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Strategies for Achieving Patient-Centered Healthcare and Cost Containment

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This is to certify that the doctoral study by

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

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MSS, United States Army War College, 2010

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Doctoral Study Submitted in Partial Fulfillment

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Abstract

Implementing successful value-centered care strategies that support patient-centeredness while reducing cost is a significant challenge for healthcare leaders. In 2001, the Committee on Quality of Healthcare in America and the Institute of Medicine identified patient-centeredness as 1 of 6 improvement goals to improve quality of care for the 21st century. The purpose of this multiple case study was to explore patient-centered strategies that healthcare managers used to reduce the cost of healthcare for elderly patients without reducing the quality of patient care. The conceptual framework that grounded this study was patient-centered care, and the opposing theory was the primary care team model. Data were collected using semistructured interviews with 6 healthcare leaders selected via purposive sampling throughout Virginia and a review of healthcare facilities' documents and website pages. Data were analyzed using Yin's 5-step process, which led to the identification of 4 themes. Themes that emerged from the study included patient-centered care matters, management leadership strategies, control methods for monitoring costs, and maximizing community healthcare services. The implications of this study for positive social change include the potential to improve the delivery of healthcare for elderly patients and access to quality patient-centered care that supports cost-reducing strategies healthcare managers can employ to increase profits through value-based healthcare.

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Dedication

I dedicate this study to my beloved father, Francis R. Handy (d. 2003) and mother, Dolores A. Handy (d. 2017). I know you both are looking down from above and cheering me on. The fire you instilled in me of life-long learning burns brighter than ever, Thank you. To my daughters Misha and Ashley: The struggles, trials, and impediments that it takes to succeed in life are what makes success more valuable. Never give up on your dreams and desires and always reach for the stars. To my wife: Georgina, thanks for being patient and supported throughout my doctoral journey. I know my absences in events were numerous, but your steadfast love and encouragement for my success never dwindled; I will never forget.

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Section 1: Foundation of the Study

In 2001, the Institute of Medicine (IOM) established patient-centeredness as one of six goals for refining the U.S. healthcare system (Zill, Scholl, Härter, & Dirmaier, 2015). In the United States and throughout many other industrialized nations, patient-centered care (PCC) is one of several strategic goals pursued by healthcare organizations (Price & Elliott, 2018). The cost shared by patients continues to increase, while the medical insurance provided to most elderly patients in the form of Medicare continues to decrease (Altman & Frist, 2015). As such, efforts by healthcare managers to mitigate cost and increase quality as stipulated within the Patient Protection and Affordable Care Act (PPACA) could necessitate requirements that healthcare managers might find difficult to achieve (Delmatoff & Lazarus, 2015). Notwithstanding, costs within the U.S. healthcare system continue to soar, while quality care spirals downward for many Americans (Hosseini, 2015). To help mitigate the cost of healthcare, a growing body of healthcare managers and scholars consider PCC as indispensable for reducing cost and delivering an improved quality healthcare system (Rahul, Press, & Conway, 2015). I analyzed the strategies healthcare managers use to reduce the cost of elderly patients' healthcare without reducing the quality of patient care.

Background of the Problem

Bartels, Gill, and Naslund (2015) stated the PPACA signifies the most significant legislative change in the U.S. healthcare system in nearly half a century. The PPACA provides provisions designed to reduce costs and encourage the development of new systems of healthcare delivery by monitoring outcomes and efficiency. Since the inception of the Medicare and Medicaid programs in 1965, a substantial portion of Americans benefited from a system that provides health and welfare benefits for aging adults, disabled Americans, and others by reducing out of pocket medical expenses (Blumenthal, Davis, & Guterman, 2015). In 1992, Medicare introduced the resource-based relative value scale to correlate the reimbursement with the actual cost of providing service and to reward rational thinking rather than adherence to procedures (Diebel, 2015). Historically, the Medicare program is a defined-benefit program whereby the U.S. Government subsidizes a portion of a patient's health benefits. However, some legislators are proposing the Medicare program become a defined-contribution system that would greatly reduce the payment of services and medical goods passing the cost to beneficiaries (Rivlin & Daniel, 2015). The impact of this action would directly affect Medicare-dependent aging adults' quality healthcare, which makes up more than 55% of all Medicare cost (Tsai et al., 2016). Hence, the healthcare industry is struggling to determine the best model to deliver quality-valued healthcare service for aging Medicare patients in an era where time and service are principal cost factors. The desire to employ a value-centered healthcare model should influence how medical facility managers develop strategies to provide sustained medical services while implementing effective cost control measures to meet shareholders' expectations.

Problem Statement

In 2014, Americans spent $2.9 trillion or $9,255 per person on healthcare, the highest per capita among developed nations. However, the World Health Organization ranks the U.S healthcare system 37th among all nations in performance (McGinnis, Diaz,

& Halfon, 2016). Medicare spending grew 3.4% to $585.7 billion in 2013, reflecting both the aging population and the increasing cost of healthcare (Martin, Hartman, Washington, & Catlin, 2017). The general business problem is some medical facilities managers' are unable to mitigate rising individual medical costs for the elderly while maintaining or improving healthcare service quality within the PCC model. The specific business problem is some healthcare managers lack patient-centered strategies to reduce the cost of elderly patient healthcare without reducing the quality of patient care.

Purpose Statement

The purpose of this qualitative descriptive multiple case study was to explore what patient-centered strategies healthcare managers use to reduce the cost of elderly patient healthcare without reducing the quality of patient care. The participants consisted of six midlevel healthcare managers from several departments located at six full-service acute care facilities in Virginia who reduced the cost of patient healthcare without reducing the quality of patient care. Conducting this study may lead to positive social change for elderly patients by improving the delivery and access of quality PCC while catalyzing, developing, and implementing cost reduction strategies that healthcare managers can employ to make healthcare more accessible.

Nature of the Study

I conducted this study using a qualitative descriptive case study approach. Sutton and Austin (2015) recommended the use of a qualitative method for studying attitudes and beliefs held by individuals to evaluate similar themes. The focus of this study was to explore patient-centered strategies from the perspective of the healthcare manager, thus making the qualitative method appropriate for this study. Ali and May (2017) stated the phenomenon of PCC is complex and multidimensional. As such, a qualitative case study was the most appropriate design for this study. I used open ended, semistructured interview questions that explore strategies healthcare managers use as they deal with the complexities of providing quality patient care. In contrast, quantitative research is deductive, whereby the researcher formulates a set of hypotheses to test the relationships of two or more variables or the differences between two or more groups (Hyett, Kenny, & Dickson-Swift, 2014). Because I was not comparing variables, a quantitative method was not appropriate. A mixed methods approach is beneficial for researchers seeking to observe a situation in its natural state as well as provide a comprehensive understanding of a phenomenon from a statistical perspective (Kaur, 2016). Without a quantitative component, a mixed methods approach was also not appropriate.

Yin (2014) and Yazan (2015) stated researchers prefer the descriptive case study method when conducting qualitative research by questioning *how* or *what.* The focus is on an existing phenomenon within a real-life environment. I considered other qualitative designs, for example, ethnography and narrative to conduct my study. Draper (2015) stated a researcher would use an ethnographic design to explore the culture and perspectives of a group in its natural setting. Because I did not explore culture, an ethnographic design was not appropriate. A narrative method was not appropriate for this study, as I did not focus on a participants’ biography or life story (Gill, 2014).

Research Question

The overarching research question driving this study was:

RQ: What patient-centered strategies do healthcare managers use to reduce the cost of elderly patient healthcare without reducing the quality of patient care?

Interview Questions

1. How do you, as a healthcare manager, view patient-centered strategies, for example, patient-centered medical homes, accountable care organizations, person-centered care, person-focus care, and client-centered care, as a means of reducing the cost of elderly patient healthcare?
2. What are the advantages of patient-centered strategies in reducing elderly healthcare costs?
3. What patient-centered strategies have the board of directors supported to improve healthcare delivery and operational cost?
4. How do you measure the effectiveness of patient-centered strategies?
5. How did your organization address key challenges to implement successful patient-centered strategies without reducing the quality of elderly patient care?
6. How do you communicate patient-centered strategies with staff at all levels to improve quality care and reduce the cost of elderly patient care?
7. How, if at all, has the PPACA affected your ability to implement patient-centered strategies and maintain quality patient care?
8. How will your organization address the cost of delivering patient-centered strategies for elderly patients if Congress restructures the Medicare Trust Fund?

9. How will your patient-centered care strategies improve the quality of care and fit into the healthcare reform movement?
10. What other information would you like to add that these questions might not have addressed?

Conceptual Framework

The core principles of a value-centered healthcare model stems from Fayanju et al.'s (2016) research on the foundation for defining patient-centeredness. The patient-centered theory is an evolutionary development based on the psychologist Carl Rogers' person-centered approach in 1940 (Miller & Moyers, 2017). Crisp (2018) stated Rogers' theory focuses on a person's trust of their innate tendency (known as the actualizing tendency) of human beings to find the fulfillment of their potentials. Rogers emphasized a client-centered therapy that supported empowering the patient as the central focus for the delivery of care, for example, PCC (Crisp, 2018; Frankel, Johnson, & Polak, 2016).

The core principles of a value-centered healthcare model emphasizes the following attributes of PCC: access, continuity, comprehensiveness, coordination and communication, cultural competency, family and person focus, and payment alignment. Locatelli, Hill et al. (2015) expanded on the conceptual framework of PCC by synthesizing previous theoretical and empirical work on organizational change with an emphasis on patient-centered innovations. Piña et al. (2015) noted healthcare organization leaders have determined that developing innovation among their various staff organizations is challenging. The view that full-service acute care hospitals are complex adaptive systems that are ever changing, reactive, proactive, and distinctive within a natural environment sets the conditions for the conceptual framework for this study. Overall, the patient-centered model applies to multiple organizations and populations. Also, using the patient-centered model enables researchers to focus on the value-centered healthcare business model.

Operational Definitions

Acute care facility: An acute care facility is an inpatient medical facility where patients receive constant medical care for periods of less than 25 days (Koenig, Demiralp, Saavoss, & Zhang, 2015).

Ambulatory care facility: An ambulatory care facility is a medical facility that provides outpatient care that includes diagnosis, observation, consultation, treatment, intervention, and rehabilitation service (Martin-Misener et al., 2015).

Fee-for-service: Fee-for-service is where medical providers receive payment for services rendered by unbundling services paid for separately. In healthcare, private insurers and the government provide incentives to physicians based on treatments, because payment is dependent on the quantity of care, rather than the quality of care. (Zuvekas & Cohen, 2016).

Managed care: Managed care is a health insurance network that manages medical care through established contractual agreements between providers and patients (Baicker & Robbins, 2015).

Patient-centered care: PCC is a type of medical care respectful of, and responsive to, an individual patient’s preferences, needs, and values, ensuring that patient values guide all clinical decisions (Zill et al., 2015).

Patient- and family-centered care: Patient- and family-centered care is a model focusing on partnerships among practitioners, patients, and their families or care partners to ensure that decisions respect patients' wants, needs, and preferences (Rawson & Moretz, 2016).

Assumptions, Limitations, and Delimitations

Understanding the complexities healthcare managers encounter when meeting their patients' needs and those of their shareholders are challenging tasks complicated by healthcare policies, cost, and the community they serve. Assumptions, limitations, and delimitations support a researcher's ability to focus their study on the participants' lived experience and gain insight from participants' personal experience (Goldberg & Allen, 2015).

In the following subsections, I discuss facts assumed to be true, limitations that might constrict the study, and delimitations that focus the scope of the study on what patient-centered strategies healthcare managers use to reduce the cost of elderly patient healthcare without reducing the quality of patient care.

Assumptions

Berssaneti and Carvalho (2015) stated an assumption is a variable independent of the scope of a study as defined by the researcher. Assumptions are facts presumed true but not confirmed. Goldberg and Allen (2015) stated the researcher should verify their assumptions with the interviewee to confirm their validity. Likewise, Wright, Wahoush, Ballantyne, Gabel, & Jack (2016) stated a researcher formulates their assumptions based on perceptions derived from known truths. When I began this study, I developed several assumptions. First, I assumed the participants would respond truthfully. Second, I assumed that healthcare managers would strive to put patients’ care and needs first. Third, I assumed a healthcare manager’s success is dependent on the quality of the actual value-care delivered**.**

Limitations

Schulenkorf, Sherry, and Rowe (2016) stated limitations are constraints that occur beyond the control of the researcher that could potentially affect the study. Hence, a limitation existed because of the potential difficulty in understanding the expectations of all healthcare leaders who support this study. Another potential limitation involved the sample size, which might not have proven to be representative of the healthcare leadership population of hospitals throughout all regions. Lastly, findings from the geographical area of the study might not apply to other regions with different socioeconomic challenges, access to employment, and opportunities for advancement. Lewin et al. (2015) stated other limitations to a study could derive from the respondents’ level of trustworthiness and the probability of bias with the participants’ interviews.

Delimitations

Yazan (2015) stated delimitations are the restrictions the researcher sets for the scope of the study to define the boundaries. Likewise, Rule and John (2015) discussed a researcher’s initial theory of a case aids in providing the thematic emphases and design of delimitations. Similarly, Nakrem (2015) indicated that understanding a hospital’s culture can vary based on the facility. Hence, the selection of a healthcare facility management team could have delimited this study. Marshall and Rossman (2016) stated delimitations are boundaries chosen by the researcher. Rural Virginia was a boundary for this study.

Furthermore, the researcher's scope of research questions could be a delimiting factor. A study's delimitation could affect the results and any conclusions drawn from the researcher's analysis. Baškarada (2014) stated choosing a case study design may be a limitation of a study. I focused on nonmedical providers and not the abundance of medical professionals who are direct providers of PCC delivery.

Significance of the Study

The significance of this study lies in the potential for identifying efficacious patient-centered strategies that reduce cost without compromising the quality of care in hospitals that provide services for patients located in rural Virginia. Administrators who study business strategies may learn how to develop, deploy, and implement patient-centered strategies to reduce ambulatory and acute cost (Galarraga & Pines, 2016). The information from this study could add value to the healthcare field through identifying and exploring successful strategies established by managers who use patient-centered strategies developed and employed within a healthcare business model from the healthcare manager's perspective. As healthcare administrators adjust to providing strategies that support ACA legislation through 2020 (Gaffney & McCormick, 2017), the future effects of this reform may challenge medical facility managers to implement strategies that mitigate costs. Moreover, hospital administrators with limited patient-centered strategies may learn to develop and implement other patient-care strategies to achieve lower costs for Medicare-dependent patients (Tsai et al., 2016).

Contribution to Business Practice

Healthcare leaders must understand that leadership is about teamwork and building relationships (Allison, 2015). As well, healthcare leaders must understand the importance of prioritizing the patient in all decisions. Consequently, as each generation ages, chronic diseases and increasing comorbidities will continue to influence the costs of care. Understanding how healthcare leaders develop plans and strategies to meet patients' needs while mitigating cost will lead to improving efficiencies, preserving hospital resources, and improving stakeholder engagement for their facility's near-term and long-term success (Pizzo & Cohen, 2016).

Implications for Social Change

From a social change viewpoint, results from this study may be valuable to assist healthcare administrators to create and develop effective patient-centered strategies. Elderly patients seeking healthcare could realize both economic and social gains through improved patient-centered strategies that improve and support quality care (Pizzo & Cohen, 2016). Several comprehensive models of care have emerged to limit long-term healthcare support that have the potential to reduce costs and improve the quality of healthcare for patients with complex needs (Bartels et al., 2017). Moreover, Castro, Van Regenmortel, Vanhaecht, Sermeus, and Van Hecke (2016) advocated that collective patient participation could shape patient-centered strategies through education, training, and policy development in support of quality healthcare. Developing such strategies may promote social change by increasing patient engagement and strengthening the ability of medical providers to connect with patients (Franzen, 2017).

A Review of the Professional and Academic Literature

The goal of this multiple case study was to explore patient-centered strategies from the perspective of six midlevel healthcare managers who work at a full-service acute care facility that services patients from rural communities in Virginia. In this literature review, I explored strategies that midlevel healthcare managers use to reduce the cost of elderly patient healthcare without reducing the quality of patient care. A thorough expositive literature review involves identifying, synthesizing, and encapsulating studies inside an extensive body of research on a specific topic (Paré, Trudel, Jaana, & Kitsiou, 2015). By exploring literature covering PCC, cost improvements, healthcare policies, PCC strategies, patient satisfaction, and other resources, useful strategies may emerge that hospital managers can implement to reduce the cost of patient healthcare without a reduction in a patient's quality of care.

The resources used for this literature review were from the Walden University Library research databases including (a) ProQuest Central, (b) Academic Search, (c) American College of Healthcare Executives, (d) Google Scholar, (e) EBSCOhost, (f) Science Direct (g) Emerald Management Journals, Management, and (h) government websites. The totals for sources referred to in this study by category were as follows: (a) six books, (b) 254 journal articles, and (c) seven reports. Of the 267 resources, 235 (88%) had publication dates less than 5 years old.

Table 1

Details of Literature Review by Year of Publication

	Older than 5 years	2014	2015	2016	2017	2018	Total
Books		2	2	1	1		6
Reports		3	1		3		7
Peer-reviewed	2	25	109	73	37	8	254
Totals	2	30	112	74	41	8	267

The body of knowledge on patient-centered healthcare and cost containment strategies is constantly transforming to meet the needs of patients, healthcare leaders, providers, healthcare organizations, insurers, and local and federal government agencies. The literature presented in this study contains current strategies managers are employing within a patient care delivery structure. Effective healthcare managers are leading healthcare organizations with the goal of improving the patient experience through proven strategies that improve safety, efficiencies, and cost (Mohammed et al., 2016). PCC strategies are essential for linking every aspect of a healthcare organization with the objectives and goals of the organization's leadership (Anderson, 2015).

I organized this literature review into the following 10 main subject categories: (a) patient centered-care, (b) primary care team model, (c) assessing PCC, (d) PCC as a measurement within healthcare, (e) PCC within the ACA, (f) how PCC emerged to its relevance in today’s healthcare delivery, (g) PCC within a value-centered healthcare model, (h) value-based purchasing, (i) patient-centered medical home (PCMH), and (j) healthcare leadership and continuous quality improvement. In the first two subject categories, I explored the theory related to this study as well as the theorist, tenets of the theory, and evolution of the theory related to this study. Next, I explored several alternate theories considered but not selected and the reasons for not selecting those theories. The remaining categories expand on the topic of this study as they relate to PCC.

Patient-Centered Care

Zill et al. (2015) stated the IOM recognizes the term PCC as the vanguard of healthcare. PCC is a strategy demonstrated when healthcare professionals freely interact with the patient and the healthcare workers to effect a positive outcome for the patient (Zill et al., 2015). However, various definitions of PCC exist resulting in multiple interpretations of who or what should be the focus of a PCC strategy. Zill et al. (2015) argued that PCC is one of six improvements used to enhance the quality of care in healthcare systems. Additionally, PCC is a fundamental capability all healthcare professionals must have to provide healthcare in this century (Bernabeo & Holmboe, 2013). Healthcare leaders should apply PCC strategies that emphasize respect, care for the patient, value, a patient’s opinions, a desire to relieve pain and suffering, care coordination, a focus on the population health, disease prevention, and a healthy lifestyle (Zill et al., 2015).

Likewise, Jun and Oh (2017) noted the patient’s perspective of PCC is relevant when the focus is the patient and not the desires of the provider. As such, healthcare providers should seek to provide patients with a personal and customizable experience (Locatelli, Turcios, & LaVela, 2015). Healthcare organizations that employed PCC benefited from improved disease management, higher patient satisfaction and engagement, reduced anxiety among patients, and an overall increase in patient perceived quality of life (Jun & Oh, 2017). Among the elderly, implementing PCC is improving the delivery of preventive care for patients suffering from chronic conditions (Liang et al., 2017).

Krupic, Sayed-Noor, and Fatahi (2017) further sought to link PCC with a theory based on caring that one J. Watson established in 1988 that addresses the basic tenets applied in the field of nursing science. Millenson, Shapiro, Greenhouse, and DiGioia (2016) stated the term *patient-centered care* emerged from the concept of patient-centeredness mentioned in a Gerteis et al. (1987) article *Through the Patient's Eyes* that presented information gathered during the Picker/Commonwealth Program in 1987.

Carl Rogers, a noted psychologist and founder of psychotherapy, established the term *patient-centeredness* in the 1940s (as cited in Lor, Croks, & Tluczek, 2016). Rogers argued that every individual had inherent qualities that one could draw from to alleviate challenges. In the 1960s, British psychoanalyst E. Balint created the term patient-centered medicine (as cited in Tanenbaum, 2015). Balint's term focused on one aspect of the patient-care team, for example, the physician, which limited the value of the other care providers.

In 1987, the Picker/Commonwealth Patient-Centered Care Program developed the term patient-centered care. The Picker/Commonwealth Foundation was developed through a partnership between Dr. Harvey Picker, his wife, Jean Picker, and the Commonwealth Foundation, an independent, nonprofit, private, public policy organization located in Pennsylvania (Rawson & Moretz, 2016). Their motivation to explore patient care resulted from a lack of responsiveness they deemed lacking when a patient received treatment for a life-threating medical condition in the 1980s (Byczkowski et al., 2015). The partnership specifically sought to bring attention to realigning the healthcare provider's focus on medical care from the disease back to the patient for improving the delivery of healthcare. Through the Picker's philanthropic donation, the Commonwealth Foundation directed their efforts to change the focus of healthcare industry delivery of care toward the patient with an increased appreciation for the importance of the patient's participation in their care (Byczkowski et al., 2015).

As time progressed, the developers of the Picker/Commonwealth Program focused patient delivery on the following: (a) valuing and respecting the patient preference and verbalized needs; (b) coordinating and integrating care for the patient; (c) sharing information, education, and open communication among providers, the patient and the family; (d) the patient's well-being; (e) supporting the patient and family's emotional and psychological well-being; (f) including the family and friends into the patient's care plan; and (g) transitioning and continuing aftercare until released (Byczkowski et al., 2015).

In 2001, the IOM presented six improvements in their report entitled "Crossing the Quality Chasm" examining the quality of healthcare in the United States and strategies to improve PCC as aims for improvement (Berwick, Feeley, & Loehrer, 2015).

As the concept of PCC evolves, the medical community continues to reshape the implementation of PCC to achieve improvements in patient care delivery based on current practice procedures. Moreover, various forms of PCC emerged substituting one word for the other with the focus remaining on the patient as specified in the IOM report. Some of these terms were *client-centered care*, *person-centered care,* and *family- and PCC* that ultimately mean the same thing and were often used interchangeably depending who performed the research (Price & Elliott, 2018).

The Europeans use the term *person-based* with the goal to put a name to the patient and not a number like many hospitals in the United States (Yardley, Morrison, Bradbury, & Muller, 2015). Overall, implementing person-centered care versus a physician-centric care delivery is producing increased positive outcomes for caregivers (Flieger, 2017). The focus of person-centered care is supporting what is most important to the patient and focusing all of the patient’s treatment team strategies toward those goals (Yardley et al., 2015).

As PCC transforms the interaction among the patient, caregiver, and the family, PCC evolved to include other providers beyond the healthcare personnel who provide direct care. Locatelli, Turcios et al. (2015) stated the patient’s team includes patient advocates, technological providers, communication supports, and various health administration personnel. The expansion of the patient’s care team has improved the delivery of care by enhancing awareness and responsiveness for the patient (Santana et al., 2017). The healthcare community defines PCC as healthcare derived from a partnership among the caregivers, patient, and their families that safeguards the patient’s needs, desires, and preferences ensuring the patient’s values guide all clinical decisions (Winn, Ozanne, & Sepucha, 2015).

Assessing Patient-Centered Care

While the healthcare community in the United States and globally focus on providing PCC, researchers and those responsible for managing healthcare organizations are assessing the quality of patients’ decisions to improve treatment planning, execution, and the delivery of PCC. Kogan, Wilber, and Mosqueda (2016) stated physicians who practice PCC could improve their patients’ results and their approval ratings. Researchers determined that patients desire to be a part of their decisions regarding healthcare and their treatment options (Bernabeo & Holmboe, 2013). Hence, caregivers who facilitate patient participation in their care are reducing the use of extraneous diagnostic testing, treatment, inpatient care, and referrals for specialty care (Schneider, Hill, & Blandford, 2016). Bernabeo and Holmboe (2013) called the process of involving patients in their treatment based on their values, beliefs, preferences, and knowledge as shared decision making. Likewise, Locatelli, Hill et al. (2015) described effective PCC as a process that involves the patient rather than the physician making decisions independent of the recipient receiving the healthcare. Bernabeo and Holmboe (2013) stated healthcare policies should reflect the concept of shared decision making among providers and patients to improve the delivery of PCC.

Winn et al. (2015) stated caregivers and healthcare managers want to know how well the patient’s care-team is informing their patients based on previous treatment received. Moreover, researchers seek the patient’s support to determine if clinicians are providing the best medical options and outcomes to treat the patient (Winn et al., 2015). Batalden et al. (2016) stressed that healthcare managers must ensure their healthcare teams are communicating with patients, mutually developing treatment plans, and thoroughly adhering to the treatment plans discussed with the patient and family to implement PCC effectively.

Another measure researchers and healthcare managers are using to measure PCC is the patient's experience (Tzelepis, Sanson-Fisher, Zucca, & Fradgley, 2015). In addition, researchers are assessing the *value concordance* or agreement to assess the effectiveness of quality decisions in support of PCC (Winn et al., 2015). Winn et al. (2015) defined value concordance as the relationship between the patients' preferences regarding medical treatment and treatment goals. Within PCC, the patient's choice and outcomes should correlate; however, when the patient's outcome differs from the expected, the patient may question the value of the treatment. Likewise, the associated cost of delivering the patient's care may exceed the standard cost, hence subjecting the patient's care for questioning (Winn et al., 2015).

Alternative Approaches

Primary care team. The primary care team model, also referred to as the practice team, direct primary care team, and interprofessional collaborative practice model (Selleck et al., 2017) was an alternate approach for this study. Körner et al. (2016) stated a primary care team is a collaborative practice intervention consisting of various members of interdisciplinary teams that include physicians, nurse practitioners, physician assistants, registered nurses, and health assistants. The primary care team primary function is to meet the healthcare needs of the patient (Doekhie, Buljac-Samardzic, Strating, & Paauwe, 2017). The primary care team model often includes monitoring and collaboration among various paraprofessionals, for example, a nurse, health assistants, and other medical professionals in support of the patient delivery of care (Coleman et al., 2017). The overall goal of a primary care team is to improve the delivery of care for patients (Freund et al., 2015). However, the primary care team model does not emphasize the patient or family as a member of the team. Schottenfeld et al. (2017) stated medical facility leaders and primary care teams will need to make profound changes in the following: (a) the culture and organization of care, (b) the environment in which medical personnel interact with patients, (c) education and training, and (d) the means by which primary care personnel and patients understand their roles and responsibilities.

Physician-centered care. Similarly, physician-centered care involves a standard of care focus around the direction, goals, and efficiency of the physician (Yurkiewicz, 2016). Lim and Kurniasanti (2015) defined physician-centered care as the evaluation and treatment of diseases, which emphasized the clinical expertise of a physician. According to Flieger (2017), physician-centered care delivery impeded effective team-based PCC. Orom et al. (2018) argued that a trusting closed physician-centered relationship could adversely reduce a patient’s willingness to participate and discuss their provider’s treatment decision-making. Moreover, Islam et al. (2017) stated the introduction of the PCMH model and other PCC models would necessitate physicians and other healthcare professionals to work collaboratively to coordinate PCC. Orom et al. (2018) stated patients that actively participate in their treatment decision within a PCC model, statistically better adhere to their treatment plan than patients who participate in a physician-centered patient relationship. Lim and Kurniasanti (2015) indicated that shared decision-making is a critical process of PCC whereby the patient and clinician participate jointly in making health decisions for treatment. However, Pollard, Bansback, and Bryan (2015) stated the shift towards a patient-centered approach by physicians has been slower, because of clinician's limited willingness to exercise shared decision making with their patients. Additionally, the traditional decision-making approach facilitated by the proponents of the physician-centered model is a sharp contrast to the PCC model (Lim & Kurniasanti, 2015). Moreover, the physician-centeredness model directly contradicts to PCC. Therefore, I did not choose this model for use in this study.

Patient-Centered Care as a Measurement Within Healthcare

It is a challenge for healthcare leaders to reduce cost by servicing more patients with fewer providers. Moreover, the maximum time a medical practitioner can provide medical care ranges between 15 and 18 minutes (Bard et al., 2016). This time model used in many medical facilities enables medical practitioners to serve as many patients as possible with the most cost-effective treatment based on the patient's medical benefit (Tai-Seale et al., 2017). As such, PCC has emerged as a significant measurement for internal organization leaders to assess standards and external evaluating organization leaders, for example, the Joint Commission to measure one facility against other like healthcare organizations.

The Joint Commission, established in 1951, is a nonprofit organization that accredits and certifies healthcare organizations with the principal aim of improving the quality of care provided to patients (Hirose, 2016). One aim of the Joint Commission is to evaluate how acute care facilities integrate patient-centered communications along with PCC into the organization strategic plan to improve the quality of patient care (Happ et al., 2015). Hence, as of 2011, the U.S. Health and Human Services (HHS) directed healthcare organizations to focus their strategies on improving the quality of healthcare by making it more patient-centered (Burwell, 2015). However, implementing PCC is not a one-size fit all concept. Based on various PCC models and strategies used by healthcare organizations, a certain amount of uncertainty occurs when managers levy PCC with diverse populations (Hawley & Morris, 2017). Consequently, the Joint Commission in their assessment expects managers of healthcare organizations to establish standards that advance communication, culture, and competence for PCC (Bucknall et al., 2016). A measure, highlighted in the (ACA) in 2010, was to strengthen cultural competency, ethnicity, and language among providers to meet the demands of a diverse population (Abdus, Mistry, & Selden, 2015).

Healthcare leaders are leveraging feedback obtained from patients through in-service surveys to meet the demands of patients and standards measured by the Joint Commission, ACA, and stockholders. Manary et al. (2015) stated the healthcare community through mandates established by the Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) developed a Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey to address measures to improve the quality of patient care. The overall goal of this survey was to improve the quality of care for patients by providing useful data to the consumer and healthcare facility leadership could use to improve PCC.

Etkind et al. (2015) stated that many healthcare organizations are utilizing patient-centered outcome measures (PCOMs) to improve PCC. PCOMs is a term focused on measuring patient and proxy-reported outcome measures derived from internal surveys to improve the delivery of PCC. Healthcare leaders of various organizations are using surveys to connect their organization's accomplishments with their values to improve the patient's experience (Manary et al., 2015). As such, Bishop and Macdonald (2017) expressed that surveyed patients often highlighted the personal professionalism of the ancillary staff, the facility maintenance, and feeling of safety are measures as important. Acknowledging patient concerns through surveys is helping to improve the patient experience and PCC (Etkind et al., 2015).

Healthcare leaders who value increasing their patients' knowledge, leveraging innovations in healthcare, mitigating cost, and reducing their competition to improve a healthcare facility position among other facilities will improve their ability to retain patients (Manary et al., 2015). Millar, Freeman, and Mannion (2015) stated researchers have ascertained that safety and trust are quantifiable measures healthcare leaders should emphasize to reduce patient attrition, improve customer value, and anticipate customer responses to various situations. These measures can improve PCC for a facility. Etkind et al. (2015) stated research has shown that many healthcare facilities are not able to correlate the outcomes measured into increased value for patients.

Overall, long-term care Medicare-dependent patients have seen the greatest improved value from measures gathered through surveys (Etkind et al., 2015). Chang et al. (2013) emphasized the challenges healthcare managers endure to sustain PCC by underscoring an increased reliance on interpersonal care and feedback from the patient or their family. Furthermore, if family members are true participants in the patients' care, medical providers must provide sufficient information to ease their anxiety so they can make knowledgeable decisions as advocates for their relatives (Mitchell et al., 2016). Moreover, the HCAHPS provides healthcare facilities a standard survey to assess the general needs of most full-service acute care facilities; however, many healthcare administrators will require specific surveys to target special populations needs for specialties, for example, pediatrics, geriatric, hospice, cardiology, and oncology patients (Ranard et al., 2016). Overall, healthcare managers are using surveys as a principal tool to improve the delivery of PCC.

Patient-Centered Care Within the Affordable Care Act

President Barack H. Obama signed the PPACA on March 23, 2010. President Obama designed the PPACA or other appellations, for instance, Obamacare and ACA, to increase access to patient healthcare and reduce an individual's out-of-pocket expense (Cunningham, 2015). Two benefits of PPACA for Americans are a reduction in pre-existing condition exclusions and the elimination of lifetime limits on insurance coverage (Cheng, 2016).

Cunningham (2015) stated the PPACA requires all Americans to have access to affordable healthcare at rates based on one's income regardless of an individual's health status. Other benefits of PPACA for Americans are statutes that restrict health insurers from discriminating the sale of insurance basis on a person’s health status and granting tax credits to both individuals and families (Ogundipe et al., 2016). According to Blumenthal, Abrams, and Nuzum (2015), 30 million of the 31 million Americans projected by the writers of the PPACA gained health insurance and 10.8 million additional Americans have enrolled in Medicaid since the enactment of the PPACA. As of 2016, the uninsured rate for Americans has declined by 43%, from 16.0% in 2010 to 9.1% in 2015 (Obama, 2016). Historically, President Obama was not the first President to argue for a comprehensive healthcare plan that all Americans could access. In 1912, President Theodore Roosevelt unsuccessfully attempted to campaign for a united healthcare plan (Doherty, 2017). Roosevelt began his initiative based on a campaign promise to provide healthcare for all industry workers who were experiencing an increase in chronic health issues during the Second Industrial Revolution (Manchikanti, Helm, Benyamin, & Hirsch, 2017).

Consequently, Franklin D. Roosevelt (FDR), the 32nd President of the United States, spearheaded several legislative efforts to include a national healthcare reform to meet the needs of Americans after the Great Depression (Gaffney, 2015). FDR sought to enact a national health insurance mandate; however, the political climate after the depression would not support a standalone healthcare insurance mandate (Doherty, 2017). Instead, FDR was able to establish the Social Security Act, which he signed into law in 1935. FDR continued to push for a healthcare provision. Through his Surgeon General, Thomas Parran, FDR sought to have national health insurance support Social

Security beneficiaries as a means to assist some portion of Americans (Kim, 2017). FDR was unable to establish a universal healthcare insurance program before his death in 1945. President Truman, FDR's successor, took up the pledge to establish a universal healthcare reform. Like FDR, Truman attempted to establish a national healthcare program but failed based on a heavy Republican Congress that did not support the idea (Manchikanti et al., 2017). After Truman, Lyndon Johnson, the 36th President, took up the task to establish a national healthcare program. Under Johnson's administration, he signed the Medicare and Medicaid Bill in 1965 (Doherty, 2017). Johnson's signing was the greatest achievement toward the concept of a national health program since the idea emerged during Theodore Roosevelt's presidency in 1912 (Doherty, 2017). President Johnson established Medicare to support Americans 65 years and older (Manchikanti et al., 2017). However, as culture evolves, the Medicare program signed into law by President Johnson is not the same program Americans are using as of 2015 (Blumenthal, Davis, & Guterman, 2015).

In 1966, 19 million Americans benefited from the passing of Medicare (Falconi, 2015). As of 2015, 53 million Americans benefit from Medicare (Blumenthal, Davis, & Guterman, 2015). In 1972, Medicare expanded to include individuals younger than 65 with long-term disabilities and patients diagnosed with end-stage renal disease (Altman & Frist, 2015). This expansion of Medicare was another step toward providing healthcare to a segment of the American population that otherwise could not afford healthcare (Blumenthal, Abrams, & Nuzum, 2015).

In 1977, during the Carter administration, the Department of Health, Education, and Welfare established the Health Care Financing Administration (HCFA) to administer both the Medicare and Medicaid programs **(**Altman & Frist, 2015). Between the 1980s through 2003, Medicare and Medicaid added measures to assist Americans and others. In 1988, Congress required all states to use Medicaid funds to pay Medicare premiums and cost sharing for qualified Medicare beneficiaries (QMBs) with incomes below 100% of the federal poverty level (FPL) (Altman & Frist, 2015). Later in 2003, President George W. Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act, which provided new outpatient prescription drug benefits beginning in 2006 (Viswanathan et al., 2015). The PPACA has the greatest impact and quantifiable effect on U.S. citizens access to health insurance since the establishment of the Medicare and Medicaid Act of 1965 (Blumenthal, Davis, & Guterman, 2015; Shaw, Asomugha, Conway, & Rein, 2014).

The ACA is an act created through ad hoc legislation (Gaffney & McCormick, 2017). An ad hoc legislature differs from a traditional legislature model by the process Congress will use to get the law they desire approved. A traditional legislature will focus on implementing one law or act (Bishop, 2014). The ACA is two bills, the PPACA and the Health Care and Education Reconciliation Act of 2010 (HCERA) passed almost immediately after the PPACA to amend that legislation (Bishop, 2014).

Upon President Obama’s reelection in 2012, Congress composition changed from a Democratic majority to a Republican-controlled Congress. This change of power lead to a push by a Republican-led Congress in 2012 and beyond, as well as the principal promise of Donald Trump, the 45th President of the United States, to dismantle the ACA as written (Ogundipe et al., 2015). Bishop (2014) stated the ACA is the first time the U.S. has preserved access for all Americans the basic right to healthcare that encompasses improved delivery of care as well as a federal government overhaul of healthcare insurances. The ACA focused more on the cost of insurance as opposed to the cost of healthcare (Obama, 2016). Ericson and Kessler (2016) stated the debate, for example health insurance mandates or tax, regarding the ACA pertain to the manner the government discourages or encourages Americans with private, individual (nongroup) insurance whose health plans may terminate due to higher premiums, coverage for fewer services, and or denial of benefits to people with pre-existing medical conditions impacts compliance among Americans.

Since the ACA became law in 2010, the uninsured rate has declined by 43% (Obama, 2016). According to Blumenthal, Abrams, and Nuzum (2015), the number of uninsured Americans declined from 49 million in 2010 to 30 million in 2015.

The remaining uninsured will have several options that follow:

- Pay a tax penalty 1% of their income in 2014 that will increase to 2.5% in 2016 if they do not obtain acceptable coverage
- Enroll in Medicaid or seek out an employer plan, if one qualifies
- Obtain subsidized private insurance on the exchange if they meet income requirements between 133% and 400% of the poverty line as determine by the U.S. Census Bureau

- One can purchase insurance on their own that will most likely incur a greater cost based on the inability to qualify for an exemption (Gaffney & McCormick, 2017).

Elderly Americans, who are a minimum of 65 years old, can use Medicare and Medicaid to cover their healthcare expenses. Provisions embedded in the law set forth measures to improve PCC as stipulated by the Patient-Centered Outcomes Research Institute (Frank et al., 2015). To ensure patients had a voice in their delivery of care, the authors of the ACA created the PCORI to examine measures for improving health and healthcare management by patients and providers by analyzing the quantifiable efficiency of current health treatments (Bishop, 2014). In 2014, the Supreme Court sustained the constitutionality of the individual mandate of the PPACA, thereby ensuring the Act remained intact as endorsed by President Obama as well as the goal of cost containment and improved patient access (Ogundipe et al., 2015).

In particular, Title V of the PPACA outlines the strategy to expand access to care to low-income, underserved, and uninsured, minority, health disparity, and rural Americans (Islam et al., 2015). In Medicaid program expansion states, the proportion of Medicaid enrollees reporting poor access to care declined from 8.5% before the expansion to 7.3% after the expansion that resulted in a 1.2% change with 5.3% of patients reporting no change in access (Ndumele et al., 2014).

How Patient-Centered Care Emerged to its Relevance in Today Healthcare Delivery

The terminology of PCC has evolved globally from healthcare policies identified from the World Health Organization, the National Health Service, U.S. HHS, and the Australian Commission on Safety and Quality in Health Care (Santana et al., 2017). Healthcare managers, physicians, nurses, and other medical professionals embrace PCC as a principle function for ascertaining a patient’s goals and use these goals to develop a patient’s treatment plan (Tinetti, 2016). Bowen et al. (2017) advocated that a patient-centered performance management system would provide a valuable platform for all those involved with providing PCC by ensuring management incorporates the patient preferences, as well as hold medical service providers accountable for a patient-centered performance measurement model. Consequently, Pluut (2016) stated healthcare providers are employing various models and methods of PCC to meet various patients’ needs. Santana et al. (2017) surmised from various data sources that three principal themes of PCC are (a) the patient participation and involvement, (b) the relationship between the patient and the healthcare professional, and (c) the environment where the patients receive care.

The delivery of PCC remains a challenge based on language, socioeconomic status, education, and cultural incompatibilities among patients (Moore et al., 2016). To deliver PCC, Blaum et al. (2017) acknowledged three universal phases as follows:

1. Ensure the family member or legal guardian and patient comprehend the patient’s diagnostic health status.

2. The process of establishing and prearranging the goals of the patients with the medical providers to plan the patients required a length of care.
3. The third phase requires the patient and provider to commit to an established plan of care based on the goals established through dialogue with patient and caregiver. A challenge many healthcare professionals encounter is converting a patient’s goals into a methodology to determine the appropriate intervention.

Bowen et al. (2017) suggested using the patient-centered performance management system to document recommendations for medical professionals and the patient with the likelihood the recommendations received would benefit the patient or provide indicators that a chosen goal could cause harm. Tanenbaum (2015) stated the goal of PCC is to avoid utilizing a one-size-fits-all PCC model. By implementing the latter strategy, healthcare professionals can establish a PCC plan that adjusts for various cultural and regional dynamics. Similarly, Blaum et al. (2017) recommended caregivers receive additional education to prepare them to care adequately for the elderly and those with advanced-care illnesses.

Patient-Centered Care within a Value-Centered Healthcare Model

In 2007, the Institute for Healthcare Improvements (IHI) developed the *Triple Aims* framework cited and used by healthcare organizations throughout the world (Storkholm, Mazzocato, Savage, & Savage, 2017). Two benefit healthcare administrators and providers have gained by implementing the Triple Aim are a focus on the patient and an increased delivery of suitable care (Conrad & Alfredson, 2016). The three aims attempt to (a) improve the patient care experience, (b) improve the health of a population, and (c) reduce per capita healthcare costs. These became the cornerstone of the ACA (Storkholm et al., 2017).

Porter and Kaplan (2016) identified value as the core function patients require and providers and stakeholders must accomplish to improve outcomes. Additionally, a function is to reduce the cost to organize healthcare around a patient-centered system. Likewise, Subramaniam et al. (2017) identified the Joint Commission, a non-profit organization responsible for accrediting over 21,000 healthcare organizations, as encouraging healthcare leaders to create a culture that promotes safety and value patient-centered communication. When the ACA became law in 2010, CMS executed several programs to transition from a volume-based reimbursement to a value-based care model (Bosko & Gulotta, 2016). Porter and Kaplan (2016) specified that value within a healthcare delivery model is health outcomes that resonate with patients alongside the expected cost required to achieve predictable outcomes.

At the national and state levels, healthcare and governmental leaders identified the lack of value gained through physician’s fee-for-service plans that limit patient and healthcare organizations’ ability to examine insurers; however, under managed care, insurance companies could negotiate cost-effective contracts subject to review and monitoring (Baicker & Robbins, 2015). Porter and Kaplan (2016) stated improving value requires improving outcomes without raising costs, lowering costs without compromising outcomes, or both. Price and Elliott (2018) determined that a lack of patient involvement could create confusion among the patient, caregivers, and healthcare providers resulting in the patient perceiving a lessening of value care. Elwyn et al. (2014) advocated that healthcare providers have determined that PCC improves their patients’ outcomes, as well as improve self-management, patient approval ratings, and improved medical outcomes. When addressing elderly patients, particularly Medicare recipients, the medical treatment team should work to ascertain what the patient values and prefers when designing a treatment plan that supports results and outcomes the patient and caregivers desire (Cox, White, & Abernethy, 2014).

Shared decision making, a method used by healthcare teams to gather information that informs the patient of their treatment options and strategies while addressing the patient’s preferences, assists in developing the patient treatment plan (Elwyn et al., 2014). Medical personnel who utilize decision aids in support of decision making have seen increasing support by patients and caregivers when developing treatment teams for those with complex illnesses often seen in elderly patients (Cox, White, & Abernethy, 2014). Elwyn et al. (2014) concluded that shared decision making in support of PCC is most effective when clinical teams can adapt based on the patient’s situation, needs, and projected outcomes. Notwithstanding, healthcare managers should be aware of the limits any decision support system may have and develop strategies that help to mitigate issues in providing the level of care expected from the patient and caregiver (Cox et al., 2014).

Porter and Lee (2016) proposed a value-based delivery model where healthcare facilities organize care around the patient needs versus a model focus on enhancing the financial performance of primary care practices under fee-for-service payments. Bosko and Gulotta (2016) attested the need for organizations to convert to a value-based plan for sustainability. A value-based plan would require a methodical change in the approach to care across the healthcare continuum. For healthcare to improve, Bosko and Gulotta (2016) stated the healthcare industry should utilize risk stratification models to manage the population and identify high-risk patients. Risk stratification models enable medical facilities managers to organize workflow and group patients based on needs.

Porter and Kaplan (2016) recommended analyzing primary healthcare as a multitude of several patient subgroups that enable managers to measure outcomes and cost, other payment models and strategies that support primary and specialty care solutions. Healthcare managers and insurers are using big data, for example, large volume of detailed electronic information accessible for the purpose of analyzing patient's medical history, inconsistency in healthcare quality, treatment strategies, hospital readmission rates, and opportunities to reduce patient cost and manage overtaxed medical resources for the purpose of improving value and efficiencies (Manogaran et al., 2017). Subsequently, Rollow and Cucchiara (2016) indicated the establishment of PCMH is a significant model for improving value, team-based care, outcomes, and costs containment.

The ACA will cover an additional 30 million Americans by 2020 with health insurance who without the ACA would remain uninsured (Rice et al., 2014). Notwithstanding, a core achievement of the ACA has been the requirement for all Americans to have health insurance at rates based on the population averages regardless of one's health status (Obama, 2016). Sommers, Maylone, Blendon, Orav, and Epstein (2017) stated one of the aims of the ACA was to provide healthcare coverage for low income citizens. One group of high-risk citizens is the elderly. Chandra et al. (2015)

stated the following factors identify the elderly as a risk factor: sociodemographic, environmental trends with outpatient care, repeated adverse drug incidences, and the number of elderly patients using multiple prescriptions. In short, Rice et al. (2014) indicated increased accessibility and affordability to health insurance regardless of a person's station would move the U.S. much closer to the concept of universal healthcare.

Value-Based Purchasing

The healthcare industry could not sustain the rate of increases in Medicare patients incurred in the late 2000s. CMS established the Value-Based Purchasing (VBP) program as a means to add value to healthcare services. Within the ACA, a statute is a means to reduce cost. All funds for inpatient health services will correlate with value and measures per (42 U.S.C. § 18001 (2010). The number of readmissions and catastrophic events increased among Medicare-dependent patients costing over $30 billion in 2009, reflecting poorly on the U.S. even though many non-U.S. citizens hailed the U.S. healthcare system as the best in the world (Raso, 2015). Lipshy (2017) described a setting that includes adverse events, for example, operations performed with foreign objects left inside of patients due to poor safety and maintenance standards. However, Kronick (2016) indicated the U.S. healthcare system saved $12 billion in Medicare and Medicaid costs from 2010 to 2013 based on collaborations between U.S. Department of Health and Human Services (HHS) agencies and other partners to achieve the goals of improving care, greater efficiency of healthcare dollars, and healthier people.

In 2014, value-based payments emerged as requirements based on provisions established by President Obama when he signed PPACA and the HCERA together known as the ACA (Burwell, 2015). Raso (2015) stated VBP funds would come from reduced hospital Medicare payments. Stein et al. (2015) recognized that VBP provides hospitals with financial incentives based on a critical factor that the patient experience is a key component of quality care.

Moreover, CMS would redistribute revenue as withheld-funds derived from Medicare payments back to hospitals based on quality performance data based on its prior year's performance (Raso, 2015). Based on the success of the VBP, former HHS Secretary Burwell announced that VBP would tie Medicare fees for service to value by 2018 (Lynn, McKethan, & Jha, 2015). Additionally, the CMS moved to expand VBP in 2015 by rewarding or penalizing hospitals with financial incentives based on their quality of care delivery and spending (Das et al., 2016).

Bosko and Koenig (2016) stated CMS established programs that incentivized hospitals for providing quality facility care and penalized those facilities that failed to provide quality care as facilities transitioned to a value-based payment system. Bundled arrangements are a focus for CMS. CMS is moving coverage of over 55 million Medicare beneficiaries and 72 million Medicaid enrollees (Pizzo & Ryan, 2016). In 2014, Section 3001(a) of Public Law 111-148 outlined the inpatient value-based purchasing program that referenced the criteria for value-based payments based on a hospital meeting performance standard for the performance period of that year.

The overall success rating of a hospital correlates directly with that hospital's pay-for-performance (P4P) strategy that supports the outcomes for increased efficiencies and positive levels of patient experiences (Stanowski, Simpson, & White, 2015). Bosko and

Koenig (2016) defined a value-based program as a payment redistribution program for qualified hospitals that subsidize a set percentage of the base operating payments to a VBP payment group; the percentage for 2017 is 2.0%. Overall, VBP rewards hospitals based on their performance. Furthermore, physicians must adhere to payments derived from servicing Medicare and Medicaid-dependent patients based on value versus volume (Ryan & Rodgers, 2018). The ACA identifies the payment as a value modifier that ties a physician's quality of care and those costs associated with Medicare Part B payments (Bosko & Hawkins, 2016). Along with the payment plans listed within Medicare Part B, physicians can take part in alternate reimbursement methods that include the PCMH model and other approved payment methods (Bosko & Hawkins, 2016).

In addition to the VBP, two other programs make up the CMS programs, the Hospital Readmissions Reduction Program (HRRP) and the Hospital-Acquired Conditions (HAC) program. The HRRP and HAC are penalty programs designed for hospitals that fail to transition to value-based reimbursement, hospitals with unnecessary, avoidable readmissions, and hospitals whose performance is in the bottom quartile for all hospitals (Bosko & Koenig, 2016). The CMS established bundled payments to motivate providers to coordinate care, increase quality, and reduce cost based on a single payment for a specified treatment over a definite period (Pizzo & Ryan, 2016).

Organizations striving to improve healthcare should align the quality components of the CMS programs, which include the quality of payment, reimbursement structural change, and provider's compensation. Organizations must evolve to incentivize behavioral change and promote adherence to quality and service metrics (Pizzo & Ryan, 2016). As such, many healthcare organizations leaders have taken steps to improve their delivery of care based on constraints outlined in the ACA and demands from local, state, and federal agencies, as well as insurance companies to provide sustainable quality healthcare at a lower cost (Douthit, Kiv, Dwolatzky, & Biswas, 2015). In contrast, hospitals located in regions where patients'incomes are higher and charitable contributions to hospital are the norm have seen a steady increase in favorable patient surveys. However, those patient's surveyed with limited income and longer travel distance to healthcare facilities have experienced difficulties accessing quality healthcare (Stanowski, Simpson, & White, 2015).

The challenge in providing PCC to those disproportioned Americans entering the healthcare market is that it is slow to see the gains established through the ACA as highlighted through patient-reported experience surveys (Schlesinger, Grob, & Shaller, 2015). Healthcare managers of medical facilities will need to develop strategies and processes to lower costs without diminishing safety and quality so that medical staffs can accomplish quality healthcare while making a profit (Porter & Kaplan, 2016). Stanowski et al. (2015) identified that hospitals could gain benefit by linking the patient experience to financial incentives that coincide with increased safety, outcome care, and patient satisfaction surveys. Similarly, Bowen et al. (2017) discussed that using the electronic health record (EHR) system; (an existing digital system used by health facilities to document a patient's medical history) can improve a patient's safety and minimize risk from unnecessary medical treatment. Mohammed et al. (2016) suggested healthcare teams that utilize patient experience data gathered from patient satisfaction surveys could improve the patient experience and the delivery of health services to increase a patient's outcome.

The task of lowering cost, maintaining safety, and meeting stockholder goals increases the challenge of making PCC a priority. As a larger portion of lower income and vulnerable Americans receive their healthcare from Safe-Net hospitals (SNH) often located in disenfranchised and rural communities, the complexities of managing a hospital increase (Andrulis, Siddiqui, Reddy, Jahnke, & Cooper, 2015). French, Guzman, Rubio, Frenzel, and Feeley (2016) stated time-driven activity-based costing (TDABC) is a tool many hospitals are beginning to use to help healthcare providers and managers improve processes within their organizations. Bhavnani et al. (2017) advocated the need for the healthcare industry to develop new patient-centered, evidence-driven models that support healthcare transformation and cost reductions. Bhavnani posited that healthcare providers and managers could accomplish the shift in focus from serial treatment to sustainable health outcomes based on ACA standards. Notwithstanding, Safe-Net hospitals have a higher chance of failing without some institutional process improvement measures implemented in support of healthcare transformation (Andrulis et al., 2015).

Bhavnani et al. (2017) emphasized that healthcare facilities should implement alternate means to communicate that include telehealth, virtual health, email, phone, and text to limit a patient's time in a healthcare facility that in turn increases cost and impact patient surveys, a principal indicator in VBP. Lipshy (2017) indicated that healthcare organizational leadership should commit to zero defect concerning the patient's safety and employ tools that support gained efficiencies to meet sustainable healthcare delivery.

Lipshy (2017) indicated that an organization’s leadership requires resilience, such as the competence to recognize errors efficiently and elicit strategies that deter and isolate them, thereby averting any damage that may result if not mitigated. HHS is the U.S. agency charged to improve and safeguard the health and well-being of all Americans. The agency focuses are (a) to provide incentives to providers and healthcare facilities, (b) to increase standards of care for Americans through improved integration of teamwork between providers and patients, and (c) to place emphases on improving communication both digital and through others forms of media between providers and patients (Burwell, 2015). According to Mamlin and Tierney (2016), other forms of communications, for example, telemedicine and telehealth support the universal goal of expanding access to healthcare to millions of additional Americans while reducing the cost to meet PCC initiatives expected from CMS and HHS.

The Patient-Centered Medical Home

The PCMH is the single best strategic model to improve healthcare quality, reduce cost, and most importantly improve the patient’s, caregiver’s, and treatment team’s experience. Evidence supports PCMH as a tremendous model for delivering primary care within patient-centered modality (Heisler, 2017). The PCMH concept originated in 1967 when the American Academy of Pediatrics (AAP) crafted the term *medical home* to define the role of the pediatric practice for chronically ill homebound children (Lerner & Klitzner, 2017). Moreover, PCMH population base consisted of children and adolescents characterized as children with special health needs (Adepoju, Preston, & Gonzales, 2015). This earlier model focused on coordinating care among specialists, thereby omitting the patient’s primary care physician. The next significant advancement to PCMH occurred between 1978 and 1990. During the World Health Organization’s International Conference on Primary Health Care in 1978, the terms access to care, continuity of care, comprehensiveness and integration of care, patient education and participation, team-based care emerged along with accompanying public policy in support of primary care goals (Bath & Wakerman, 2015). In 1990, reports emerged that mention the terminology medical home.

Based on Ed Wagner’s chronic care model developed in the 1990s, the IOM medical home concepts, and joint principles developed by several medical professional organizations that included the American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP), establish the current criteria developed for PCMH (Johnson et al., 2015). As PCMH took root, professional journals and other literature, scholars, and practitioners began to incorporate lean processes to improve the PCMH model within various organizations (McGough, Kline, & Simpson, 2017). The earliest definition of PCMH as it related to care for adults emerged in 2007 when a study conducted by the AAFP focused on interventions and outcomes linked with several large initiatives known as medical homes (Lerner & Klitzner, 2017). In 2007 the AAP, AAFP, ACP, and the American Osteopathic Association collaborated to refine the medical home concept with patient-centeredness, in their Joint Principles of the patient-centered medical home (McHugh, Harvey, Hamil, & Scanlon, 2016).

To that end, the current model of PCMH emerged when it formalized in 2007. Coleman, Wagner, Schaefer, and Reid (2016) stated the National Committee for Quality

Assurance (NCQA), a privately own organization, helped to propel the PCMH model through its recognition and accreditation for many healthcare initiatives and models used throughout the U.S. government. Over the next 3 years, PCMH would become a principal model within the ACA. Notwithstanding, interface within the ACA is the concept PCMHs as defined in Section 3502 of the ACA to advance healthcare advantages for populations, preventive health, persistent chronic illnesses as well as other healthcare needs (Nowinski Konchak, Moran, O'Brien, Kandula, & Ackermann, 2016). Miller et al. (2017) stated the United States' depleting economic resources and decreasing healthcare budgets provide the perfect setting for healthcare providers to implement the PCMH model as an innovative approach to improving healthcare quality while reducing costs.

The Agency for Healthcare Research and Quality (2017) defined the patient-care medical home model as the standard of primary care that delivers the central functions of primary healthcare. Nevertheless, the writers of the ACA include provisions that assist and endorse the PCMH model as a financial incentive for Medicaid programs to transition patients from an inpatient model to a home-based model that supports technology advancements, safety, outcomes, and cost reductions (Nielsen et al., 2016).

Based on the literature, the PCMH consists of five functions and attributes that include (a) comprehensive care, (b) patient-centered, (c) coordinated care, (d) accessible service, and (e) quality and safety. These five elements aim to place the patient in the center of their care and streamline the care across the continuum of healthcare (AHRQ, 2017). Van Hasselt et al. (2015) stated scientific data supports the claim that the PCMH model is less resource intensive than traditional standards of medical delivery and positively improves disease management and effective preventative health.

Overall, the establishment of PCMHs involves (a) transforming physician-centric care processes by incorporating all members of a healthcare team, (b) placing the patient at the center of care to improve quality, and (c) increasing healthcare team’s access to their patient. Since the enactment of the ACA, scholars generally support the following: (a) treating chronic illnesses, (b) promoting preventive care and mitigating acute care needs, (c) employing multidisciplinary healthcare teams, (d) coordinating care transitions, (e) developing strategies that leverage multiple communication and technological systems, (f) monitoring risk mitigation, safety, and clinical based treatment care, and (g) improving electronic health records management as strategies to institute PCMH (McGough et al., 2017). Current studies support PCMH as the best model to mitigate a patient’s total cost, meet patient satisfaction, and improve hospitalization rates across multiple diverse populations (Nielsen et al., 2016). Bilello et al. (2018) supported evidence that the PCMH model is a capable model that underscores all levels of healthcare delivery while decreasing cost. PCMH has been the fastest growing model for managing patients with chronic health issues (Conrad & Alfredson, 2016). Overall, healthcare facility administrators that have implemented the PCMH model are seeing cost reductions based on a decrease of chronically ill patients utilizing emergency room services (David et al., 2015).

Healthcare Leadership and Continuous Quality Improvement

Healthcare leaders today continue to struggle with the goal of delivering quality healthcare to all patients. The PCMH model helped close the gap for most Americans despite the deficiency of effective communication and coordination of PCC across the wide range of healthcare delivery systems (Cantiello, Kitsantas, Moncada, & Abdul, 2016). Moreover, the relationship between the patient and the medical team providing the service is the core function that supports customer’s support for or against various modalities associated with PCC (Chang et al., 2013). Consequently, Balbale, Turcios, and LaVela (2015) stressed that the evidence supports healthcare workers are transitioning from the physician-centric care model to a PCC model that supports tailoring treatment centered on the patient and family needs. However, at the core of the delivery of healthcare is the healthcare leader. These leaders vary among hospital managers, physicians, treatment teams, and other administrative personnel. Bradbury and Lifvergren (2016) suggested that effective leaders understand and embrace the needs of their patients through a PCC strategy that strengthens and promotes innovative ideas to enhance the overall patient’s experience and quality care.

Transition

The purpose of this qualitative descriptive case study was to understand what patient-centered strategies healthcare managers use to reduce the cost of elderly patients’ healthcare without reducing the quality of patient care. In this literature review, I provided a historical perspective and discussion of PCC, assessing PCC, patient centered-care as a measurement within healthcare, PCC within ACA, PCC relevance in today’s healthcare delivery systems, PCC within a value-based healthcare model, value-based purchasing, PCMH, healthcare leadership and continuous quality improvement in healthcare. In the next section, I will describe the validation for the use of a qualitative descriptive multiple case study to explore patient-centered strategies healthcare managers use to reduce the cost of elderly patients' healthcare without reducing the quality patient care. In Section 3, I will provide my presentations of the findings with a description of the finding's application to professional practice and implications for social change.

Section 2: The Project

The purpose of this qualitative descriptive multiple case study was to explore and present an enhanced understanding of how healthcare managers strategically apply patient-centered strategies to reduce the cost of elderly patients' healthcare without decreasing the quality of a patient's care. Using a multiple case study enabled me to address the principal research question based on feedback from multiple viewpoints within a healthcare setting.

Purpose Statement

The purpose of this qualitative descriptive multiple case study was to explore what patient-centered strategies healthcare managers use to reduce the cost of elderly patient healthcare without reducing the quality of patient care. The participants consisted of six midlevel healthcare managers from several departments located at six full-service acute care healthcare facilities that employ 150 people or more in Virginia, who have reduced the cost of elderly patients' healthcare without reducing the quality of patient care. Conducting this study may lead to positive social change for elderly patients by improving the delivery and access of quality PCC while catalyzing, developing, and implementing cost reduction strategies that healthcare managers can employ to make healthcare more accessible.

Role of the Researcher

The role of the researcher in this study was to collect, analyze, and interpret data and results garnered from participants' interviews and archival data. Hyett et al. (2014) suggested a researcher seek out generalities and uniqueness about a case by considering cautiously and thoroughly the environment, historical background, physical setting, and other institutional and relative regulatory factors. Noble and Smith (2015) noted that the role of the researcher is to facilitate participants' sharing of perspectives and experiences regarding the phenomena. Houghton, Murphy, Shaw, and Casey (2015) stated that a role for a researcher is to gather material from observations and attempt to comprehend the phenomenon of interest based on the meanings that participants provide. I did not have a personal or professional relationship with the participants. I do not work in the healthcare field; therefore, my career experience should not have affected research outcomes.

I sought to maintain all ethical standards during this study by adhering to the protocols outlined in the *Belmont Report* (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). I stressed the adherence to protecting the rights and welfare of participants as well as their autonomy as stipulated in the *Belmont Report*. I adhered to Walden University's Institutional Review Board (IRB) process by conforming to ethical standards compliance requirements before conducting research. To meet this objective, I submitted an electronic submission of the IRB form with the inclusion of the research proposal description, data collection tools, research participants, and informed consent. To meet the ethical standards of Walden University and U.S. federal regulations, I did not collect data until I received approval from the Walden IRB.

Ponelis (2015) stated using a qualitative exploratory multiple case study allows the researcher to explore the strategies in a real-life setting. As the study proceeds, the researcher should work to include shared experiences among participants through interview questions, data collection, and data analysis. I sought to mitigate bias by identifying and engaging in a process that exposed and eliminated predispositions. A researcher can reduce bias through a self-assessment, which connotes reflexivity while increasing dependability through the transparency of the study's development (Moon Brewer, Januchowski-Hartley, Adams, & Blackman, 2016). Sorsa, Kiikkala, and Åstedt-Kurki (2015) indicated *bracketing* provides researchers the means to mitigate predetermined experiences, attitudes, and beliefs during the extent of the study to avoid tainting the process with bias. According to Antwi and Hanza (2015), the researcher should remain neutral during the data collection process. A lack of a relationship with the participants should improve the researcher's ability to mitigate personal bias in a study (Fusch & Ness, 2015). Also, I used peer debriefing as well as new information to help clarify bias when I analyze themes and outcomes.

This case study data included interview transcripts, researcher notes, and associated documented evidence. Yin (2014) suggested interviewing participants with different views throughout the organization as a value-added method. Goldberg and Allen (2015) suggested researchers prepare for future discussions from readers by presenting preliminary results to participants while incorporating their feedback throughout the study. I reviewed my case study results with my participants to garner feedback for validating transcripts to verify their responses.

Participants

Robinson (2014) stated identifying the participants who can best enlighten the research question and understanding of the phenomenon for a qualitative study is purposive sampling. Elo et al. (2014) indicated convenience, theoretical, and snowballing are other types of qualitative sampling for identifying participants’ knowledge of the research topic. Elo et al. (2014) stated researchers could improve the reliability of a study by specifying the sampling method and the participants for their study. As such, the participants a researcher selects should be those individuals capable of supporting the researcher’s questions and able to enhance the understanding of the study (Sutton & Austin, 2015).

The target population included six midlevel healthcare managers from six acute care facilities in Virginia that execute strategies to reduce the cost of elderly ambulatory and acute patients’ healthcare without reducing the quality of patient care. I solicited these participants through the hospital’s human resources department and the American College of Healthcare Executives national and local chapters, where I am a member. Palinkas et al. (2015) stated participants who meet a precise standard by having a higher knowledge of the phenomenon of interest through their capabilities are desirable participants. Yin (2014) stated the participants of a case study should be knowledgeable about the phenomenon of the researcher's study. Palinkas et al. (2015) recommended selecting individuals or groups that are knowledgeable of the phenomenon. Antwi and Hamza (2015) recommended the researcher encourage participants under study to speak freely on the phenomenon with which they have experience.

According to Merriam and Tisdell (2015), it is important for researchers to establish relationships with potential participants. Lowther et al. (2016) recommended researchers develop relationships with their participants by (a) employing compassion,

(b) using open and nonjudgmental conversations, (c) communicating trust and support, and (d) reiterating to participants the importance of their contribution to society. I instituted honest and mutual relationships with participants, abided by the ethical principles of nonmaleficence, and ensured participants’ privacy to enhance a successful working relationship with participants (Petrova, Dewing, & Camilleri, 2016). Palinkas et al. (2015) indicated a researcher using a qualitative method often relies on specific rules for defining the number of participants. Palinkas et al. (2015) stated the type of analysis stipulates the level of detail required for homogeneity, for example, a small sample size of 3-6 participants versus a large sample group.

I garnered interviewees through purposeful sampling via the American College of Healthcare Executives membership database, telephone, and e-mail to solicit and communicate with participants. Palinkas et al. (2015) defined purposeful sampling as a technique for identifying and selecting information-rich cases based on limited resources. Palinkas et al. (2015) specified that purposeful sampling involves selecting individuals or groups of people specifically who may provide an in-depth understanding of the research phenomenon. I followed up with an email before data collection to confirm the volunteers’ participation in the study. Participants used e-mail to specify their preference for a face-to-face interview or Skype that explains the ethical and privacy protection of participants. Yin (2014) recommended researchers use an open-ended question when engaging participants by e-mail, telephone, and face-to-face. Johnston et al. (2016) stated interviews should last a maximum of 60 minutes so the researcher can capture the voice of the participants. Researchers should use a semistructured process when conducting an interview (McIntosh & Morse, 2015).

Research Method and Design

Hyett et al. (2014) stated a research method includes an established set of specific processes, tools, and techniques to gather and analyze data. Healthcare researchers can use qualitative analysis to develop effective strategies for exploring healthcare managers' experiences in providing the delivery of PCC strategies that reduce the cost of elderly patient healthcare without reducing the quality of patient care (Lewis, 2015).

Research Method

Three research methods used by healthcare researchers are qualitative, quantitative, and mixed methods (McCusker & Gunaydin, 2015). I used a qualitative research method. Leung (2015) defined qualitative research as a systematic collection and interpretation of documented material obtained through conversations and observations within a natural setting. Sutton and Austin (2015) asserted healthcare researchers should seek an increased understanding of their study participants' or group's natural experiences to gain a fuller description of the phenomenon. Kalu (2017) stated a qualitative research method signifies an orderly and objective means of labeling and measuring phenomena. Healthcare researchers can use qualitative research to understand and experience the actual phenomenon in its natural setting (Sutton & Austin, 2015). Tayabas, León, and Espino (2014) concluded researchers who pursue qualitative research for healthcare research would benefit by identifying areas and programs that need improving and processes required to create change within an organization. According to

Marwick (2014), most researchers who use quantitative studies use observation and ex post facto designs within a controlled environment based on statistics and numbers. Barnham (2015) stated researchers use quantitative methods to examine social phenomenon, test theories, and establish a problem based on variables consisting of statistics to determine if their theory explains or predicts phenomena of interest. A quantitative approach would not have provided the means to examine the participants' perceptions and experiences.

Although researchers support the use of a mixed methods approach to study a phenomenon, it was not an appropriate method for this study. A mixed methods study is a combination of qualitative and quantitative methods. However, the quantitative method cannot account for the experiences and assumptions of healthcare managers concerning the impacts of healthcare for Medicare-dependent patients. A mixed methods design supports a researcher's aim to extend and validate qualitative and quantitative methods, hence detailing a comprehensive meaning of the phenomenon (Palinkas et al., 2015). However, the goal of this study was to explore strategies of a phenomenon based on personal experiences of healthcare leaders; a qualitative inquiry was beneficial for studying those strategies used to reduce the cost of elderly patient healthcare without reducing the quality of a patient's care. French, Luo, and Bose (2017) suggested that mixed methods is a holistic approach for researchers to pursue new initiatives. Through face-to-face interviews and data collecting, a mixed methods researcher can assess the demands of caregivers and the logistics to analyze their business processes. The rationale used to employ a qualitative case study over a quantitative or mixed methods study was the ability to attain a deeper universal view of the research problem that can assist understanding of the problem and situation (Yin, 2014). The goal of this study was to explore patient-centered strategies from the perspective of the healthcare manager. A qualitative method was advantageous for studying the experiences of healthcare managers.

Research Design

To evaluate patient-centered strategies used by managers to reduce cost and maintain quality patient care, I chose the case study design to explore this phenomenon. Yazan (2015) stated a case study design provides the researcher with the means to assess the complexities and comprehensive study of a phenomenon. According to Moeyaert, Maggin, and Verkuilen (2016), the case study design provides researchers the means to focus on one or more subjects via observation repeatedly over a defined period until one achieves their desired outcomes.

Houghton et al. (2015) suggested healthcare researchers require qualitative research skills to interpret data collection, the nature of a healthcare system, and the organizational structure. A qualitative case study approach can provide the means to explore what patient-centered strategies healthcare managers use to reduce the cost of elderly patient healthcare without reducing the quality of patient care. By exploring and analyzing a multiple case study, a researcher can fully understand and communicate the significance of conducting a study into a single problem (Morse & McEvoy, 2014).

Additional study designs considered included phenomenology and ethnography (Maggio, 2016). Gill (2014) summarized phenomenology was both a philosophical movement and a family of qualitative research designs subdivided as either descriptive or interpretive. Van Manen (2017) emphasized a phenomenology study includes exploring the quintessence of a participant's knowledge through interviews and observation. Furthermore, Yin (2014) stated the phenomenological design focuses on how the experience of a phenomenon affects participants. Howlett (2014) noted an ethnographic design is for developing a description and interpretation of culture, social system, or group. Researchers who implement an ethnographic design seek to explore the culture of individuals possessing shared behavior patterns and beliefs (Balyer, Karatas, & Alci, 2015). Baskerville and Myers (2015) argued that ethnography addresses conceptual issues of human behavior from actual accounts of field experiences.

Zill et al. (2015) explained the differences between a phenomenon and perspective referring to the different manner healthcare managers and medical professionals define and implement PCC. While PCC may delineate the constraints of the study, healthcare managers, and medical professionals may apply various strategies to accomplish improved patient care. As such, Yin (2014) stated the boundaries between the phenomenon and context might not be transparent. The study's limitations provide the parameters of the case. A multiple case study design was beneficial for exploring the delivery of PCC strategies that reduce the cost of elderly patient's healthcare without reducing the quality of patient care. Multiple design constraints include a researcher's budget, time, and access to quality participants. Constraints can influence a researcher study; however, small groups of participants who are resourceful and informative are more often better suited to achieve data saturation when the study's scope is narrow (Malterud, Siersma, & Guassora, 2016; Power & Gendron, 2015).

Population and Sampling

I used purposeful sampling to select participants who have the prerequisite experiences and skills necessary to address the study interview questions. Gentles, Charles, Ploeg, and McKibbon (2015) stated purposeful sampling provides criteria for researchers to select participants with specific skills, expertise, and education. A sample size of six midlevel healthcare managers should offer the breadth of experiences, knowledge, and perceptions of strategies for reducing the cost of patient care without reducing the quality of patient care. According to Fusch and Ness (2015), a qualitative researcher study can limit the number of participants to between three and six participants.

Cridland, Jones, Caputi, and Magee (2015) stated the semistructured interview is the most common type of interview that researchers can adjust to meet the needs of various interviewees. Semistructured interviews are value-added for increasing the reliability and validity of data collection based on the interviewee 's knowledge and understanding of the questions (Yin, 2014). I used semistructured interviews composed of 10 questions to facilitate with two to four subquestions to enable the participants to address the main research question.

Morse, Lowery, and Steury (2014) stated the number of participants in a study should enable the researcher to gather enough data to sustain researching the problem. A sample size of six midlevel healthcare managers should provide suitable data and saturation for this study (Yin, 2014). Morse et al. (2014) stated data saturation is the means by which a researcher determines when there are sufficient data for exploring the phenomenon. The target population consisted of six midlevel healthcare managers from six acute care facilities in Virginia who developed and implemented strategies to reduce the cost of patients' care without reducing the quality of patient care. I solicited six participants for this study based on input from the hospital's human resources department and the American College of Healthcare Executives national and local chapters, where I am a member. I attained data saturation by gathering critical and substantial data through interviews and focus groups. According to Fusch and Ness (2015), researchers will reach data saturation when they have attained enough information to reproduce the study. Morse et al. (2014) stated a researcher's study achieves saturation when data collection meets a threshold where no new information or themes emerge from study participants and other types of data. According to Malterud et al. (2016), the selection of six participants in a study should be an adequate sample size to achieve saturation when I no longer receive information that adds to the development of my study.

Fusch and Ness (2015) asserted conducting interviews is a method a researcher can use to obtain data saturation. Fusch and Ness (2015) stated there is no one-size-fits-all method for a researcher to obtain data saturation; however, more is not essentially superior than less. Qualitative researchers aim to explore and detect the key issues associated with the phenomena; hence, no one-size-fits-all method for a researcher to obtain data saturation; however, more is not essentially superior than less (Roy et al., 2015).

The following five factors affect attaining data saturation within a qualitative study: the scope of the investigation, characteristics of the target audience, expertise of the research, resources, and research audience. Malterud et al. (2016) suggested the more information a population of interviews presents relevant to the actual study, the fewer participants the study will need to explore the phenomena. As the researcher, I reached data saturation by focusing on controlling the scope of this study through established restrictions that support a thorough exploration of participants' feedback throughout the case study (Fusch & Ness, 2015). The characteristics of my study participants were homogenous. For example, participants sharing similar traits; hence, the target interviewees will enable saturation for the reason individual interviews will share similar responses to research questions (Condon et al., 2015). Roy et al. (2015) stated proficient researchers rarely need a large group of interviews to acquire data saturation.

The sample size for this study was appropriate for this study because healthcare managers are leading complex organizations with the responsibility for ensuring safety, patient-care, cost management, and information-rich data regarding the phenomenon (Roy et al., 2015). Fusch and Ness (2015) stated researchers must ensure data saturation within their study to guarantee quality research and achieve validity. A researcher's saturation of themes determines the point at which one has sampled sufficient participants (Morse et al., 2014). Robinson (2014) stated a researcher achieves theoretical saturation when continued data collection results in no new emerging themes. At this point, the researcher has gathered enough data to justify claiming to achieve data saturation (Fusch & Ness 2015).

Ethical Research

Ethical issues and challenges vary across cultural sans regions; henceforth, respect for participants, consent, and integrity are mandatory for any study (Vitak et al., 2016). According to Bromley, Mikesell, Jones, and Khodyakov (2015), the researcher should ensure one's study is ethically acceptable by the participants, the studied organization, and the institute the researcher seeks to gain approval. I took every measure to ensure conducting this study complies with the highest level of ethical standards. I completed a National Institute of Health (NIH) Protecting Human Research Participants course to meet the basic requirements to conduct a study.

Ali and May (2017) stressed that researchers seek out voluntary participants by determining if they satisfactorily understand the nature of the study and the consequences of participating in the study. Vitak et al. (2016) recommended that the informed consent document involves the researcher providing identified participants pertinent information about the research while engaging the participants in writing to confirm their willingness to be a participant in the study. I requested each participant to sign the informed consent document. I informed the participants before and during the study that they could withdraw from this study based on their desire, with no penalty. If they decided to withdraw from the study, I would have asked the participant to send an email to quincy.handy@waldenu.edu or call to inform me of their intent not to participate. However, if participants neither called nor sent an email, I followed up with each participant that had not confirmed their participation by phone, email, or certified mail.

The IRB board provides the researcher with the best opportunity to ensure the study meets the prerequisites to conduct a successful study (Hudson & Collins, 2015). I did not identify my study participants by name; however, I identified the geographical location of the facilities where I conducted my study. I submitted my IRB application for approval before seeking support from participants. I met with each participant before engaging him or her for a signature in support of my study. I exercised characteristics based on the Belmont Report three guiding principles that are (a) respect for the participants, (b) beneficence, and (c) fairness in participant selection (Vitak et al., 2016).

As the researcher, I exercised professionalism throughout the entire study by emphasizing timeliness, patience, adhering to defined protocol measures, and conditions established within the participant’s consent form (Kass et al., 2015). Belmonte and Opotow (2017) defined data archiving as the transfer of records from the participant to a repository authorized to assess, preserve, and offer access to the participants’ records. Data archiving is a process for storing, securing, and preserving research data and resources for future research and continuations of similar studies (Wang, Kung, & Byrd, 2018).

I took every precaution to safeguard my participants’ information from loss and damage. All data collected both electronically and manually will reside in a secure, fireproof safe for 5 years. After 5 years, I will destroy all stored data.

Data Collection Instruments

Throughout this study, I was the primary instrument for data collection, using open-ended, semistructured questions in face-to-face interviews with healthcare managers or by Skype. McIntosh and Morse (2015) stated researchers should use semistructured interviews to discover participants' viewpoints about a phenomenon or situation relating to the study topic. Kallio, Pietilä, Johnson, and Kangasniemimi (2016) stated semistructured questions provide the researcher flexibility and the chance to address issues that arise extemporaneously during the interview. I used Yin's (2014) protocol framework to structure my interview and improve the reliability of my case study. Yin's (2014) protocol consists of four sections: (a) an overview of the case study, (b) protocol purpose, (c) data collection procedures, and (d) a guide for the case study report (see Appendix A).

I aimed to conduct my interviews by asking semistructured questions in a logical order. I decided to change the order each participant receives the interview questions if the conversation flow of exchange stimulates the need to alter the order of the interview questions (Crocker et al., 2014). As the researcher, I used open-ended semistructured questions and additional questions as needed. Yin (2015) stated the researcher should administer the same interview protocol to all participants to maintain consistency throughout the study. The semistructured interview consisted of ten open-ended questions to inspire participants to provide an in-depth understanding of the research question (see Appendix B).

Yin (2014) stated the interview is one of the best techniques for conducting qualitative research. Researchers can employ several methods to conduct an interview. Three of these methods are face-to-face interviews, group interviews, and telephonic, for example, Skype interviews. Based on Carter and Baghurst (2014), the researcher becomes the instrument of data collection because they provide a means for participants to discuss their experiences. Barnham (2015) stated the interview is a method distinguishable in various research methodologies. Sutton and Austin (2015) recommended the researcher audio record all interviews and analyze the findings by transcripts. As well, researchers should use Skype when participants are difficult to garner a face-to-face interview. Data obtained through Skype can provide an increased account of participant viewpoints on patient-centered strategies an important theme of this paper (McIntosh & Morse, 2015). As the researcher, I used a coding system to identify study participants and minimize ethical concerns, confidentiality, and privacy. Sutton and Austin (2015) stated a researcher should methodically read each line of the transcript and apply the code to ensure one captures the participant's conversation. Yin (2014) emphasizes that researchers establish a protocol when conducting a qualitative study. I defined my interview protocol (see Appendix A) with four sections: an overview, data collection procedures, data collection questions, and a guide for the case study report. Before initiating this study, I restated to the participants that their participation is voluntary; they had the right to withdraw at any time, and that confidentiality would remain in effect throughout this study.

I safeguarded each participant's data to ensure I adhere to Walden University institutional review board (IRB) processes. As the researcher, I electronically submitted my IRB form along with a description of the research proposal, data collection instruments, research participants, and Federal Regulations applicable to this study. I did not collect any data until receipt of approval from the Walden IRB committee.

As the principal data collection instrument, I coded participants' experiences from face-to-face, group, telephonic interviews, and Skype interviews. Participants' perceptions included discussion regarding reducing the cost of elderly care for patients and the viability of patient-centered strategies to maintain quality patient care. Three issues explored in the interviews include (a) use of midlevel healthcare managers, (b) patient-centered strategies, and (c) elderly-dependent patients. Cypress (2017) stated the reliability and validity of a data collection instrument are critical measures that extend interviews' answers by summarizing questions, goals, and objectives of the study. Dependability is the qualitative equivalent of reliability within a quantitative design (Hays, Wood, Dahl, & Kirk-Jenkins, 2016). Researchers can achieve reliability in a qualitative study through consistency from using original sourced form and context (Leung, 2015). Evaluating the reliability and truthfulness of a study aids in authenticating the research findings (Elo et al., 2014). To achieve the reliability of the data collection instrument, the researcher should explain to the participants the process and a list of identical interview questions for each participant. To help ensure reliability in interviewing, McIntosh and Morse (2015) recommended researchers request clarification and follow-up information if the researcher is unclear about the meaning of the information.

A quality control technique important for conducting a study that I used is member checking. Member checking is a process of validating the credibility of participants' results (Birt, Scott, Cavers, Campbell, & Walter, 2016). According to Birt et al. (2016), participants can review the data they provided to the researcher for accuracy.

Member checking provides the researcher with the ability to reduce risk and misunderstanding (Lub, 2015).

Data Collection Technique

The multitude of data collection techniques requires researchers to center their techniques on a few versus the variety of techniques available to researchers. According to O’Cathain et al. (2015), qualitative researchers should select from the following range of data collection techniques to conduct their research telephone, face-to-face interviews, focus groups, nonparticipant observation, case notes, paper, audio, video, diaries, discussions in online chat rooms, and social media. Elo et al. (2014) stated a researcher should select a data collection technique and analysis that support the framework of the data collection and the overarching research question.

Snowball sampling is a method whereby researchers seek out additional participants for their study based on their acquaintances and peers (Robert, 2015). Snowball sampling provides a means for researchers to acquire participants that may respond unlikely to a volunteer request due to the nature of the study (Robinson, 2014). A disadvantage of snowballing is some of the participants may lack the mixture of experiences and knowledge necessary to expand on the study (Palinkas et al., 2015).

Purposeful sampling is a method used by researchers when their study has a clearly defined theoretical or conceptual framework (Leung, 2015). Additionally, researchers who use purposeful sampling seek participants who provide relevant and productive data about the questions developed for their study to provide a definite explanation of the phenomenon (Cleary, Horsfall, & Hayter, 2014; Gentles et al., 2015).

Robinson (2014) noted snowball and purposeful sampling are both instrumental for conducting qualitative research. Both of these sampling methods are useful for maximizing efficiency and validity (Palinkas et al., 2015). I selected my participants through purposeful sampling. A weakness of purposeful sampling is that the researcher's own bias with choosing the participants can impede one's ability to draw inferences from the participant pool (Etikan, Musa, & Alkassim, 2016). Baškarada (2014) asserted researchers must guard against influencing the participants of the study that could skew the data collection and analyses.

The primary data collection technique used throughout this study was semistructured interviewing. Utilizing semistructured interviews provides the researcher with the ability to conduct in-depth conversations with the interviewee based on experiences expressed, perceptions and opinions garnered from the interviewee (Cridland et al., 2015). Semistructured interviews provide the researcher freedom to ask additional questions, adjust the order questions are given and adjust the intent of the questions to gain a greater understanding of the subject discussed (Kallio et al., 2016). Cridland et al. (2015) stated the researcher should encourage participants throughout their interview to emphasize portions of the discussion they indicate important to the discussion.

The participants for this study received an estimate of the time I would spend with each person and a list of predetermined questions. I used the interview questions to conduct face-to-face interviews with each participant based on the combination of literature reviewed and my personal experience and education. I used an alphanumerical code to ensure I maintained confidentiality for all participants. A data analysis technique

I employed is member checking. Elo et al. (2014) stated member checking is a continuous process researcher’s use during data analysis where participants can check the findings to ensure they accurately reflect their experiences. Morse (2015) stated using member checking improves the credibility of a researcher’s findings through increased engagement and enabling observations of participants. Member checking can help ensure the credibility of a researcher’s findings from recorded interviews of participants (Cope, 2014).

I developed follow-up questions to explore themes and ideas to help increase clarity and stimulate discussion from interviewees while ensuring I maintained participants’ privacy. Using a case study requires secondary data that can include archival data, financial reports, and internal transcripts as provided by participants along with participant interviews to accomplish methodological triangulation for this study (Whitmore, Baxter, Kaasalainen, & Ploeg, 2018). I sought secondary data, for example, internal publications and Joint Commission reports from participants.

Data Organization Technique

Employing data organization helps to ensure the researcher can prevent and mitigate errors, and that the instruments and material used during the interviews are valid and reliable (McIntosh, Kamei, Adams, & Hassan, 2016; Dikko, 2016). I collected data via semistructured interviews to better recognize the participant's experiences and my observations. The researcher who uses semistructured interviews can garner flexibility with issues that are important to the participants (Cridland et al., 2015). Based on Whitmore, Baxter, Kaasalainen, and Ploeg (2018), I employed semistructured interviews supported through audio recordings and laptop for manual transcribing. Also, I established a file system coordinated with labels where I will store each type of data, for example, recordings, e-mail, and consent forms. I will secure all data collected via password-encryption on a computer file and secure data within a fingerprint secure file container for a minimum of 5 years. After 5 years, I will destroy all data collected to ensure participants' confidentially,

Data Analysis

Qualitative data analysis requires the researcher to identify, sort, integrate, and synthesize information gathered through observations, interviews, and other methods; determine patterns and themes to answer the research question. Bengtsson (2016) suggested that data analysis in qualitative research encompasses working with data, organizing it, synthesizing it, and searching for themes and patterns. Yin (2014) suggested that data analysis consists of five steps: collecting the data, coding the data into groups, regrouping the data into themes, evaluating the information, and developing conclusions or findings. Twining, Heller, Nussbaum, and Tsai (2017) agreed with Yin that data analysis involves examining, categorizing, tabulating, testing, or combining evidence for empirically constructed conclusions. Based on the nature of this study, my data analysis followed the abovementioned Yin's (2014) five steps.

Noble and Smith (2015) stated a researcher could improve credibility through triangulation, which one can use to study a phenomenon. Morse (2015) stated triangulation assures validity through verification for clarifying the phenomenon the researcher is studying. The main purpose of triangulation is to confirm data and ensure the data collected are complete and valid (Morse, 2015). Researchers can attain triangulation of their case study by comparing various paradigms simultaneously and comparatively (Lub, 2015). Researchers use methodological triangulation to assure the validity and reliability of emergent themes through cross-checking, comparing, and contrasting professional journals and previously studied data (Morse, 2015). I used methodological triangulation to check and recheck, compare, and contrast the consistency of the findings to ensure the validity and reliability of the results. I obtained the data and information for this study by conducting semistructured interviews with six midlevel healthcare managers from six acute care facilities located in Virginia. I also utilized archival documents and online secondary data that includes financial reports, annual reports, mission statements, and other working papers. Dun et al. (2015) stated the secondary data requires less cost to obtain and is readily available eliminating the need to incentivize research participants. Whitmore, Baxter, Kaasalainen, and Ploeg (2018) stated one could collect data during the interviews with a digital recorder and via manual transcription to analyze the data. Likewise, Hays et al. (2016) stated researchers involved with analysis use data to discern significant themes, patterns, and descriptions that support the critical research questions of one’s study. Scholars determined that data software tools are critical assets for researchers when conducting analyses to finalize data captured from interviews and manual transcripts (McIntosh et al., 2014).

Moreover, computer-assisted qualitative data analysis software (CAQDAS) is a critical tool that provides researchers the capability to manage multiple tasks, organize data sources, consolidate information according to themes, and identify patterns for data

(Talanquer, 2014). I used NVivo 12 software to support analyzing my data. NVivo is software that specifically supports qualitative analyses as well as provides the researcher immediate access to data results after input. Zamawe (2015) stated using NVivo enables a researcher to code transcripts and audio files effectively and efficiently. I uploaded all recorded data and manually-transcribed information into NVivo to organize, to code data, analyze, and validate data.

Carter and Baghurst (2014) stated coding is a process that requires the researcher to tag category data with type names or descriptive words and then group that data into themes. I maintained the participants' confidentiality throughout this study by using standard initials that represent a title with a two letter and number combination. Chief Patient Health Experience Officer (CPHEO A-1) Chief Population Health Officer (CPHO A-2) and Chief Transformation Officer (CTO A-3) are examples of hospital representatives. As such, coding of data is for identifying patterns and themes (Sturges et al., 2015). Gale (2014) stated one should classify all of the data and link it methodically with other parts and types of data. Once the transcription phase was complete, I transcribed the participants' interviews and uploaded it into NVivo 12 to facilitate analyzing the data.

Reliability and Validity

Quality is a goal researchers' aim to achieve within their study by assuring studies' reliability and validity (Cypress, 2017). According to Hays et al. (2016), reliability reflects the dependability of measures while validity is a concept concern with being justifiable, accurate, and truthful. Failure to obtain saturation in case studies can negatively affect the studies’ validity and reliability (Fusch & Ness, 2015). Transferability resembles external validity, dependability mirrors reliability, and confirmability reflects objectivity within a qualitative study (Hays et al., 2016).

Reliability

Morse (2015) described reliability as dependability, consistency, or repeatability of a researcher’s data collection, interpretation, and analysis. Objective researchers seek to enable other researchers to repeat their results using the same or similar methods. Noble and Smith (2015) stated reliability describes the consistency of the analytical processes, as well as accounting for participants and research method biases that might influence a researchers’ findings. Noble and Smith (2015) stated the researcher could assess the reliability of their study findings by making a judgment about the soundness in relation to the application and appropriateness of methods accepted and the integrity of the conclusion. According to Twining et al. (2017), a researcher establishes reliability for their study when the data collection procedures replicate the same results. Cypress (2017) stated researchers assert rigor in qualitative research through reliability and validity that are essential components of quality. Hence, I assured reliability by checking this study for repeat patterns, checking for processes’ consistency with response to the methods and scored results of data, auditing interviews, and analyzing notes and data collected throughout this study.

Dependability. Connelly (2016) stated dependability occurs when the researcher establishes an audit trail to log research notes of all activities that occurred during the study to review data captured during interviews and observations. A researcher achieves dependability by using overlapping methods such as triangulation to ensure trustworthiness (Morse, 2015). Cypress (2017) stated a researcher could enhance dependability by having a doctoral committee review a researcher’s acquired themes and descriptors for validity. Likewise, member checking provides the data for review by participants to improve the dependability and credibility of data gathered during the study (Pashaki et al., 2015). I employed member checking techniques to increase the dependability of my study.

Validity

Noble and Smith (2015) stated validity refers to the truthfulness and application of the methods used by researchers and how well the results of their study can be accurately reproduce. Equally, the researcher should consider the validity of their study by framing the discussion regarding conscientiousness, empathy, sensitivity, and respect (Lub, 2015). Kern (2018) stated triangulation increases the assurance of validity and enhances the researcher’s understanding of the studied phenomena. Kern (2018) concluded that methodological triangulation results from the convergence of different data collected from multiple sources on the same phenomenon, which assures the validity of the study. I observed my participants and collected secondary material from the acute care facilities to study the phenomenon through methodological triangulation. Hays et al. (2016) described the validity of a qualitative study as credibility and transferability.

Credibility. Credibility is the qualitative equivalent to quantitative studies’ internal validity (Hays et al., 2016). Elo et al. (2014) stated that a central tenant of validity is trustfulness. A researcher can meet the goal of truthfulness by approaching the analysis phase of the study through preparation, organizing, and reporting on results. Researchers who select a method suitable for others to understand their study design will help to ensure the credibility of the study analyze (Elo et al., 2014). Baroudi, Chileshe, Hosseini, Zuo, and Baroudi (2015) suggested achieving credibility in qualitative studies through peer-debriefings conducted in face-to-face meetings and analytical memos to improve findings. As such, a researcher can achieve credibility throughout their study for similarities and consistencies. Triangulation is a means used to reveal as much depth as possible in a study (Hyett et al., 2014). Hays et al. (2016) recommended researchers employ triangulation to collect more data from additional sources as well as cross-check their data for reliability to assure the validity of qualitative research. Henceforth, triangulation enhances the credibility of a researcher's findings. I used NVivo 12 software program to help facilitate finding themes and verbatim transcription from participants' interviews with healthcare managers and administers.

Transferability. Transferability denotes the extent a researchers' qualitative study findings are transferable to other contexts and individuals which in quantitative studies compares to generalizability (Morse, 2015). Transferability within a qualitative study infers the findings of a study will enable others to advance or extend the original study or provide research material that another individual can generalize for their research (Cope, 2014). Cypress (2016) stated purposive sampling enhances the transferability of the study results. I positioned this study to meet the basic tenets for transferability by establishing case study protocols and databases, for example, a protocol guide for case studies, data collection procedures, and interview questions (Yazan, 2015; Yin, 2014).

Confirmability. Qualitative researchers acknowledge that dependability, credibility, transferability, and confirmability are analogous criteria to achieve trustworthiness and ensure the rigor of qualitative findings (Anney, 2014). Cope (2014) stated a researcher achieves confirmability in a qualitative study when the data represent the participants' responses and not the researcher's biases or viewpoints. Connelly (2016) stated confirmability is the neutrality or the degree researchers can repeat consistent results. I ensured confirmability by conducting an audit trail to confirm findings, interpretations, and recommendations supported by data (Chellan & Sibiya, 2018). I utilized an audit trail to review and study all procedures, themes or categories identified, and interpretations by implementing a running account of the process (Cypress, 2017). I also used a reflexive journal to achieve conformability by recording all events, data collection, analysis, and personal reflections (Anney, 2014). I retained a reflexive journal to capture participants' views to bracket observations and bias (Cope, 2014).

Data Saturation. Sutton and Austin (2015) stated a researcher achieves data saturation after interviews with the new participant's experience with the phenomenon in question reveal redundancy among data set. Saturation occurs when a researcher can no longer obtain new data and when further coding is no longer practical (Fusch & Ness, 2015). Palinkas et al. (2015) recommended researchers employ an iterative methodology of sampling and resampling to ensure theoretical saturation occurs. I ensured data saturation while achieving the goal of confirmability for this study. I utilized in-depth interviews and field notes as a strategy for collecting data. According to Palinkas et al. (2015), researchers use purposeful sampling in a qualitative study to help identify and choose information-rich cases linked to the phenomenon of the research. Furthermore, Robinson (2014) stated the sample size helps to ensure rigor and the appropriateness of the sampling strategy. According to Yin (2014), a case study with 10 or few participants could obtain data saturation essential for establishing credibility. Hence, I chose a sample size of 6 participants for my study. Anney (2014) stressed that member checks are critical processes for researchers; as the researcher must test all the data to alleviate internal conflict in their quest for credibility and data saturation.

Transition and Summary

The purpose of this qualitative multiple case study was to understand what patient-centered strategies healthcare managers use to reduce the cost of elderly patients' healthcare without reducing the quality of patient care. I employed semistructured interviews through audio recordings, a laptop, and publicly available documents to explore the strategies and participants' experiences. I used methodological triangulation to assure credibility. I selected participants at the mid to upper levels of management who work for a healthcare system that has implemented patient-centered strategies to reduce the cost of elderly patient healthcare without reducing the quality of patient care.

The objective for this section was to describe the role of the researcher, the participants for the study, the research methods and design, population sampling, ethical research, data collection techniques, and analysis for assuring reliability, validity, and transferability of the research instrument and data collection process. In Section 3, I will complete the following: (a) the presentation of findings, (b) applications to professional practice, (c) implications for social change, (d) recommendations for action, (e) recommendation for future study, and (f) my principal conclusions.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative multiple case study was to explore what patient-centered strategies healthcare managers use to reduce the cost of elderly patient healthcare without reducing the quality of patient care. In Section 3, I provide a detailed review of the data collected, the conceptual framework, and the findings related to the research question. The data analysis findings provide awareness of strategies healthcare managers employ that support PCC while ensuring a profit for their stakeholders. I conclude Section 3 with recommendations for further studies, thoughts on my experience while conducting this study process, and a summation of the study conclusions.

Presentation of the Findings

I conducted semistructured interviews with six midlevel healthcare managers who have the responsibility for leading, developing, implementing, and monitoring PCC strategies within their medical facilities located throughout Virginia. All of these full-service acute care facilities are complex adaptive systems that are ever-changing, reactive, proactive, and distinctive within a natural environment. I collected the following hospitals’ opened-sourced reported performance information as secondary data: the Joint Commission Gold Seal of Approval Quality Report, The CMS Compare Datasets reports, mission and vision statements, and list of the hospitals’ websites-leadership structure. I coded all documents to maintain confidentiality and concealed each participant and their facilities with the following codes: P1H1, P2H2, P3H3, P4H4, P5H5, and P6H6. The codes H1–H6 denoted hospitals and P1–P6 denoted participants. The conceptual framework that grounded this study included PCC and the valued-centered healthcare model. I conducted data triangulation based on analysis of interview data, secondary data, and the literature review. I used member checking and methodological triangulation to ensure credibility, data saturation, and confirmability of data outcomes.

In this study, I explored the perceptions of healthcare managers concerning the effects of the patient-centered model within their business model. The main research question for this study was the following: What patient-centered strategies do healthcare managers use to reduce the cost of Medicare patient healthcare without reducing the quality of patient care? Throughout this study, I served as the primary instrument for data collection using open-ended, semistructured questions in face-to-face interviews with healthcare managers. The four themes that emerged from my data analysis were PCC matters, management leadership strategies, control methods for monitoring cost, and maximizing community healthcare services. I used NVivo 12 analysis software to organize and evaluate my data and link comparable coding categories together for the data analysis. The data analysis process I used comprised compiling, disassembling, and reassembling data to arrive at my four major key themes. In summary, Section 3 covers the following topics: (a) an introduction (b) a detailed presentation of the findings, (c) applications to professional practice, (d) implications for social change, (e) recommendations for action, (f) recommendations for further research, (g) personal reflections of the study, and (h) a conclusion.

The primary research question for this study was: What patient-centered strategies do healthcare managers use to reduce the cost of elderly patient healthcare without reducing the quality of patient care? Effective strategies within a healthcare organization are about making choices necessary to differentiate one organization from another to meet their customers, for example, patients and stakeholders, needs (Porter & Lee, 2015). According to Lee et al. (2016), value-based payment models stimulate the delivery of efficient, high quality, PCC through financial penalties and rewards. The frequency of the codes and the resultant four themes aligned with the conceptual framework of this study. Table 2 shows the frequency of references to the key themes that I derived from the data triangulation process, which included documents reviewed, interviews, personal notes, and peer-reviewed literature.

Table 2

Frequency of Themes and Number of Participants

Description of themes	*Frequency of theme reference*	*Occurrences*
Patient-centered care matters	40	P1, P2, P3, P4, P5, P6
Leadership strategies	21	P1, P2, P3, P4, P5, P6
Cost reduction strategies	20	P1, P2, P3, P4, P5, P6
Maximizing community healthcare services	19	P1, P2, P3, P4, P5, P6

Theme 1: Patient-Centered Care Matters

All six participants in this study identified the importance of implementing a PCC model within a system that emphasized value-based health services, cost reduction, and value for the patient. Participants' responses revealed the importance of training and monitoring staff to evaluate their ability to provide and communicate effective PCC. P5 noted H5 staff annually participate in training to meet regional and state regulations per the CMS. P2 noted the treatment team has the responsibility to educate the patient and family to ensure they understand the treatment plan and who will be delivering the treatment. P2 further stated, "A good treatment plan would eliminate wasted time the medical treatment team spends with the patient that in turn will reduce labor cost and employee burnout." P4 noted that as an executive director, all staff members including medical, support services, and administration personnel receive training on customer service and the importance of using multiple forms of communications in support of enhancing the patient's experience. P5's responses confirmed participants 1, 2, and 4's reactions by stating, "When you have a well-trained staff, and everybody is doing what they are supposed to do based on their training, you find that patient-centered care quality goes up." P1 stated,

> Across all specialties, patient-centered care not only reduces costs but also through good communications, the care team can keep that patient at the center of their care, which helps to ensure the patient buys into the proposed treatment plan that the care team wants to provide the patient.

October et al. (2016) denoted a similar finding and underscored that good communication decreases conflict between the medical team and families as well as increased family and patient trust and satisfaction with care. P4 stated, “We have been looking at asking the patient what we can do better for you.” According to Castro et al. (2016), several initiatives healthcare organizations have implemented are patient participation to help improve quality of care, increase patient safety, and increase patient satisfaction. To help meet this challenge, all of the participants noted their use of morning huddles to address the needs of patients and set goals for the patient and team members. Ghorob and Bodenheimer (2015) confirmed that high performing facilities that employ huddles are associated with improved care, better patient experience, and considerable staff satisfaction. P4 noted the executive team also conducts a daily huddle to synchronize activities, identify gaps, and fill those gaps to ensure they are meeting the needs of their patients.

P1 explained the benefits of using huddles within the PCMH model to ensure the patient’s needs are communicated and synchronized among the care team, the patient, and family. P1 stated,

> The patient-centered medical home model has been around for a while having the patient receive treatment for their recovery/aliment at home by a care team that communicates to each other and the patient regarding the management of services and care.

P1 noted that PCMH was instrumental for reducing cost and keeping the patient at the center of that care, making sure they buy into their care. According to Ehrenberg et al.

(2016), healthcare leaders who support patient-centeredness in their delivery of care models have shown increased functional capacity and decreases in the mortality rate of elderly patients. Shi et al. (2017) surmised that PCMH has been a critical model for servicing low-income, racial, and ethnic minority patients in medically underserved and rural areas. P6 noted that H6 routinely incorporates PCMH as a strategy to step down the patient’s level of care from an inpatient acute care setting to a home healthcare setting. P6 added, “We utilize PCMH to help reduce the cost of patient’s healthcare, emergency department visits, and readmission rates.” P3 noted H3 aims to focus their teams, led by providers along with paraprofessionals and nurses to engage routinely with their patients. P3 further stated, “H3 leadership will often employ their paraprofessionals and nurses to the extent of their license so that they can meet the patient's needs potentially without even engaging the provider with routine management.” Participants 1, 2, and 4 noted the value of PCMH as a model for keeping patient-centered, enhancing quality improvement processes, and supporting the implementation of preventive care programs. According to Bilello et al. (2018), the PCC model advocates within a PCMH setting that the patient remains central to their care delivery, which is essential for ensuring high-quality care and better patient outcomes.

Building well-trained staffs, supporting good communications among care teams and patients, communicating patient’s concerns through huddles, and leveraging PCMH to improve patient access and value are components of the patient-centered theory and value-centered healthcare model. The findings align with the conceptual framework of the patient-centered theory and a value-centered healthcare model. The participants explained the importance of implementing a PCC model within a system that emphasized value-based health services, cost reduction, and value for the patient. This study demonstrated (a) communication, (b) access to care, (c) continuity of care, (d) comprehensiveness, (e) coordination and communication, (f) cultural competency, (g) safety, (h) family and person focus; and (i) educating the patient and family contributed to PCC matters (Chumbler, Otani, Desai, Herrmann, & Kurz, 2016; Lim & Kurniasanti, 2015). Additionally, all six participants discussed and concurred on the value of implementing a PCC model through their perceptions based on the primary research question. The participants' responses, documents, literature review, and current research provided information that helped to identify the key theme PCC matters.

Theme 2: Leadership Strategies

P3 stated, "A key leadership strategy H3 staff has implemented in support of patient-centered strategies is to make the organization fit the patient flow." According to DiGioia Lorenz, Greenhouse, Bertoty, & Rocks (2010), a critical leadership step in improving patient-centeredness is care flow mapping that leadership can use to understand patients' desires through the lens of the patient and family. P4 noted H4's management uses continuous quality improvement strategies to address areas in which their performance fails to meet the patient's needs. The participant's statement aligned with the evidence presented by Henke et al. (2018) that healthcare leadership and stakeholders are investing in infrastructure and technology to improve patient flow, share transfer information and collaborate across care settings to meet patients' needs and quality of care based on clinical best practices.

P3 stated, “H3 leadership continuously looks to leveraging their staff, for example, case managers to take on complex cases to reduce the volume and care for those individuals categorized as chronic high utilize patient (CHUP) that are considered high prescribers.” Participants 1, 6, 3, and 4 noted their facilities’ leaders rely of various data to measure the effectiveness their staffs are meeting PCC goals and value. P1 stated, “H1 leaders consistently review emergency department (ED) trends to determine if patients are seeking routine care at ED’s vs. seeking service with their primary care team.” P6, noted H6 leadership considers multiple key performance indicators like length of stay, readmissions rates, percentage of our patients discharged to community, and their function independent measure scores, to develop strategies to improve PCC, quality, and cost reductions. P6 further noted H6 leadership utilizes benchmarks data to compare their performance against their competition to develop strategies to improve areas they are underperforming. Participants 6, 5, and 2, noted a leadership strategy used within their organizations focuses on retaining and recruiting experience and trained labor. All participants expressed challenges in retaining nurses and other staffs to meet the needs of their patients. P4 noted H4’s leadership is beginning to employ strategies that address changing the culture among teams and management to improve communication to improve patient-centered delivery of care. P4 added, “H4 leadership is leveraging continuous quality improvement committees (CQIC) to improve training sessions by communicating daily email messaging delivered periodically throughout the day to keep staff abreast of trends and safety concerns.” P6 noted H6’s board of directors are sharing data gathered from their quality improvement committee or Council with management to ensure actions implemented reflex the concerns of patients and directors who participate in those committees. This finding is in alignment with Pomey et al. (2015) who concluded that healthcare leaders are increasingly integrating patients as members of their organization's continuous quality improvement committees to aid with improving PCC by incorporating their experiences to redesign health and healthcare services.

Healthcare leaders are employing strategies to improve patients-centered care to address better patient's needs, values, and concerns through increase care practices garnered through data that align with the conceptual framework value-centered healthcare model and patient-centeredness theory. All six participants elaborated their use of data collected through various modalities that include patient flow mapping, continuous quality improvement committees, and benchmarking to improve the continuum of care and develop strategies to reduce patient's cost. The data derived from semistructured interviews, documentation collected, and the literature view directly correlate to the importance of effective leadership strategies. Additionally, the participants' leadership strategy aligns with complex adaptive systems that are ever-changing, reactive, proactive, and distinctive within a natural environment correlates with the conceptual framework for this study.

Theme 3: Cost Reduction Strategies

All participants agreed that lowering the cost of care was critical to their success as healthcare managers. Honaganahalli, Melissa-Gateley, and Neufeld (2017) summarized those healthcare organizations that support PCC could reduce patient's short-term and long-term morbidity, that in turn, positively impacts lower long-term healthcare costs. According to Huang (2016), patient access and long waits continue to impact staff productivity, quality, and increase healthcare cost. P1 noted maximizing patient access, and scheduling have reduced cost for H1. P1 indicated even across specialties; reduced cost occurred because of improved communications between patients and case management. Bard et al. (2017) stated healthcare manager’s current challenges to provide quality care while reducing cost increases in complexity when leadership must also consider competition, problematic scheduling, and an elderly population with recurring chronic illnesses. Participants 1, 2, 4, and 6 noted their facilities leadership supports primary and post-acute care throughout their hospital to coordinate on behalf of the patient to provide the best care, reduce duplication of services, and alleviate unnecessary cost to the patient. P2 stated, “Leadership goals at H2 are to leverage the right labor based on the patient's needs.” P2 further noted, “Paraprofessionals perform treatments under the directions of the provider. Hence, you want your more expensive labor (physicians, etc.) doing things that only they can do like assessment and complex treatment. All follow-up treatment, routine activities, you want to make sure your cheaper labor pool (para-professionals, nurses, etc.) conduct those tasks, which is a cost-effective approach to treating patients.”

Participants 3, 4, and 6 noted educating their patients on the cost of pursuing care from their primary care team versus seeking care at the emergency room is a strategy their facilities senior leadership are employing to help reduce patient’s cost. Cosgrove et al. (2013) denoted similar findings that healthcare leaders should use patient-centered communication to aid with achieving faster recovery, improved clinical outcomes, better care experience, and fewer diagnostic tests and referrals. Pourat et al. (2015) noted the cost of care decreased and the continuity of patient's care increase when patients sought care with their primary care provider instead of visits to emergency rooms.

Another strategy all participants noted was the use of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) to measure consumer's satisfaction. Farley et al. (2014) indicated a hospitals performance is one of the most critical measures for obtaining the CMS financial incentives as stated in the PPACA (P.L. 111-148, Section 3001) that authorized the establishment of the Hospital Value-Based Purchasing Program. According to Chumbler et al. (2016), patients' satisfaction correlates with the frequent use of health services and influences both patient compliance and the continuity of care. P2 stated, "Our leadership receive HCAHPS Surveys on a week to week basis from Press Ganey Associates, an HCAHPS administrator. HCAHPS surveys give us feedback via a scoring process based on percentages that provides this facility a ranking in comparison to the other healthcare facilities." P1 noted H1 leadership makes ever attempt to meet their patients' needs by reviewing HCAHPS, compliance officer feedback, and feedback from Joint Commission surveys. All participants indicated that HCAHPS surveys are effective tools management uses to develop strategies necessary to focus resources on improve PCC that support optimize future payments.

According to Elf et al. (2017), an essential criterion for value-based healthcare is an organizations strategy to transition towards reimbursement for patient's complete care cycle as oppose to a single care provider. P2 and P3 noted their leadership must ensure the medical staff present are capable of supporting all patients seeking care. This issue continues to be a problem as efficiency of care and crowding affect disproportionately patient satisfaction that, in turn, negatively influences HCAHPS surveys (Farley et al., 2014). P6 stated, “Maintaining a sufficient nursing staff is a big challenge for many organizations that can compromise safety and care for patients.” P6 noted that H6’s human resources department have developed programs focus on boosting employee morale, training as well as external recruitment strategies to attract more nurses to their hospital.

Moreover, healthcare managers that employ and recruit well-trained staff sufficiently to meet the patient population they serve will improve their opportunities to secure positive HCAHPS surveys. Crilly et al. (2015) indicated that crowding has negatively impact patient delivery of quality care in the areas of safety, timeliness, patient-centeredness, efficiency, effectiveness, and equity. Schreyer and Martin (2017) noted crowding has influenced staff stress, retention, prolonged inpatient lengthen of stay, and increased cost across the patient’s continuum of care.

Healthcare leaders are employing cost reduction strategies that expand on the conceptual framework of PCC and the value-centered healthcare model by reviewing HCAHPS and Joint Commission surveys, leveraging labor based on patient needs, and educating patients to utilize their primary care team versus seeking treatment through an emergency room. All six participant concurred that HCAHPS surveys are useful tool that improve PCC and optimize future payments that correlates with the conceptual framework of PCC and the value-centered healthcare model. In analyzing the opened-sourced reported performance information retrieved from all participants’ facilities and the literature review, cost reduction strategies seemed to be an accurate assessment of what healthcare leaders are implementing to accomplish value-centered healthcare. Korenstein et al. (2016) expanded on the conceptual framework of value-centered healthcare by noting that value equates to the balance between care quality (in terms of patient satisfaction and health outcomes) and costs, though specific delineations as defined by various healthcare organizations business models.

Theme 4: Maximizing Community Healthcare Services

Many healthcare facilities have not accounted for the total cost patients sustain related to the price for quality (Lee et al., 2016). According to Bernhardt et al. (2016), the expenses related to many elderly patients' care includes substantial medical, pharmaceutical, and surgical services, adapted housing, and extensive support from family and other community based supportive services makes 65 years old and older the most expensive phase of life for most Americans. A strategy many hospitals that support rural and under-deserved populations have used are collaborations with community-based healthcare centers. The ACA implemented the extension of health centers as a vital part of its strategy for ensuring that rural, under-deserved populations, for example, elderly and low-income, would gain access to quality healthcare (Shin et al., 2015). P5 noted one of H5 goals is to return patients identified from rural communities with resources established through healthcare centers to ensure a continuum of care. P6 stated, "Our job is to make sure the patient continues to get care and are progressing fast enough that they can live independently in their community and home performing daily living activities."

According to Shi et al. (2017), an emphasis on using healthcare centers has improved accessible, cost-effective, and high-quality primary care and has helped to reduce health disparities. P1 stated, “We collaborates with the patient’s community healthcare center to provide a continuum of care which is another way the community has embraced, providing care not just for the elderly, but to the entire population of patients that otherwise would not get their care and would be an emergency room.” Community healthcare centers have been a crucial component of the U.S. safety net system. According Nguyen, Makam, and Halm (2016), the safety-net system is a mix of public hospitals, clinics, community health centers, and other healthcare organizations distinguished by their shared mission to provide care to individuals regardless if the patient uses Medicaid, Medicare, private insurance, or no ability to pay for healthcare. P2 noted, “Providing quality healthcare in the community of the patient is value-added because when a patient does not like the care at one hospital vs. the next, they will choose to seek care in another community if they feel the services for certain care is of a lesser quality in their healthcare service area.” Leveraging community collaboration to meet the needs of patients can help to establish stability in their lives and improve their health and quality of life as well as considerably reduce cost (McCulloch, 2017).

Other strategy healthcare leaders are using to deliver and promote the continuum of healthcare within the community for patients is telehealth. Neville (2018) defined telehealth as a collection of electronic communication methods used to provide enhanced patient care and education for the patient and family. According to Doarn (2016), telehealth has increased access to healthcare for patients living in remote and underserved areas. P1 stated, “Our organization and several other organizations in the community are going to clinical video telehealth where the patient receives care in their home, and the providers and or specialists can remain at the Medical Center to treat the patient. Participants 2, 3, 4, and 5 discussed similar strategies for utilizing telehealth to improve outcomes and patient access to care to reduce emergency room visits, chronic diseases, post-acute care, and readmission rates from long term care. Participants 1, 2, 3, 4, and 5 acknowledged telehealth has improved patient access to high-quality healthcare particular when great distances separate the provider and patient. P1 noted that PCC remains a critical function within telehealth. P1 stated, “If the patient agrees, we will set them up with home telehealth and follow and track the patient with a registered nurse and other members of the patient’s care team for post-acute care.” According to Neville (2018), telehealth is changing the daily delivery of care by reducing outpatient visits, increasing medical staff capacity to focus on diagnosing and treating patients sooner, considerably reducing trauma center cost, and closing the spatial distance for patient’s access to quality healthcare who reside in rural areas.

By using the conceptual framework for this study, both patient-centeredness and value-centered healthcare models serve to recognize the need for healthcare managers to implement strategies that support and maximize community healthcare organizations. All six participants elaborated their organizations are using telehealth to help meet the needs of patients in the most restrictive environment which correlates with the conceptual framework of value-based healthcare by using innovations that support the elements of PCC: access, continuity, comprehensiveness, coordination and communication, cultural, and person focused. The semistructured interview process and organization documents further confirmed valued-based care in the theme maximizing community healthcare services. The documentation collected outlining the strategy of collaborating with community-based healthcare centers used by healthcare leaders in their organization, supported the importance of PCC strategies. The findings of this study support the conceptual framework that healthcare managers are embracing PCC and a value-based healthcare model based on their organizations strategies to reduce patient cost by serving patients in their community as authorized through the ACA.

Applications to Professional Practice

The findings of this study illuminate patient-centered strategies healthcare managers can use to reduce the cost of elderly patient healthcare without reducing the quality of patient care. The four themes that emerged from the data analysis were PCC matters, management leadership strategies, control methods for monitoring cost, and maximizing community healthcare services. While this research offers meaningful information for healthcare managers that support a rural population, these strategies are applicable across all populations. According to Shin et al. (2015), the largest population of low-income patients receiving healthcare from federally-funded community centers are working adults at 61% and children at 32%, and elderly adults at 7%. However, the 7% served are costing the most to treat based on their individual needs. An aging population of people living with chronic illnesses today have increased the demand for complex care and social services and add to rising healthcare cost (Williams-Roberts, Abonyi, & Kryzanowski, 2018). Healthcare managers can apply the findings of this research to their business practices of managing and leading healthcare facilities, continuous process improvement teams, and stakeholders to enhance their implementation of PCC to meet the needs of patients, their families, and staffs. The findings of this study could assist healthcare managers to develop other processes to meet the needs of patients that live in a rural area by combining patient's HCAHPS surveys and community healthcare. The findings show that healthcare leaders are utilizing various strategies to help reduce elderly patient cost without diminishing the quality of a patient care. The results support the need for managers to continue developing strategies that meet the various desires of patients. The findings of this study advocate the importance of communication between the patient, family, and care team. In addition, the lines of communication between healthcare manager, healthcare providers, and other stakeholders should maximize feedback received from patient's surveys and turned into actionable strategic objectives that help to meet the needs of patients. The results from this study could help improve patient safety and care coordination, which the CMS track to measure the delivery of quality healthcare service. CMS reports patients discharged to post-acute care facilities have seen a reduction in readmission rates based on improve communication, medication safety, innovated care planning, and improve emphases in training staff at medical facilities that treat Medicare and Medicaid patients (Kripalani, Theobald, Anctil, & Vasilevskis, 2014). The results from this study may enable healthcare managers to consider keeping the patient and integral member of the patient's treatment and proactively implementing measures to improve patient satisfaction. Also, the results support acknowledging that the voice of the patient is credible and that promoting health literacy through multiple mediums for patients, caregivers, and family members supports strategies to reduce out of pocket medical cost.

Implications for Social Change

Healthcare managers with the responsibility to develop strategies that help reduce the cost of patient healthcare while ensuring the quality of care remains are value added in today’s healthcare industry. According to Bauer et al. (2014), healthcare leaders are accountable for the delivery of care and the payment models that incentivize providers for delivering quality care and achieving good metric outcomes. Conversely, experienced healthcare leaders that implement strategies to improve healthcare efficiencies and the delivery of PCC are critical within a modern healthcare environment. Similarly, Sfantou et al. (2017) stated PCC matters when quality of care is a vital component for attaining superior productivity within a healthcare facility for patients.

The implications for positive social change for this study embrace the importance of including the patient, the patient’s family, and caregiver among the critical stakeholders in developing the patient’s treatment plan. Another positive social change from this study may benefit the development of leadership strategies that support care team and physicians actively engaging their patients to participate in their treatment planning. Educating the patient, their family, and caregiver on the importance of their participation in their care through correspondence when entering a healthcare facility may improve HCAHPS surveys. According to Delany (2018), Australia has seen a great deal of success actively engaging patients through correspondence on the standards of

PCC that they can expect from their care team, which has enhanced the safety and quality of care provided.

Other implications for positive social change are the development of cost reduction strategies to improve use of resources through improved communication between the patient, care team, and other ancillary support staff. Conversely, healthcare facility leaders that fail to address the amount of waste in their facilities will eventually find their bottom-line disappear. According to JAMA, researchers have determined that healthcare spending accounts for 20 percent of the U.S gross domestic product with 2.5 percent accounting for as waste (Carroll, 2017).

Recommendations for Action

I recommend several actions for all healthcare managers charged with delivering and managing healthcare regardless of the demographics being service. Novice and experienced healthcare leaders should embrace lifelong learning, as such; the recommendations from this study apply to promoting PCC strategies in all healthcare environments. The key themes expressed in this study included: (a) PCC matters, (b) management leadership strategies, (c) control methods for monitoring cost, and (d) maximizing community healthcare services. Addressing the themes present opportunities for healthcare leaders and those charged with developing policies to continue promoting the importance of patient-centeredness when structuring cost models and strategies that support value-based incentive payments.

Conversely, this will shape increase discussion for the delivery of healthcare as healthcare leaders continue to look within their ranks to structure strategies and staffs to meet the needs of patients, families, caregivers, and stakeholder objectives. Action from this study may encourage an increase in dialogue between C-suite leaders and middle management where staffs are providing services to patients. According to Vaughn et al. (2014), C-suite leaders in higher-performing hospitals have shown to be more effective at communicating and modeling their vision of quality care by fashioning a culture that supports an expectation that staff and leadership will work across traditional boundaries to improve quality. Further, according to several participant's feedback, middle managers would embrace more interface with C-suite leaders where the continuum of care takes place. The implementation of successful leadership strategies could contribute to a healthcare facility by improving C-suite and management commitment to monitor performance based on predetermine patient-centered goals that ensures shared feedback and accountability to key stakeholders, staff, and the community they serve.

Recommendations for Further Research

The subject matter of exploring patient-centered strategies healthcare managers use to reduce the cost of elderly patient healthcare without reducing the quality of patient care merits further research given the lack of studies that focus on elderly patient care. Below are three limitations to this study that may provide transparency for future research.

1. The analysis for this study only included hospitals that served a large population of rural patients. This focus was justified to get an account of patients receiving care from acute care facilities; however, this excluded

patient care centers and other community-based treatment centers that serve elderly patents.

2. A second limitation, beyond the design of this study, was the lack of additional measures and methods in the evaluation set; these methods include survey instruments, PCC meta-measures, patient outcomes, quality measures, participant observation, and process evaluation. The results of this study may have varied if the researcher examined the problem using all the methods above to develop a comprehensive methodology that support understanding of how healthcare managers apply PCC in different medical locations.
3. Third, all the participants were non-medical degreed healthcare managers with multiple years of experience leading teams and staffs, which may limit the generalizability of the findings.

Reflections

As a student and facilitator of healthcare policies and strategy development, I was knowledgeable of the various models employed by healthcare administrator. I took every effort to minimize bias throughout this research process by remaining neutral and objective during the interview and secondary data research process. Throughout the interview process, I was able to gain a greater understanding of the challenges healthcare managers' experience in their employment of patient-centered strategies to provide the highest quality of care while keeping an eye on the costs associated with the delivery of care. I had no prior knowledge of or relationship with the participants; henceforth, the task of gathering participants willing to participate in this study was not easy. However, the participants selected were experts based on their years of experiences and knowledge of PCC and openness to support my research. Each participant felt comfortable with my interview techniques, questions presented, and length of time spent during their interview session. I gave all participants a chance to add or change their interview transcription to ensure reliability and validity throughout the interview and data collection process. Using triangulation, secondary data, literature reviews, and member-checking immensely aided in developing the findings presented for this study.

Conclusion

The focus of this study from its conception has been to explore what patient-centered strategies healthcare managers use to reduce the cost of elderly patient healthcare without reducing the quality of patient care. According to Norman (2019), fifty-five percent of Americans consider the affordability of healthcare the number one concern for the past five Gallup listing of problems facing the United States. Notwithstanding, healthcare spending in the US accounts for 18% of the gross domestic product, which continues to strain the federal, state, and individual budgets (Johnson et al., 2015). Because healthcare leaders are a significant driver for a healthcare facilities financial success, they must demonstrate an ability to develop and monitor cost-reducing strategies that promote CMS value-based incentives, while remaining vigilant of what strategies work and those processes to improve those strategies considered ineffective. According to Elwyn et al. (2014), healthcare managers must institute PCC at its core values and continuously monitor and assess the outcomes of PCC to ensure the care team collaborates with the patient in their delivery of care.

The findings from this case study showed that healthcare managers are using multiple strategies to reduce patient cost while ensured their patients receive quality PCC. Healthcare managers who exercise excellent communication skills with providers, staff, and patients are seeing improved CMS surveys that in turn are increasing value-based incentive payments for their healthcare facility. Several areas all participants have seen improvements based on communication among their stakeholders are improve safety outcomes, enhanced patient experiences, a reduction in waste as determine through continuous improvement committees, and greater patient-care team satisfaction. Moreover, the findings of this study provide strategies managers have found effective to deliver quality cost-effective PCC as well as an opportunity for others to look within their organizations to assess the viability to implement some of the strategies identified in this study.

I recommend healthcare leaders continue to build relationships with other community-based facilities in their communities. The least amount of risk a large hospital facility could consider is an affiliation with a community partner. As the uncertainty of healthcare delivery and the complexities of adjusting payment models that support patient-centeredness, out of pocket cost containment and reduction, and a continuum of quality care remains a concern for Americans, healthcare leaders may benefit their organizations footprint and bottom line through community based strategic partnerships and telehealth.

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Appendix A: Study Protocol

Strategies for Achieving Patient-Centered Healthcare and Cost Containment

A. Overview of the Case Study

1. The goal of this qualitative descriptive case study is to explore patient-centered strategies from the perspective of the healthcare manager work at full-service acute care hospital in Virginia that services patients from rural communities.
2. The purpose of this qualitative descriptive case study using Yin's (2014) analysis process is to understand what patient-centered strategies healthcare managers use to reduce the cost of elderly patients' healthcare without reducing the quality patient care. Hyett et al. (2014) suggest healthcare researchers require qualitative research skills to interpret data collection, the nature of a healthcare system, and the organizational structure. A descriptive case study design provides the researcher the means to focus on one or multiple subjects via observation repeatedly over a defined spectrum of time until ones achieve their desired outcomes (Moeyaert, Maggin, & Verkuilen, 2016).

B. Protocol Purpose

Yin (2014) emphasizes that researchers establish a protocol when conducting a qualitative study. Using a protocol aids in establishing validation for a researcher's study (Moeyaert, Maggin, & Verkuilen, 2016).

C. Data Collection Procedures

1. The researcher will provide the interviewees' schedules and establish availability.

2. The researcher will use open-ended semistructured questions and additional questions as needed.
3. The researcher will establish the location in agreement with the participants.
4. The researcher will conduct several activities before contacting the participants by face-to-face, telephonic, virtual, and email.
    a. Send invitations via email and other forms of communication before initiating the interviews
    b. Review the hospital's annual reports and other documents
    c. Distribute informed consent forms to each participant
    d. Review interview procedures and National Institute of Health (NIH) Protecting Human Research Participants standards

D. Guide for the Case Study Report

1. The researcher will use the format of this case study as depicted in the Walden University Doctoral study rubric and research handbook.
2. The researcher anticipated viewers of the content of this case study are non-profit and for-profit healthcare organizations, patient centered advocacy agencies, think-tanks, and academia.

Appendix B: Interview Questions

1. How do you, as a healthcare manager, view patient-centered strategies, for example, patient-centered medical homes, accountable care organizations, person-centered care, person-focus care, and client-centered care as a means of reducing the cost of elderly patient healthcare?
2. What are advantages of patient-centered strategies in reducing elderly healthcare costs?
3. What patient-centered strategies have the board of directors supported to improve healthcare delivery and operational cost?
4. How do you measure the effectiveness of patient-centered strategies?
5. How did your organization address key challenges to implement successful patient-centered strategies without reducing the quality of elderly patient care?
6. How do you communicate patient-centered strategies with staff at all levels to improve quality care and reduce the cost of elderly patient care?
7. How, if at all, has the Patient Protection and Affordable Care Act (PPACA) affected your ability to implement patient-centered strategies and maintain quality patient care?
8. How do you turn patient-centered care strategies into a competitive advantage?
9. How will your patient-centered care strategies improve the quality of care and fit into the healthcare reform movement?
10. What other information would you like to add that these questions might not have addressed?