; Harris, Ellerby, et al., 2015). Hybrid data, on the other hand, consists of both, medical record and administrative data. DeVoe et al. explained that records require an analysis of a randomly selected sample, or claims end up not including abstract data

received for the medical records. In addition, the data in this category includes comprehensive diabetes care, immunizations, prenatal care, and childcare among others (DeVoe et al., 2015). The data accuracy allows primary care leaders to establish improvement goals.

HEDIS offers benefits to various stakeholders of primary care facilities. For example, HEDIS is beneficial to the health care participants due to its ability to address consumer interests regarding quality assessment data (Pawlson, Scholle, & Powers, 2007; Trivedi et al., 2016). Additionally, it is considered and recognized in the U.S. as a secure method used for quality assessment in health care settings (Trivedi et al., 2016). HEDIS measures ensure quality in primary care since it provides for national data comparisons and aid in the subsequent health care decisions by the various users of information.

HEDIS contains more than 40 different standardized administrative and clinical performance measures (NCQA, 2018). Origination of performance benchmarks for the various outcomes or quality processes in the health care setting follows the data derived from different health care plans. Therefore, the measures have a significant role in closing the gaps in the care of patients and reducing expensive acute care using preventive services (Rosenthal, Sinaiko, Eastman, Chapman, & Partridge, 2015). The standards focus on quality improvement and value-based care across health care establishments, thus holding a critical place in helping health care providers achieve objectives related to positive patient outcome and high standards of care.

Quality under the Health Care Reform. Lawmakers implemented the Patient Protection and Affordable Care Act (PPACA) with the aim of expanding health care

coverage to all Americans by containing costs and improving quality of care. Although the act faced severe criticism during its implementation, it provided coverage for more than 20 million people, the health care costs declined, and the value of care following the enactment of the health reforms improved (Orszag, 2016). Shaw, Asomugha, Conway, and Rein (2014) explained that PPACA contains provisions on the improvement of efficiency and quality of the health care system as well as testing new ways for delivery and payment of health care services. According to Abrams et al. (2015), an integral part of the act is performance measurement and an assessment for evaluation of how good the provision of care is, which is useful in public reporting programs, value-based purchasing, payment reforms, and quality improvement. The law covers the strategies aimed at strengthening primary care, accelerating adoption of health information technology, and supporting patient and clinical decisions through the use of the available evidence-based information.

Infrastructure for measurement of performance in the act strengthens support efficiency, quality improvement, delivery reform, and payment. Burwell (2015) explained how the act mandates that the Department of Health and Human Services (HHS) implement a national strategy for growth and delivery of quality in health care. The HHS designed a template to guide agencies in the development of quality strategic plans to create consistency across the plans and ensure alignment with the National Quality Strategy, and various pilot programs already demonstrated some success (Goerlich Zief & Cole, 2016; Quraishi & Jordan, 2015). Additionally, HHS identified gaps in quality processes to fund the development of steps necessary to fill those gaps by

prioritizing care coordination, health results, shared decision making, functional status, disparities, and efficiency (Burwell, 2015). Performance measurement will continue to promote quality of care.

PPACA has made remarkable headway in resolving the long-standing problems that had been facing U.S. health care arrangement concerning access, quality, and affordability. Advancing Honest and Ethical Medical Research (AHRP) through the Center for Quality Improvement and Patient Safety plays a critical role in ensuring quality in the health reform by conducting and supporting research and development of the best practices (Blumenthal, Abrams, & Nuzum, 2015). From the time the act passed as law, the rates of uninsured have dropped from 16% in 2010 to 9.1% in 2015 leading to an estimated decline of 43% to include a decrease of 5.5% of non-elderly adults with the inability to access care (Obama, 2016). These advances show the act's effectiveness in improving quality in primary care.

Quality Improvement Strategies

Quality improvement in primary care practices is essential for enhancing the health level of the population. Enhancement of patient experiences and outcomes, improvement of the services of the provider, and reduction of per capita expenses are paramount steps in quality improvement strategies (Harvey & Lynch, 2017). Quraishi and Jordan (2015) described how the efforts made to create quality in health care systems have seen health providers, insurers, quality improvement organizations, and delivery systems engage in primary care safety and performance. Primary care leaders looking to

improve quality in their organization must focus on efficient quality improvement and safety strategies.

Primary care practices should use quality improvement orientations, which seek continuous improvement of the outcomes of patients and their performances. Abdallah (2014) described orientation as one of the drivers of quality initiatives because it guides primary care practices in setting priorities in areas requiring improvement of the strategies to achieve quality improvement goals. Quality improvement efforts will determine the specific areas of practice to address, and the methods that will be used to deal with the particular issues. The choice of practices and the methods used to improve these aspects will vary based on the facility, circumstances, and the resources allocated for the exercise (Van der Biezen, Derckx, Wensing, & Laurant, 2017). Typical areas that need improvement include identification of patients, monitoring and following up of patients with diabetes, and ensuring growth in delivery of recommended prevention services for all patients.

Quality improvement in primary care is a new activity to many health care facilities. The need to utilize new skills to meet quality improvement goals is essential (Renedo & Marston, 2015). The methods to improve quality include identification of areas for improvement, studying the available data to understand current situations in health care practices, planning and initiating change, and monitoring the performances through time. Silver et al. (2016) described the need to use performance boards to display a commitment to quality improvement. Solberg et al. (2014) explained how

external support might be required while undertaking a quality improvement strategy. The additional support can assist in carrying out quality improvement.

Stakeholders in health care, the private, and governmental sectors should participate in providing support for implementing changes in the quality of primary care. External support within the hospital setup can efficiently assist primary care practitioners by providing work facilitation and coaching (Scott et al., 2017). External facilitators help the primary care practitioners to improve their approach toward quality improvement and developing skills. Hudson et al. (2014) described how external facilitators also provide expertise and quality improvement tools, thus enabling the participants to troubleshoot challenges and barriers to implementing quality improvement in primary care. Coaching allows the practitioners to adapt to the new ways of doing business (Crouzet et al., 2014). Facilitation and coaching assist primary care leaders in developing internal capacity for activities related to quality improvement.

Peer-to-peer mentoring and consultation by experts provide primary care practitioners with knowledge from experts outside their sphere of activity. Lessard et al. (2016) explained how such experience facilitates new implementations in the facility. In addition, benchmarking and the provision of feedback to the primary care practice allow obtaining the information on quality improvement performance in comparison with regional and national averages, which are essential in achieving quality improvement (Simou et al., 2015). Feedback data will assist the teams in processing information on important indicators of processes and the outcomes regarding services, costs, experience, and patient quality.

Health care plans should create a community in which stakeholders and practitioners can share learning experiences. The community strengthens the culture of continuous quality improvement (Thomas, 2017). In addition, Makary and Daniel (2016) indicated how communities and entities would support quality improvement in primary care by sharing best practices, lessons learned, challenges encountered, and enhancing inspiration. Having a sense of community rather than individual practices allows other organizations to lead parallel initiatives for health and care in the same area.

Lean Strategies. Primary care systems adopted different strategies to accelerate improvement in quality. Lean is a continuous process improvement methodology that aims to reduce activities that do not add value to the primary care facility (Ha et al., 2016). Leaders use this strategy to reduce mistake proofing tasks and focus on the elimination of wastes to improve the delivery of care (Gavriloff, Ostrowski-Delahanty, & Oldfield, 2017). Lean strategies assist in creating change in workflows, handoffs, and long-term processes. Following a Lean strategy enhances the effectiveness of the clinic by changing processes to accommodate the patients who require longer appointment time ensuring the involvement of allied health staff to develop previsit dates, follow-ups, and outreaching.

Primary care leaders should adopt principles of lean strategies to effectively reduce waste and improve efficient care delivery. Ha et al. (2016) and Moraros et al. (2016) explained that the process of determining which practices add value to the delivery of primary care is achieved by considering both external and internal perspectives. For example, patients may value reduced phone time, whereas primary care

providers may value taking time to know all the information available during appointments. Leaders should identify the activities that contribute to quality because practices that do not fall in this realm are wasteful.

Streamlining the flow of activities and information by practice leaders follows identification of non-value and value-added operations. The streamlining activities will ensure smooth flow of services (Hudson et al., 2014). Using a pilot program will allow leaders to test the improved process for a specified period (Kaplan & Witkowski, 2014). Primary care leaders can use the pilot program to identify lessons learned and make changes to fit the intention of the process and improve quality.

Six Sigma Principles. The Six Sigma approach is a quality improvement management strategy that seeks to improve efficiency (Abdallah, 2014). While Lean strategies focus on process efficiency and waste reduction, the Six Sigma principles focus on reducing process variation (Basta et al., 2016; Ha et al., 2016). Proper use of the approach allows identifying and removing defects as well as minimizing variability in business processes (Basta et al., 2016). Six Sigma creates a unique infrastructure of persons within the primary care organization who are experts in improving quality and reducing waste.

Six Sigma improves the quality of primary care through analyzing practices and making changes. The initiative defines and measures process indicators, analyzes statistics, and develops the right method and plans based on the results acquired (Gavriloff et al., 2017; Young et al., 2017). For example, to improve coordination between physicians for primary care and diabetic specialists, the strategy will reduce

unnecessary appointments and time wasted on seeking specialists. Primary care leaders must ensure data analysis drives Six Sigma interventions.

Developing a quality improvement strategy is necessary for implementation success. Six Sigma has five principles to establish a quality improvement strategy for primary care (Abdallah, 2014; Basta et al., 2016). The principles are (a) define, (b) measure, (c) analyze, (d) improve, and (e) control, also known as the DMAIC roadmap. In, the *define* principle, health care managers identify the problem, define goals, and clarify boundaries (Improta et al., 2015). Specification of the necessary input required to enhance the quality of primary care is also specified.

After defining the process and outcome to be improved, leaders must track the primary care quality improvement performance of the practice by collecting data. Data collection in primary care can be captured using the electronic health record (Hudson et al., 2014). Other methods include surveys and observation. Once the data collection is complete, primary care leaders must analyze the data to obtain a baseline before initiating new processes. Reviewing the data first helps primary care leaders in identifying the problems and causes of the lack of quality of the practice.

Primary care leaders use the results of the data analysis to establish improvements to the practice. Improvement strategies may require different methodologies depending on the organization (Ha et al., 2016). However, by using the Six Sigma approach, leaders have a framework that will allow for prompt identification of the desired outcomes. Lee et al. (2016) demonstrated that success of a Six Sigma approach depends on the ability to obtain data, to process, and to provide results. The last principle is control, and it

involves monitoring improvements in primary care and taking appropriate measure to maintain the standard.

Quality Improvement Challenges in Primary Care

Primary health care systems face similar challenges throughout the United States. A primary concern of the health systems pertains to the ways of improving the quality of care delivered by general practitioners. Gauld et al. (2014) explained that policymakers have put in place quality outcome programs and strategies to enhance the quality of primary care. An example of such approaches is offering incentives to general practitioners if they meet the specified outcome metrics. The general practitioners may be awarded additional reimbursement if they manage to lower blood pressure of hypertensive patients to normal range. These programs have been successful in improving scores of specific metrics; however, it does not reflect the overall improvement in the general practitioners' quality of service (Doran, Maurer, & Ryan, 2017). The lack of reliable information to guide the implementers of quality care in gauging the relative quality of services related to primary care is also a concern. Consensus about what constitutes the best quality metrics for quality care is still low.

Primary care leaders also face challenges when integrating primary care with the rest of the health care system. General practitioners act as the gatekeepers of health systems and are typically required to coordinate with other departments delivering care to patients (Greenfield et al., 2016; Hickner et al., 2014). Gatekeeping policies balance clinical needs, patient choice, and system constraints. Despite the role of the general practitioners in connecting with other health providers, few health systems have such a

channel of communication that would enable the general practitioners to deliver care efficiently.

Health care organizations do not always need change as some result in unnecessary or adverse effects (Kouzes, Posner, & Morgan, 2014). The staff has to spend a great deal of energy and time in implementing unnecessary change that lacks their interest. For this reason, the leaders should have well calculated and designed plan for change to avoid such result **(**Baker, 2001). It is also important to foster the right culture in health organizations to ensure that the staff and the team offer respected, kind, and high-quality medical services. Eckert et al. (2014) found that culture-sensitive leadership sets the basis for collective leadership. Leaders should be able to identify and develop modeling behaviors, supporting investments, accurate feedback, timely shared responsibility, developing the individual and team coaching, evidence-based assessment, engaging all levels of staff and establishing vision and trust.

Change is not always welcome. Not a single type of leadership or process can overcome all barriers in its implementation (Belias & Koustelios, 2014; Lines, Sullivan, Smithwick, & Mischung, 2015). Therefore, an organization needs to identify which process works best for it. Kotter's eight-step process can formulate a well-designed plan, integrate improvement, assess performance, communicate, and empower the staff and develop efficient strategies. By having an abled leadership culture, change implementation can ensure that services are of high quality and reduced waste in primary health care organizations.

Transition

Section 1 contained a discussion of the historical background and the problem statement. In the purpose of the study, I provided information on how the study could affect the implementation of quality improvement initiatives in a primary care setting. Section 1 also contains information on the research questions, the significance of the study, and the qualitative nature of the study. Additionally, I provided an in-depth review of the professional and academic literature to include the conceptual framework utilized as the lens for review of the data collected.

Section 2 includes an introduction to the qualitative method and research design selected for the study and the criteria for the participant population and sampling. The ethical research techniques encompassed the process to acquire participants' consent, instructions to withdraw from the study, and methods to protect the data over a required timeframe. In addition, I discussed my role as a researcher, procedures for data collection, reliability, validity, and data analysis.

Section 2: The Project

Section 1 contained evidence that leaders of primary care facilities require implementation strategies for quality improvement initiatives. Section 2 comprises the project plan of the study, and it begins with a restatement of the purpose of the study. The plan also includes the research method and design, and the role of the researcher. In addition, Section 2 contains a discussion of research methods, data collection, analysis, and validity and reliability.

Purpose Statement

The purpose of this qualitative multiple case study was to explore strategies primary care leaders use for implementing quality improvement initiatives to improve patient outcomes and reduce waste in primary care facilities. The target population consisted of health care leaders of three primary care facilities in Southern California who successfully implemented quality improvement initiatives. The implications for positive social change include the potential to develop strategies that primary care leaders may use to implement quality improvement initiatives to increase efficiency, reduce health care cost, and improve patients and community health.

Role of the Researcher

My role as a researcher was to act as the primary data collection instrument. In this role, I collected the data using semistructured interviews. I conducted the interviews using open-ended questions. To conduct the interviews, I utilized an interview protocol to have consistency during each interview. According to Yin (2017), interview protocols allow researchers to question participants in a systematic and comprehensive manner. In

addition, researchers can use interview protocols to develop a conversation within a subject area in a conversation style (Yin, 2017).

As a researcher, I must be transparent regarding my experience with the research topic to alleviate personal bias. Presently, I work in the health care field as an administrator. In my current role, I work as a fiscal officer of a medium size federal hospital. My relationship to the research topic is by working in the health care field. In addition, Chapman, Kaatz, and Carnes (2013) stated that researchers mitigate bias by documenting them in the study. Besides using a qualitative data analysis software, I also utilized bracketing, triangulation, and member checking to mitigate my bias.

According to Anneli, Kiikkala, and Astedt-Kurki (2015), a researcher may alleviate bias by recognizing preconceived notions about the research topic, which is also known as bracketing. Dempsey, Dowling, Larkin, and Murphy (2016) explained that bracketing allows the researchers to set aside their understandings and assumptions in an effort to allow the phenomenon to speak. The second tool previously mentioned, triangulation, assisted me in analyzing data from more than one source. To facilitate that analysis, I collected additional documents from the facilities to gather information on the primary care quality core measures. Lastly, member checking is a technique to enhance the validity of the study by sharing a summary of the initial interpretations with the participants (Elo et al., 2014). I used this technique to identify misinterpretations.

The Belmont Report provides researchers ethical standards for conducting research studies. Those standards include respect for persons, beneficence, and justice (U.S. Department of Health and Human Services, 2016). Following the Belmont Report,

I maintained the confidentiality of participant responses and anonymity of the study findings. Additionally, because the participants were voluntary, they were able to withdraw from the study at any time they desired. Celie and Prager (2015) explained how the Institutional Review Board (IRB) upholds the moral scope of research; therefore, I supported beneficence and justice by ensuring I received IRB approval before I contacted the participants of the study. The IRB approval number was 06-25-18-0473892.

Participants

Selecting the appropriate participants is an important step in qualitative research (Palinkas et al., 2015). Yin (2017) described the importance of developing eligibility criteria to identify participants that have the proper experience and knowledge to answer the research question. According to Conte (2014), utilizing participants who meet the eligibility criteria assists researchers in producing a trustworthy research study. For this study, I conducted a semistructured interview with a senior health care manager from each of the primary care facilities. The eligibility criteria for the senior health care manager consisted of (a) being 21 years of age or older, (b) being employed by a primary care facility in Southern California, and (c) having experience with successful implementation of quality improvement initiatives in primary care.

Gaining access to participants may appear as an easy task; however, Peticca-Harris, DeGama, and Elias (2016) discussed the difficulties of securing participants for dissertation studies. To alleviate some of those challenges, I utilized publicly available information from the Internet and company websites to identify senior health care

managers that have implemented successful quality improvement initiatives. According to Gagnon, Jacob, and McCabe (2015), building a relationship with participants allows researchers to acquire more in-depth data. Therefore, I requested their participation through email invitations and built relationships through constant communication to provide additional details of the study.

Research Method and Design

Research Method

Using a qualitative research method for this study provided me the opportunity to explore strategies health care leaders use to implement primary care quality improvement initiatives. Researchers use qualitative methods when they require extensive understanding of consumer attitudes, behavior and motivations (Barnham, 2015). The goal of qualitative research is to capture and communicate participants' experiences through observation and interviews (Yin, 2017). Therefore, it was appropriate to use this method of research for the study. I rejected a quantitative approach because I was not testing a hypothesis. Park and Park (2016) and Barnham (2015) described how quantitative research explains occurrences based on numerical data and hypothesis generation and testing. In addition, mixed methods research includes a quantitative element, which made this method of research inappropriate for the study.

Research Design

Barnham (2015) described several types of qualitative research designs, and for this study, I considered: a) ethnographic, b) phenomenological, and c) case study designs. An ethnographic study was not appropriate for this study because it focuses on exploring

the culture of a group within their specific environment (Renedo & Marston, 2015), and that was not the intent of this study. I also rejected a phenomenological design because the intent was not to inquire about people's perspective of a situation. Tumele (2015) utilized case study design to explore in detail a program, event, or process and develop historical explanations that can be generalized to explain other events. A case study was appropriate for this study because it allowed me to explore successful strategies utilized by primary care leaders during the implementation of quality improvement initiatives.

To achieve data saturation, researchers must reach a point of conceptual depth that allows them to theorize (Nelson, 2016). Although the number of participants in my study was limited to three primary care facilities, I utilized participants who had the breadth of knowledge and experience to address the research questions. In addition, I continued to review documents until no new themes emerged from the study data.

Population and Sampling

Researchers conducting qualitative research use purposeful sampling to identify participants rich in information (Palinkas et al., 2015). Elo et al. (2014) and Malterud, Siersma, and Guassora (2015) explained that sample sizes for qualitative studies could be small when the study aim is narrow, and the analysis includes longitudinal in-depth exploration. Nelson (2016) added that sample size should not focus on the number of participants, but in the depth of the data; therefore, I emphasized on the concept of data saturation. Nelson (2016) described data saturation as the point where no additional themes emerge from the data. I used this concept as a tool to determine if there was a need for additional participants for the study.

Current guidelines for thematic analysis in qualitative research suggest a sample of two to 10 participants for finding sufficient themes of the desired prevalence (Fugard & Potts, 2015). The population of this study consisted of three senior health care managers from primary care facilities in Southern California who have successfully implemented quality improvement initiatives. The eligibility criteria for the senior health care manager consisted of (a) being 21 years of age or older, (b) being employed by a primary care facility in Southern California, and (c) having experience with successful implementation of quality improvement initiatives in primary care. Morse, Lowery, and Steury (2014) described how purposive sampling provides an opportunity to select participants who meet the criteria to answer the interview questions. Elo et al. (2014) also added that researchers interested in participants who have the most knowledge on the research topic could use purposive sampling. Utilizing purposive sampling was appropriate for this study because I selected a specific group of participants to seek specific knowledge.

I sent email invitations to prospective participants. Once the potential participants responded with interest in the study, I made appointments to conduct the semistructured interviews. The interview location and space play an important role in the research process, and it requires critical reflection from the researcher (Gagnon et al., 2015). I conducted the interview where the participant felt comfortable and was able to focus on the interview questions.

Ethical Research

Researchers utilizing human participants in research studies must comply with ethical rules and regulations (Abernethy et al., 2014). The Belmont Report provides researchers ethical standards for conducting research studies, and the standards include respect for persons, beneficence, and justice (U.S. Department of Health and Human Services, 2016). The IRB ensures that research studies do not put participants at undue risk and that participants give their informed consent (Abernethy et al., 2014). Before I contacted the participants and collected data for the study, I sought IRB approval to meet the board guidelines and comply with the Belmont Report ethical standards. Once I received IRB approval, I contacted the participants by email. The IRB approval number was 06-25-18-0473892. Participants then signed the informed consent indicating their agreement to participate in the study.

Aaltonen (2017) discussed ethical reasons for seeking informed consent from the participants. To start collecting data, I pursued gaining informed consent from each of the participants of the study. According to Tam et al. (2015), the informed consent should include information such as the purpose of the study, voluntary participation, confidentiality, and the freedom to withdraw at any time. I met with each participant to explain the components of the informed consent and got the participant's signature. Abernethy et al. (2014) also stated that the informed consent must explicitly state that participants may withdraw from the study at any time. During my meeting with the participants, I explained that withdrawal from the study may occur at any time during the

study through email, phone, or in person. I also informed them that they were not receiving compensation for their participation in the study.

Confidentiality or anonymity minimizes risks to participants of research studies (Vitak, Shilton, & Ashktorab, 2016). To preserve the confidentiality of the participants, researchers suggest utilizing pseudonyms or false names throughout the study (Allen & Wiles, 2015). Allen and Wiles (2015) discussed various methods to assign pseudonyms for each participant. I used alphanumeric codes such as P1, P2, and P3 to maintain confidentiality and abide by ethical standards. I am the only person able to connect the codes to the identities of the participants. I retained the electronic documents from the interviews in password protected files on my computer. All the paperwork that I gathered during the study will remain in a locked cabinet in my home office. I will destroy the electronic files and shred the documents 5 years after completion of the study as required by Walden University.

Data Collection Instruments

Data collection may include one-to-one interviews, focus group studies, mail surveys, and audiotaped interviews (Sutton & Austin, 2015). According to Doody and Noonan (2013), structured interviews are the most common types of interviews in qualitative studies. Because I was the primary data collection instrument, I conducted semistructured interviews (Appendix A) that consisted of nine open ended questions to guide the interviews. All responses were audio recorded for documentation purposes. Using open-ended questions allows the participants to explain their experience and how the world makes sense around them (Barnham, 2015). In addition, open-ended questions

permit researchers to present the participants' experiences without predetermined standpoints.

Asking participants the same set of questions promotes consistency and increases reliability and validity of the study (Barnham, 2015). I asked the same open-ended questions about implementation strategies that senior health care managers need for quality improvement initiatives to each of the participants. I also obtained documents from the participants after they signed the informed consent and document release form. The documents were related to communication of the quality improvement initiative in the organization.

Barnham (2015) stated that techniques for producing data affect the credibility of a qualitative study. Member checking is one of those techniques, and it is used to share a summary of the initial interpretations of the data collected with the participant to identify misinterpretations (Elo et al., 2014). I completed the summary of the audio records, and then provided the documents within 1 week of the interview to the participants for easy recollection of the interview.

Data Collection Technique

Semistructured interviews are the most common type of interviews, and they involve using predetermined questions (Doody & Noonan, 2013). Conducting this type of interview has advantages for data collection. First, researchers can be flexible and use open-ended questions for data saturation. In addition, interviewers can ask additional questions if a new path not initially considered emerges during the interview (Doody & Noonan, 2013). A clear disadvantage of conducting face-to-face interviews is that

researchers may encounter difficulties scheduling a time that is beneficial for all. For this study, I conducted semistructured interviews to collect data from health care managers. Sutton and Austin (2015) recommended researchers audio record interviews to transcribe recordings verbatim; therefore, I also audio recorded each of the interviews for the study.

To arrange the interviews, I obtained contact information of health care managers via publicly available information through company's website. I contacted those health care managers, and I scheduled the interviews when they agreed to participate. I chose a convenient date, time, and location for the participants, and I requested for a minimum of 60 minutes to complete the interview. The interview protocol (Appendix A) guided the interview. Elo et al. (2014) stated that member checking enhances validity and trustworthiness of the study. Once the transcription was complete, I utilized member checking for this study.

Triangulation involves utilizing multiple methods to collect and analyze data, and an advantage of this method is that it enhances the reliability of results (Fusch & Ness, 2015). Fusch and Ness (2015) argued that researchers are unable to capture all the important data from one single method; however, it is important to understand that a disadvantage of triangulation is that it may also provide conflicting results or information. I requested documents from the participants who did consent to release documents. Correlating the data from multiple sources ensured data was rich in depth.

Data Organization Technique

Confidentiality is essential to minimize the risk of participants (Vitak et al., 2016). Allen and Wiles (2015) suggested using pseudonyms or false names throughout

the study to preserve anonymity. Therefore, I used alphanumeric codes to abide by ethical standards. The codes I used were P1, P2, and P3 since there were three participants. I also ensured the participants did not use their name during the audio recorded sessions of the interviews to maintain confidentiality. In addition, I created a file for each participant to keep his or her informed consent, interview transcripts, and any other documentation.

I utilized Microsoft Office to transcribe the interviews and organize and label the data using the pseudonym. The data went into NVivo data analysis software to summarize the data by developing themes and categories for data organization. The data will remain secure on a password protected laptop computer and a private cloud data storage account accessible only to the researcher. As required by Walden University, the data will stay secure for five years. After the five year requirement expires, the paper and electronic documents will be destroyed or erased.

Data Analysis

This study involved various sources of data, which included interviews and documents from participating organizations. Fusch and Ness (2015) described how data triangulation requires using multiple sources of data to enhance confidence and reliability in the results of the study. The four types of triangulation are (a) data triangulation, (b) investigator triangulation, (c) theory triangulation, and (d) methodological triangulation (Joslin & Müller, 2016). Data triangulation refers to utilizing multiple sources during the study, and these sources may vary depending on location and time of collection (Fusch & Ness, 2015; Joslin & Müller, 2016). Investigator triangulation is using at least more than

one person in the data gathering and analysis process (Fusch & Ness, 2015). The third type, theory triangulation, refers to approaching the data with several theories in mind to increase the opportunities to produce additional knowledge (Fusch & Ness, 2015; Turner, Cardinal, & Burton, 2017). The last and most commonly used type of data triangulation is methodological triangulation (Joslin & Müller, 2016). Methodological triangulation allows researchers to use multiple approaches to analyze a research problem. Two categories of the methodological triangulation are (a) within-method triangulation and (b) across- or between-method triangulation (Joslin & Müller, 2016; Turner et al., 2017). For this study, I utilized a methodological triangulation to analyze data collected from interviews and company documentation.

The five phases of data analysis in qualitative studies include compiling, disassembling, reassembling, interpreting and concluding (Essary, 2014; Santos & Baptista, 2016; Tuapawa, 2017). Essary (2014) suggested compiling the data immediately after the interview to ensure participants can clarify information if necessary. Once I compiled the data, I disassembled or broke down the data into smaller pieces. According to Tuapawa (2017), themes emerge from keywords and patterns when researchers disassemble the data. In the reassembling stage, researchers identify themes and patterns (Essary, 2014). After identification of themes for coding, I completed the data interpretation and engaged the participants to conduct member checking. According to Elo et al. (2014), member checking is the process of reviewing the summary of the data interpretation. I used member checking to ensure I derived appropriate meaning.

According to Zamawe (2015), qualitative studies generate an extensive amount of data in the form of text; therefore, it is important to be aware of Computer Assisted Qualitative Data Analysis Software (CAQDAS). The data analysis package I used for this study was NVivo. CAQDAS helps researchers reduce the amount of time and labor due to its ability to manage sizable transcripts and ease for coding, adding notes, and removing data (Cope, 2014a). Using NVivo helped the researcher stay organized and focused on the research question.

I grouped the data by identifying recurring words or phrases, and I developed codes by arranging responses and company documents into themes of similar phrases or ideas. I continued by interpreting the data and validating the interpretations through member checking. The data interpretation identified central themes and ensured alignment with the conceptual framework. I analyzed the data through the lens of Kotter's eight-step process of change theory.

Reliability and Validity

Results from research must be credible and generate useful learning. Trustworthiness and quality of the study increase when researchers adhere to sound methodological practice (Leung, 2015; Nelson, 2016). In addition, trustworthiness during the data collection process is essential for reliability. The four criteria to establish the trustworthiness and rigor of a study are dependability, credibility, transferability, and confirmability (Houghton, Casey, Shaw, & Murphy, 2013).

Reliability

Dependability. Dependability establishes the study as repeatable and consistent, which allows researchers to replicate the results. Houghton et al. (2013) compared dependability to the concept of reliability and described it as how stable the data are. According to Noble and Smith (2015), consistency during the semistructured interview improves the credibility of the study. Therefore, I ensured dependability of the study by asking each participant the same set of questions in order.

Validity

Credibility. Houghton et al. (2013) established that conducting research in a believable manner establishes credibility. They also explained how using member checking addresses the credibility of the interpretation. Member checking is a process of asking participants to review the interpretations to ensure the researcher captured the intent of the responses. This technique refers to the process when the researcher provides a summary of themes and requests feedback from the participants. Participants validate the information if the researcher interprets the data correctly (Cope, 2014b). As a way to ensure credibility, I used the member checking technique to verify the accuracy of the responses.

Transferability. Transferability allows findings to be transferred to a similar situation or setting (Houghton et al., 2013). Researchers must provide detailed descriptions of the original context of the research to allow readers to make informed decisions about the transferability of the study (Houghton et al., 2013). I included rich

details of the context of this study so that readers can determine if the results are transferable.

Confirmability. Confirmability refers to the accuracy of the data. Noble and Smith (2015) also referred to confirmability as neutrality. The process of establishing confirmability assimilates the process to establish dependability of the study (Houghton et al., 2013). I utilized member checking in this study to enhance confirmability.

Data saturation occurs when no new themes materialize from the interview (Nelson, 2016). Malterud et al. (2016) discussed the impact of sample sizes in qualitative research. Researchers can achieve data saturation with the least number of participants when the study aim and dialogue with the participants is strong (Malterud et al., 2016). In addition, Nelson (2016) explained the importance of utilizing participants that have extensive knowledge to address the research question. I continued the interviews until no new themes emerged, and I achieved data saturation.

Transition and Summary

Section 2 encompassed a description of the research method and research design. In this section, I discussed the population and sampling, data collection instrument, data collection procedures, and data analysis utilized for this study. In section 3, I will focus on presenting the study results and recommendations. I will include a discussion of the presentation of the findings, applications to professional practice, implications for social change, and recommendations for further research.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative multiple case study was to explore strategies primary care leaders use for implementing quality improvement initiatives to improve patient outcomes and reduce waste in primary care facilities. According to Nuckols et al. (2017) and Snowden et al. (2017), researchers studied quality improvement initiatives in various types of health care organizations; however, in this study, I focused on quality improvement initiatives in primary care facilities in Southern California. I collected data by conducting semistructured face-to-face interviews with three health care managers from three different primary care facilities. I applied qualitative data analysis to the transcripts and document review to address the overarching research question. Using methodological triangulation, four major themes emerged from the data analysis process. The themes identified were (a) communication, (b) leadership engagement, (c) inclusive decision-making, and (d) recognition.

Presentation of the Findings

The principal research question that guided the study was: What strategies do some primary care leaders use for implementing quality improvement initiatives to improve patient outcomes and reduce waste in primary care facilities? I recorded and transcribed interviews with three senior health care managers from primary care facilities in Southern California. Participants had experience implementing quality improvement initiatives. I derived the findings from the data analysis of interviews and document review. I used Microsoft Word to transcribe the audio-recorded data and organize the

data. I accessed a public website containing HEDIS data for review of quality scores for each of the primary care facilities compared to national averages. I used NVivo data analysis software to organize and analyze the data.

Table 1 is a description of the sample. The health care managers participating in this multiple case study had a range in length of health care leadership experience between 3 and 19 years in duration. I used the codes P1 to P3 to mask the participants' identities in the order I completed the interviews as demonstrated in Table 1. Throughout the data collection and data analysis phase of the research, I used Microsoft Word and NVivo computer software to assist in data organization and data analysis, using the participants' codes instead of real names in the data to maintain confidentiality.

Table 1

Description of Sample and Participants Codes

Participants	Years as health care leader
Participant 1	19
Participant 2	18
Participant 3	3

The subsections below include detailed information regarding how the four major themes emerged from the data triangulation of the interviews and documents review. Data analysis involved the identification of the common key terms that represented patterns among the qualitative data. Table 2 contains a summary of the main key terms that formed patterns for the major themes. These major themes provide answers to the research question and relate to the successful implementation of quality improvement initiatives in primary care.

Table 2

Thematic Data Groups

Major Themes	Key Terms of Phrases
Theme 1: Communication	meeting, call, information, communication, face-to-face, email
Theme 2: Leadership Support	lead, champion, management, accountable, authority
Theme 3: Inclusive Decision-Making	team, staff, involved, feedback, roles, providers, contribute
Theme 4: Employee Recognition	accolades, recognize

Emergent Theme 1: Communication

Communication emerged as a theme from the semistructured interviews and documents provided by the participants. The data analysis of the interviews revealed that communication is an important component of implementing quality improvement initiatives. Baxter et al. (2016) discussed how developing effective horizontal and vertical communication pathways prior to change implementation promote team collaboration, effectiveness, and efficiency. Table 3 includes the key terms participants used to refer to communication. Participants mentioned communication key terms a total of 99 times during the interviews.

Table 3

References to Communication

Reference	Frequency
Meeting	34
Call	27
Information	12
Communication	11
Email	8
Face-to-face	7

Participants described vertical communication as a key element of successful quality improvement implementation. Saruhan (2014) explained that vertical communication flows downward or upward. Downward communication was the first type described by participants because leaders informed the employees of the change and shared the importance of the initiative. P1 stated that it was imperative to success to have a face-to-face meeting with employees for the first notification of change. P1 also noted that a follow-up email summarizing the meeting and restating the importance of the change contributed to successful implementation of the quality improvement initiative. P2 and P3 shared similar information regarding kickoff meetings. P2 stressed the importance of having face-to-face communication with the employees, and then following up with email communication. P3 shared organizational documents where the communications plan for the quality improvement initiative included an initial face-to-face meeting and follow up emails summarizing the meeting and discussing the way forward.

Upward communication is another type of vertical communication, and participants shared various examples of how it made implementation successful. P1 explained that during meetings, leaders encouraged staff to share information with leadership to make decisions based on their inputs. P1 also stated that expert deference was also important because employees are the most knowledgeable in their respective areas; therefore, leaders needed to listen to employees' input and make decisions based on the feedback from the experts. P2 stated that upward communication played an integral role to success in their quality improvement initiative because one of the team members was a provider. Seeing the provider give input and feedback to senior leadership encouraged other team members to participate.

Horizontal communication emerged as a type of communication necessary for a successful quality improvement initiative. Saruhan (2014) explained that horizontal communication occurs when employees on the same level communicate with each other. P3 conveyed that communication among team members is extremely important for success. During the interview, P3 shared that horizontal communication motivated team members to contribute to success because discussion generated a sense of competition because employees did not want to be outperformed by their peers.

The findings outlined in Theme 1 tie directly to the conceptual framework of this study. Kotter (1995) described the importance of communication for successful change in steps one and four of the eight step model of change management. In step one, Kotter (1995) explained how leaders must make a concerted effort to earn employee buy-in. Leaders of the participating primary care facilities were able to get employee buy-in by

conducting face-to-face meetings to kick off the quality improvement initiative. In addition, step three of the conceptual framework encourages leaders to find the most effective methods to communicate the change to the employees. All participants shared that vertical and horizontal communication is necessary for effective quality improvement initiatives.

Emergent Theme 2: Leadership Support

The second theme that emerged from the data analysis indicated that leadership support is an imperative consideration for successful quality improvement initiatives. All participants referenced the support of the organizational leaders during the interviews. Table 4 displays the number of times participants cited leadership support during the interviews. Key terms describing leadership support appeared 34 times in the data analysis.

Table 4

References to Leadership Support

Reference	Frequency
Lead	14
Management	9
Champion	8
Authority	2
Accountable	1

Participants expressed how leadership support is necessary during several steps of the quality improvement initiative. Silver et al. (2016) found that leadership support for quality improvement projects was a contextual factor influencing project outcome. Assigning leadership support to quality improvement projects is necessary for success

(Silver et al., 2016). P3 attributed part of their successful initiative to the assignment of a sponsor from the c-suite. P2 also had a c-suite sponsor to the project; however, the participant found that mid-level managers provided more support during their initiative since their initiative was central to their clinic.

Two of the participants referenced leadership helping remove barriers during the quality improvement initiative. Silver et al. (2016) confirmed that leadership support helps remove barriers during quality improvement. For example, P2 stated that during their quality improvement initiative, they had a staffing shortfall. Leaders were supportive and did not use the shortage as an excuse to not improve quality, which ultimately led to a successful initiative. P1 also shared the facility's experience with leadership support, which included having all the leaders of the clinic participate in the meetings related to quality improvement. P1 said that leaders made a concerted effort to be at every meeting to remove barriers and acquire outside support when needed.

Leadership support increased commitment from employees at each of the participating facilities. Rogiest, Segers, and van Witteloostuijn (2018) and van der Voet (2016) explained that leadership support is an important lever to increase commitment during change. P3 cited increased staff commitment to the quality improvement initiative when the leaders provided support with removing barriers to success. The participant explained that after listening to recommendations from the team to get additional laptops to support the project, leaders immediately responded by getting the needed equipment for the initiative. P2 also disclosed increased commitment from team members when

leaders appointed a project champion that was determined to make the initiative a success.

The findings based on the experiences of the participants are consistent with the conceptual framework. Kotter (1995) discussed leadership support extensively in step two of the model of change management. Kotter (1995) explained that leadership is the focus of the team and must be visible in supporting the people of the organization. However, leadership support alone may result in failure. Team members must form a coalition and develop a shared commitment to success.

Emergent Theme 3: Inclusive Decision-Making

Data analysis from the interviews revealed inclusive decision-making as the third theme of the research study. Inclusive decision-making refers to employees having input regarding proposed change (Rogiest et al., 2018). Table 5 shows that Theme 3 was the most notable theme of the findings. Participants mentioned key terms of the theme in 124 instances.

Table 5

References to Inclusive Decision-Making

Reference	Frequency
Team	61
Staff	40
Involved	12
Roles	8
Participant	3

All participants noted the relevance of inclusive decision-making during the interviews. This finding aligns with a research proposed by Abrams et al. (2015), which

considered inclusive decision-making as a quality benchmark. P1 recognized inclusive decision-making as a priority for success of quality improvement initiatives when discussing input on data and possible solutions to problems. P1 stated that during the initial meeting it is helpful to include as many employees as possible even if they are not directly involved with the initiative because that allows everyone to be informed on the need for urgency on the matter and the upcoming changes. P2 also mentioned during the interview that it was imperative to have brainstorming sessions where employees provide input.

When employees have the opportunity to map out the current reality and desired outcomes, leaders encourage participation and inclusiveness in the decision to make changes. Rogiest et al. (2018) explored the need for participation and explained that workers involved in constructing the change influence outcomes. Additionally, participation allows employees to voice concerns and provide input. Ultimately participation creates a sense of fairness and respect (Rogiest et al., 2018). P1 referred to inclusive decision-making and participation as an opportunity to empower employees and make them feel invested in the initiative. P3 added that employees are often the subject matter experts; therefore, participation is essential for success of the initiative.

Theme 3 aligns with the conceptual framework of this research study. Inclusive decision-making was a fundamental discussion in steps one and four of Kotter's eight step model of change. According to Eckert et al. (2014), primary care leaders must embrace inclusive decision-making when improving the health care quality because it drives staff members to help achieve high quality care. Drupsteen, van der Vaart, and

Van Donk (2016) added that leadership should have the right people and sufficient trust to improve the decision-making process. Leaders must also make an effort to retain high-performing staff members.

Emergent Theme 4: Employee Recognition

Employee recognition emerged as the fourth theme of the data analysis. When an organization makes an effort to reward and recognize employees, the employees reciprocate by fully engaging in their roles and responsibilities (Downey, van der Werff, Thomas, & Plaut, 2015). Table 6 demonstrates that participants cited key terms of Theme 4 a total of 11 times. All participants discussed this theme during their interviews.

Table 6

References to Employee Recognition

Reference	Frequency
Accolades	4
Recognize	7

Staff recognition is a tool leadership can use to increase staff engagement during quality improvement initiatives. As noted by many researchers, employee recognition affects job satisfaction and commitment to the organization (Ramdhani, Ramdhani, & Ainisyifa, 2017). Data analysis from the interviews aligns with previous research as it demonstrated the importance of employee recognition for successful change. P1 stated that it was important to recognize staff in public because it motivated other staff members to become high performers as well. P2 acknowledged the importance of staff recognition

by attesting that employees who received a monetary reward stayed motivated to see the initiative be successful. Document review from P3 also had examples of staff recognition. Email communication from leaders had acknowledgements to staff members whose performance was distinguishable.

Another aspect of employee recognition discussed during the interviews was the form of recognition or reward. Rewards and recognition take many forms, and leaders must ensure that the program is in line with the goals and objectives of the facility (Bakotić & Rogošić, 2017). Kosfeld, Neckermann, and Yang (2017) presented two types of employee recognition: (a) financial incentives, and (b) nonfinancial incentives. According to P2, financial incentives played a key role in the success of their initiative. The team champion remained motivated to ensure the project was a success after receiving a monetary reward for performance. P1 and P3 discussed nonfinancial incentives during their interviews. P1 enjoyed recognizing staff during meetings by just thanking them in public. Doing that encouraged the rest of the staff to perform to their potential. P3 provided a document that contained an email from organizational leaders recognizing specific team members for completing a quality improvement project. The email was sent to the entire organization.

The data analysis findings emerged from the participants' interviews and documents. The findings also align with the conceptual framework. Step eight of Kotter's model of change is to cultivate a culture of change, which portrays a notion that reward and recognition policies should incentivize good behavior (Kotter, 1995). Bakotić and Rogošić (2017) added the importance of using recognition to support the

objectives of the organization. It is evident from the findings that each participating organization used some type of recognition to motivate staff members and increase commitment to the quality improvement initiative.

Applications to Professional Practice

The analysis of the data presented from this study reduces the knowledge gap of primary care leaders on improving quality measures. According to Almorsy and Khalifa (2016), the cost of health care continues to rise at an alarming rate due to operational inefficiencies and waste. Lee et al. (2016) added that the cost of health care is related to quality. A demand for primary care leaders to improve patient outcomes and reduce waste is evident as external pressures such as the Affordable Care Act proliferate attempts to contain cost (Fleming et al., 2017). This research provides successful strategies for implementing quality improvement initiatives in primary care facilities. The results of the data analysis from this study provide insightful information for primary care leaders to implement initiatives that improve patient outcomes and reduce waste in primary care facilities. The findings are applicable within the health care environment. McFadden, Stock, and Gowen (2015) also explained the relationship between improving quality, reducing waste, and increasing patient safety, which is an urgent national concern due to unnecessary errors and high cost. This study offers primary care leaders an opportunity to make a significant positive impact increasing patient safety and reducing health care costs by using the strategies identified by participants to improve quality and reduce waste.

Implications for Social Change

This study contributes to positive social change in any primary care facility. McFadden et al. (2015) described the need that exists in health care organizations to improve quality, efficiency, and safety. The findings of this research might affect social change by increasing health care leaders' ability to develop strategies to successfully implement quality improvement initiatives in primary care facilities. The implications for positive social change include improving primary care practice, which benefits the community by providing access to affordable care to those in need. Implementation of quality improvement initiatives is in the best interest of the patient because it reduces negligible waste from inefficiencies, overuse, and preventable harm.

Recommendations for Action

Current and future primary care leaders may consider recommendations based on this research study to assist with implementing quality improvement initiatives geared toward improving patient outcomes and reducing waste. The study findings indicate that action steps could be beneficial when using innovative models of care to provide quality care in primary care settings. The recommendations flow logically from the conclusions and contain several action steps that leaders may incorporate in their efforts to improve quality of care. The recommendations for action are the following: (a) communicate the purpose of the initiative and its value toward quality improvement, (b) establish a leadership presence to show support and remove barriers, (c) institute inclusive decision-making through input and feedback, and (d) employ a rewards and recognition program that aligns with the objectives of the organization.

The first recommendation of this research is to communicate the purpose of the initiative and its value toward quality improvement. The importance of vertical and horizontal communication was evident in the findings. Participants also expressed the urge to use downward and upward communication in the organization. By using different communication techniques, participants were successful at implementing quality improvement initiatives.

The second recommendation is to establish a leadership presence to show support and remove barriers. All the participants cited the need for leaders to be present and assist employees with removing barriers that could jeopardize success of the initiative. Barriers discussed by participants included staffing shortages and support needed from other areas not involved in the initiative. Leadership support also increased employee commitment to the initiative and the organization.

Inclusive decision-making through input and feedback emerged as the third recommendation. Brainstorming sessions helped leaders encourage input from the employees. Additionally, including employees in the process of constructing the change and giving them opportunities to express concerns influenced outcomes of the initiative. Employee inclusion when making decisions surfaced as an integral part of quality improvement initiative success.

The last recommendation is to employ a rewards and recognition program that aligns with the objectives of the organization. Each participant shared their experience with rewards and recognitions and noted the importance of having a program. Two types of rewards that materialized from the findings were financial and nonfinancial rewards.

Rewards and recognition of employees was imperative to success of the quality improvement initiative.

Dissemination of the results of this study will occur through various methods. I will provide a compilation of the results to the leadership of the primary care facilities that participated in this study as well as within my own health care organization. I will publish the results through the ProQuest/UMI dissertation database, which will be available to colleges and universities across the country. Additionally, I will seek opportunities to present the findings through training sessions, annual conventions, and conferences to disperse the results at a local and national level.

Recommendations for Further Research

The purpose of this qualitative multiple case study was to explore strategies primary care leaders use for implementing quality improvement initiatives to improve patient outcomes and reduce waste in primary care facilities. The population consisted of health care leaders of three primary care facilities in Southern California who successfully implemented quality improvement initiatives. Helmich et al. (2015) described how limitations are weaknesses of the study. There were two limitations identified in this study that could be addressed with further research. They include the sample size and transferability to other industries.

According to the California Health and Human Services (2018), there are 1,359 primary care clinics in the state. Since I included only three primary care facilities, adjusting the sample size for a larger number could impact the results. The study could have a different outcome by utilizing a larger sample size; therefore, the study warrants

additional research of sustainability strategies primary care leaders could use for improving quality and reducing waste. The study also focused on primary care leaders that implemented quality improvement initiatives. It may be beneficial to explore the perspective of executive leadership or other employees within the primary care realm regarding quality improvement and its effect on cost, quality, and care.

Researchers should follow this study with a quantitative research. Park and Park (2016) explained that qualitative studies play a crucial role in research discovery, and quantitative studies are excellent for justification of the findings. Conducting quantitative research may provide different implementation strategies of quality improvement initiatives. Understanding the frequency of the strategies discovered in this study such as communication or recognition may provide the potential correlation with outcomes.

Reflections

My journey at Walden University was lengthy since I endured two military moves, one deployment to the Middle East, and several other life events that required leave of absence. Despite many challenges throughout this process, completion of the program was possible with perseverance and consistency. As a health care administrator, I could have influenced the research approach and analysis of the data. I have easier access to potential participants compared to someone who has no relationship with health care. The reason for selecting these primary care facilities was that leaders implemented successful quality improvement initiatives that reduced waste and improved quality outcomes. To mitigate bias, I followed the interview protocol closely, and I conducted member checking with each participant to confirm the findings.

Prior to this research, I observed leaders in primary care settings fail in implementing quality improvement initiatives, which created a perception of lack of leadership strategies for successful implementation. During the study, my perception changed because health care leaders shared their success, which gave hope on decreasing the high incidence of failure when implementing change in health care. In addition, the participants shared valuable insight on the importance of how employees must understand their relationship to the mission and how to work together to achieve a common goal. This study was an eye-opening experience that also expanded my knowledge on critical-thinking and decision-making.

Conclusion

The purpose of this qualitative multiple case study was to explore strategies primary care leaders use for implementing quality improvement initiatives to improve patient outcomes and reduce waste in primary care facilities. I conducted semistructured interviews with three senior health care managers to collect data. I also conducted member checking to ensure the accuracy of the interpretation of the interviews. Additionally, I gathered documents from participants to perform methodological triangulation. Data saturation occurred when no new themes surfaced from the data. Data analysis revealed four major themes including: (a) communication, (b) leadership engagement, (c) inclusive decision-making, and (d) employee recognition. I aligned each theme to the existing body of knowledge and the conceptual framework, which was Kotter's eight step of change management. The study findings reveal that

implementation of quality improvement initiatives can improve quality and reduce waste in primary care facilities.

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Appendix: Interview Protocol

Date:

Interviewee:

Semistructured interview questions, and follow-up and probing questions focusing on the participants' experiences:

1. What has been your experience with implementing quality improvement initiatives?

2. What role did you play in the implementation of the quality improvement initiatives?

3. How did you communicate the change vision to employees?

4. Who was involved in the planning process for the quality improvement initiatives?

5. What steps did you follow when implementing the quality improvement initiatives?

6. What successful strategies did you use to implement quality improvement initiatives?

7. What strategies failed to meet the intended results, and why they were not successful in your opinion?

8. How did you overcome the challenges posed by those failed strategies?

9. What other comments or additional information would you like to add regarding strategies used to implement primary care transformation initiatives?