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Accounts Receivable Management Strategies to Ensure Timely Payments in Rural Clinics

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Walden University

College of Management and Technology

This is to certify that the doctoral study by

Anthony Natividad Medel

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2019

Abstract

Accounts Receivable Management Strategies to Ensure Timely Payments in Rural Clinics

by

Anthony Natividad Medel

MBA, University of Phoenix, 2005

BSHS, University of Phoenix, 2003

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

Walden University

April 2019

Abstract

Healthcare business leaders in a rural clinic setting can enhance profitability by implementing strategies to ensure timely payments. The purpose of this multiple case study was to examine strategies applied by healthcare leaders in rural clinics to improve profitability. The population included 10 rural clinic managers and billing staff from 5 rural clinics in the southwestern region of the United States. The conceptual framework for this study was Wernerfelt's resource-based value theory. Implementing Yin's multiple-step data analysis process, data from semistructured interviews were transcribed, coded, and analyzed to identify strategies used by rural clinic managers and billing staff to enhance profitability. Four primary themes emerged regarding revenue cycle management that could increase profitability, including developing effective communication between medical providers and billing staff, implementing payment plan strategies, ensuring accuracy of billing claims, and consistently reviewing open receivable accounts. The implications of this study for positive social change include insights for clinic managers in the development of strategies to increase cash from accounts receivables, which may contribute to the financial stability of the clinic and improve the provision of healthcare for citizens of the southwestern region of the United States.

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Dedication

I dedicate my study to my wife, Karen. You have been with me through every step of this process, and I could never thank you enough for standing by side in this process. I love you very much, and I look forward to sharing the rest of my life with you. To my children, Cheryl, Andrew, Kaitlan, and Alexander, for all of the times that I missed your activities. To my brothers and sister Steve, Manuel, Rene, and Christina, as the family is everything. Also, I dedicate this doctoral study to the memory of my parents Manuel Young and Clementina Natividad Medel for instilling in me a strong work ethic and a faith in God that can never be broken.

Acknowledgments

First, I thank God the Father Almighty for his guidance, and granting me the strength, patience, and perseverance to complete this educational journey. With God, all things are possible and I would not have made it without the strength and faith that His presence in my life.

I thank my family, friends, and coworkers for their support, encouragement, and listening to me throughout this process and providing uplifting words during the most difficult times in this process. Thank you to my maternal Aunts and Uncles as we have had some pass away during this time, but I have kept them all in my heart and blessed that they were a part of my life. Thank you to Dr. David E. Bealer (1955-2016), for a meeting we had back in 2016 and providing words of wisdom, encouragement, and support, your memory will not be forgotten.

Finally, I thank my Chair, Dr. Roger Mayer. You have worked with and assisted many doctoral graduates by providing your time, encouragement, and most of all support. Thank you for everything that you have done to help students reach their educational goals, and you came into my life at a time when I needed direction and you far exceeded this task. Also, thank you to my committee members Dr. Warren Lesser, Dr. Robert Hockin (1950-2019), Dr. Jill Murray, and Dr. Judith Blando for your feedback and dedication to help students place an emphasis on the quality of work produced. This has been an unforgettable journey, and I will be eternally grateful for all those who have been there for me along the way.

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Section 1: Foundation of the Study

Effective revenue cycle management in rural clinics is essential to their economic sustainability (Lubberink, Blok, van Ophem, & Omta, 2017). In the initial phase of a revenue cycle strategy, a healthcare organization summarizes potential revenue outlets based on the volume of patients and mix of insurance payers (Johnson & Garvin, 2017). Revenue, in the form of accounts receivable collection processes, of healthcare organizations are unlike most with other industries (Mindel & Mathiassen, 2015). Healthcare providers must deal with multiple payers and unique rules such as bundled payments, case-based payments, copayers, and contractual allowances (Hernandez, 2017). Healthcare managers must deal with payment delays, challenges by payers for services provided and unreimbursed services (Cascardo, 2015). Thus, healthcare clinic managers must develop strategies to address these revenue cycle challenges in order to obtain timely payments from patients and their insurance payers.

Background of the Problem

Developing an effective means to collect payment for health services rendered during a routine visit is a challenging task in the health care industry. Rural clinics that serve a high number of indigent patients would close without adequate reimbursement. The goal of the Medicaid program enacted in 1965 was to provide medical services to lower income individuals and families (Leemon, 2014). The passage of the Affordable Care Act (ACA) in 2010 became another form of health coverage introduced to the public. It provides health insurance to the uninsured, which constitutes approximately 27.3 million individuals or 8.6% of the population (United States Census Bureau, 2016).

Other forms of coverage or payment can include private pay insurance plans, direct payment, and a sliding fee scale based on one's ability to pay (Barbaresco, Courtemanche, & Qi, 2015). Clinic managers and financial support staff will benefit from successful strategies to obtain timely payment for medical services from patients, which relate to strategies for collecting accounts receivables.

Problem Statement

Rural clinic managers struggle to generate cash flow from unpaid patient accounts (Lail, Laird, McCall, Naretto, & York, 2016). Healthcare organizations spend roughly $26 billion on revenue cycle management addressing reimbursement and collection processes (Hayes, Subhan, & Lakatos, 2015). The general business problem was that healthcare leaders do not develop effective revenue cycle strategies and cash flow shortfalls may threaten the survival of the organization. The specific business problem was that some rural clinic managers lack strategies to obtain timely payments from patients and insurance payers.

Purpose Statement

The purpose of this qualitative multiple case study was to explore strategies rural clinic managers use to obtain timely payment from patients and insurance payers. Study subjects included clinic managers from five rural clinics in southwestern region of the United States who have incorporated strategies to obtain timely payment from patients and insurance payers. The implication for positive social change could come from insights for clinic managers when they develop strategies to increase cash from accounts

receivables, which may improve the financial stability of the clinic and increase the wellbeing of individuals in southwestern region of the United States.

Nature of the Study

The three research methods are qualitative, quantitative, and mixed methods (Denzin & Lincoln, 2011). Qualitative researchers gather in-depth data, discover the meaning of the unknown, and reconstruct stories of participants on a conceptual level (Guba & Lincoln, 1994). I have selected the qualitative methodology to recognize multifaceted comprehensive medical services performed in rural clinics. A quantitative researcher focuses on empirical evidence by using statistical processes (Petrescu & Lauer, 2017). A quantitative methodology was not an appropriate method, because I was not examining numeric data with statistical processes. The mixed methods methodology incorporates both quantitative and qualitative components (Polit & Beck, 2010). This was not a suitable choice, as I do not intend to incorporate statistical methods to explore my research question.

I considered four qualitative research designs, including (a) phenomenology, (b) ethnography, (c) narrative design, and (d) case study. Phenomenology researchers emphasize the meaning of participants' lived experiences (Moustakas, 1994). The phenomenology design was not appropriate for this study because my goal was not to explain the meaning of the participants' lived experiences. Ethnography researchers emphasize the meaning of the participants' expression of culture (Symons & Maggio, 2014). I do not propose to explore a participant's individual customs or culture and an ethnography design was not appropriate for this study. A narrative design provides the

researcher the opportunity to focus on the lives of individuals as told through their own stories (Denzin & Lincoln, 2011). I did not intend to focus on the lives of the participants through their own stories and rejected a narrative design for this study. I used a case study design to explore the research question as the case study approach allows the researcher to view the issue in a natural setting.

Research Question

What strategies do rural clinic managers use to obtain timely payments from patients and insurance payers?

Interview Questions

1. What strategies do you use to obtain timely payments from your patients and insurance payers?
2. What strategies do you use to collect from uninsured and underinsured patients?
3. What strategies do you use to manage doubtful accounts and bad debt?
4. What strategies does your organization use to ensure staff complete billing forms correctly with no errors that delay payments?
5. What techniques does your office staff use to collect copayment either before or after the patient visit?
6. How does the organization provide training to the billing staff to ensure they are able to meet the organization's standard for timely collections?
7. How does the organization ensure that the billing staff has the current training or professional development regarding health information technology?

8. What billing techniques does the organization use that would be a competitive advantage over other similar organizations?
9. What are the necessary attributes and abilities of a biller to ensure continued profitability and sustainability for the organization?
10. What additional information can you make available that accounts receivable strategies ensure timely payment from patients and insurance payers?

Conceptual Framework

The resource-based value theory (RBV) served as the foundation for this qualitative multiple case study. Wernerfelt (1984) provided an approach in finding a balance between manipulation of existing resources and the expansion of resources to an organization's firm strategic management design to yield increased profits. The RBV indicates a correlation between profitability and resources as well as managing organizations' resources for the long term (Wernerfelt, 1984). RBV theorists and strategists are contributors in the RBV development.

The healthcare industry exemplifies the RBV within the internal organizational resources to include attributes, abilities, organizational procedures, and expertise formulated at the administrative level of an organization (Patidar, Gupta, Azbik, & Weech-Maldonado, 2016). RBV theorists Warnerfelt (1984) and Barney (1991), proposed to improve an organization's efficiency and effectiveness with an increase in profitability and sustainability. The prevalence of internal resources to maintain a competitive advantage over rival competitors can be found using RBV. A turbulent period for the healthcare industry is transpiring due to competition, an adjustment in

reimbursement for services rendered, and struggles in keeping current with health information technology and electronic medical records (Angeli & Norwood, 2017). The RBV combines superior resources and competencies to achieve increased financial earnings. The RBV perspective emphasizes the development of dynamic capabilities and useful resources as possible foundations for a definite competitive advantage (Kash, Spaulding, Gamm, & Johnson, 2014).

Operational Definitions

Arizona Health Care Cost Containment System (AHCCCS): A version of the Medicaid system in the state of Arizona that provides medical benefits to those with lower to moderate incomes (Langellier, de Zapien, Rosales, Ingram, & Carvajal, 2014).

Contractual adjustments: The difference between healthcare organizations' fully charged amounts for services and payments received (Chen et al., 2015).

Contractual allowances: The financial difference between what the healthcare organization bills and the agreement entered into financial conditions with a third party payer (Rosolio, 2016).

Customary allowable rate: The rate of reimbursement intended to mirror the value of the services provided by the provider (Panning, 2014).

Government-funded health plans: A provision as part of social wellbeing to provide healthcare services to lower income individuals (i.e., disabled, children, and the elderly; Bradbury, 2015).

Multifaceted health care organization: Healthcare organization with many different elements or combinations of services or roles provided to customers/patients (Prowle & Harradine, 2014).

Reimbursement rate (normal/customary): The fee or charge associated based on the volume of services provided to a customer or patient during an encounter with a medical provider (Jones & Ku, 2015).

Timely payments: A reimbursement for services rendered by the health care provider within a payment timeframe defined by the payor (Fitzpatrick, Butler, Pitsikoulis, Smith, & Walden, 2014).

Assumptions, Limitations, and Delimitations

Assumptions, limitations, and delimitations can limit the methods and examination of the research within the study. Assumptions and limitations are outside the scope of the researcher's control. Delimitations are essential within the context of the research managed by the researcher. Furthermore, these concepts are integral in outlining methodology within the context of the research detailed as part of the study.

Assumptions

The rural clinic acknowledged a responsibility to provide the patient with quality healthcare services regardless of the volume of ailments during an encounter with the assumption the clinic would be paid. Another assumption was the accounts receivable management strategies in collecting co-payments or deductibles imposed by organizational leadership was determinate in the collection of timely payments from the patient. Second, an essential assumption was specific strategies and methods pertaining to

the collection process were abided by according to company financial policy (Grant, 2014). The last assumption was that implemented revenue management strategies developed by clinic managers would positively affect payments from patients and insurance payers.

Limitations

Marshall and Rossman (2016) defined limitations as elements of the study outside the control of the researcher. A significant limitation of this study was that payment information could not be gathered from patients or insurance providers. One of the limitations of this study was that participants potentially could withdraw at any time in the study thereby skewing the data due to the small sample size. The participants' interview responses are subject to their personal presumptions (Yin, 2017).

Delimitations

Delimitations define the scope of the research study determined by the researcher (Yazan, 2015). This study included 10 clinic managers from southwestern region of the United States to include South County and East County. This study included clinic managers who reside in Arizona and live in southwestern region of the United States and who confirmed insurance payers for treated patients.

Significance of the Study

Rural clinic managers and individuals residing in southwestern region of the United States could benefit from the outcomes of this study. The healthcare industry prevails as a change agent for reducing costs and improving patient outcomes. Reducing costs, lowering or bundling healthcare services, and establishing strategic processes in

obtaining payments from insurance payers may result in a higher volume of patients. An examination of the accounts receivable management processes may provide awareness to rural clinic managers regarding attaining payment from patients and insurance payers.

Contribution to Business Practice

Rural clinic managers could benefit from this study by understanding their role as it relates to reimbursement practices. Healthcare leaders must demonstrate strategic business practices interpreting the development of volume and scale of insurance payors in conjunction with the business model (Kemperman et al., 2016). The healthcare business model requires transparency in the reimbursement process of services rendered. . Ideally, a healthcare organization must provide patients with a high quality of care at affordable prices to form an organizational culture of accountability (Mkanta, Katta, Basireddy, English, & de Grubb, 2016). Rural clinic business leaders may gain awareness of strategies to increase cash flow, which could increase resources necessary to provide quality services.

Implications for Social Change

Organizational leadership, hospitals, and physician-based groups considering collaboration could benefit from the results of this study on rural clinics while influencing the quality of care. The healthcare business model of requiring payment in advance of services has demonstrated ineffective in the inability to provide adequate healthcare to underserved communities (LeFevre, Shillcutt, Broomhead, Labrique, & Jones, 2017). Patients decide their healthcare needs based on the qualities and expertise of the medical provider (Reddy & Mythri, 2016). Effective cash collection strategies that

allow for payments of co-pays, deductibles and uninsured payments may increase the likelihood of health care services to residents in underserved communities, which will impact the patients' well-being.

A Review of the Professional and Academic Literature

Reviewing prior published research is a strategy researchers use to gain a more in-depth understanding of a research topic. Lubberink et al. (2017) stated that the literature review is an essential component of the research because it provides systemic, activities-based approach to reported context. The purpose of this qualitative multiple case study coincides with research related to evolving changes in reimbursement. Included in this section is a review of the academic and professional literature on the RBV theory as used by other researchers to investigate related research topics. I examined literature from other scholars who deliberated regarding rural clinic managers' strategies to obtain timely payments from patients and insurance payers and my findings aim to help managers reduce the interruption or delay in receiving payment from patients and insurance payers for medical services rendered.

The information gathered from this study came from a multitude of sources including ABI/INFORM Global, ProQuest, SAGE Publications, Google scholar, Wiley Online, Academic Search Complete, Emerald Insight, MEDLINE, Proquest Central, Proquest Health and Medical Collection, Proquest Nursing & Allied Health Source, and EBSCOHost. The keyword search terms for this research included: *health care, health care industry, business model*, *government involvement*, *financial options*, *medical care*,

Medicaid, *ACA*, *fee-for-service*, *value-based purchasing*, *Resource Base Value*, and *total quality management*. .

The financial health care models in the literature illustrate how healthcare services can be efficient and which methods are cost-effective. The reimbursement models indicate the delivery of healthcare services, efficiency of effective billing procedures, and exhibit cost-effective methods to develop the success of a healthcare operation. I presented the value-based purchasing model, which was the defining standard for healthcare operations' performance. The core business values of this model consist of cost control, financial stability, and sustainability of healthcare operations. Consistency of adequate reimbursement of healthcare organizations maintains sustainability. With this intention, healthcare organizations determine adequate reimbursement fee schedules concerning payment for the businesses to remain flexible for future success.

The U.S. healthcare sector has changed as health insurance plans provide an array of healthcare services. The clinic manager is responsible for reimbursement and assessing strategic business models for obtaining timely payment within the clinic. The continuity of care diminishes when patients are required to choose their provider solely based on insurance coverage. The delivery of healthcare is a focal point for patients who can be loyal to a medical provider or turn to a competitor for the same services based on insurance (Hegwer, 2014). The value-based purchasing model holds medical providers accountable for the cost and quality of care. Healthcare organizations using a value-based purchasing model focused on cost containment accompanied by quality care, presuming patients will choose quality. The literature review consists of 299 references from peer-

reviewed journals, government reports, and books with at least 94% of the sources published between 2013 and 2018, or within 5 years of my expected graduation.

Resource-Based Value Theory

The RBV is a relevant framework for service-based industries where there is a requirement of trust. The organization's ability to gain the patient's trust will increase its competitive advantage and improve its financial performance (Lin, Chang, & Dang, 2015). The central tenet of RBV theory is that healthcare leaders should focus on efficient and strategic uses of resources to remain viable (Ozuru & Igwe, 2016). The profitability of an organization stems from the implementation of strategies based on resources identified by organizational leaders (Liu, Zhu, & Seuring, 2017). The RBV model concentrates on the service-concept methodology and is dependent on the performance of individuals executing roles within the organization. It becomes necessary to apply resources to provide medical services that benefit the patient. An organization must consider the implementation of services and equipment, specialty amenities, and quality improvement for their patients as assets and strengths.

Only recently have researchers and business leaders applied RBV to the healthcare field. It is a relevant framework because it claims product-based endeavors are part of a grand business strategy. RBV indicates resources are scarce and unique in stature; these strategic resources are necessary to maintain a competitive advantage in a healthcare market (Gerber & Hess, 2017). The financial and operational well-being of the organization hinges on internal resources within the business (Neghina, Bloemer, van Birgelen, & Caniëls, 2017). Managers can use RBV to develop a strategic plan for using

internal resources to enhance financial success and sustainability.

Managers in the healthcare industry face difficulties in implementing RBV strategies when the business is at an early stage of development (Voss, Perks, Sousa, Witell, & Wünderlich, 2016). Healthcare leaders can base organizational policies on the RBV theory to specify assets that support the delivery of medical care to patients (Wilden & Gudergan, 2017). In the healthcare industry, the roles of patients, healthcare organizations, and medical providers are still evolving. The RBV framework includes a service delivery model emphasizing employee skills and knowledge expertise which is a foundational piece of financial success (Ozuru & Igwe, 2016). As healthcare systems develop towards financial prosperity, the connection with RBV amplifies.

The RBV framework includes strategies to remain competitive. RBV when applied as a business strategy exposes possible disadvantages involving profitability and reputation to the organization (Jain & Singal, 2014). The RBV as a strategic business model proposes using internal resources to outperform competitors. The healthcare organization used resources to strategically coordinate with the medical practice to secure a competitive advantage (Abidemi, Halim, & Alshuaibi, 2017), and key resources are employees, who all need to be included in the strategy (Pinto, 2017). Rural clinics leaders also consider the revenue cycle process to guarantee payment, a resource that organizational leaders need to manage. Business leaders manage internal resources in order to keep revenue consistent with the long-term financial growth of the organization.

In rural clinics, the focal point is services provided to patients (check-up, follow-up care, or consultation). The healthcare industry is a service-model based exchange, and

with the flow of internal resources and potential employees' capabilities, a creation of value will develop over time indicating innovation as the focal theme (Schneider & Sachs, 2017). RBV within a healthcare organization improves patient outcomes through the use of internal resources within the healthcare organization towards continuity of care (Szymaniec-Mlicka, 2016) and guides business strategies towards competitiveness in the marketplace (Li, Jiang, Pei, & Jiang, 2017). The healthcare industry has integrated RBV into its business models to drive potential success, economic prosperity, and strategic preparation.

RBV in the management environment. The methodology of RBV strategy in a management setting focuses on internal business resources. The healthcare industry is service-based and must ensure approaches are successful and services provided exceed those of competitors (Jali, Abas, & Ariffin, 2016). The indicators regarding internal resources needs rethinking with the managerial emphasis placed on varying differences and unique characteristics of health care services (Neghina et al., 2017). Successes stem from creating new and innovative ways to deliver services by reducing costs and passing on the value to the patients.

Rural health clinics need to develop new and innovative ways to build their patient base and management's ability to expound, implement, and reintroduce strategic resources. The healthcare industry must adapt to healthcare reform and seek innovative processes regarding internal resources to attain a competitive advantage (Lillis, Szwejczewski, & Goffin, 2015). The control over strategic resources gives businesses a unique competitive advantage that creates barriers to entry (Ferlie et al., 2015). Managers

following RBV concentrate on their most valuable assets to achieve continued sustainability. The progression of the RBV is achievable, but a path towards organizational development follows a period of increased growth to meet an organization's financial goals (Maurer & Ryan, 2016). The objective of rural clinics is to enable access to medical providers, establish growth, become more productive, and maintain a consistent and sustainable profit margin.

RBV within rural clinics emphasizes using internal resources to improve the quality of care for patients, stressing improvements toward operational goals and objectives. The operational and performance goals of a healthcare organization include balancing healthcare services, reducing costs, and improving patient outcomes (Adebanjo, Laosirihongthong, & Samaranayake, 2016). Thus, essential characteristics surrounding RBV within the healthcare environment include producing positive results while managing revenue collections to provide long-term fiscal sustainability. Healthcare leaders must continue to focus on the improvement of patient care while ensuring the financial growth of the medical practice.

RBV methods can contribute to a medical practice's success by building its strategic resources and hence improving its competitive advantage (Maurer & Ryan, 2016). Corporate social responsibility also builds organizational goodwill by improving reputation (Sheikh, 2017). Some medical practices focus on collecting payments from insurance payers without any impediment or delay in payment (Lai & Gelb, 2015). Increasing the timeliness of payments is a strategy that increases the competitive advantage of a clinic.

An organization's resources align with RBV based upon the value to the organization (Lin et al., 2015). The service-based model is grounded on an ecosystem of multiple variables as internal resources become tangible for the strategic betterment of the organization (Voss et al., 2016). The service-based model goes through a shift where the focus is on tangible resources creating capabilities for future strategic planning (Wilden & Gudergan, 2017).

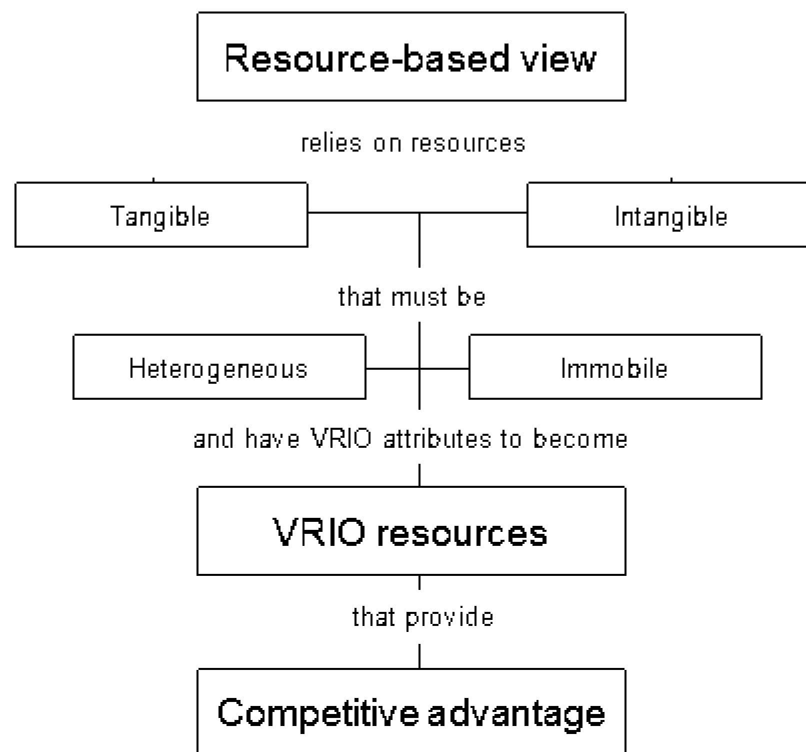

Figure 1. The resource-based view.

RBV in the healthcare setting. RBV principles emphasize the importance of the delivery of services and resources for rural clinics to set themselves apart from competitors. Healthcare organizations allocate resources efficiently to give legitimacy to management and leadership in the decision-making process of RBV (Angelis, Kanavos,

& Montibeller, 2017). Business leaders consider the healthcare organization's resources to be valuable assets. The healthcare organization is poised to use all available internal resources to provide consistency and continuity of care to patients. The internal resources available to the healthcare organization are well thought-out, have identifiable characteristics, and designated as VRIO (valuable, rare, inimitable, and organized; Lin et al., 2015). The VIRO characteristics selected are the foundation for RBV.

The connection between products and services are intertwined and generate combinations of resources (Benedettini, Neely, & Swink, 2015). The resulting resources are significant to the rural clinic advantage over competitors, but are not sustainable and will not benefit the healthcare organization over the course of time (Mweru & dan Muya, 2015). Rural clinic managers use RBV strategies to recognize and implement approaches to make improvements in efficiency and effectiveness (Teece, 2017). Rural clinics incorporate resources into their strategic planning for the purposes of financial achievement (Patidar et al., 2016). Healthcare organizations value internal resources, which are components of their competitive advantage (Helmig, Hinz, & Ingerfurth, 2014). Their competitive positions regarding administration efficiency influence potential operational development of competitive strategies (Krzakiewicz & Cyfert, 2017). The rural clinics' used for this doctoral study have strategic approaches in line with RBV, as cost and organizational performance are devices providing the business with sustainability and competitive advantage for years to come (Abidemi et al., 2017).

Through strategic planning, an organization can establish a competitive dominance over its rivals (Kash et al., 2014). RBV is becoming a strategic management

model trending towards organizational management, and developing applicability of external resources within the healthcare industry (Hitt, Xu, & Carnes, 2016). The RBV framework in the healthcare industry is an innovative approach within the confines of the management structure and all internal resources within the organization has not been sufficient to establish RBV within healthcare strategic planning. However, healthcare organizations are willing to be a part of this rapidly growing model. The U.S. healthcare sector follows and identifies common strategic initiatives put into practice by hospitals, community health centers, and urgent care facilities. Accordingly, a broader view of RBV includes internal viable resources, adding to increased capabilities, employees and staff, and financial assets (Wilden & Gudergan, 2017).

The healthcare industry consists of operational and clinical professionals and their collaboration within the health care environment is essential. Business leaders consider VIRO attributes to be valuable, inimitable, rare, and organized difficult to replace that lead towards a competitive advantage for the health care organization. The health care organization's administration explores competitive advantages coming from within the firm's specific resources and limitations, depending on the location (Yang, 2014). The healthcare profession has organizations that can strategically manage resources to improve their performance (Evans, Brown, & Baker 2015). RBV's place within rural clinics in combination with strategic resource planning remains driven by healthcare professionals whose objective is quality care.

RBV methods put into place the needed resources to provide patients with the continuum of care and offer a strategy to sustain competitive advantage (Popli, Ladkani,

& Gaur, 2017). The strategic business model is a representation of the view of a health care organization reflecting potential sustainability and viability (Goyal, Sergi, & Kapoor, 2014). The RBV approach, a health care business implementation, is the building block of competitiveness not only in the present but in the future and reinforces sustainable benefits for the long-term (Teece, 2017). Rural clinic managers can use RBV as a reliable business model to properly use internal resources to facilitate sustainment. The financial results were referencing accounts receivable segments of the business focus on the strategies implemented by leaders within the establishment. A rural clinic manager uses RBV in conjunction with its business model to develop financially and clinically to build the community's trust.

Alternative Theories

RBV addresses the roles or control of one's resources as a primary method to create a strategic advantage over competitors (Popli et al., 2017). Critics indicate the RBV approach is limited because it focuses on the user of the resource (Gerber & Hess, 2017). The utilization of internal organizational resources becomes part of the landscape, and the user of the resource takes on a far lesser role in the overall encounter. The potential for the business to sustain its resources over an extended period will prolong a fierce competitive advantage during specific phases of time (Lee, 2017). Resource dependence theory (RDT) has similarities to RBV with the role of the RDT taking on external environmental linkages within the organization (Shaukat, Qiu, & Trojanowski, 2016). I used both RDT and TQM as analytical frameworks to explore health care

organization management strategies. Wernerfelt (1984) details RBV as a means to use internal resources and includes components to separate businesses from its competitors.

Resource dependence theory. In 1978, Pfeffer and Salancik addressed resource dependencies and indicated the effect external resources had on the role of an organization. Pfeffer and Salancik (2003) detailed that health care organizations are providers of significant resources, and like other organizations, they need to make changes to fulfill positive outcomes. RDT indicates organizations require resources from competing organizations within a similar market to innovate, resulting in distinctive qualities within competing organizations (Van den Broek, Boselie, & Paauwe, 2017). Pfeffer and Salancik (2003) stated that organizations have more power drawing from the interdependence of others and the need for their positions in the marketplace. RDT describes dependent players in the organization as having a weaker position within the competitive market to offset structures to collaborate (Christensen, 2016). From the organizational aspect, minimal information in the form of external constraints affecting management decisions ought yet to be determined (Pfeffer & Salancik, 2003). RDT has three specific factors: the significance of the resource to the organization, scarceness of the resource, and the level of internal organization competition (Selviaridis, Matopoulos, Thomas-Szamosi, & Psychogios, 2016). Business leaders manage potential constraints and uncertainties potentially resulting in the acquisition of external resources (Pfeffer & Salancik, 2003).

The viability of the health care organization is contingent on RDT in which a strategy may alter a power-dependent relational dynamic (Doyle, Kelly, & O’Donohoe,

2016). Management sets the strategy, and these individuals play a crucial role in the process and scheming of resource dependencies. Any organization can build resources both internally and externally to assemble competencies to enter and leave the market and to take a competitive advantage (Pfeffer & Salancik, 2003). RDT researchers focus on the use and outcomes of resources utilization (Coupet & McWilliams, 2017). An organization's management may devise a scheme to ensure resources remain supported and seek a clear competitive advantage over market rivals (Pfeffer & Salancik, 2003).

Total quality management. In 1985, Deming addressed the Western style of management called total quality management (TQM), which introduces organizational attempts to deliver quality products and services. TQM emphasizes planning and introducing methods to improve an organization's products and services to decrease costs (Deming, 1985). The focus of enhancing quality concentrates on the customer (Deming, 2000), which is supervised by management. Health care managers introduced TQM into the field in the late 1980s, intending to increase patient satisfaction, reduce costs, and increase productivity at all levels within the organization (Chiarini & Vagnoni, 2017). Management is fully responsible for creating processes, ensuring stability, and establishing strategies for the success of the organization (Deming, 2000).

Deming's approach centered on process improvement (Matthews & Marzec, 2017). Deming (2000) provides a thorough concept showing that any considerable improvement must come from actions introduced by operations management. TQM methodology has in the past focused on the supply side of operations, but now has a presence in an organization's services sector (Iqbal et al., 2017). The service-based

industries such as health care apply various TQM improvement practices by enhancing services and reducing costs for patients during a routine encounter (Deming, 2000). The implementation of TQM within a health care organization has led to improved processes in the quality of patient care, patient satisfaction, and increased financial prosperity (Mosadeghrad, 2015). RBV is the best choice for this study, as the theoretical lens focuses on quality improvement organizational concepts.

Historical Involvement by Government in the Health Care System

Governmental involvement in the health care system has gone through an evolutionary process since the initial phase in the early 1900s. The U.S. government implemented health care services emphasizing the health and welfare of its citizens. The first model of health care reform began with the Sheppard-Towner Act of 1921, one of the catalysts in the health care reform movement (Haeder & Weimer, 2015). In subsequent years following the Sheppard-Towner Act, President Harry S. Truman tendered a plan for universal health care, a measure unable to pass through the government (Manchikanti, Helm, Benyamin, & Hirsch, 2017). Haeder and Weimer (2015) stated that federal health care programs aimed to expand health care services to influence care reimbursement and financial outcomes, with an overarching goal of universal health care.

As the movement towards universal health care continued, the health concern continued into the Great Depression. The Social Security Act of 1935 provided stability in the health care system and identified residents who were either elderly or disabled to receive health care through Medicare and Medicaid (Haeder & Weimer, 2015). Federal

and state governments were delivering health services and sharing the cost provided stability for U.S. citizens and medical providers taking care of the sick and infirm. Welfare state policies became part of society with the combination of health care insurance and retirement funding for the public (Mayhew, 2015).

The enactment of Medicare and Medicaid as health care programs did not appeal to both the federal and state governments and not all states participated initially (Haeder & Weimer, 2015; Leemon, 2014). The health care recipients in those states receiving government-funded health care plans have to use either of these health care plans based on income and age requirements. Individuals who are apathetic regarding health care dwell on the ineffectiveness of programs established by government leaders. The individuals receiving health care assistance viewed government intervention in a negative context by the lack of transparency of the government regarding cost, quality of care, and treatment outcomes (Maurer et al., 2017).

The principles of health care were to ensure services of value and quality is accessible to individuals with moderate to lower incomes. The design of health care reform existed as a social and societal norm, and economic instability has occurred in the form of a conservative fiscal approach or terms of limited government intervention for health care services (Schimmel, 2013). Reforming the health care system based on an economic point of view will provide health care to all citizens as a cheaper and more efficient alternative (Pineda & Hermes, 2015). In addition, the scope of health care expansion is to ensure all citizens have access to health care services (i.e., hospitals, public clinics, and health centers). The health care claim is that individuals pay from their

income if they do not need health care services. However, people should receive health care services based on need, not income (Nardin, Zallman, Sayah, & McCormick 2016).

Government's role in health care is not the solution and may hinder positive advancements in health care reform (Manchikanti et al., 2017). Approximately 45 million Americans are without health care coverage and millions more deal with lapses in their health care insurance and are considered to be underinsured (Schimmel, 2013). The concern with health care reform continues to come from the involvement of the government, and the government has only marginally controlled health care costs (Howrigon, 2016). There is market demand for health care services for the millions of individuals without health care insurance. The health care industry is in a phase of fluctuation, and the challenge ahead for rural clinics is to identify proactively potential changes in health care reform.

The reform of health care insurance does not follow in the footsteps of socialized medicine, as services remain vulnerable now and in the upcoming future. The idea concerning health care as an inalienable right would regulate and conflict with other's rights and freedoms, as coordinating health care services is not the primary focus (Roberts, 2012). The marketplace is a determinant regarding financial control in health care with the emphasis placed on profitability and not necessarily on treating the illness (Darrow, 2015). The concern of state or federal government officials is not to engage in the agreement of social, economic, or even cultural rights between citizens but to play a role in the scope of health care reform. Early health care reform had a lasting effect on legislation in the United States (Durenberger, 2015). There is controversy about

government involvement in health care today, and without consensus, reform cannot take place. The debate over universal health care is prevalent and divisive, but the right to have health care remains unsettled with the advent of the ACA.

During the past 50 years, much of the health care system remains pieced together ensuring individuals have access to hospitals, clinics, doctors, and medical supplies (Farnsworth, 2015). Business leaders seeking for-profit benefits focus financially on volume while spending less time providing adequate care (Joynt, Orav, & Jha, 2014). The extension of health care benefits aimed to ensure those who were uninsured received sufficient health care assistance, though a segment of the population is still without health care insurance or is underinsured because of cost control means put in place by the government (Schimmel, 2013).

The progression of health care services within the American health care system results from the efforts of the public, private, government, businesses, and other industries to create a universal health system. The evolutionary process of the American health care system from a historical perspective exists in addressing enhanced accessibility to services, upgrading the quality of care, and cost-effectiveness, or control (Farnsworth, 2015). The U.S. health care system remains segmented into three groups: government-assisted insurance, private insurance, and no insurance (Marshall et al., 2016). There are differences between public and private health care, and evidence shows that private health care according to US standards remains the best option (Nardin et al., 2016). The idea persists that each citizen is responsible for his or her health care services

and may need to seek health care by any means possible through state-funded, federally based, or private options.

The American legislature has different methodologies regarding health care reform, and hence nothing has emerged as a clear means for all citizens to have adequate health care. The past 50 years of government involvement has led from Medicare/Medicaid to the ACA with no affordable options to all citizens (Durenberger, 2015). The selection of health care reform models comes from a form of compensation for health care organizations who can deliver skilled and superior care (Barinaga et al., 2017). The decision for health care reform comes from the government, which can fluctuate between liberal and conservative perspectives, but operational or business functions must address the financial stability of the organizations (Noh, 2016). The selection of different reimbursement methods, such as fee-for-service (FFS) or value-based purchasing (VBP) determines the economic outcome of a health care organization and will be the catalyst for creating a cost-effective health care system (Schneider & Hall, 2017).

Health Care Financial Options and Medical Care

Health insurance representatives base their coverage decisions on factors such as cost, effectiveness, and outcomes of care. A misunderstanding is to base a model of health insurance with the resulting cost of delivering care. The government related options available to U.S. citizens are minimal regarding health care, as they are referred to as “safety nets.” The fail-safe system set up by the federal government to ensure necessary care exists for individuals with lower to moderate income (Chokshi, Chang, &

Wilson, 2016). Thirty-one million Americans are without health care coverage, and health care organizations need possible financial outcomes to provide coverage and care (Hall & Lord, 2014). The rural clinic manager's goal is viability in providing a public health commodity and service (Reddy & Mythri, 2016). Medicaid and the ACA provide stability of health care services, but individuals at or below the poverty level will use one model or another irrelevant of the cost (Durenberger, 2015). The number of Americans without health care coverage is a determining factor regarding reimbursement progress affecting health care organizations (Kessell et al., 2015).

The quality of health care is a crucial financial consideration in addressing adequate health care. The viability of health care concerning Medicaid and the ACA was due to the expansion of Medicaid support to the states ensuring health insurance would be accessible to low-income adults (Nguyen & Sommers, 2016). The premise towards the expansion of Medicaid services was not only to meet the growing need for new patients, but a determinant of the ACA to deliver quality care (Franz, Skinner, & Murphy, 2016). Patients choose their health care services based on their health insurance and the necessity of medical treatment or service. Uninsured individuals may experience lower quality health care in comparison to those with private health care insurance (Nardin et al., 2016). A rural clinic should implement services and treatment models following private health care insurance.

The fiscal model for private insurance may not be adequate for all health care organizations, as there are regional differences in access to appropriate health care. Thus, if the area does not have a medical specialist, Medicaid and ACA patients, who depend

on the safety-net providers such as community-based health care services, will visit primary care providers (Nguyen & Sommers, 2016). The advantage of health care organizations is in facilitating and examining costs to the health care facility, while in turn ensuring the quality of health care services promoting positive patient outcomes (Shortell et al., 2015). Rural clinics build a kinship with patients in their regions with an undertaking that medical services are available in each community. Ultimately, the care and treatment is available for individuals who are in federal or state health care plans regardless of the ailment or sickness, and the medical practice will build an assortment of various payer sources.

The financial barriers associated with the ACA originated from the Massachusetts Health Reform of 2006. The proposal is to expand Medicaid in a provision to decrease the number of uninsured individuals. The financial obligation has been the ability of health care organizations to provide affordable health care insurance to individuals with moderate to low incomes (Nardin et al., 2016). The quality of health care in the United States has languished over the past several years; however, costs have soared caused by the reimbursement process (Choi, Lai, &Lai, 2016). Since the introduction of the ACA in 2010, the number of insured persons has increased by around 20 million, which has reduced the number of persons not insured (Oberlander, 2017). The rural clinic benefits with growth in the number of insured but the provision of quality health care is also essential.

Limitations of both Medicaid and the ACA are a focus of legislators (Nardin et al., 2016). The changes to the delivery of health care to Medicaid or ACA should not

affect the utilization of health care services or deny needed care (Nardin et al., 2016). Health care organizations benefit from ACA because providers can generate high net revenues from the increase in expanded coverage (Glied & Jackson, 2017). The quality of care given a patient does not affect the amount of reimbursement (Glied & Jackson, 2017).

There is a movement towards personalized health care to hold patients accountable for their lifestyles and tailored treatments. The principle of customized health care has a dual purpose of enhancing the quality of health care services while lowering costs (Teng, 2015). The rural clinic must ensure accountability for the total costs and move away from past FFS beliefs towards risk-sharing measures (Blumenthal, 2016). Similarly, the idea of personalized health care and price do not associate with each other, but there are segments of the health care system to indicate care and treatment are universal (Teng, 2015). The evidence-based information shows personalized health care is a cost-effective approach to health care in the United States (Kuramoto, 2014). Overall, implementing personalized care will bring focus on patient-centered care, but other aspects are involved such as cost-effectiveness and containment.

The cost savings to the rural clinic does not appear to be evidence indicating improved patient satisfaction. Personalized health care can educate, teach, and encourage patient care, leading to financially supportive reimbursement arrangements (Teng, 2015). Health economics plays an essential role in the identification of a payment system, but the assurance of quality care will come at a significant cost (Chen & Goldman, 2016). Preventative care is a necessary part of the quality goals of health care reform. Such an

incentive-based health care policy will enable cost-effective health care for all citizens: the right care at the right time for the appropriate individuals (Kuramoto, 2014).

Health care reform potentially harms insurance profitability over time due to shifts in reimbursement payments (Teng, 2015). Health care insurance existed before the ACA in the form of private insurance, government funded, subsidized, regulated health care, as Medicaid and Medicare coverage was primarily for the poor and elderly. The objective was to have health care reform much like Canada, a single-payer system emulating universal health care (Hall & Lord, 2014). The concept of a universal health care system exceeds the financial accountability of Medicaid, and expanding Medicaid would ease the financial burden on the states (Langellier et al., 2014). The concept of a temporary health care system is universal and far exceeds financial accountability based on poverty. Expanding Medicaid to ease the financial burden on the states to cover medical services for individuals who remain uninsured is a temporary solution (Langellier et al., 2014).

The correlation between financial preferences and health care is a crucial way to solve the problems that overwhelm state and federal governments. The payment structures for receiving medical care historically centered on FFS (fee-for-service) and the capitation rate structure (predetermined rate to reimburse medical providers or capitated rate or managed care) (Leemon, 2014). Health care organizations are developing an infrastructure to move from previous ways of thinking about payment modalities and creating revenue (Conrad, Vaughn, Grembowski, & Marcus-Smith, 2016). Consequently, risk/reward plays a factor in financial preferences and the delivery of

services to the patient. The customary allowable rates are a risky proposition for rural clinics due to the flat rate becoming a point of contention for the rural clinic depending on the negotiation of the signed contract. Health care reform in Medicaid and ACA has benefits for most Americans, regardless of the patient's ability to pay. The objective of health care reform is to provide adequate health care to the patient at a reasonable cost.

The challenges are facing health care financing options and medical care rest on the patient's ability to pay. Rural health care facilities face increased challenges in comparison to urban areas due to differences in levels of income of patients (Allen, Davis, Hu, & Owusu-Amankwah, 2015). The U.S. government offers rural health clinic services through Medicare and Medicaid to the needy (Ortiz, Meemon, Zhou, & Wan, 2013). The rural health hospitals in smaller communities are financially unstable, but they become viable substitutes for the patient in search of health care (Allen et al., 2015). The mission of rural health clinics is to provide medical services to an underserved population due to financial and operational issues. The rural clinic managers must contend with the increased patient flow while managing costs and quality.

Fee-For-Service (FFS) vs. Value-Based Purchasing (VBP)

The duality of rural clinics is to serve the patients who walk through their doors and manage the financial well-being of the operation. Reimbursements to health care organizations are important considerations within the health care reform framework (Oberlander, 2017). Business leaders will need to address reimbursement approaches in preparing a profitable business model for the future (Gurganious, 2016). With health care costs rising, reducing costs will lead to a decline in accessibility or value of the American

health care industry (Rudnicki et al., 2016). Thus, changes in coverage for patients to visit hospitals, health care facilities, and providers will have a profound impact on the operational bottom line.

Rural clinics link prospective payment for medical services to either FFS or VBP, which encompasses payment through improved performance and reduced cost. This form of payment holds health care providers responsible for the costs and quality of their care and attempts to reduce and identify and reward inappropriate care (Kessell et al., 2015). In order to establish continuity, rural clinics need a strategy for collecting reimbursement and payment. FFS or VBP are important financial choices to a health care organization and for the provider of medical services (Feldman, 2015). The future of health care reform centers on price and value, and less on status, with the emphasis on conventional health care economics (Gerben, 2016). Operations management makes decisions regarding the volume or value of these payment options. Overall, rural clinics select the most common and reliable payment types to establish consistency in the changing landscape of health care reform.

The modes of payment for health care services have reached critical levels as proponents of both sides view each system with flaws. The FFS model places accountability for costs on medical providers (Feldman, 2015). The majority of health care leadership analyzes payment reform as an approach to motivate medical providers to incorporate the delivery of services (Murphy, Ko, Kizer, & Bindman, 2015). However, the objective is to maximize profits, and the number of services and potential outcomes is difficult for rural clinics to predict. The rural clinic distinguishes the best possible

payment opportunity for the business to create increased volume. Many contend having one payment source and a financial plan to address lengthy payment delays is better for the health care organization (Cascardo, 2015).

Health care reform interests should bring about restrictions on the way rural clinics decide to accept or deny revenue streams. Health care providers recognize the FFS model, but in some areas, the bundled payment is part of VBP and is standard for medical generalists (Kuramoto, 2014). Business leaders determine the soundest payment structure to ensure medical providers and the business receive compensation while still emphasizing quality and efficiency (Ojeifo & Berkowitz, 2015). A mode of collection is not to isolate specialists from accepting one form of payment for services (Palinkas et al., 2015). Rural clinics comprise of a mixture of general practitioners and specialists.

Health care organizations must anticipate changes in health care reform as cost conflicts could take place among medical providers regarding lower reimbursement rates. The perception of clinical equity is something an organization must confront due to cost-effectiveness or the anticipation of high-quality care and treatment (Kuramoto, 2014). The health care system has gone through changes in the language of policy and inconsistency with the delivery of medical services, leading to gaps in coverage, conflicting outcomes, and inexcusable costs (Larkin, Swanson, Fuller, & Cortese, 2016). The perspective of the business is to follow any advantage obtained or accept one payer source over another, focusing on the overall value of the provided services. Rural clinics address possible changes in the reimbursement fee schedule while identifying potential opportunities to expand business and cost-effectiveness (Abidemi et al., 2017). Finally,

business leaders establish strategies to separate themselves from competitors and limit the need for unnecessary risk-taking.

The U.S. health care system has migrated away from an FFS option regarding reimbursement and is trending towards VBP as a financial alternative. Health care clinicians are progressing towards VBP for services rendered (Joynt et al., 2017). The transformation of the reimbursement revenue cycle has caused business leaders to assess operational infrastructure with the limited resources available in the selection of a payment model (Granata & Hamilton, 2015). Additionally, enrollment of individuals in the ACA or Medicaid remains scripted as these plans continue for persons with lower to moderate incomes (Durenberger, 2015). Business leaders will initiate a plan for accepting either reimbursement arrangement (FFS or VBP), and the economic impact of the decision-making process may result in financial implications for days, weeks, months, and years.

The financial impact of health care reform on health care organizations is not entirely clear. The FFS model remains monetarily centered on one particular service-taking place for the patient (Leemon, 2014). Conversely, the VBP payment modality provides a consistent financial revenue flow for the health care organization, along with the element of increased quality of care and higher health outcomes for patients (Joynt et al., 2017). Health care organizations seek revenue streams that provide an incentive base for the business and do not discourage utilizing capitation rates (Doran, Maurer, & Ryan, 2017). Overall, payment modalities have a financial impact on the organization, and sustainability is the groundwork for success.

Rural clinics need to focus on the delivery of services to address prospective payment reimbursement concerns to ensure a consistent source of revenue. This analysis should emphasize the elements of risk and reward to incentivize to include expectations on treatment expenses, value, and results (Halfon et al., 2014). Higher expectations fuel increasing health care costs, as health care organizations plan to improve patient satisfaction and reduce costs (Moraros, Lemstra, & Nwankwo, 2016). While the U.S. health care system is meant to provide affordable services, they are often ineffective and high priced. The business strategies implied by an association with an FFS model serves as a volume-driven entity, while the modality of VBP promotes costs and quality of care (Noether & May, 2017). Rural clinics identify a recurring payer source as suitable for financial growth while providing patients viable health care solutions.

The reimbursement process considers aspects such as improvement in the quality of care, managed spending, and a patient’s access to health care services. The involvement of federal and state governments regarding health care is a primary source, and the Centers for Medicare and Medicaid Services (CMS) is presently in the middle (Haeder & Weimer, 2015). The directive is to initiate replacing the reimbursement model of FFS with the model of VBP (Schneider & Hall, 2017). CMS established an enhanced version of paying for the quality of care (Cassel, Kerr, Kalman, & Smith, 2015). The justification for change stems from the quality and quantity of the medical services provided to the patient by the medical provider. Overall, the financial risk implied with this VBP process emphasizes the value of health care services provided to patients.

The concern about health care exchanges with Medicaid and the ACA focuses on inducements that reduce health care costs and provide improved service quality. The research regarding FFS and VBP or bundling of services has lasting fiscal effects on federal and state governments (Noh, 2016). The budgetary durability of our health care system rests with federal and state governments determining a balance between cost containment and quality care (Landers et al., 2016). Accordingly, federal and state governments have addressed changes regarding health care reform and considered reducing funds due to sustained debt at federal and state levels (Maurer et al., 2017). The financial implications of health care reform with the implementation of the ACA remain a temporary solution with the revamping of health care, as it currently exists.

Medicaid and ACA address cost, utilization of services, and trends in the health care system. The forecasting of federal and state budgets regarding health care services is a complex task; roughly, 20% of a state’s budget consists of health care funds, second only to education (Gerstorff & Gibson, 2016). Health care spending is a national issue and reforms can result in increased health care expenses (Duijmelinck & van de Ven, 2016). Data collection is important because the resulting reports illustrate the cost efficiency of programs relative to the type of reimbursement model used (Eggbeer & Bowers, 2014). Financial and operational strategies that result from data collection prioritize cost containment, and health care outcomes are essential for the operation to be successful.

Many individuals affected by health care reform and who are covered by Medicaid (AHCCHS-Arizona) or the ACA reside in rural communities. Most of these

areas are underserved locations or populations that have other forms of payment for medical services, including deductibles or co-pays or, for patients with lower to moderate income, a sliding fee scale payment (Gao, Nocon, Sharma, & Huang, 2017). The reduction in health care costs may become pivotal to enhance our current health care system (Nocon et al., 2016). Consequently, smaller community clinics associated with an entirely different patient base may limit the number of health care providers. The health care coverage will fall into Medicaid and ACA categories, as they may be a split between either of these payer sources (Noether & May 2017). Conversely, demand for rural health care clinics to serve patients with low to moderate incomes remains essential within the community.

The economic impact of FFS and VBP revolves around increased patient volume for the rural clinic. Engagement with payer sources remains crucial for the organization, but a fixed amount of revenue from the FFS or the provision of high-quality care implied by VBP needs to be taken into account (Noether & May, 2017). Providing better care for patients, lowering costs, expanding health care coverage for individuals, and reinforcing infrastructure are the prime objectives (Kessell et al., 2015). Rural clinics thrive on increased volume, and the distribution of a higher quality of care will equate to lower costs. The organization's selection of a particular payment revenue cycle will translate into future financial success (Lubberink et al., 2017). Overall, the health care industry faces pressures for reform and to ensure health care services are cost-effective and delivered with quality.

Accounts Receivable Management and Health Care

An accounts receivable management strategy is a factor in the success of rural clinics (Aidoo-Buameh, 2014). Members of the management team with expertise in accounts management and those within the financial department who consult regarding payment collection are responsible for strategic planning (Lai & Gelb, 2015). Health care organizations manage their revenue cycles from billing and reimbursement from insurance companies (Boden, 2014). This highlights the importance of accounts receivable management, which is vital for the financial well-being of the medical practice.

The operational working capital is critical to profitability (Talonpoika, Kärri, Pirttilä, & Monto, 2016), which relies on accounts receivable management (Foerster, Tsagarelis, & Wang, 2017). A revenue cycle manager aims to ensure the collection of revenue for the organization (Mindel & Mathiassen, 2015). Payment delays are typical in the health care profession, unlike shopping at the grocery store or having a vehicle serviced.

Accounts receivable management involves collecting payment from patients and insurance payers. The accounts receivable component of any health care organization is paramount to the level of profitability (Shorr, 2015). Health services are available before payment, and the provider relies on the patient’s intention to pay. The business model for reimbursement for services provided by health care organizations is the intention to pay for the medical provider’s service (Gurganious, 2016). Accounts receivable management apply strategies to ensure payments made by patients and insurance payers for services

rendered are effective and efficient (Aidoo-Buameh, 2014). Rural clinic managers' ability to collect compensation from patients and insurance payers is essential for sustainability and financial independence.

The collection process enlisted by health care organizations attempts to maximize the revenue cycle management for the medical practice. The collection of payment for medical services rendered is not a direct process, but it is essential for the practice to thrive (Weinstock, 2015). Barriers to the collection process can include billing mistakes, insurance payers underpaying, or an inability to collect from the right patient due to misinformation (Shi, Zurada, Guan, & Goyal, 2015). Consequently, the incorporation of strategic planning within the rural clinic and implementing processes to prevent the lack of payment from patient and insurance payers becomes significant in the collection process. The monitoring of accounts receivables ensures payment is timely and that the dollar amounts owed to the organization decrease over time (Lail et al., 2016). The traditional form of compensation is the FFS model, as insurance companies pay for each service provided to the patient (Mabotuwana, Hall, Thomas, & Wald, 2017), and collecting payment on time is a formula for sustainability.

The accounts receivable management role influences the financial future of the rural clinic. The knowledge of where the revenue is coming from and the cost associated with services are vital components. The strategic planning implemented by the financial manager creates a primary construct for good fiscal control within the health care organization (Sheet, 2017). Health care organizations receive payment from patients and insurance payers through a mix of insurance types and payment methods (Loy et al.,

2016). Ultimately, the financial stability of the organization supports the accounts receivable management strategies, and financial management staff incorporates plans to maximize profits.

Analyzing accounts receivable revolves around the number of days it takes to receive reimbursement from the payer including patients, insurances payers, and government entities (Dong, 2015). The accounts receivable cycle breaks down into time increments by days, weeks, or months; an improvement in accounts receivable management will increase efficiency and profits (Aidoo-Buameh, 2014). Additionally, the incorporation of accounts receivable management strategies into the operations management will improve the consistency of payment from patients and insurance payers. Financial managers analyze the mix of patients and insurer plans (Johnson & Garvin, 2017). The accounts receivable manager strategizes with operations to identify ways to improve profitability and sustainability through the selection of patients and insurance types.

The financial and operational benefit of accounts receivable management is narrowing the margin between profitability and the cost incurred by the health care entity. The health care industry is going through extreme changes in which reimbursements are steadily decreasing (Yaduvanshi & Sharma, 2017). Operations management strategies must direct health care professional towards dealing with financial survival concerns (Krzakiewicz & Cyfert, 2017). Managing earnings within the context of a health care organization include reducing costs and increasing cash flow (Dong, 2016). Accounts receivable management must integrate strategic procedures in collecting payment from

patients and insurance payers to avoid cutting costs or provide ineffective care.

Transition

Section 1 consisted of the foundation of the study; I provided the background of the problem and purpose statements, nature of the study, research question, interview questions, and conceptual framework. As part of Section I, I also presented operational definitions, assumptions, and delimitations. In Section 1, I discussed the importance of the study and the review of the professional and academic literature on accounts receivable management strategies used by rural health care clinics to obtain timely payment.

As part of Section 2, I presented data collection techniques and data analysis. I finish Section 2 with the reliability and validity of the study. In Section 3, I introduced the findings and implications of my research. The information consists of the data collected, applications to professional practice, implications for social change, recommendations for action, further study, and my reflections as the researcher.

Section 2: The Project

In Section 2, I focus on the factors employed by rural healthcare clinic managers to implement accounts receivable management strategies to ensure timely payments from patients and insurance payers. The section included the restatement of the purpose statement, the role of the researcher, study participants, and the research method and design. Also in this section, I covered population and sampling, ethical standards, data collection instruments, and techniques. Furthermore, I concluded Section 2 with data analysis, reliability, and validity of the study.

Purpose Statement

The purpose of this qualitative multiple case study was to explore strategies rural clinic managers use to obtain timely payment from patients and insurance payers. Study subjects included clinic managers from five rural clinics located in southwestern region of the United States who have incorporated strategies to obtain timely payment from patients and insurance payers. The implication for positive social change could come from insights for clinic managers when they develop strategies to increase cash from accounts receivables, which may improve the financial stability of the clinic and increase the wellbeing of individuals in southwestern region of the United States.

Role of the Researcher

The role of the researcher is to ensure the quality and value of the study results (Isaacs, 2014). The qualitative researcher plays a significant role in the methodology and interpretation of the collected data (Swafford, 2014). In my role as a qualitative case study researcher, I identified participants and maintained a working relationship with

these participants during the study. I involved myself in every facet of this study including the selection of participants, selection of an appropriate research method, collection of data, transcribing interviews, data analysis, and writing an account on the outcomes.

Researchers incorporate their unique perspective to the research study (Brett et al., 2014). I have 12 years of healthcare management experience, in which I independently and objectively collected and analyzed relevant data. This experience provided me with knowledge that assisted in this doctoral study. In addition, I understand how my experience could predispose me to bias and this knowledge will help me minimize my personal bias.

Researchers must possess knowledge of ethical issues and challenges involving the study with the goal to attain accurate results (Sanjari, Bahramnezhad, Fomani, Shoghi, & Cheraghi, 2014). The Belmont Report issued in 1979 identified ethical standards and procedures for researchers to implement while researching human subjects (U.S. Department of Health and Human Services [USDHHS], 1979). The Belmont Report includes principles of respect for individuals, beneficence, and justice (USDHHS, 1979). The application of the Belmont Report provides research participants protection from undue harm or exploitation and ensures confidentiality for participants.

During the study, researchers recognize the potential harmful effects of defined beliefs or opinions regarding the phenomenon under study (Bradbury-Jones, Taylor, & Herber, 2014). Researchers implementing a case study methodology should have an awareness of the issues studied, as this awareness may become influential with the

understanding of the data collected (Yin, 2017). Some researchers may use other resources and place an emphasis on reviewing the data, as opposed to doing additional research to determine whether the data is acceptable or unacceptable (D'Andrea & O'Dwyer, 2017). Researchers need to be neutral during interpretation of the data and adopting neutrality will assist with potential future studies (Morgado, Meireles, Neves, Amaral, & Ferreira, 2017). In my role as the researcher, I reduced bias by maintaining high moral and ethical standards through integrity, professional competence, and extensively reading prior research related to the study. Researchers must be wary of bias, and at the same time, avoid having a negative mindset, which could affect objectivity (Simons, Bester, & Moll, 2017). Hence, to mitigate bias, I maintained an understanding of the topic and expectations of a researcher.

Researchers can increase the consistency of data collection using an interview protocol, which enhances the validity of the study (Yin, 2017). With the use of the protocol, a case study researcher can increase continuity and efficiency with the collection of data (Yin, 2017). The interview protocol is a vital aspect of the data collection process, as research design will have an influence on the data obtained and define the kind of analysis used in exploring the data (Manning & Kunkel, 2015). During the collection phase of gathering information, it is vital to review the information immediately as there could be a need to obtain further evidence (Yin, 2017). The setting up of the interview protocol for a case study is the basis for the audit path leading to the trustworthiness of data and eventually the quality of the research (Ang, Embi, & Yunus, 2016). Consequently, I used an interview protocol (see Appendix A) to determine a level

of trustworthiness during this study. A researcher must prevent misinterpretations or decrease bias (Thomas, 2017). The use of the interview protocol will assist me in reducing bias by treating each of the participants in the same manner.

Participants

A crucial element in choosing participants is that researchers identify participants with reliable knowledge of the research question (McCalman et al., 2017). The participants in a study focused on a balance between operational issues surrounding a patient-centered approach or using the older fee-for-service model for the collection of payment for services rendered (Pittmam, Masselink, Bade, Frogner, & Ku, 2016). Research participants should include only those who are readily available and willing to participate (Yin, 2017). The eligibility criteria for the participants in this study was individuals who work at a management level, (southwestern region of the United States, and who confirmed insurance payers for treated patients. Participants included clinic managers, accounts receivable managers, and the director of revenue cycle. These individuals remain involved in the direction of payment cycles and putting strategies into action to ensure payments occur promptly with no disruption to the organization.

The researcher must use strategies for gaining access to each of the preferred participants from each of the sites. Researchers may use specific resources and community support to acquire ideal study participants (Katigbak, Foley, Robert, & Hutchinson, 2016). A gatekeeper is an individual who has power and control over specific access within an organization, and negotiate terms and conditions to ensure the best interest of all parties was met (Caretta & Riaño, 2016). The ability to have access to

the gatekeeper is a challenge and building a relationship is a critical aspect of the foundation of the study (Brooks & Jean-Marie, 2015). Gatekeepers exist within the organization as responsible representation of the organization and protect the organizations' best interests (Rattani & Johns, 2017). As part of the study, I asked the gatekeeper, Director of Revenue Cycle Management to sign a letter of cooperation (see Appendix B) in conjunction with IRB approval process from Walden University to work with the gatekeeper identifying appropriate participants. I used the gatekeeper to identify appropriate documentation for triangulation of data in this study. Subsequently, after the gatekeeper signed the letter of cooperation and identified appropriate participants, I included an introductory letter (see Appendix C) to the participants inviting them to participate in the study. As part of the introductory letter, I incorporated the informed consent form which provides confidentiality and protects their privacy. Before conducting an interview, I asked participants to read, review, and sign the informed consent form.

Participants have a significant impact on the researcher. The roles of the researcher and participant deemed to be essential in all aspects of the study (Råheim et al., 2016). The formation of a working relationship existed early in the study with participants, as I provided a detailed explanation of the study, events, disadvantages and advantages of participating in the study, and adherence to confidentiality for participants. I also went over the study with the potential participants to make sure they fully understood the purpose of this study before agreeing to participate.

Research Method and Design

The purpose of this qualitative multiple case study was to explore strategies rural clinic managers use to obtain timely payment from patients and insurance payers. The researcher can choose between qualitative, quantitative, or mixed research methodologies to delineate an occurrence (Wilson, 2016). Researchers use a qualitative multiple case study design to explore and enlighten human experience (Yin, 2017).

Research Method

Rebs, Brandenburg, Seuring, and Stohler (2017) argued that quantitative research methods like analysis of empirical data produce stronger results than illustrated durable numerical examples. A quantitative researcher uses systemic numerical indicators, along with empirical inquiry to comprehend the existence of a phenomenon (Chang, 2017). A researcher’s selection of quantitative methodology exists as an expertly constructed process in obtaining clear, concise results either validating or disapproving a hypothesis (Saxena, 2017). A quantitative research method was not appropriate for this proposed study due to no testing of relationships among variables. Also, did not use the quantitative research method for the reason no hypotheses exist for this study.

The researcher bringing a mixed method approach incorporates strategies from both the qualitative and quantitative methods, and to integrate these practices to reflect inquire of importance (Mertens et al., 2016). The carrying out of a mixed methods research is difficult, as opposed to implementing a single research method (Yin, 2017). The mixed method researchers implement this method of research primarily based on the phenomenon under inquiry, which needs to be understood (Annansingh & Howell, 2016).

I eliminated the use of the mixed method research model, as I did not incorporate numerical data in this study. I implemented the qualitative method approach to investigate and interpret occurrences encountered by the participants.

To remain alert when a research question occurs, it is vital in fulfilling an outcome in the research methodology (Isaacs, 2014). The exploration of strategies used by rural health care clinic managers to ensure timely payment from patients and insurance payers dictate that I selected a qualitative research method. Qualitative researchers focus on what and how components of events revolve around individual experiences (Bazzano, Martin, Hicks, Faughnan, & Murphy, 2017). With the use of a qualitative research method, I improved my understanding of how clinic managers promptly collect payments amid difficult circumstances. The implementation of a qualitative research method entails the use of interviewing skills and observation and a systematic form of deduction to confirm or contradict findings (Arino, LeBaron, & Milliken, 2016). Researchers use a qualitative methodology to gain more in-depth information to provide further meaning.

Research Design

I used a multiple case study design to explore the research question as the case study approach allows the researcher to view the issue in a natural setting. The primary reason for the research design of a study is to lead the researcher through the collection of the data, analyze the information, and provide a deduction to the findings (Yin, 2017). The researcher's research design focuses on the research question and remains suitable to conduct the study (Santiago-Delefosse, Gavin, Bruchez, Roux, & Stephen, 2016). The

qualitative researcher can seek to use different design methods including case study, ethnography, and phenomenological (Colorafi & Evans, 2016).

Researchers use a qualitative multiple case study to reinforce study findings through replicating research at multiple sites (Solomon & Casey, 2017). Researchers use the case study design to explore phenomena using numerous data collection methods (Wang, Sadler, & Shee, 2017). Researchers use a qualitative case study design to focus on the *how* and *why* questions within a study (Fitzsimmons, 2017). I used a qualitative multiple case study to look at strategies rural clinic managers use to obtain timely payments from patients and insurance payers.

Ethnographers construct the possibility of exploration of insight and examination of shared patterns within individuals and cultures (Jaimangal-Jones, 2014). The researcher using ethnography design engages and learns more about a particular group of participants based on the interest (Desmond, 2014). Ethnographers engage extensive periods in the field investigating and connecting with a specific culture group (Rouleau, de Rond & Musca, 2014).

The examination of the culture within the rural clinic staff potentially could have provided valuable information. However, the purpose of the study did not include observation of the rural clinic staff, but reporting strategies applied by rural clinic managers to ensure timely payments from patients and insurance payers. For this study, an ethnographic design was not appropriate. Researchers utilizing a phenomenological design concentrated on the line of inquiry that focuses on the participant lived occurrence (Ziakas & Boukas, 2014). A phenomenological researcher's interest is to illustrate what

and how all participants' respond to the phenomenon encounter (Bourne, 2015). Using a phenomenological research design, a researcher firmly situates to describe and analyze possible interpretations from all participants during this investigative process (DeFelice & Janesick, 2015). The phenomenological research design was not an appropriate design for this study, as my objective was to delve into strategies used by clinic managers to obtain timely payment and not to look at participants lived experiences.

The data saturation approach used by the researcher exists on concepts identified as part of the study, along with the research method and design (Saunders et al., 2017). Boddy (2016) indicates that data saturation occurs at the point where no new information or themes detected in the data. A researcher conducting a qualitative research methodology uses exact data collection methods towards receiving an answer to the research question (Fusch & Ness, 2015). An occurrence may take place during a study in which a novice researcher due to their level of data saturation inexperience maybe at risk and unachievable (Wilkinson & Hayward, 2017). I interviewed rural clinic managers and financial personnel until I reached a point of data saturation, as indicated by no further substantial information or new themes emerged.

Population and Sampling

The purpose of this qualitative multiple case study was to explore strategies used by rural health care clinic managers to ensure timely payment from patients and insurance payers. The sample population for this study consisted of clinic managers and financial personnel from rural health care clinics in southwestern region of the United States. Researchers will select participants based on the role they play within the

organization concerning the research question (Palinkas et al., 2015). A researcher should be able to justify the inclusion of participants in a study (Cleary, Horsfall, & Hayter, 2014). The participants must meet parameters within the purpose of the study to reduce the potential risk for inauthentic or improper settings and processes (Khan, 2014). The selection of participants exists on the premise that the information generated is plentiful and insightful to the research topic (Mountford & Kessie, 2017). Consequently, the sampled population supported the research question: What strategies do rural clinic managers use to obtain timely payments from patients and insurance payers?

I used purposive sampling as the sampling method for this research study. Researchers use the purposive sampling method to obtain participants based on their extensive knowledge or verbal expression within a group or subculture of their belonging (Gentles, Charles, Ploeg, & McKibbon, 2015). The sampling of a study must represent an accurate alignment of the purpose and ideas throughout the study (Solomon & Casey, 2017). Researchers use sampling to enhance the effectiveness used through the collection of data to validate the study (Sharafizad & Coetzer, 2017). For this study, I purposively selected rural clinic managers and financial staff because they are in the position to provide detailed information and insight into their experience and familiarity with timely payments.

Data saturation and gathering takes place after which data collected is repetitious, and no additional data can be acquired (Pourghane, Ahmadi, & Salimi, 2017). Data saturation is confirmation of high-quality information tested to solidify the validity and reliability of the study (Wang, Gellynck, & Verbeke, 2016). A qualitative researcher will

cease the interviewing of additional participants recognizing no further information will emerge complementing the phenomenon studied (Gligor, Esmark, & Gölgeci, 2016). Data saturation happens through the beginning analysis of data collected when rural clinic managers and financial staff provide no new information on strategies to obtain payments from patients and insurance payers. The sample size of this study was 10 rural clinic managers and financial staff within the rural clinic setting.

A researcher can use interview surroundings to put the participants in a state of increased comfort or feelings of ease by conducting interviews in a place of neutrality and privacy (McGhie-Anderson, 2017). I conducted face-to-face in-depth interviews at the location of the clinic managers or financial staff members to ensure the wellbeing of all participants in the study. The participants in the study chose their work setting as a place of comfort and security to conduct the interviews. The participants feel comfortable in a face-to-face interview and are placed in a setting to discuss feedback results relevant to the event studied (Strasser, 2017). The participants provided commentary with confidence in an environment free from disruption with an ability to share their observations (Wardale & Lord, 2017).

Ethical Research

The participant informed consent process is critical to control ethics regarding the research of the study (Graham, Powell, & Truscott, 2016). The method of informed consent keeps the lines of communication open with the participant and provides comprehension and education within the context of the study (Gordon, Mullee, Skaro, & Baker, 2016). By presenting and reviewing the consent form (see Appendix D) with

participants, I ensured the explanation of the study, their rights as participants, and my contact information as the researcher. Before interviewing the participants, I ensured that I attained a signed informed consent from each participant. Also, each participant received a copy of the document for his or her records.

A researcher must allow a participant the opportunity to withdraw from the research study at any time and without reason (Hinnekens, Vanhee, De Schryver, Ickes, & Verhofstadt, 2016). The participants received a copy of the informed consent in the initial phase of the study; provisions within the context of the informed consent allow the participants to withdrawal at any time (Nilsson et al., 2016). I explicitly stated that the participants may request to withdrawal or opt out of the study at any time, without repercussions.

I reiterated to participants that participation was strictly voluntary and no financial incentives were part of this study. McNaughton, Adams, and Shucksmith (2016) asserted that offering financial incentives may be ineffective and counterproductive. The provision to provide monetary incentives or stipends reduced the level of participation (Begley, McCarron, Huntley-Moore, Condell, & Higgins, 2014). Some financial incentives offered by researchers encourage participants to provide valuable information (Smaglik, 2016). I restated that participation in this study was strictly voluntary and there are no incentives for participation in the study.

I protected the confidentiality of the names of the participants by not including identifiers that may allow others to determine the names of the participants in the study. The concealing of participant identities is a primary goal of researchers to ensure

discretion (Raman & Pramod, 2017). To protect the anonymity of participants, I used pseudonyms to ensure privacy. I ensured that only I have access to the interview information.

After I collected and analyzed study data, I stored all confidential study information in a secured file cabinet at my home. After 5 years of securely storing the data, I intend to shred all interview notes, paper files, consent forms, and delete any electronic files or data stored in my possession. Finally, I remained compliant with the requirements outlined by Walden University Institutional Review Board to ensure the welfare of the participants.

Data Collection Instruments

In qualitative studies, a researcher is the principal data collection instrument (Yin, 2017). As a primary data collection instrument, a qualitative researcher engages directly with participants, and the engagement will have an impact on the study (Forsythe et al., 2016). Hasle, Limborg, Grøn, and Refslund (2017) stated that qualitative researchers collect data through interviews, a review of written organizational and archival documents, email correspondence, and observations. As a qualitative researcher, I was the primary data collector for this research study, and I ensured the implementation of the semistructured interviews as part of this research study.

A qualitative researcher can use semistructured interviews to seek information and clarification on vital points in the study (Shalhoub, Marshall, & Ippolito, 2017). I conducted face-to-face semistructured interviews utilizing open-ended formatted questions to collect data for this study. Researchers who use semistructured interviews

connect with participants and elicit responses about experiences in the study (Fowler, Coffey, & Dixon-Fowler, 2017). A researcher using semistructured interviews has a predetermined list of questions going into the study (Van den Berg & Struwig, 2017). The semistructured interviews for this study comprised 10 prearranged open-ended questions that primarily focus on the pivotal phenomenon of the study. Each semistructured interviews lasted 30-45 minutes. During the semistructured interview process, I asked participants constructive interview questions, stayed accommodative, and avoided biases.

A qualitative researcher will use triangulation of multiple data sources to develop a comprehension of the phenomena within the study (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). A qualitative researcher applies triangulation less as a strategy for the validation of results than an option to validate the consistency, intensity, and range of a study (Wilson, 2014). A researcher needs to be exact about the collection and analyzing of the data to support rigor within the study (Tibben, 2015). I implemented methodological triangulation to promote the authenticity, consistency, and accuracy of the study. As a researcher, I employed methodological triangulation by including referred organizational documental evidence to include IRS Form 990 form, specific health center data from Health Resources and Service Administration (HRSA), and casual observations of the environment to enhance my data collected from face-to-face interviews. Arfaoui, Damak-ayadi, Ghram, and Bouchekoua (2016) stated the selection of methodological triangulation allows for control over possible bias and the empirical justification for the study. The data collection methods I used included informal observation, semistructured

interviews utilizing open-ended questions, and an examination of the documental support within the study. Documental support that I collected consists of policies, internal organizational data, and other relevant in-house documentation.

Member checking is a proven technique used by qualitative researchers to ensure the validity and accuracy of the study (Schaik, O'Brien, Almeida, & Adler, 2014). A researcher will use member checking to ensure the findings become available to the participants before the completion of the study (McNulty, 2015). To make sure accuracy and authenticity exist as part of the data collection process, a qualitative researcher can make use of member checking (West, 2015). I applied member checking by asking participants to validate my conclusions and emergent themes from the interviews.

A qualitative researcher is the prime data collection instrument and must prevent any or all misinterpretations from decreasing bias (Thomas, 2017). Researchers use interview protocols steadily as a gradual progression to direct them through the interview process (Karen, Kennedy, Hunter, & Maksabedian, 2016). Yin (2017) stated a researcher could use interview protocols to obtain access to significant participants and coordinate schedules to complete the collection of data at any time during the study. A researcher will use interview protocols to focus and concentrate on structural boundaries of the study to reduce the risk of bias (Venkat, Shank, Rickard-Aasen, Pringle, & Johnjulio, 2017). I consistently applied the same questions, in the same order, to help minimize investigator bias. Using an interview protocol (see Appendix A), I was able to adapt each interview consistently reducing researcher bias.

Data Collection Technique

Data collection included open-ended semistructured face-to-face interviews and a review of documental resources. The data collection techniques of researchers include detail processes aimed at assembling relevant information connected to the phenomenon of interest (Eisenhardt, Graebner, & Sonenshein, 2016). A researcher will use multiple data sources within the same study to ensure validity (Aslinda & Ibrahim, 2016). Data collection techniques for this doctoral study involved 10 face-to-face semistructured interviews utilizing open-ended questions (see Appendix E), documental evidence, and informal observations. All interviews were conducted at the business site and conducted during regular business hours. Researchers use semistructured interviews to probe beyond the participant's responses to gain further insights, perceptions, and experiences related to the research phenomenon (Peters & Halcomb, 2015). A qualitative researcher uses semistructured interviews to allow participants to offer their experiences as a contributor to the study (Campbell, Manns, Hemmelgarn, Sanmartin, & King-Shier, 2016). As a qualitative researcher, I implemented documental support, and informal observations to explore the strategies required by rural health care clinic managers to obtain timely payments from patients and insurance payers.

Participants who were willing to participate in the study received the consent form in advance through an in-person visit. Before conducting interviews, I visited each prospective participant during an in-person onsite visit to provide and review the informed consent form (see Appendix D). After the meetings, participants signed the informed consent documents and provided a copy to me of each signed form. The

following week I called or emailed each of the 10 participants to schedule a date, time, and place for the interview. Before conducting each interview, I informed participants that I would be recording the interview using a portable electronic audio recording device to ensure accurate data transcription.

Researchers use semistructured interviews to explore further insight from the participant's perspective to expand on added knowledge of the phenomenon studied (Yagasaki, Komatsu, & Takahashi, 2015). I used audio recorded semistructured face-to-face interviews and documental analysis to explore strategies implemented by health care leaders to increase profitability. A researcher will use semistructured interviews to collect data identified by participants as experiences during the study (Spinks, Chaboyer, Bucknall, Tobiano, & Whitty, 2015). The rationale for using this protocol was to make the process easier and more manageable for the participants. Researchers utilizing semistructured interviews will have a comprised set of listed open-ended questions with no preconceived designed response options (Alhaddad, Smith, Robertson, Watman, & Taylor, 2015).

I followed my prescribed interview protocol (Appendix A) questions to engage in an extensive exchange with the participants. A prepared researcher will effectively employ interview questions to evoke hidden or imperceptibly improper data (Mlinar, Petek, Cotic, Metka, & Zaletel, 2016). A researcher will use informal observations to access pertinent information as depicted by the participants in the study (Joe, Young, Moses, Knoki-Wilson, & Dennison, 2016). A researcher will interject realistic actions or events of participants while observing (Yin, 2017). I carefully assured all these elements

during the interview process by reviewing all journal entries and documented notes at the conclusion of each interview.

The qualitative researcher uses member checking to allow the participants to review the interview transcript or data interpreted in the study (Birt, Scott, Cavers, Campbell, & Walter, 2016). Member checking is the method a qualitative researcher uses concerning the acquisition of participant feedback and confirming the authenticity of the findings (Charmaz, 2006; Harvey, 2015). A researcher implements member checking as part of the interpretative portion of the data collection for increasing confidence and validity (Dorsey, Conover, & Revillion-Cox, 2014). To ensure reliability within this study, I presented my findings to the participants with my interpretations of the interviews and provided them with the opportunity to corroborate the accuracy of my interpretation of the collected data as part of this study. I emailed my summary to the participants within 7 days of the interview and asked for a response within 14 days of receiving the summary. There were no significant changes during the review process, and all information was confirmed through an email sent to participants verifying all interview responses. As part of the member checking process, participants confirmed the accuracy of my interpretations during the interview.

Data Organization Technique

A researcher organizes data based on the relevance of the data to the study framework (Nielsen & Nielsen, 2015). Yin (2017) detailed that a qualitative case study researcher should organize data based on the relevance of the research question. A researcher will organize data in a form that safeguards the integrity and confidentiality of

the information (Van Zyl, Mathafena, & Ras, 2017). My objective was to develop a proficient data technique; I created a research log utilizing an Excel spreadsheet to keep a structured record of the dates of the interviews, names of the interviewees, and other data acquired from participants and online searches. A researcher uses reflective journaling to document personal accounts with participants along with a provisional for opportunities for questions, feedback, and critiquing (Baillie, 2015). Also, I maintained a reflective journal that includes notes from interviews, observations, and analysis of organizational documents. A qualitative researcher applies coding to aid in the process of data organization (Chowdhury, 2015). Thus, I used the coding process to assist in the organizing and retrieval of data in my research log.

Researchers ensure sensitive information remains encrypted and compliant with ethical guidelines. Researchers initiate protective measures stay in place by using a password-protected filing system secured in a locked cabinet (Fairfield & Shtein, 2014). A researcher must ensure data remains secure to prevent unauthorized discovery or use (Peng & Gala, 2014). To ensure the confidentiality of participants, I stored all data collected in a password-protected personal computer, and hard copies of information accumulated will remain secure in a locked file cabinet. Researchers need to predetermine a retention policy (Cullington et al., 2016). After 5 years of securely storing the participant data, I intend to destroy all written documents and electronic data from all electronic devices used to gather information.

Data Analysis

Qualitative data analysis coincides with the exploration, categorizing, and coding of data into themes (Iancu, Zweekhorst, Veltman, & van Balkom, 2015). Data analysis entails multifaceted and contextually rooted data generated with the intent to prepare, manage, and report from the perspective of multiple sources (Patterson, Smith, & Bellamy, 2015). Data analysis is one of the most challenging aspects of research, especially for a beginning researcher (Yin, 2017). The data analysis process suitable for this case study research was methodological triangulation. Wilson (2014) provided a practical approach regarding the four aspects of triangulation including data, investigator, methodological, and theory. In methodological triangulation, a researcher implements a series of data collection techniques and analysis in the exploration of a phenomenon (Oleinik, 2015). Thus, I employed three collection methods including face-to-face semistructured interviews utilizing open-ended questions (see Appendix E), review of organization documents, and informal observations to enhance the validity of the findings of this study.

Using a logical and sequential process addressing multiple facets of the study is a crucial component of the researcher's data analysis process (Pradabwong, Braziotis, Pawar, & Tannock, 2015). The data analysis process for a researcher begins immediately after conducting the initial interview and throughout the research process (Fletcher, 2017). A case study researcher will have strategies in place to ensure a prominent role in linking the collected data to the research question is at the forefront (Yin, 2017). Rose and Lennerholt (2017) defined the data analysis process consisting of (a) acquiring data

and related sources, (b) extracting, coding, and formatting information in an orderly manner, (c) grouping data into subject matter, (d) analyzing and assessing text, and (e) interpreting results and formulation a conclusion. After collecting the data from the participants through semistructured face-to-face interviews, document reviews, and informal observations, I immediately transcribed each interview and field notes. Subsequently, I organized the data into thematic relevance as recommended (Percy, Kostere, & Kostere, 2015). The coding process ensures themes remain grouped into categories (Percy et al., 2015). Once coding the data into segmented themes, I presented my preliminary findings to the participants to confirm the emerging themes through member checking and follow-up emails to the participants. A qualitative researcher interprets the data to ensure consistency and significance (Chavira, Bustos, Garcia, Ng, & Camacho, 2017). I complied, disassembled, and reassembled data to develop a final list of emergent themes.

The use of computer-based software in the process of data analysis assists researchers reflect on the data in the thematic development process (Zamawe, 2015). The options of qualitative data analysis vendors include NVivo, ATLAS.ti, RQDA, and MaxQDA (Chandra & Shang, 2017). NVivo is an efficient system used by researchers to assist in interpretation and time management while developing qualitative themes (Heisler, Firmin, Firmin, & Hundley, 2015). A researcher can use NVivo to influence data by deriving codes and rules connected to the data to affect bias (Sotiriadou, Brouwers, & Le, 2014). I applied NVivo 12 Plus software in the data analysis portion to assist in the retrieval of information and to salvage time.

A researcher will implement a thematic analysis to uncover a collection of patterns associated with the themes (Braun & Clarke, 2006; Fugard & Potts, 2015). Researchers use thematic analysis as a means to capture and organize data in a way to derive meanings and create a detailed understanding (Crowe, Inder, & Porter, 2015). A researcher should ensure thematic interpretations are a direct reflection concerning the research question (Henning et al., 2015). Researchers use a thematic analytic process to ensure appropriate analysis of data (Gallagher, Phillips, Lee, & Carroll, 2015). I used NVivo 12 Plus for my thematic analysis to create and organize essential themes. Through the triangulation process, I developed themes with supporting documentation from financial information reported in the IRS Form 990, specific health center data from the HRSA form, and my journal notes. Included in my journal notes were comments I made related to my observations of the environment. The RBV theory was the framework I used to explore the themes related to improving receivable collections of accounts.

Reliability and Validity

Reliability and validity of a qualitative research study are essential components of research dependability (Bengtsson, 2016). Reliability and validity are critical standards to the construct of a qualitative researcher emphasizing objectivity as the primary purpose of research (Power & Gendron, 2015). In evaluating reliability and validity of a qualitative study, a researcher can use the criterion of dependability, credibility, transferability, confirmability, and data saturation (Dubois & Gadde, 2014; Yin, 2017). The reliability and validity of a study substantiate rigor and integrity of the research

findings (Cypress, 2017). I incorporated reliability and validity strategies during my study to improve trustworthiness.

Reliability

A researcher should consider reliability within the context of a research study (Fida et al., 2016). Dependability contains the essentials of stability of data over time under different conditions (Holm & Severinsson, 2014). A researcher will establish reliability to ensure details of the qualitative study transpire in a detailed manner (Eriksson, 2015). To assess dependability, a researcher addresses internal and external auditing to ensure the reviewing process occurs in a research study (Smith & Smyer, 2015). As a researcher, I preserved an auditing path to augment the assessment of dependability of this study. The relationship between dependability and quality ensures the processes and rigor in the study (Lin, Han, & Pan, 2015). In alignment with (Lin et al., 2015), I employed member checking with participant follow up. Participants reviewed my preliminary themes and validated my interpretation of the collected data. Makola (2015) provided a detailed approach that a qualitative researcher uses member checking to concentrate on emerging themes, confirm findings, and elicit precise results. A qualitative researcher uses intrinsic and extrinsic motivation in member checking, thus ensuring themes are precise, thorough, and interpretations are practical (Bassous, 2015). To enhance the reliability and validity of findings in this study, I established several sources of data collection including face-to-face semistructured interview using open-ended questions, a review of organizational documents, and observations. Organizational

documents will include policy and procedures, collection templates, and other significant internal documents.

Validity

According to Leung (2015), reliability and validity are primary principles for a study. Validity entails the degree of accuracy of data (Chahal & Dutta, 2015). A researcher can confirm the validity of a research discovery by upholding the formulation of internal consistencies in the research process (Slife, Wright, & Yanchar, 2016). To confirm the validity of the study, a researcher can use to support the fundamentals of credibility, transferability, confirmability, and data saturation (Bennett & McWhorter, 2016; Yin, 2017).

Credibility. Qualitative researchers can augment the credibility of the findings in a study by determining dependability from the perspective of the participants (Munn, Porritt, Lockwood, Aromataris, & Pearson, 2014). Schipper et al. (2014) purposed the use of reflective journaling and member checking as methods researchers can implement to confirm findings in the study. A qualitative researcher can establish credibility when a participant confirms the findings brought about by the researcher (Rosenthal, 2016). Researchers use member checking to gain further insight into the phenomenon of the study (Welch, 2017). To address credibility, I established member checking and reflective journaling. Both techniques allowed me to maintain a comprehensive, detailed account of the participant interviews and subsequent interpretation of the data.

Transferability. Researchers meet the criteria of transferability if the findings add meaning to studies in different settings (Rapport, Clement, Doel, & Hutchings,

2015). Researchers can ensure transferability when the results of the research involve a degree of importance to other groups (Pompeii, 2015). The intensity of transferability increases as researchers present a detailed description of data (Vermeulen, Niemann, & Kotzé, 2016). In demonstrating transferability future researchers crossing multiple disciplines and readers of a study could find the data resourceful and valuable (Smith et al., 2015). To enhance transferability, I ensured to provide adequate information regarding the details of my study.

Conformability. The conformability criteria arise from the data accuracy of information and data provided by participants (McInnes, Peters, Bonney, & Halcomb, 2017; Polit & Beck, 2010). Rich, Viney, Needleman, Griffin, and Woolf (2016) assert that conformability as the neutrality of the researcher in the research process. A qualitative researcher can apply conformability by establishing an audit trail by ensuring the research method is engaged in the study (Ang et al., 2016). I used methodological triangulation to assure conformability. In methodological triangulation, researchers employ multiple data collection methods to investigate a phenomenon (Fusch & Ness, 2015). I used different data collection methods including face-to-face semistructured interview using open-ended questions, a review of organizational documents, and observations.

Researchers reach data saturation at the point when collecting additional data does not produce new ideas relating to the phenomenon of the study (Saunders et al., 2017). Researchers use data saturation to increase the level of reliability and validity of the findings of a study (Fusch & Ness, 2015). At the point of sufficient data saturation, a

qualitative researcher will cease with interviews (Boddy, 2016). To ensure data saturation, I continued to conduct interviews until no new or sufficient data to replicate the themes identified in the study.

Transition and Summary

Section 2 consisted of a comprehensive description of this study. I started Section 2 by restating my purpose statement. Next, I expanded on my role as the researcher with provisions including in-depth accounts about the participants selected for the study. As part of Section 2, I described the research method and design along with the population and sampling. Next, I included ethical research and established data collection instruments, techniques, and organization. Furthermore, I concluded Section 2 with data analysis, and methodology addressing reliability and validity.

In Section 3, I presented the research findings and the application of professional practice and implications for change. In the introduction, I reiterated the purpose statement and research question. I also presented study findings and applications to professional practice. Finally, I inquired into the applications for social change, recommendations for action, further research, reflect on the research process, and concluded the study.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The objective of this qualitative multiple case study was to explore strategies rural clinic managers use to obtain timely payment from patients and insurance payers. The processes and strategies used by rural clinic billing staff establish and maintain profitability and sustainability for the entire organization. As a result, multiple revenues generating strategies exist that financial billing staff uses to increase economic prosperity. After interviewing participants and reviewing other document sources, I identified four major accounts receivable management strategy themes: (a) communication between medical providers and billing staff, (b) payment plan set up, (c) accuracy of billing claims and (d) consistent accounts receivable reviews. These themes represented strategic approaches to assist financial leaders in collecting payments from patient and insurance payers in a timely and efficient manner.

Presentation of the Findings

The overarching research question for this study was: What strategies do rural clinic managers use to obtain timely payments from patients and insurance payers? To answer the overarching research question, I conducted semistructured face-to-face interviews with a combination of 10 clinic managers and billing staff from rural clinics in southwestern region of the United States. During the interview process, I followed an interview protocol (see Appendix A). I called and spoke with both the Director of Revenue Management and Accounts Receivable Supervisor to obtain permission to meet with each participant individually and asked each participant the same set of questions in

the same order. I informed each participant that each interview would be audio recorded and I would be integrating their responses into the documented results. The semistructured face-to-face interviews occurred at the request of the Director of Revenue Cycle, and dates and times were allotted to meet the needs of the research participants. At the instruction of the Director of Revenue Cycle, who was also the gatekeeper, I received a list of participants and used the list to organize each individual interview. The interviews took place over a 2-day time span; however, I returned on a third day to meet individually with the Director of Revenue Cycle for a followup interview.

The data collection configuration appropriate for this study was methodological triangulation. Triangulation is collecting and examining multiple data sources (Wilson, 2014). To gain a dynamic understanding of strategies implemented by rural clinic billing staff and clinic managers to maintain profitability and sustainability for the organization, I chose this method.

I coded the participants CL1 through CL10. I confirmed my interview data through methodological triangulation. Additional data sources confirming my interviews included data from reviewing HRSA documentation and the IRS-990 form along with casual observations. I also met with both the Accounts Receivables Supervisor and Director of Revenue Cycle to process accounts receivables strategies for capturing payment from patients and insurance payers to ensure sustainability and profitability.

Yin (2017) provided researchers with a multiple step data analysis process: (a) collection, (b) dismantling, (c) aggregation, and (d) interpretation. I used each of these steps for data collection and analysis. I collected information by taking notes during the

interview process. After each interview prior to ending the recording, I verified the identity of the participant, their specific job title, and the date and time of the interview. I also emailed a transcription copy to each participant to allow them to corroborate the data. I transcribed the taped results with Microsoft Word. The aggregation of the information occurred as I transferred transcribed audio interview results into NVivo 12. I used queries, narratives, accounting of the results, and coding to identify significant themes during the interpretation process.

I wrote up my conclusions following the data interpretation. Throughout the data analysis process, four main themes emerged: (a) communication between medical providers and billing staff, (b) payment plan setup, (c) accuracy of billing claims, and (d) consistent accounts receivable reviews. The rural clinic managers and billing staff were all consistent in terms of their standards regarding these four major themes for accounts receivables strategies that improve sustainability and profitability.

Theme 1: Communication Between Medical Providers and Billing Staff

All but one of the 10 study participants articulated how consistent communication between medical providers and billing staff provides stability, which increases profitability. CL1 explained that specific departments, for example obstetrics and gynecology, will incorporate billing requirement changes from specific payers regarding billing for obstetrics and referrals. These changes are communicated to the billing office. CL1 mentioned that medical assistants (MAs) provide required information regarding encounters with patients, and all billing codes are used and sent to the insurance company

for reimbursement. CL1 stated, “Without the front desk, without the MAs, and without the doctors, we wouldn’t be able to bill the claim.”

CL2 explained that it was essential to ensure that billing staff update patient demographics with correct information. Obtaining correct and timely information requires a high level of communication between the medical provider and billing staff. CL2 stated, “We make sure that we [billing staff] go from time to time to the front office to make sure that they are doing everything correctly and entering everything correctly.” CL2 explained the importance of ensuring charges match medical diagnoses and procedures performed by the medical provider. In order to increase communication with medical providers, billing staff monitors patient accounts to determine if the accounts are current or inactive. CL4 described effective communication as the process of updating patient information. CL5 also confirmed the importance of consistent communication with other departments:

> It [billing] affects our doctors, our medical records staff; it is a team effort. Whatever the front desk person does, what the medical doctor does in the notes, whatever he is going to charge and a bill to when we get it, as it is truly a team effort. There is no way to get around it.

CL7 added that they review patients’ financial charts to ensure that payments occur and verify previous payments. CL8 identified that the primary indicator of prompt billing was the timely documentation of the services received from the provider to submit for billing purposes. CL8 in addition stated “the encounter [patient visit] is complete and

submitted for billing within 72 hours." The timeliness of the billing will ensure that claims submitted to the insurance payer are received and payment occurs.

CL9 further added that communication with other departments improves billing accuracy. CL10 focused on how accurate information reduces the possibility of insurance payers denying or rejecting a claim. CL10 described the importance of closing the encounter and promptly submitting the claim. CL10 alluded to the open lines of communication between medical providers and billing staff was important to ensure correct billing information resulting in increased revenue. During the interview process at the central billing location, I observed interaction between billing staff, coding staff, accounts receivable supervisor, and the Director of Revenue Cycle Management. I noted collaboration within the various departments, which ensured the accuracy and timeliness of claims.

Gurganious (2016) said that the reimbursement model for services provided by healthcare organizations is intended to pay for the services the patient received from the healthcare provider. The profitability of healthcare organizations depends on effective communication between medical providers and billing staff, who oversee the reimbursement process for the services provided. The RBV is a relevant framework for a service-based industry such as healthcare. The concept of providing continuity of care for the patient and the ability of the organization to win the confidence of the patient increases its competitive advantage and improves its financial performance (Lin et al., 2015). Al Achkar et al. (2018) indicated apart from ensuring clinical services remain adequately compensated, accurate coding and billing reflect the appropriate assessment

of the complexity of medical conditions. CL2 stated ensuring demographic information is correct, in order to assure correct billing information and avoid declined claims, and communication between the medical providers and the billing staff are crucial for timely reimbursement.

CL1, CL3, CL5, CL9, and CL10 shared that consistent communication departmentally between providers and billing staff are vital and without one another the claim could not be submitted for payment. These comments align with Mkanta et al. (2016) who stated that the U.S. health care officials must focus on the cost and quality of health care and evaluate operational aspects, including scheduling of providers, clinical methods, payment methods, and management structures. All, but one of the 10 participants confirmed that communication between medical providers and the billing staff are imperative towards the consistency of billing which affects increased profitability.

Theme 2: Payment Plan Setup

The second identified theme from this study was the payment plan setup to ensure that payment occurs at the time of the medical encounter. All 10 participants mentioned the flexibility of setting up a payment plan that meets the needs of the patients and their monthly budgetary constraints was important. During the interview process, the study participants each expressed collectively the ease in which payment plans are setup specifically to address the patient’s financial needs. CL1 shared that discounts and sliding fee scale payment are arranged for those patients who are uninsured or under-insured. CL1 stated:

> We can offer a small payment plan for those patients before sending them to collections even if we do send them to collections, $5.00 or $10.00 a month, something that can work for them. We work on a payment plan, even if it is a small dollar amount. Whatever the patient's financial needs are, that's what we work with.

CL2 further added that the sliding fee scale payment option was available and if a patient comes in with no health care insurance, they are offered a 30-day discount. The objective of the biller is to collect a form of payment or instead of no payment, a partial payment is an acceptable means of collection. A sliding fee scale intends to assist the patient to make a form of payment and helping the patients is a form of excellent customer service. CL3 stated, "Usually it depends on what the patient can give, and some patients give $20, and some give $50, it depends on what the patient can do at that time." CL4 indicated that if a patient was already in collections, an alternative to making a payment to the collection company would be that the organization accepts payment in the billing office. CL4 stated, "We do take a lot of payments from people who are already in collections. They always say they would much rather talk to us than the people in the collections."

CL5 added that a discounted payment plan applies to single individuals, as well as families and children. CL5 also mentioned that before the patient visits the front desk, personnel inform the patient of the co-pay or deductible. If the patient cannot afford to make the entire co-payment or deductible, arrangements occur at the time of the appointment for payment options. CL6 stated, "We always try to work around and help

them [patients] out if they have little income." The implementation of the payment plan ensures revenue for the organization and the ease in which the patient can make a payment promotes community engagement.

CL7 indicated the flexibility of the payment plan and the expectation is not that the patient makes the full amount at one time. CL8 added that discounts are offered depending on a patient's level of income. CL8 stated, "Payments can pay as little as $15, $20, $38, and up to $43. Again, based on their income, how many in the household, we can reduce down their office visits." CL9 shared the uniqueness of the organization is their ability to engage the patients in a payment plan that serves both the uninsured and under-insured population. During the interview process, I had the opportunity to observe clinic staff engage patients, address their co-pays, and address methods of payment for their medical encounters. CL10 added that for some of the patients the sliding fee scale is a primary option. As CL10 stated, "Using a sliding fee scale is a requirement of being a federally-funded community health center. We offer a type of discounts to low income patients. We also offer payment arrangements up to 12-month for balances over $150." CL10 further added that the health center accepts credit and debit cards and can set up the payment arrangement through the credit or debit card. Having a payment plan setup increases flexibility and improves financial options.

Theme 2 findings, payment plan setup, are also relevant to RBV conceptual theory and an ability of billing staff to win the confidence of patients, which improves accounts receivable collections. According to Lai and Gelb (2015), the goal of billing department managers is collecting payments from insurance payers with limited obstacles

or delays. Business leaders manage internal resources to keep revenue consistent with the organization's long-term financial growth. The profitability of an organization relies on the implementation of strategies based on organizational resources (Liu et al., 2017). One of these corporate organizational procedures is a payment plan. Once the payment plan setup is confirmed, commitment to consistency in the collections process is essential. Study participants were specific that operational approaches, such as payment plan setup, produced positive results by improving customer satisfaction and improving the medical care experience.

Farnsworth (2015) further confirmed in the literature the evolutionary process of improving accessibility to services, improving quality of care, and reducing costs affects the generated revenue. Health care leaders are developing an infrastructure to move away from previous approaches to payment methods and revenue generation (Conrad et al., 2016). The evolutionary process of billing from paper to electronic has quickened the timeframe in which providers receive revenue. In recent literature since this study, payment collection methodology focusing on factors involving a patient's insurance plan as reimbursement potentially may become modified with minimal notice (Tamblyn, Winslade, Qian, Moraga, & Huang, 2018).

Evidential to the second theme, all 10 participants discussed the importance of offering a payment plan setup for uninsured and under-insured patients. As a result, the participants identified that making a payment plan setup available to patients established a consistent flow of revenue for the organization. The payment plan set up option gives patients financial flexibility which, in turn, builds community rapport. Chen and

Goldman (2016) alluded to health economics playing a pivotal role in identifying a payment system that benefits the providers and the patient. By introducing a payment plan, patients are able to receive care and rural clinic mangers are able to receive timely payments

Theme 3: Accuracy of Billing Claims

I observed how the billing staff focused on gathering accurate information for billing claims. All 10 participants mentioned that accuracy in billing was one of the primary results of prompt revenue collection. Themes 2 and 3 relate to revenue and profitability, which are connected. Study participants mentioned effective billing ideas and processes 53 times, which reinforced foundational components for organizational leaders, clinic managers, and billing.

CL1 stated, “Make sure the ‘I’s are dotted, that everything is completed the first go around because the more you submit the greater chance you have of the claim not being paid in a timely manner. The more you work on it, the more it costs the company to get paid on that claim.” CL2 indicated that the biller who is placing the information on the claim must ensure that the information is correct with no mistakes. This strategy of focusing on accuracy reduces the number of claim resubmission due to errors. CL5 further stated, “Each insurance has their time in which we can bill before it is either processed to pay or it can be denied and they we have some additional time that we have for denials.” CL5 stressed the importance of gathering the information correctly to process the claim promptly with an emphasis on receiving the reimbursement quickly without delay.

CL6 stated, “If there are any errors in the claim, we want to make sure we get that fixed as soon as possible.” CL6 added that billing on time was the key component; but if charges remain denied, working on the claim quicker will increase the process of receiving payment in a shorter period. CL8 added, “As a biller, keeping up with the changes in the organization with regard to claims billing and processing is important. It is important to read, research, and keep informed of what is coming up that may affect your organization, so you can help the organization.” CL10 explained that with the information technology (IT) and software any errors or missing information that does not relate to the medical encounter could be detected. The comment from CL10 supported this conclusion:

> A lot of our staff members review the denials and will sparse it out depending on who is responsible for what aging. Then the charge entry sends them back to the staff for reviews so not only are they correcting the staff but learning for future claims the help reduce the same mistakes.

Further, health care leaders must deal with payment delays and unreimbursed services (Cascardo, 2015). Theme 3 substantiated the overarching research question: What strategies do rural clinic managers use to obtain timely payments from patients and insurance payers? In health care, organizations emphasized improved patient satisfaction, reduced costs and increased productivity at all levels of the organization (Chiarini & Vagnoni, 2017). Cascardo (2018) concluded that staff training increases the productivity of billing staff. Revenue cycle leadership must be involved in all aspects of the billing staff from training, continuing education, coder application, and audit resources to be

successful in the billing of claims (Cascardo, 2018). The goal of leaders is to develop a fully engaged billing department, which is a critical element of the reimbursement process.

Other forms of payment include private payment insurance, direct payment, and a sliding rate based on the ability of the patient to pay (Barbaresco et al., 2015). Angeli and Norwood (2017) concluded the health care industry is experiencing a turbulent period due to competition, contractual adjustments in reimbursement for services rendered and a struggle to keep up with health information technology (electronic medical records). The transformation of the reimbursement revenue cycle leads to the evaluation of the operational infrastructure with the limited resources available to select a payment model (Granata & Hamilton, 2015). Revenue cycle managers, clinic managers and billing staff must collaborate to ensure that consistent accounts receivable reviews are occurring steadily.

Theme 4: Consistent Accounts Receivable Reviews

All but two of the 10 participants expressed the importance of consistent accounts receivable reviews, as a critical component in determining patient accounts and method of payment. Consistent accounts receivable reviews coincide with theme two, payment plan setup and theme three, accuracies of billing claims. CL1 shared the importance of completing a more extensive review of patient accounts. CL1 stated “Make sure that everything charged is correct; if something is incorrect, we correct it immediately. This has more to do with doubtful accounts for the collection of payment and consistent review of patient accounts.” CL2 described the billing activity of the patient accounts and

the importance of determining if the patient has made a payment towards the statement or if there has been no activity in that patient's claim. CL2 added:

> Once the billing process is done, there is a report that shows a claim rejected, if something is incorrect, if the claim wasn't put in right, if the policy number was wrong, it rejects them. Doing the charge entry daily and then the billing is done daily, also once that is done and if they are rejected we correct them at the moment and they get billed again.

CL3 explained that charge entries are corrected based on the accounts receivable reports that are run on a daily basis. CL3 reiterated that the report flags claims prior to submission for reimbursement. CL6 emphasized that they run reports daily to ensure that accounts remain reviewed and that claims to insurance payers are not getting behind due to lack of payment from the insurance companies. The timeliness of the review of accounts receivables is dependent on the week, but these reports are worked on consistently by revenue cycle management leaders, clinic manager, and billing staff. CL7 commented that data analyst staff review the report to determine if the patent is self-pay or has insurance. Billers review the reports to confirm that third-payer collectors have not received payment and to follow up on accounts that have not completed payment as this list could be used for double or triple checking of lost revenue.

CL8 revealed that they continually monitor the patient aged-trial balance to identify accounts with old outstanding balances. The objective is to review and identify accounts that require assistance from other departments. CL8 stated, "We send these reports daily, if these accounts are sitting there for 120 days with no payments, they are

sent back to us, and we then flag them and send them to a third-party collector." If no payments transpire on the patient accounts sent by the third-party collector, these accounts are taken off the books as non-collectible accounts. CL8 added that these reports are easily located to find out exactly what is going on with these accounts, and those billing staff who look at the accounts take ownership and ensure that there is not going to be revenue lost due to irresponsibility or losing focus due to lack of follow-up.

CL9 noted that when accounts receivable staff review reports, they could detect where the errors occur in the billing process, and the information in the reports are available to the staff to prevent future mistakes. CL9 added that revenue cycle managers and billing staff use ageing reports to identify old claims that require additional work. I observed substantive conversation among billing staff members who discussed collecting accounts receivable in accordance with organizational standards. CL10 stated, "I think accounts receivables within the name itself is just making sure all parties are accountable for their ownership within the process."

Supporting theme 4, leadership within the accounts receivable component of any health care organization is of the utmost importance concerning profitability (Shorr, 2015). The consistency of accounts receivable reviews is to decrease barriers to the collection process may include billing errors, underpayment of insurance payers, or failure to collect information from the correct patient (Shi et al., 2015). The leaders of rural clinics also consider the revenue cycle process to guarantee payment as a resource to be managed by organizational leaders. Accounts receivables claims are reviewed promptly to ensure the dollar amounts due to the organization decrease over time. (Lail et

al., 2016). The utilization of the consistent accounts receivable reviews is the revenue cycle manager's strategic plan to create a primary structure for good fiscal control in the health care organization (Sheet, 2017). The key concept is to ensure the follow through of the accounts receivable review on a consistent basis leading towards organizational sustainability.

An example of research contribution for consistent accounts receivable reviews since the initial proposal approval of this study included Zenilman and Freischlag (2018). Zenilman and Freischlag addressed the element of a detailed review process examining every facet of the patient encounter. The pillar of system integration at the organization includes administrative infrastructure to support the essentials of the review process for the collection of each patient encounter (Zenilman & Freischlag, 2018). The objective of the organization is to achieve financial transparency, and this occurs by scheduling a regular meeting, one-to-one meetings with staff, and ensuring that follow-up happens to address any concerns brought up by staff members (Zenilman & Freischlag, 2018).

I reviewed available IRS Form 990 and HRSA documentation to support data collected from interviews. Abzug, Olbrecht, Sabrin, and DeLeon (2016) noted IRS Form 990 information is publically available and includes financial information reported to the IRS. I calculated two critical metrics of accounts receivable management including turnover and days sales outstanding (DSO). Turnover (credit sales divided by average accounts receivable) and DSO (turnover divided by 365) represent key ratios in accounts receivable management. Turnover at the research site increased from 3.1 to 4.6 between 2015 and 2016, and DSO decreased to from 119 days to 80 days for the same period.

Both ratios represent improvements in accounts receivable management. In the same two year period the organization saw an increase in total patients (9.4%), uninsured patients (0.26%), and dual eligible patients with both Medicare and Medicaid (1.27%; HRSA, 2018). The documentation I reviewed supported the importance the organization placed on account receivable management. CL10 added the following comment:

> It has been tedious for the billing department to run all those reports, but in the long run we benefit. Because now they don't have to write off because of eligibility. So it decreases the aging. Because before we would just check the patient in and we were done. Even as coordinator, we did not know that we were writing off thousands of dollars just because this wasn't being done. We were so separate from them (billers), and we didn't know the long-term effect it would have or how much was being written off.

Overall Findings Applied to the Conceptual Framework

The findings revealed strategies rural clinic managers used to obtain timely payments from patients and insurance payers. These findings supported the conceptual framework, and Wernerfelt's RBV as the basis for this study. Wernerfelt's theory included a detailed approach to an organizational resource as a strategic management design to yield higher profits (Wernerfelt, 1984). The RBV indicated a connection between profitability and resources and the long-term management of the organization's resources (Wernerfelt, 1984). Barbaresco et al. (2015) identified forms of payment including private insurance, direct payments, and a sliding rate based on one's ability to pay. The tenets of RBV can be relevant for health care leaders regarding organizational

resources, including administratively formulated attributes, skills, organizational procedures, and expertise. (Patidar et al., 2016). The concepts established by Wernerfelt enhanced the theory of resource-based value by Barney (1991) with the concepts of organizational resources, competitive advantage, and the utilization of sustained competitive advantage.

Managers play a crucial role in ensuring that billing staff assess the patient's insurance coverage and potential form of payment (Barbaresco et al., 2015). Rural clinic managers must deal with reimbursement delays, insurance payers' denials for services provided, and unreimbursed services (Casardo, 2015). Organizational leaders examine the competitive advantages of the specific resources and limitations of each location (Yang, 2014). Strategic findings from this study are pertinent to the professional practice for revenue cycle manager and medical billers.

Applications to Professional Practice

Health care leaders could benefit from this study's findings by identifying strategies to increase the collection of payment from patients and insurance payers. According to Gerstorff and Gibson (2016), roughly 20% of a state's budget consists of health care funds. The findings of this study indicate the professional practice procedure steps followed by rural clinic managers maintaining profitability and sustainability are: (a) communication between medical providers and billing staff, (b) payment plan setup, (c) accuracy of billing claims, and (d) consistent accounts receivable reviews.

The findings corroborate findings of other researchers, showing that communication between clinical and billing departments, setting up payment plans,

accuracy in the filing of billing claims and reviewing accounts consistently provide a path to long-term profitability. The results of this study could be relevant across other industries and may enhance further understanding of those with minimal management experience as well as qualified managers. Furthermore, health care policies formulated at the administrative level incorporate organizational resources including attributes, abilities, organizational procedures, and expertise (Patidar et al., 2016). Each of the themes identified supportive strategies to ensure timely payments from patients and insurance payers to sustain profitability. Organizations increase awareness of ensuring payments from patients and insurance payers by developing dynamic capabilities and increasing resources (Kash et al., 2014). Emergent themes in the study represent strategies that apply to professional practice.

Implications for Social Change

Society could benefit from the results of this study. Approximately 45 million Americans are without health care coverage insurance and are underinsured (Schimmel, 2013). The findings from this study could lead to tangible improvements to individuals, communities, and organizations. The findings include strategies to improve the sustainability of health care organizations. In this study, I focused on rural clinics. Financial stability of rural clinics directly benefits the health of individuals and the public health of communities. I found that strategies including communication, attention to detail, and consistent patient account reviews impact cash flow. Engagement with payer sources is also crucial to the collection cycle (Noether & May 2017). The staff of rural

clinics provides support to underserved populations. Increased collection rates can result in the support that rural clinics provide to the wellbeing of underserved communities.

Recommendations for Action

The objective of this qualitative multiple case study was to explore strategies rural clinic managers use to obtain timely payment from patients and insurance payers. Study findings identified four major accounts receivable management strategy themes to increase sustainability and profitability are: (a) communication between medical providers and billing staff, (b) payment plan setup, (c) accuracy of billing claims, and (d) consistent accounts receivable reviews. I noted some recommendations to financial leaders in collecting payments from patients and insurance payers in a timely and efficient manner to increase overall profitability.

Health care leaders may consider attempting to establish an atmosphere encouraging a strategic approach for collecting payments from patients and insurance payers. The leadership develops accounts receivable management strategies and ensures that the organization’s staff abides by company financial practices, policies, and procedures (Grant, 2014). The five rural clinics I chose for this multiple case study were successful clinics committed to helping build a healthy community. Each participant I interviewed appeared committed to using effective strategies into their daily, weekly, and monthly schedule to increase collections from patients and insurance payers.

How a company’s managers and staff use their resources is a critical strategic factor in many industries, and many other fields could benefit from this study. Multi-faceted health care organizations must adapt to identify new and innovative processes

regarding the use of internal resources to achieve a competitive advantage (Lillis et al., 2015). The participants from the research organization I selected were reliable and concise in their approaches to ensure timely collection of payments from patients and insurance payers. These strategies could assist leaders in other industries.

Recommendations for Further Research

The purpose of this qualitative multiple case study was to explore strategies rural clinic managers use to obtain timely payment from patients and insurance payers. The targeted population included 10 rural clinic managers and billing staff from five rural clinics located in southwestern region of the United States, who have incorporated strategies to obtain timely payment from patients and insurance payers to maintain sustainability and profitability. The study findings concerned further research for numerous reasons. First, the results of the study may extend to other industries in a way that improves cash collection and payment management.

Second, there are numerous facets of research that other investigators can explore. For example, there were less significant themes that emerged, such as ways to elicit information from patients and insurance payers instead of going directly to rural clinic mangers and billing staff. Finally, researchers could also consider accounts receivable management strategies, insurance payer-mix types, location, and short and long-term financial goals of the organization. To promote further discussion of the results, I will share a summary of the findings with the research participants. Additionally, I will publish this study through the ProQuest/UMI dissertation database for future researchers

to use and work with my Doctoral Chair to present the results of this study at professional health care conferences or seminars and to publish my findings in peer-reviewed journals.

Reflections

Completing a DBA has been one of the most demanding, yet, rewarding opportunities of my life. I knew going into the program would be challenging; however, I accepted the challenge. Also, I had prior experience in the health care field, but I did not have any outside experience with the participants before collecting the data. As a researcher, I understood the importance of maintaining high scholarly and research standards when conducting interviews. Also, I gained new knowledge about how rural clinic managers and billing staff are regarding the accounts receivable process to increase profitability.

My goal as a qualitative researcher was to collect data without personal bias or preconceived views. I made sure that I consistently addressed the guidelines I wrote in the initial proposal to ensure the process demonstrated legitimacy. The research participants provided detailed responses. I was appreciative for that part of the process. Participants provided precisely and detail orientated responses and conveyed how each person defined their task and how it related to the team. I learned from participants about accounts receivable management strategies used to ensure payment for patients and insurance payers to improve profitability.

Conclusion

Accounts receivable management strategies are essential to organizational strategic success. The overarching research question of this multiple qualitative case

study was: What strategies do rural clinic managers use to obtain timely payments from patients and insurance payers? I conducted face-to-face semistructured interviews to obtain data. I also reviewed HRSA documentation and IRS Form 990s to complement the data collection. I applied information from the methodological triangulation data collection process to validate data source themes

Study findings revealed four significant themes regarding accounts receivable strategies applied by rural clinic billing staff to increase profitability: (a) communication between medical providers and billing staff, (b) payment plan setup, (c) accuracy of billing claims, and (d) consistent accounts receivable reviews. The social change enrichment exists when the rural clinic is successful: operations are effective and efficient, profits increase, job opportunities proliferate, and cohesion develops within the community.

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Appendix A: Interview Protocol

Interview Title: Finding out about competitive strategies rural clinic managers need to obtain timely payments from patients and health insurance payers.

1. I will begin the interviews with greetings and thank them for their participation in the interview process. Next, I will make sure I introduce the research topic and myself to the participants.
2. I will explain the voluntary nature to participate in the study and the opportunity to withdrawal from the study at any time.
3. I will ensure that participants read and ask any questions related to the study before agreeing to sign the informed consent form.
4. I will ensure that the participants have a copy of the signed consent form for their records.
5. I will inform participants that the interview will last between 30 to 45 minutes, and the interview procedures and that the interview will be audio recorded.
6. I will begin the interview process.
7. I will explain to all participants that as part of member checking procedure, I will present my interpretations of the interviews to them for corroboration.
8. At the end of the interview process, I will stop audio recording, and thank the participants again for taking part in the research study.

Appendix B: Interview Questions

1. What strategies do you use to obtain timely payments from your patients and insurance payers?
2. What strategies do you use to collect from uninsured and under-insured patients?
3. What strategies do you use to manage doubtful accounts and bad debt?
4. What strategies does your organization use to ensure staff complete billing forms correctly with no errors that delay payments?
5. What techniques does your office staff use to collect copayment either before or after the patient visit?
6. How does the organization provide training to the billing staff to ensure they are able to meet the organization’s standard for timely collections?
7. How does the organization ensure that the billing staff has the current training or professional development regarding health information technology?
8. What billing techniques does the organization use that would be a competitive advantage over other similar organizations?
9. What are the necessary attributes and abilities of a biller to ensure continued profitability and sustainability for the organization?
10. What additional information can you make available that accounts receivable strategies ensure timely payment from patients and insurance payers?