A case study: the executive leadership response at a community hospital to the value-based purchasing requirements of the Patient Protection and Affordable Care Act

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A CASE STUDY: THE EXECUTIVE LEADERSHIP RESPONSE AT A COMMUNITY
HOSPITAL TO THE VALUE-BASED PURCHASING REQUIREMENTS OF THE PATIENT
PROTECTION AND AFFORDABLE CARE ACT

by

Lawrence Russell Smith

A dissertation submitted to the Doctoral Program Faculty in Educational Leadership in partial
fulfillment of the requirements for the degree of

Doctor of Education

UNIVERSITY OF NORTH FLORIDA
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DEDICATION

This dissertation is dedicated to my wonderful wife Kathleen Ann (Ford) Smith who has been the wind beneath my wings for the past 31 years. I am so grateful for your love and support of this educational goal of mine. I will do my best to make up for lost time (e.g., Hawaiian vacation). For the official record, I did have $42 and not $34 in the bank when we got married (Lol…..).

To my beautiful children, Lawrence Russell Smith II and Gabrielle Danielle Smith. Words cannot express how much I love you and what a privilege it is to be your Dad.

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ABSTRACT

This qualitative case study examined the perceived effectiveness of executive leadership team processes at a community hospital in the southeastern U.S. in relation to the Value-Based Purchasing (VBP) requirements of the Patient Protection and Affordable Care Act (PPACA) through an analysis of documents and a repository database (http://www.hospitalcompare.hhs.gov) relating to service quality, patient satisfaction, and governmental reimbursements; and, structured interviews. Today, the PPACA or “Obamacare”, continues to challenge the executive leadership teams at U.S. hospitals to effectively navigate the intricacies of the legislation in order to remain solvent in a volatile healthcare arena. The Plan-Do-Check-Act (PDCA) model was utilized to guide the theoretical framework for this qualitative case study in terms of process improvement. Hill’s (2010) team leadership model was also applied to examine the perceived effectiveness of the executive leadership team processes in terms of analyzing any change in core measures and patient satisfaction scores from the federal fiscal year (FFY) 2013 and 2014, respectively. The VBP data reflected consistent core measure scores in the 48th percentile and an increase in patient satisfaction scores from the 20th to 33rd percentile. The results revealed that the executive leadership team processes were perceived by the researcher as effective as evidenced by a strong collaboration among administration, the board, and medical staff in implementing several strategies via a team oriented approach that impacted Medicare patients during the FFY of 2013-2014. This study offers a starting point in terms of generating more understanding of the importance of executive leadership team processes at a community hospital in relation to the VBP requirements of the PPACA which can be studied on a broader scale in the future.
Chapter One:

Introduction

The U.S. healthcare system is perceived by many as the best in the world because of the continuous development and use of cutting-edge technology, the increased competency of physicians, and evidence of outstanding clinical outcomes (e.g., Coronary Artery Bypass Graft) provided to millions of patients both domestic and abroad. However, as Werner, Canamucio, Marcus, and Terwiesch (2014) found, the sad truth for millions of Americans is primary care access to basic services is still often noted to be poor.

Fortunately, access to medical care for Americans was made possible when the U.S. Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA-42 U.S.C. § 1395 dd) in 1986 (2012) to ensure public access to emergency medical services regardless of their ability to pay for services rendered (Melkun, Ford, Brundage, Spain, & Chang, 2010). The EMTALA statute requires patients to be stabilized in the emergency department and was designed principally to address the problem of “patient dumping” where hospital emergency departments denied uninsured patients the same medical care provided to paying patients, either by refusing care outright, or by transferring patients to other facilities. Unfortunately, this has not proven a successful model because millions of Americans continue to utilize the emergency department for non-emergency medical conditions (e.g., cold, ear ache). This trending not only takes time and attention away from patients who truly require emergency treatment (e.g., chest pain, trauma, fracture), but is also driving up healthcare costs because the emergency room is one of the most expensive ways to access healthcare versus being evaluated by a primary care physician in a less-expensive outpatient setting (Morganti, Bauhoff, Blanchard, Abir, & Iyer,
Primary care was once referred to as a “loss leader”, but in the latter half of the 2010 decade, the U.S. government is encouraging patients to utilize their primary care physician as a better means to manage their healthcare needs more efficiently (Zismer & Werner, 2012).

Szostak (2015) further reported the U.S. healthcare industry has become one of the largest sectors of the economy where in 2012, healthcare consumed 17.8% of the gross domestic product (GDP) or $2.8 trillion in spending. This accounts for more than one-sixth of the entire U.S. economy and is projected to increase to 20% of the GDP by 2018. Healthcare executives working in organizations around the country, including hospitals, also face daunting challenges in terms of improving organizational performance. A few examples include increasing the quality of care provided to the patient, elevating patient satisfaction; while simultaneously attempting to reduce costs and patient errors. In order to achieve these lofty goals of performance in this volatile environment, hospitals will need to rely on a different deployment of leadership.

The passing of the Patient Protection and Affordable Care Act (PPACA-42 U.S.C. § 18001 et seq.) in 2010 (2012), gave hope to millions of uninsured Americans who can now access healthcare through the insurance marketplace. However, Dafney (2014) reported the PPACA which is commonly referred to as the ACA, is also currently having a detrimental effect on the ability of U.S. hospitals to remain solvent and many are considering merging with competing organizations in order to survive because of decreasing reimbursement for services, an increase in Medicaid expansion, employer mandates that have forced a reduction in staffing, an increase in health insurance premiums for covered employees, pay for performance (P4P), and higher taxes. Neuman and Chiang (2013) further reported there are over 5700 U.S. hospitals and the associated expense for these institutions tallied over $770 billion in 2011. These complex
issues that confront U.S. healthcare leaders are creating a huge demand for effective senior leadership and high quality decision-making in order for these facilities to survive in the years to come.

The review of literature demonstrates that no scholars have studied the executive leadership team processes at a community hospital, as it relates to the VBP policy provisions of the ACA. Because the VBP program (2011) is still in its infancy, the literature is not explicit if U.S. acute care hospitals have improved the service quality for inpatient visits on behalf of Medicare patients. As a result, this study provides a starting point to fill a void in the literature and information that was not available prior to this study. Additionally, it is vital to increase the understanding of executive leadership team processes about the threat or opportunity this CMS intervention has presented or will present to the future solvency of U.S. hospitals. These senior healthcare leaders can provide a place to start in terms of offering diverse insight into how they can impact service quality levels and connecting acute care hospital Medicare reimbursement to publicly reported data.

Problem Statement

Prior to the implementation of the VBP program (42 CFR § 412.160 et seq.) in 2011 (2016), as a component of the ACA, national standards did not exist for hospitals to publicly report information relating to quality outcomes (e.g., core measures) and patient satisfaction (HCAHPS) for the patients they serve. VBP was developed in response to many U.S. hospitals that were severely underperforming in both domains, yet still received the same governmental monies as top performing hospitals that consistently produce outstanding quality. The VBP program is a Centers for Medicare and Medicaid (CMS) initiative that rewards acute care
hospitals with incentive payments for the quality of care they provide to Medicare recipients. CMS rewards hospitals based on the quality of care provided, how closely best clinical practices are followed, and how well hospitals enhance the patient’s experience of care during inpatient hospital stays. Hospitals are no longer paid solely based on the quantity of services they provide. Consequently, a monumental challenge faced by executive leadership teams at approximately 3000 U.S. acute care hospitals who participate in VBP is maximizing reimbursement within the new payment model. This will allow them to remain solvent and continue to provide vital healthcare services to their communities. This is especially important taking into consideration the average U.S. hospital typically exhibits a very modest profit margin goal of one to five percent annually (Blumenthal & Jena, 2013).

Purpose of the Study

The purpose of this qualitative case study was to examine the perceived effectiveness of executive leadership response at a community hospital to the VBP requirements of the ACA through an analysis of documents/repository database (http://www.medicare.gov/hospitalcompare/) relating to service quality, patient satisfaction, and governmental reimbursements; and structured interviews. This study assessed the perceived effectiveness of the executive leadership team processes in terms of analyzing any change in core measures (e.g., quality outcomes) and patient satisfaction scores (HCAHPS) from the federal fiscal year (FFY) 2013 and 2014 respectively. Furthermore, the interviews were conducted with eight senior hospital executives in an effort to understand what strategies were implemented that both attempted to improve quality outcomes and patient satisfaction, as well as maximizing governmental reimbursement for Medicare patients. The senior executives included the chief
administrative officer (CAO), the chief executive officer (CEO), the chief financial officer (CFO), the chief medical information officer (CMIO), the chief medical officer (CMO), the chief nursing officer (CNO), the chief operating officer (COO), and the vice president of operations (VPO) who routinely provide top level leadership that drive decisions within the organization which impact service quality to Medicare patients.

Research Question

The research question that will guide this study and provide the structure for presenting the results of this research is:

1. What was the perceived effectiveness of the executive leadership team processes at a not-for-profit, acute care, community hospital in the Southeastern U.S., as it relates to the value-based-purchasing (VBP) policy provisions (2011) of the ACA (2010)?

Theoretical Framework

This qualitative case study contains theoretical concepts from two disciplines (e.g., healthcare, education) in examining the executive leadership response at a community hospital to the VBP policy provisions of the ACA. This framework reflects on key theories and concepts that will guide the study. First, the plan-do-check act (PDCA) design is utilized by many hospitals to evaluate the effectiveness of executive leadership strategies relating to patient outcomes. This community hospital is no exception, as the PDCA model is the preferred performance improvement (PI) tool and has been applied to a plethora of hospital initiatives (e.g., improving hospital readmission rates for congestive heart failure, reducing rates of catheter associated urinary tract infections-CAUTI) in the past. PDCA will be used in this study to describe how the executive leadership team adopted each component of the model with the goal
of implementing evidence based practices that positively impacted service levels for Medicare patients. Patwardhan and Patwardhan (2007) also purported PDCA provides consistency of purpose which is vital for ongoing continuous improvement of products and services, assigning resources to meet long term goals versus immediate revenue, and maintaining a plan to remain competitive in the market.

A second type of theoretical framework that will be applied to this qualitative case study is Hill’s (2010) team leadership model which executive leadership can utilize to assist in making decisions about the current state of the team and the specific actions they need to take in order to improve team functionality. This theory will be used in this study to provide a rubric for understanding the complex experience of team leadership, which starts at the top of the organization with its initial leadership decisions, and then moves to leader actions, and lastly, focuses on the indicators of team effectiveness. A major strength of the model is the ability to place the ongoing work group or team in an environmental context within the organization (e.g., hospital). This enables executive leadership teams to focus on performance/team effectiveness and to diagnose/correct issues that arise.

Methodology

Marshall and Rossman (2011) provide a good argument for utilizing the “research funnel” as a method to help conceptualize the procedures for justification of a qualitative research study within a targeted discipline (e.g., healthcare). The top of the funnel or justification to pursue this qualitative case study, points to the complex issues that confront healthcare leaders at over 5,700 U.S. hospitals today (Litvac & Bisognano, 2011). As a result, the demand for
quality decision-making among hospital executives is paramount if they hope to continue to provide vital healthcare services to Medicare patients in the ACA era.

This qualitative case study assessed the perceived effectiveness of the executive leadership team processes at an acute care, community hospital, in relation to the Value-based Purchasing (VBP) policy provisions of the Affordable Care Act (ACA), for the period of FFY 2013-2014. The ACA (2010) established the Hospital VBP program, which applies to Medicare payments beginning in fiscal year (FY) 2013, and affects payment for inpatient stays in 2,985 participating hospitals across the country (Orr & Davenport, 2015). The hospital VBP program is a Center for Medicare and Medicaid Services (CMS) initiative that rewards acute care hospitals with incentive payments for the quality of care they provide and how well they enhance the Medicare patients’ experience.

The site selection for the study was a 335-bed, acute care, community hospital located in the southeastern U.S. and that provides services to multiple counties. The community hospital employs over 1,800 physicians, nurses, technical, administrative, and clerical staff to accomplish their mission of “providing the best care, with the best staff.” For the local residents, geographically, it is the only hospital located within 25 miles to the north and south which makes healthcare access vital to the community for routine and emergency services. The author chose to study this community hospital because they service Medicare patients, which is a condition of participation in the VBP program, and due to the vital role the institution plays in providing healthcare services to the local community because it is the only hospital that resides within the county. These elements and the fact that the researcher has been employed as director of radiology over the past 9 years at the community hospital and had ready access to documents and
the senior leadership team, made it viable to study the perceived effectiveness of the executive leadership team processes in relation to the policy provisions of the VBP program, as part of the ACA, where their decision making had an impact on the solvency of this community hospital.

Data were collected from three primary areas with the goal of answering the research question. The first source of data was conducting a document analysis, with the explicit goal of uncovering information rich data that lead to determining what was the perceived effectiveness of the executive leadership processes that were implemented at a community hospital in relation to the VBP program. Documents examined included policies and procedures, board meeting minutes, memoranda, physician newsletters, medical executive committee (MEC) minutes, accountable care organization (ACO) meeting minutes, and department director meeting minutes.

The second source of data consisted of the aggregate of both core measures and HCAHPS scores for the FFY of 2013-2014. Please note the community hospital fiscal budget mirrors the FFY which commences on October 1 of the same year and concludes on September 30 of the following year. This data source is available publically on the website. Because this community hospital services Medicare beneficiaries and thus participates in the VBP program, it is required to report both core measures and patient satisfaction scores quarterly to the government. This is important to the community hospital not only for reimbursement purposes, but many Medicare patients today may choose or not choose the community hospital for their healthcare services based on a comparison of performance data among competing hospitals located within this public report card (Faber, Bosch, Wollersheim, Leatherman, & Grol, 2009).
The third source of data involved open-ended, structured interviews with the following key leadership at the community hospital which included 8 physician and non-physician senior executives: CAO, CEO, CFO, CMIOI, CMO, CNO, COO, and VPO. Turner (2010) reported that open-ended interviews are very structured in terms of the wording of the questions and this study was no exception. The open-endedness of the questions encourages the participants to provide a rich description of detail and allows the researcher to ask probing questions as a means of follow-up. Standardized open-ended interviews are a very common method of interviewing utilized in qualitative research studies because it allows the participants to freely give their accounts of their experiences and viewpoints.

Creswell (2007) purported one of the weaknesses associated with open ended interviews is coding the plethora of data can be difficult. Gall, Gall, and Borg (2003) also found although it can be a difficult process for the researcher to evaluate the narrative responses in order to appreciate an overall perspective of the interview responses. However, coding can reduce researcher biases within the study.

Processing naturalistically obtained study data was performed by applying the principles outlined by Lincoln and Guba (1985) who reported that data analysis is a synthetic one, where the constructions have been molded by inquirer-source interactions that are reconstructed into meaningful wholes. The primary role of data analysis is not an effort of data reduction, but rather induction. In particular, the data processing activities that were adopted for this study include: unitizing, categorizing, filling in patterns, and member checks. Unitizing refers to the “units” of information that will serve as the basis for defining categories of data. The role of categorization is to bond together provisional categories that relate to the same content. Filling in patterns is the
process for the treatment of incomplete data. After categorizing has concluded, a few categories might be deficient of data that can support conclusions. Last, member checking is where the findings of the study were submitted to the participants in order to assess respondent validation. The purpose of this comprehensive check is to provide evidence for the credibility of this study (Lincoln & Guba, 1985).

*Significance of the Study*

This qualitative case study is the first attempt to examine the executive leadership team processes at a community hospital as it relates to meeting the requirements of VBP program. This might be significant to executive leadership teams at U.S. hospitals as several authors have reported that at no other point in history, have healthcare consumers paid so much for services, yet with very small returns on investment (Berwick, Nolan, & Whittington, 2008; Sirgi, Lee, & Yu, 2011). Levin-Scherz (2010) further reported the U.S. exhibits the largest per capita healthcare expenditures in the industrialized world. For example, the U.S. has witnessed a steady increase in healthcare expenditures from $1.3 trillion in 2000 to $2.2 trillion in 2007, and this increase does not represent a sustainable model for the future of healthcare.

The study will benefit executive leadership teams at U.S. acute care hospitals by creating the type of understanding that will assist leaders in keeping their facilities financially solvent in the current ACA era. This is vital because healthcare leaders today are routinely faced with improving the following organizational performance measures: increasing the quality of care provided to the patient and elevating patient satisfaction while simultaneously attempting to reduce costs and patient errors. In order to achieve these goals of performance, healthcare leaders
today will need to rely on a proven methodology that produces results as clearly outlined in the VBP requirements of the ACA.

What remains obvious is the U.S. healthcare system is still in a crisis mode. As a result, policymakers on both sides of the political aisle need to continue their focus on reforming the ACA to ensure it not only delivers high quality healthcare, but at a cost that is affordable. The results of the study can inform executive leadership at U.S. hospitals by validating if the perceived effectiveness of the response from a community hospital to the VBP requirements of the ACA was effective or not.

Definition of Terms

Please note that some of the definitions within this list were taken directly from “Medicare.gov” – the official U.S. government site for Medicare (N.p., n.d. web, 14 Aug 2016).

Accountable Care Organization (ACO): A model of healthcare reform where a group of provider’s from a network receives payments from an insurance agency or Medicare based on the quality of care provided as opposed to the quantity of services provided (Sell, Rothenberg, & Chapman, 2013).

Acute Care Hospital: “A hospital that cares primarily for patients with acute diseases or conditions and whose average length of stay is less than 30 days” (O’Leary, 1994, p.19).

Affordable Care Act (ACA): 2010 legislation designed to provide healthcare for all American citizens, curtail health fraud, and prevent insurance companies from imposing coverage
restrictions on pre-existing conditions (Sell, Rothenberg, & Chapman, 2013).

Chief Administrative Officer (CAO): The individual responsible for the strategic operations of the hospital (CAO Interview, May 23, 2016).

Chief Executive Officer (CEO): “The individual appointed by a governing body to act on its behalf in the overall management of an organization” (O’Leary, 1994, p. 176).

Chief Financial Officer (CFO): “The individual responsible for management of an organization’s financial plans and policies and the administration of accounting practices. The job typically includes directing the treasury, budgeting, auditing, and tax accounting” (O’Leary, 1994, p. 176).

Chief Medical Information Officer (CMIO): The individual responsible for building and maintaining the information technology (IT) architecture in the electronic medical record (EMR) which includes building order sets that include evidenced based practices that impact the quality of care for patients (CMIO Interview, May 23, 2016).

Chief Medical Officer (CMO): The individual responsible for ensuring quality of care is delivered to patients of the community hospital (CMO Interview, May 18, 2016).
Chief Nursing Officer (CNO): “The individual responsible for management of a hospital nursing staff. The job also includes overseeing patient care and clinical outcomes (O’Leary, 1994, p. 176).

Chief Operating Officer (COO): “The individual responsible for the management of the day-to-day and internal operations of an organization. In many organizations, the COO is the second highest management officer and, in the absence of the chief executive officer, is responsible for administration” (O’Leary, 1994, p.176).

Fee-For-Service: A payment mechanism in which a provider is paid for each service rendered on behalf of a patient (Sell, Rothenberg, & Chapman, 2013).

Medicaid: A joint federal and state program that helps individuals with medical costs who have low income and resources. Medicaid also offers benefits not normally covered by Medicare, like nursing home care, and personal care services. Each state has different rules of eligibility and applying for Medicaid (https://www.medicare.gov).

Medicare: A federally funded health insurance program that is administered by the Healthcare Financing Administration (HFCA). The program reimburses
hospitals and physicians for healthcare provided to qualified people aged 65 and older, certain younger people with disabilities, and people with end stage renal disease. The different parts of Medicare help cover specific services: Part A: Covers inpatient hospital stays, care in skilled nursing facilities (SNFs), hospice care, and some home healthcare services. Part B: Covers certain doctors’ services, outpatient care, medical supplies, and preventive services.

(https://www.medicare.gov)

**Not-For-Profit Hospital:**
“A general or acute care, non-taxable hospital that operates on a not-for-profit basis under the ownership and control of a private corporation. Profits are turned back into maintenance and improvement of the hospital’s facilities and services. Not for profit hospitals are usually owned by a community, a church, or another organization concerned with community services and resources” (O’Leary, 1994, p. 545).

**Value-Based Purchasing (VBP):**
A CMS initiative that rewards healthcare providers that deliver better outcomes in health and healthcare for the Medicare beneficiaries and communities they serve at a lower cost (VanLare & Conway, 2012).
Vice President Operations (VPO): The individual who administrates over the clinical and technical operations over several community hospital departments which include laboratory, plant operations, radiology, and supply chain (VPO Interview, May 16, 2016).

*Delimitations*

Roberts (2010) reported that delimitations clarify the boundaries of the study and point out to the reader how the researcher narrowed the scope of the project. The researcher controls the delimitations in terms of what factors are pertinent to include and exclude from the research study. For the purposes of this study, the delimitations include:

1. Only one acute care, not-for-profit, community hospital in the Southeastern U.S. was included in this study.
2. The time frame of the study was FFY 2013-2014.
3. Those participants interviewed as part of this study were female and male, non-physician and physician senior executive leaders that worked at the community hospital during the period of FFY 2013-2014.
4. The study included only those organizations that matched the selection criteria outlined for this study. The selection criteria for this study included one community hospital who participates in the VBP program as part of the ACA.
5. The only repository database that was utilized for the purposes of this study for the period of FFY 2013-2014 in terms of the executive leadership response at a community hospital to the VBP policy provisions of the ACA was
(http://www.medicare.gov/hospitalcompare/). This data is publicly reported quarterly by the community hospital and all other hospitals who participate in the VBP program.

**Limitations**

Mauch and Birch (1993) referred to a limitation as a factor that is impactful to the research study, but is not in the control of the researcher. Most of the limitations are listed in Chapter Three because they mostly involve weaknesses in the methodology of the study. Outlining the limitations of the study is paramount as it allows the reader to proceed with caution with any assumptions or conclusions they may make regarding the research. For example, the structured interview questionnaire was purposely designed to be concise in an effort to account for the time of a busy senior leadership team at the community hospital. The compactness of the questionnaire may be considered a limitation by some readers and researchers as a more comprehensive tool might provide thick, descriptive detail of the phenomenon of interest under study. The researcher’s intent was to narrow the focus of the questions in an effort to extract the best data possible from those interviewed. Other major limitations were the small sample size (N=8), the limited timeframe in which to analyze the data from the repository database (2013-2014), and conducting a research study at only one community hospital in the Southeastern U.S.

**Organization of the Study**

This qualitative case study will be reported in five organized chapters. Chapter One provides an overview of the study. This chapter discussed the background and contextualization of the issue, includes a problem statement, outlines the purpose of the study, describes the research question, provides a theoretical framework, definition of terms, significance, delimitations/limitations of the study, and a summary.
Chapter Two outlines the review of literature and is organized into the following sections which will provide clarity of the topic: a chronological history of healthcare reform in the U.S., a section on policy analysis, a cost versus quality analysis, a report of how the VBP program impacts a community hospital in the southeastern U.S. and hospitals in general, and a discussion of leadership theories.

Chapter Three presents the theoretical framework for the procedures and methods that are pertinent to this study and is organized into the following sections: research design, site selection, data sources, data collection procedures, credibility, transferability, dependability, ethical issues, data analysis techniques (e.g., member check), and limitations.

Chapter Four outlines the findings (data analysis, results) of this study including the perceived effectiveness of the executive leadership processes at it relates to the VBP program as part of the ACA. The results were compared to approximately 3000 community hospitals nationally. The chapter finishes with a discussion of the research question that ultimately provided the framework for the study.

Chapter Five provides a summary of the study including an overview of the problem, major findings, relationship of the findings to the previous literature, and implications of the study as it relates to theory, research, and practice. This chapter concludes with discussions of implications for action and recommendations for pursuing future research related to this study.

Summary

The purpose of the study was to examine the perceived effectiveness of the executive leadership team processes at a community hospital in the southeastern U.S. in relation to the VBP requirements of the ACA through an analysis of documents and a repository database
(http://www.hospitalcompare.hhs.gov) relating to service quality, patient satisfaction, and governmental reimbursements; and executive interviews. These senior executives are the leaders within a hospital environment and possess the ability to make process improvements that impact service quality levels at their individual institutions. Furthermore, this study also assessed the difference in VBP scores for both core measures, HCAHPS patient satisfaction scores, and associated governmental reimbursement for the FFY period of 2013-2014.

Today, senior leadership teams across the U.S. have great motivation to improve the quality of care/patient experience for Medicare beneficiaries because since 2013, these scores are available to the public through the (http://www.medicare.gov/hospitalcompare/) website and directly impact reimbursement levels. As a result, many Medicare patients are shopping healthcare similar to a commodity service (Faber et al., 2009). The community hospital VBP scores are not only compared to the local competition in the Southeastern U.S. region, but can also be compared nationally to any hospital that participates in the VBP program. This data is not only important to local Medicare patients, but is also important to Medicare patients who vacation in same area as the community hospital which is well established as a tourist area. Ultimately, the results of this study will provide research data that was not available prior to the pursuit of this study.
Chapter Two:
Review of Literature

This qualitative case study investigated the executive leadership team response at a community hospital in the Southeastern U.S. to the Value-based Purchasing (VBP) requirements of the Affordable Care Act (ACA) in terms of their perceived effectiveness in impacting both core measures and patient satisfaction for Medicare patients. Because of the payment penalties imposed by the Centers for Medicare and Medicaid Services (CMS) on acute care hospitals that do not meet the established benchmarks as participants of the VBP program, the ACA legislation (42 USC § 18001 et seq.) of 2010 (2012) has motivated hospital executives to critically think about not only improving the quality of care provided at their facilities, but also to positively impact the perception of care from their patients. This study examined the perceived effectiveness of the executive leadership response in terms of how well did the community hospital compare to other U.S. hospitals in maximizing VBP reimbursements during the period from FFY 2013-2014. The nine-month performance period CMS utilized to determine the reimbursement to the community hospital in fiscal year 2013, was July 1, 2011-March 31, 2012 (McHugh, Neimeyer, Powell, Khare, & Adams, 2013).

The review of literature is organized into the following sections: a chronological history of healthcare reform in the U.S., a description of policy analysis as a field of study, a cost versus quality analysis, an overview of how the VBP program affects hospitals in general, and a review of multiple leadership theories. Lastly, the chapter concludes with a summary that connects the relevant literature to a justification of the need for this study.
Background on Healthcare Reform

While multiple researchers have reported recently on the need for healthcare reform in the U.S., policymakers have been evaluating the effectiveness of the healthcare system and have supported subsequent reform efforts for many decades (Baucus, 2009; Seltzer & Zhang, 2011). Lehman (2013) further reported healthcare reform is not a new initiative as evidenced by 11 industrialized countries enacting some form of national insurance coverage programs in the late 1800s. Additionally, Theodore Roosevelt, the 26th U.S. President, backed healthcare reform efforts in 1912, through his call for the protection of a quality home life from the ills of sickness, uncertain employment, and aging, while channeled through the adoption of a form of social insurance program. Gorin (2011) also purported that during the period of the 1930s, Franklin Delano Roosevelt, the 32nd U.S. President, aimed to incorporate health insurance as part of his social security law. Ultimately, Roosevelt deserted the idea of a proposal for healthcare coverage because he feared hostility from the American Medical Association (AMA) and other special interest groups would defeat the entire bill.

Knoblauch (2014) reported that Roosevelt’s fears were realized as the AMA focused much of its political clout and fiscal influence from 1939-1962, on arguing that any type of federal healthcare system would be considered socialistic, expensive, bureaucratic, and would degrade the physician-patient relationship. Furthermore, after Harry Truman, the 33rd U.S. President, failed to pass universal healthcare coverage for Americans, advocates began a shift in focus to providing care for the elderly. Wilbur Cohen was an instrumental leader towards this initiative, who also was a staff member on Roosevelt’s Committee on Economic Security; and the secretary of Health, Education, and Welfare under Lyndon Johnson, the 36th U.S. president.
Cohen is credited with negotiating the critical components in the passing of the Medicare and Medicaid legislation (H.R. 6675, PL 89-97) in 1965 (2006). Furthermore, former Kansas Senator Bob Dole also conveyed his concerns regarding the healthcare crisis facing the U.S. more than 40 years ago (DeWitt, 2003).

Fickenscher and Kindig (1993) reported in the past few decades multiple proposals have been produced whose aim was guided at solving the major issues plaguing the U.S. healthcare system. However, in the period of 1982-1992, calls for reform have become even more intense, as failed attempts to control costs multiplied, and Americans’ access to basic healthcare (e.g., routine physicals, mammograms) has further declined. The denial of access to preventative care frequently leads to costly critical care (e.g., heart disease, diabetes, peripheral vascular disease, hypertension, stroke) in the future, which unfortunately could have been mitigated with early medical intervention or prevented altogether. Additionally, a CBS News/New York Times Poll conducted in 1992 indicated that support for national health insurance escalated to a 40 year high of 62%, where U.S. citizens believed the U.S. healthcare system was in crisis and in need of some type of major reform.

Wellstone and Shaffer (1993) further reported that similar to 1965, policymakers, special interest groups, and the U.S. public are all debating what type of healthcare reform will control costs, while improving access and quality. The increasing public and governmental interest led directly to the development of the Healthcare Security Act (HSA), H.R. 3600, which President Bill Clinton, the 42nd President, introduced on September 23, 1993. The purpose of the HSA was to guarantee a wide range and secure healthcare coverage, to simplify the healthcare system for patients and providers; to control the cost of healthcare for employers, employees, and all
citizens who pay for healthcare coverage; to give individual choice among health plans and
providers; to ensure high-quality healthcare; and to encourage all patients to take responsibility
for their own healthcare coverage. The HSA legislation framework of universal coverage,
spending and managed competition, insurance for low-income residents, and patients’ rights died
a year later largely due to the plans complexity, the administrations excessive partisanship, and a
lack of understanding from the American public (Budetti, 2003; Stocpol, 1996).

The continued focus from U.S. policymakers regarding the need for healthcare reform
was sparked by the Institute of Medicine’s (IOM) report in 2001, which found the U.S.
healthcare system does not provide high quality care to all people on a consistent basis.
According to the IOM, this was because the U.S. healthcare system is not organized well to meet
the challenges it faces in terms of the translation of knowledge into clinical practice and the
ability to apply new emerging technologies safely. The IOM committee also reported previously
on an urgent care problem regarding patient safety in a 1999 report titled To Err is Human:
Building a Safer Health System, which outlined that tens of thousands of Americans die every
year as a direct result of healthcare mistakes that are largely preventable. Lastly, McGlynn, Asch,
and Adams (2003) found that the majority of U.S. citizens assume they are provided high quality
healthcare during hospital visits.

In spite of all of the failed reform efforts in the past century, persistence paid off as
policymakers were able to pass the ACA or “Obamacare”, on March 23, 2010, which many
authors view as the most significant social policy legislation since the inception of Medicare and
Medicaid in 1965 (Berenson, 2010; Gruber, 2010; Orszag & Emanuel, 2010). The ACA was
designed to increase access to quality healthcare for millions of Americans who are currently
either not insured, underinsured, or were not insurable based on pre-existing medical conditions. Gruber (2010) also found there are 220 million Americans who currently possess health insurance and CMS predicts another 34 million will be insured by 2019, because of the ACA.

However, the passage of the ACA legislation did not occur without some serious challenges from several fronts, especially taking into consideration a very contentious political landscape. McDonough (2012) reported the ACA was enacted in 2010, and upheld by the U.S. Supreme Court in the National Federation of Independent Business et al., v Sebelius, Secretary of Health and Human Services, et al. case on June 28, 2012, has survived a series of life-threatening events since it was proposed for Congressional approval in June, 2009. One of the most critical threats occurred when Scott Brown (R) won the U.S. senate seat in Massachusetts by defeating Attorney General Martha Coakley (D) in the 2010 special election to succeed U.S. Senator Ted Kennedy for the remainder of the term ending, January 3, 2013. This was a significant event because it deprived Democrats from reaching their 60-vote Senate majority and left many healthcare authorities doubtful that comprehensive healthcare reform was a real possibility (McDonough, 2012).

Prior to the oral arguments presented to the U.S. Supreme Court in March, 2012, very few healthcare experts projected it would be a life threatening event for the future of the ACA. However, the dissents issued by justices Kennedy, Scalia, Thomas, and Alito, pointed to the stakes for the future of the ACA legislation were an all or nothing proposition. A few very consequential benefits of the ruling were six million Americans were now enrolled in their parents’ health plans, 5.2 million Medicare participants have saved money on prescription-drug
costs, there were also 600,000 new adult Medicaid enrollees in seven states, and 12.8 million consumers who would receive $1 billion in insurance-premium rebates (McDonough, 2012).

A major reason for the high number of uninsured Americans was the high cost for health insurance. U.S. executive leadership in hospitals face challenges every day in providing services to patients who do not possess healthcare coverage. As a result, many hospitals write off millions of dollars in charity care annually because providing care to all Americans remains at the core of their missions. This financial model is not sustainable for most hospitals whose annual profit margin ranges between one and five percent.

However, January 1, 2014, marked the period where Americans whose annual income fell between 133% and 400% of the federal poverty line (e.g., between $15,282 and $45,960 for a single adult) who do not have access to other forms of health insurance were now be eligible for income based federal tax credits. The purpose of the tax credits was to reduce the cost of health insurance that is now available through the new federal or state health exchanges. Also, Americans whose household income fell below 250% of the federal poverty benchmark were also eligible for cost sharing subsidies, which will now limit cost sharing for deductibles, co-insurance, and co-payments. Additionally, private employer health plans are now connected to generous tax deductions that can lower the cost to employees by a third or more for Americans with the highest incomes. The established tax credits and cost sharing incentives mandated by the ACA marks the first time it is unmistakable from the revert nature of current tax deductions. The Congressional Budget Office estimated that 25 million Americans will secure personal health insurance through the new exchanges by 2018, and 20 million will have received some
Policy Analysis

VBP is a federal policy provision component of the ACA. As a result, it is important to align the reader of this study to policy analysis as a field of study, which is not a new endeavor and can be traced back in history for many centuries. For example, Pheng & Fang (2005) found lean construction principles could be influenced by military strategies adopted by Sun Tzu in the *Art of War* approximately 2500 years ago. Several scholars found the ideas of “lean thinking” were originally developed within the Toyota Manufacturing System and are comprised of continuous improvement, a flattened organization structure, increased team work, the elimination of waste, the efficient utilization of resources, and cooperative supply chain management (Green, 2000; Womack, Jones, & Roos, 1990). Lean thinking can also be applied to the healthcare discipline as a community hospital in Montana successfully applied lean principles and were able to reduce the amount of waste and errors within the organization (Jimmerson, Weber, & Sobek, 2005).

Walt et al. (2008) also reported that policy analysis consists of a multi-disciplinary approach to public policy with the goal of explaining the interaction between institutions (e.g., hospitals), interests, and ideas in the public process. It is helpful both retrospectively and prospectively, to understand past policy failures (e.g. Health Security Act of 1993) and successes (e.g., Affordable Care Act of 2010), and to plan for future policy implementation (e.g., VBP). Additionally, several scholars have made an argument for the importance of undertaking policy analysis because it is vital to healthcare reform (Parsons, 1995; Walt & Gilson, 1994).
Unfortunately, as policies and policy rationales move forward, many policymakers and researchers treat their beliefs about the intent of public policy as if they were true, and infrequently subjecting them to research evidence and public scrutiny (St. John, Daun-Barnett, & Moronski-Chapman, 2013).

Furthermore, Collins (2005) referred to policy analysis as a generic term for a range of techniques and tools to study the components of established policies, how the policies developed, and what their outcomes were. More specifically, as policy analysis translates to healthcare, a main concern is the outcome of healthcare policies (e.g., ACA, VBP) or the effects the legislation has on its people. The World Health Organization (WHO) (1999) further narrowed the focus of policy analysis when it defined health policy analysis as an agreement on healthcare issues, goals and objectives that need to be addressed, the competing priorities among the objectives, and the primary directions for their achievement.

Sen (2009) also provided another view on policy discourse by including the perspectives of people impacted by policy (e.g., ACA) through the adaptation of social choice theory. One of the steps in applying social choice theory is to compare the conditions of entities such as hospitals that are influenced by policy. This provides a method of distinguishing between access and the basis for the differences. Additionally, it is also important to use a rubric that focuses on the relational and practical characteristics of decisions and allowing for the facilitation of re-examination. Executive leadership teams need to understand the strategies that have been contemplated may not completely resolve the entire conflict, which makes it important to further scrutinize challenging policy issues with reassessment. This makes it important to assimilate the voices of those entities affected by policies with the persuasion from informed leadership as they
review and interpret data. However, what remains clear is because the ACA and VBP are still in their infancy, and the long term effect on U.S. citizens and the quality of care provided to Medicare patients at acute care hospitals may not be determined for quite some time.

Cost versus Quality

The perception among many U.S. citizens is the healthcare system ranks among the best in the world, especially when comparisons are made to third world countries who continue to struggle to provide even the most basic healthcare services. However, Sirgy, Lee, & Yu (2011) contradict this thinking by reporting that at no other time in history have citizens spent so much, for so very little return on investment. Levin-Scherz (2010) additionally purported the U.S. per capita healthcare spending far outweigh the other industrialized nations as evidenced by U.S. healthcare expenditures demonstrating a steady increase from $1.3 trillion in 2000 to $2.2 trillion in 2007.

The World Health Organization Statistical Information System (2008) also found the U.S. exhibited the highest per capita total expenditure on healthcare at an average exchange rate (e.g. U.S. $) of $6,714 as compared to 9 other industrialized countries (e.g., Australia, Canada, Denmark, France, Germany, Japan, Norway, Sweden, United Kingdom), whose combined average was $3,996. These sobering statistics present a strong signal the U.S. healthcare system is in crisis, and also point to the overreliance of the U.S. government on a failing libertarian-market based model which is based on consumer-directed care.

Davis, Schoen, and Stremekis (2010) additionally reported the U.S. healthcare system continues to mount increasing costs and exhibit lower quality as compared to many industrialized countries in the categories of preventable mortality, total number of uninsured, and
care efficiency results. For example, the Organization for Economic Co-operative Development (OECD) (2011) reported the U.S. spends 81% more for healthcare than the average OECD country. U.S. hospital executives need to pay close attention to the rise in healthcare costs because the largest growth area is providing hospital care services. For example, inpatient and outpatient healthcare services comprise 32% and 18% of the total U.S. healthcare budget, respectively (Milliman, 2012). The U.S. also exhibits a below-average infant mortality rate as compared with the average OECD nation (OECD, 2011). Quality benchmarks are also at risk of vanishing as evidenced by CMS no longer requiring multi-hospital systems to have a local community board in 2012.

Kochner and Sahni (2011) also reported the increasing trend of hospitals employing physicians which gives hospital leadership more control and has resulted in the disappearance of the independent medical staff which had been an institution among physician and hospital relationships in the past. Hospital leadership who endorse the employment of physicians are motivated by the impact of the ACA which leans towards accountability and packaged payment plans. Ultimately, the goal is to promote the efficient delivery of care provided to inpatient/outpatient customers which will control costs and can only be achieved by both entities working together in a unified effort.

Two recent studies pointed to one in seven patients receiving care in a hospital were harmed by an adverse event and 44%-66% of these events were deemed preventable (Landrigan et al., 2010; Office of Inspector General, 2010). Unfortunately, in many cases hospital leadership did not even realize these adverse events had occurred, as evidenced by the Office of Inspector General (OIG) who reported that only 14% of these adverse events are tracked in a hospital
database (OIG, 2012). Downey, Hernandez-Boussard, Banka, and Morton (2012) additionally found that after studying the Agency for Healthcare Research and Quality (AHRQ) patient safety indicators from 1988-2007, demonstrated virtually no change in comparison to the previous decade. This equates to a very ineffective response to the Institute of Medicine (IOM) 1999 report which estimated that 100,000 patients die annually as a direct result from medical errors in U.S. hospitals (IOM, 2000).

Another problem area for hospital executives are the rising rates of nosocomial infections (e.g. originating in a hospital) that add additional cost to the bottom line and often cause harm to the patient. The World Health Organization (2012) reported the most common type of nosocomial infection in U.S. hospitals are surgical infections, bloodstream infections, and pneumonia. Multiple authors suggest hospital acquired infections (HAIs) affect 1.7 million hospitalized patients annually, or about 1 in 20 patients, at a cost to the U.S. healthcare system of $35.7 to $45 billion, causing nearly 100,000 deaths and a number of unreported disabilities (Klevens et al., 2007; Scott, 2009). A recent National Public Radio, Robert Wood Johnson Foundation, Harvard Public Health (2012) survey also found that eight percent of U.S. hospitalized patients developed HAIs.

Multiple authors also argued that because the U.S. healthcare system is based on consumer-directed care or a libertarian-market based model which stresses equal access, it is widening the gap between the underprivileged and privileged (Bloche, 2007; DeNavas-Walt, Proctor, & Lee, 2007). The 2006 National Healthcare Disparities Report, issued by the U.S. Department of Health and Human Services, further documents the monumental differences in the quality of healthcare provided to poor and rich U.S. citizens. According to the report, poor
Americans received a lesser quality of care on 12 out of 13 core measures as compared to affluent citizens. The report also suggests that African Americans fared worse than Whites, and Hispanics were provided worse healthcare than non-Hispanic whites. Hasnain-Wynia et al. (2010) further purported the healthcare quality for racial and ethnic minorities is frequently variable. Governmental efforts to reduce these disparities in quality include VBP initiatives proposed through CMS.

This is just the beginning of the debate over the design of the ACA legislation and its intended purpose. For example, many critics of the ACA have expressed concerns regarding its cost containment measures and the overall fiscal impact to the government’s budget. The CMS actuary points out that the ACA will increase healthcare expenditures by two percent by 2019 (Gruber, 2010; Harrington, 2010; Lantz, 2013). Gruber (2010) puts this in good perspective when he reported that U.S. healthcare spending is a source of grave concern, but we need to be more focused on the growth rate of medical spending versus the level of spending which is a better indicator that accounts for the financial well being of the country.

Without the ACA legislation, current trends would position the country towards a 38% GDP spend for healthcare by 2075, as the growth rate of healthcare costs marches past the growth rate for the total economy. In this out-of-control spending environment, whether annual healthcare costs rise from one percent or even five percent does not matter, it just moves judgment day farther out. What remains clear is one of the keys to the long term solvency of the U.S. healthcare system is to implement strategies to slow the rate of cost growth and which is referred to as “bending the cost curve” (Ginsburg, Ichiseki, & Punwani, 2012).
Many reform advocates, including President Barack Obama, committed to “bending the cost curve” to decrease the worry of insured Americans about their healthcare insurance costs escalating above their means to pay for it (Nather, 2009; Wayne & Armstrong, 2009). However, White (2013) reported the cost control provisions of the ACA are not effective because they are relatively straightforward and inherently flawed, which prevents a successful implementation. Furthermore, effective and equitable cost control will require an all-payer fee setting, which has proven to be successful in other countries (e.g., France, Germany, Japan, Netherlands, & Switzerland). These advanced countries like the U.S. have multiple insurers that coordinate payments based on a standardized fee schedule in which hospitals and physicians are ultimately paid.

Marmor and Oberlander (2011) reported the ACA is also an attempt to cure the many deficiencies in the U.S. health insurance market. It was a by-product of legislative compromises that targeted support from conservative democrats. The ACA was molded by many years of debate within the health policy faction, which supports that cost containment will require a reorganization of how healthcare is delivered in the U.S. Ultimately, these positions argue for regional variations in medical practice, which demonstrate that care is unscientific, and needs rationalization, which would increase the efficiency of the system (Berwick & Hackbarth, 2012; Health Affairs, 2012b; Skinner, 2011).

Korda and Eldridge (2011) further reported in an effort to “bend the cost curve” the ACA opened the door towards monumental changes in healthcare organization, delivery, and financing. The ACA offers a plethora of financial and other incentives for patients, providers, and health plans. The ultimate goal is to move forward with value-based healthcare through
improved health outcomes via quality care that is accessible, affordable, and which impedes cost escalation. As healthcare costs are rising towards 18% of the GDP, value-based approaches are developing as a popular alternative to price regulation. But this has sparked a stout opposition from providers over concerns about access and which have mitigated cost reduction efforts (McClellan, 2011).

Crosson (2009) additionally reported some of the inefficiencies of the U.S. healthcare delivery system originate from the development and growth of expensive medical technologies and fee-for-service payment of physicians. This is problematic because although physicians provide patient care based on scientific evidence, financial incentives can influence their treatment plan. The transition from fee-for-service with a capitated payment system has been proposed as one approach to improve the efficiency of healthcare delivery. But, changing the physician payment structure alone cannot lead to the desired goal of cost reduction. Enthoven (2009) further purported physician practices need to be reorganized and integrated across multispecialty groups and hospitals in order to be receptive to new forms of payment reforms. Thereby, healthcare reform efforts need to target the redesign of integrated systems of care.

Maeda, Lee, and Horberg (2014) found that due to rising healthcare costs and broad variations in healthcare quality, the U.S. healthcare system is presently experiencing rapid changes in payment reform towards an integrated delivery system. An established integrated delivery system can work to identify the factors that result in outstanding patient outcomes in response to policymakers’ concerns over the U.S. healthcare system trends of escalating costs and decreasing quality. According to Enthoven (2009), integrated delivery systems are a model of healthcare that encompass an organized, coordinated, and collaborative network that unites
physicians to deliver a continuum of services to a specified patient population. These systems are clinically and fiscally accountable for the health status and outcomes for the population served, and are responsible to have systems in place to manage and to improve clinical outcomes.

Korda and Eldridge (2011) further reported that payment methods and incentives are critical components of the integrated delivery models under the ACA. This includes patient-centered medical homes (PCMHs) and accountable care organizations (ACOs), who rely on interdisciplinary provider teams to provide coordinated healthcare services. The PCMH model takes the delivery of care from population health to the individual, and provides each patient with a primary care physician (PCP) who leads an interdisciplinary team to promote efficient care across multiple services.

Grumbach and Grundy (2010) also reported the PCMH model has been implemented in diverse environments and has proven successful in improving quality, improving patient and provider satisfaction, and has been effective in decreasing healthcare costs. Furthermore, Berwick (2011) reported ACO’s are voluntary teams of physicians, hospitals, and other healthcare providers that accept responsibility for the care of a clearly defined population of Medicare beneficiaries which are assigned to them based on a patient’s access of primary care services. If an ACO is successful in delivering high quality healthcare, while simultaneously lowering costs, physicians and hospitals will share in the savings reimbursed from Medicare.

Guterman and Blake (2010) further reported the ACA promotes payment incentives which drive integrated care delivery, including contingencies for shared savings when physician provider groups and organizations (e.g., hospitals) achieve ACO quality and cost targets. These ACA incentives are expected to be vital levers to advance the agenda of integrated care delivery,
while encouraging healthcare providers to collaborate towards increasing responsibility for providing higher quality at a lower cost, as well as rewarding accountability for meeting these quality goals.

In order to achieve value from integrated approaches like the PMCH and ACO models, healthcare reimbursement is shifting from a fee-for-service model to bundling, pay-for-performance (P4P), and gain sharing methods that reward quality care. This is important as Hussey, Ridgely, and Rosenthal (2011) found that the fee-for-service payment model in which single services (e.g., pharmaceuticals, laboratory, x-rays) are reimbursed are to blame for many of the cost problems within the current U.S. healthcare system. Moreover, bundling provides a payment for the entire scope of care a patient requires over the course of a clinical episode or period of management. However, pay for performance arrangements give providers incentives to improve performance by rewarding them for achieving established objectives such as appropriate levels of service. Furthermore, gain sharing arrangements issue bonus payments to physicians and other providers to reward their efforts to deliver clinically appropriate care at significantly lower cost by being efficient in their clinical choices for ordering procedures, supplies, and devices that comprise a large portion of inpatient care costs.

Last, Martin, Lassman, Washington, Catlin, and the National Expenditure Accounts Team (2012) reported U.S. healthcare spending grew more slowly in 2009 (3.8%) and 2010 (3.9%), than in any other years in the 51-year history of the National Health Expenditure Accounts. Much of this is attributed to the recession where many Americans who lost their health insurance exhibited lower median household incomes, and financial uncertainty. As a result, the health spending share of the GDP stabilized at 17.9%. Additionally, Cutler and Sahni
(2013) also confirmed the rate of healthcare spending has slowed in the past four years, which is consistent with the trend that started on the early 2000s. If these trends continue from 2013-2022, public sector healthcare spending could be reduced by $770 billion less than predicted. The ultimate question that remains to be determined is: how much of this cost slowing is attributed to the ACA and did it increase the quality of care for Americans?

*Impact of VBP on U.S. Hospitals*

Although the ACA was enacted into law in 2010, VBP has actually been in development for many years. For example, Maio, Goldfarb, Carter, and Nash (2003) reported an abundance of roundtables, conferences, meetings, and discussions were organized in the U.S. in the past 10 years in an effort to keep healthcare purchasers updated on new payment models and tools. These efforts were primarily concerned with improving health plans and provider (e.g., physician) performance, combined with the sharing of data, and establishing areas of collaboration among healthcare purchasers (e.g., hospitals). For example, federal entities, such as the Agency for Healthcare Research and Quality, and not-for-profit companies, such as the Foundation for Accountability, and various other organizations like the Business Coalition on Health, have been instrumental in advancing healthcare purchasers’ attention towards VBP.

The following three federal legislations were instrumental in laying the groundwork for the development of the VBP program: (1) Medicare Modernization Act (MMA, 42 USC § 1305 et. seq.) of 2003 (2012); (2) Deficit Reduction Act (DRA, 42 U.S.C. § 1305 et. seq.) of 2005 (2012); and (3) the Medicare Improvements for Patients and Providers Act (MIPPA, 42 U.S.C. § 1305 et seq.) of 2008 (2012). The MMA (P.L. 108-173) was established as a direct result of the U.S. Congress challenging the Institute of Medicine (IOM) to pinpoint and focus on options
which will align hospital performance to payment for Medicare beneficiaries. Furthermore, the
DRA (P.L. 109-171) mandated the Department of Health and Human Services (HHS) to create a
plan to execute a VBP program for Medicare payment for subsection (d) for hospitals, and
commencing with fiscal year 2009. Last, the MIPPA (P.L. 110-275) required HHS to develop a
VBP transition plan for hospital providers that were eligible for Medicare payments. HHS
submitted a report to the U.S. Congress in December 2008, outlining a draft transition plan for
the Medicare VBP program that impacted physicians and other professional services. (Keckley,
Coughlin, & Gupta, 2011).

In 2011, CMS released its VBP Final Rule, required under the ACA, and applied under
Medicare’s Inpatient Prospective Payment System (IPPS). Multiple authors have reported VBP
might be transformational for healthcare and is driven by the National Quality Strategy of the
U.S. Department of Health and Human Services who widely describes the quality outcomes that
CMS desires to obtain through the healthcare it buys on behalf of its beneficiaries (Eldridge &
Korda, 2011; Jordan, Van Lare & Conway, 2012). The strategic goals of improved health,
increased quality of care, and cost containment perfectly describe CMS’s vision of value-
 improved outcomes for individuals and the U.S. population at a more affordable cost. The VBP
program incentivizes acute care hospitals who consistently deliver improved quality outcomes in
healthcare for Medicare beneficiaries in the communities they service at lower costs.

The Federal Register reported on Friday, May 6, 2011, the agency for the Department of
Health and Human Services, as a component of CMS, issued a final rule which implemented a
Hospital Inpatient Value-Based-Purchasing program under section 1886(o) of the Social Security
Act. VBP is also referred to as U.S. code 42 CFR, parts 422 and 480. According to the Federal
Register, VBP mandates which value-based payments will be made in a fiscal year to hospitals that meet performance standards with respect to a performance period for the fiscal year involved. The VPB program will apply to payments for hospital discharges occurring on or after October 1, 2012, in accordance with 1886(o), as added by section 3001(a) of the ACA.

Blumenthal and Jena (2013) reported the foundation of VBP and reimbursement for U.S. hospitals center around two domains utilized to measure performance improvement. The first domain includes the patient experience of care or the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) which is the first national, standardized, publicly reported survey of patients’ perspectives of hospital care. The HCAHPS survey is a 27-item instrument and data collection methodology that measures patients’ perceptions of their hospital experience. HCAHPS includes the enclosed eight VBP measures: nursing communication, physician communication, responses from staff, pain management, communication of medications, discharge information, cleanliness and quietness of hospital environment, and an overall rating. Since 2008, HCAHPS has allowed a valid comparison to be made across U.S. hospitals locally, regionally, and nationally (www.hcahpsonline.org/facts). Additionally, the second domain is referred to as core measures and relates directly to how well hospitals perform in 12 clinical processes of care in the following five core measures: acute myocardial infarction (e.g., heart attack), heart failure, pneumonia, healthcare-associated infections, and surgical care improvement. CMS determines all participating hospital reimbursements by weighting the HCAHPS score at 30% and core measures at 70%.

Additionally, Mullins and Pines (2014) reported there continues be an increased focus on quality measures and improvement in U.S. hospitals. CMS and non-governmental agencies, such
as the National Quality Forum have promoted quality measures, with the goal of improving the care provided to Medicare patients. For example, Medicare healthcare beneficiaries are able to obtain a summary of the quality of hospitals in their region and nationally by reviewing the hospital compare data in the following aspects of healthcare including: general information, patient satisfaction, timely and effective care, complication rates, hospital readmission rates and deaths, utilization of imaging services, and payment and value of care.

General information includes the name, address, telephone number, and the type of hospital. Patient satisfaction data includes how recently discharged Medicare patients responded to a national survey about their hospital visit. One of the sample questions was how well did hospital doctors and nurses communicate with patients and manage their pain? A category of timely and effective care includes how often and quickly each hospital provides recommended treatments for certain conditions like heart attack, heart failure, pneumonia, children’s asthma, stroke, influenza, blood clots, and follows best practices to prevent surgical complications.

Additionally, the complication category included how likely patients will suffer from adverse events while in the hospital or after undergoing some type of inpatient surgery. Next, the readmission rates and death rate category included how well a particular hospital compared to national standards. The use of medical imaging includes the utilization rates for the high end imaging modalities of cat scan (CT) and magnetic resonance imaging (MRI). Lastly, payment and value of care reflected how each hospital’s payment for heart attack, heart failure, and pneumonia compared to the national average payment for each condition as well as the Medicare spending per beneficiary.
U.S. hospital leadership now have extra incentive to improve the quality of care and the perception of the care they provide on behalf of their Medicare patients due to the impact the VBP program can have on their bottom line. For example, since October 1, 2012, one percent of hospital Medicare payments have been held back in order for bonuses to be awarded by CMS based on meeting quality outcomes and patient satisfaction measures. In order to be eligible for Medicare reimbursement as part of VBP, hospitals needs to be enrolled within the inpatient prospective payment system (IPPS), which means they receive Medicare IPPS payment per discharge for Medicare enrollees with inpatient visits. IPPS is spelled out in section 1886 (d) of the Social Security Act and outlines a system of payments for the operating costs of acute care hospital inpatient stays under Medicare Part A (e.g., hospital insurance) based on prospectively set rates. Under the IPPS system, each case is categorized into a diagnosis related group (DRG) where each one has a payment rate associated with it which is based on the average resources used to treat Medicare patients in that DRG (www.cms.gov). The U.S. Congress and CMS are confident that this pay for performance program, which the ACA refers to as “value-based purchasing (VBP), will improve the quality of healthcare for Americans. The timing could not have been better as the Institute for Medicine (2012) estimated that 100,000 patients die every year due to medical mishaps in U.S. hospitals. However, there are many skeptics of the ACA and VBP in terms of will it actually improve the quality of care delivered to Americans (Kavanaugh, Cimiotti, Abusalem, & Coty, 2012; Weissert & Frederick, 2013).

The ACA affects U.S. hospitals in a plethora of ways and continues to challenge hospital leadership to effectively navigate the intricacies of the legislation in order to remain solvent in a very competitive healthcare market. Koepka (2012) reported the hospital business in general
does not produce large profits as evidenced that even in positive economic times, 20-30% of hospitals lose money in any specified quarter. For example, in the third quarter of 2008, the amount of hospitals with total negative margins peaked at about 55%. In spite of many hospitals recovering financially by the second quarter of 2009, the proportion losing money leaped again in the second quarter of 2010, and the third quarter of 2011. The drawback of these economic numbers is hospital leadership may be forced to reduce services or go out of business entirely.

Multiple authors have also found that along the very difficult road to both the passing and implementation of the ACA, January 1, 2014, stands out as a landmark date in terms of the health of U.S. citizens going forward (McDonough & Adashi, 2014; Wright, Damiano, & Bentler, 2014). This is because the 4 major provisions took effect: the extension of the “guaranteed issue” provision to all individual health policies inclusive of removing medical underwriting due to pre-existing conditions; implementation of the shared responsibility referred to as the “individual mandate”; a provision of tax credits and subsidies to lower and middle income adults that incentivize them towards the purchase of individual health insurance, and the expansion of Medicaid coverage in participating states that previously excluded low-income adults. However, many U.S. citizens and healthcare professionals may not understand the overwhelming nature of these provisions largely because of the multitude of issues related to the HealthCare.gov website where millions of Americans struggled to sign up for health insurance, and the cancellation of personal health insurance policies from several payers.

Prior to January 1, 2014, there were only six states that mandated health insurance companies to adopt the “guarantee issue” or the issuance of personal health insurance to all Americans even if pre-existing medical conditions were present. As of January 1, 2014, all 50
states and the District of Columbia are now in compliance. A positive by-product of the ACA legislation is the devious practice of “selective underwriting”-the rating of personal health insurance policies based on medical history or socioeconomic status is now an illegal practice. This new legislation is projected to affect approximately five percent of U.S. residents or 15 million under the age of 65 who currently buy health insurance by way of the individual market and those citizens who enter the market for the first time through new federal and state health insurance exchanges. The good news for U.S. is for the first time individual healthcare policies will include 10 categories of “minimum essential benefits” which are now covered services and include: ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health services, prescription drugs, rehabilitative services, laboratory services, preventive and wellness services, and pediatric services. Additionally, the ability of insurance companies to impose lifetime limits on health insurance policies are not allowed (McClelland et al., 2014; McDonough & Adashi, 2014; Planning, 2014).

What remains clear is the provisions of the ACA are confusing to many stakeholders including hospitals, physicians, non-physician healthcare providers, and U.S. citizens alike. The ACA also requires that by January 1, 2014, most U.S. citizens to purchase a qualifying health insurance plan or be subject to a tax penalty. Some of these misconceptions are embedded within the “individual mandate” provision of the ACA, which in effect does not actually mandate an American citizen to purchase individual health insurance. The provision instead levies a tax penalty ($95 or 1% of household income in 2014, increasing to $695 or 3% in 2016) for those Americans who can afford healthcare coverage but elect not to. Kamiat (2012) reported the individual statute is referred to as ACA 1501, 26 U.S.C., 5000A (Supp. IV 2010). The individual
mandate has proven to be one of the most controversial provisions of the ACA and the focus of multiple unsuccessful legal challenges in terms of its constitutionality. A good example of this was the U.S. Supreme Court’s decision to upheld this provision in 2012 by a narrow five to four vote (Gostin, 2012; McDonough & Adashi, 2014).

Today, the implementation of the ACA is having a significant effect on expanding the Medicaid population in the U.S. and which will have a large impact on hospital emergency departments. McClelland et al., (2014) reported that hospital-based emergency departments (ED) are referenced in the ACA as environments to avoid and with a specific focus on the reduction of these visits. This is because the E.D. has become the providers of low acuity care largely due to the enactment of the Emergency Medical Treatment and Active Labor Act (EMTALA) legislation passed in 1986, which is part of section 1867 of the Social Security Act (SSA), which require a hospital to treat all patients regardless of their ability to pay. Hospital-based EDs to a large degree have replaced the primary care physician’s office as the chief source for hospital admissions and providing a safety net for an uninsured population in the U.S. Furthermore, the ACA does not provide any provisions for new payment models that focus on ED care or plans to account for ED specific quality through new measurement initiatives.

As expanding populations in the U.S. gain access to health insurance through the ACA, ED volumes will increase proportionately. Ginde, Lowe, and Wiler (2012) reported that a National Health Interview Study found ED utilization rates were higher among the newly insured as compared to those individuals who have been continuously insured. This is because many uninsured patients do not have a primary care physician directing their care and which is much more efficient versus accessing the U.S. healthcare system via the local emergency room. As a
result, hospitals need to be prepared for this increase in patient volume because one of the largest
group of Americans that will gain access to health insurance coverage because of the ACA
legislation are newly eligible Medicaid beneficiaries.

Taubman, Allen, Wright, Baicker, and Finkelstein (2014) further reported that an analysis
of Oregon’s Medicaid expansion revealed a 40% increase in ED utilization versus those
Americans who were uninsured. Unfortunately, many U.S. hospitals are not equipped to handle
this projected increase in volume and will lead to overcrowding and delays in treatment for many
patients. However, multiple authors have reported a growing number of hospitals are combating
overcrowding and increased wait times by implementing new patient workflow processes in the
ED and which has increased hospital efficiency (Liu, Hamedani, Brown, Asplin, & Camargo,
2013; McClelland et al., 2011; Viccellio et al., 2013).

As the ACA drives an increase in patients towards the EDs in many states because of the
increase in insurance expansion, it will be imperative for hospital leadership to implement
strategies that will reduce overcrowding, increased wait times, and delays in treatment for urgent
patients. Also, continuing scrutiny will be assigned to hospitals in an effort to reduce
overcrowding through public reporting of ED turn-around-time (TAT) measures and inclusion of
ED metrics, such as patient satisfaction survey information and inpatient hospital reimbursement
calculations (McClelland et al., 2014).

Leadership Processes

Stogdill (1974) reported there are more definitions of leadership as those individuals
who have attempted to define it. For many people it is similar to the common vocabulary words
of democracy, love, and peace. Although we may understand the meaning of these words, they
can exhibit different interpretations for various people. For the purposes of this research study, leadership will be defined as, “a process whereby an individual influences a group of individuals to achieve a common goal” (Northouse, 2010, p.3). Furthermore, leadership from a process perspective suggests that leadership is a phenomenon that exists in the context somewhere between the leader and follower and can be available for all (Jago, 1982).

Great Man Theory (GMT) is a source of which much of the leadership literature derives (Bass, 1990; Burns, 1978). Northouse (2010) further reported GMT is considered to derive from trait theory where leaders possessed innate qualities and characteristics possessed by famous social, political, and military leaders (e.g., Joan of Arc, Napoleon Bonaparte, Abraham Lincoln). Mann (1959) additionally examined 1400 findings regarding personality and leadership in small groups, but de-emphasized how the situation influenced leadership. Mann proposed that personality traits could be utilized to distinguish between leaders and non-leaders. The results of Mann’s study identified leaders as very powerful in the enclosed six traits: intelligence, masculinity, adjustment, dominance, extraversion, and conservatism.

Katz (1955) identified the importance of different types of management skill (e.g., technical, human, conceptual) as necessary components of providing leadership at various levels within an organization. Technical skill is having knowledge and competency in a specific type of work (e.g., pedagogy) or activity. Technical skills are most important at the lower and middle management level and is less important for senior leaders. A good example would be the senior leadership team at the community hospital who routinely rely on skilled directors to navigate the technical issues of the physical operation. Furthermore, human skill is possessing knowledge about the ability to work with people. Human skills are often referred to as “people skills” which
are the abilities that assist senior leadership to work effectively with both lower and middle levels of management to assist with accomplishing organizational goals. Last, conceptual skills consist of the ability to work with complex ideas and concepts. Conceptual skills are central to developing a vision and a strategic plan for the organization and is most important for senior leaders. For example, when senior leaders do not possess strong conceptual skills, it can jeopardize the entire organization. This might be the case for those who do not navigate the policy provisions of the VBP program effectively as it relates to how it affects hospital operations.

Furthermore, the historical development of distributive leadership dates back to the 1940s and 1950s. Gronn (2008) attested that the originator of the actual term distributed leadership was C. A. Gibb (1954), who discussed this principle in a chapter on leadership in the “Handbook of Social Psychology”. Ironically, Gibb shared his own skepticism of this theory because in the course of group planning, leadership usually changes from one individual to another as a situation shifts.

Gronn (2008) further reported that Benne and Sheats (1948) should also be credited with touching faintly on the possibility of a type of shared leadership because they renounced explicit distinctions between the leader and member responsibilities. This virgin concept of distributed leadership emphasized there was a multilaterally shared responsibility involved in the problem solving process. A number of scholars further describe distributed leadership in terms of leadership practice in lieu of the traditional approach of viewing leaders in their routine roles, functions, structures, and duties (Spillane, 2005; Gronn, 2002). Spillane (2005) further defined leadership practice as a result of the interactions of leaders, followers, and their circumstances.
Lastly, multiple authors also question how leadership distributes itself across time and task, the situation, people, and technology (Connaughton & Daly, 2005; Sinclair, 2005).

Furthermore, shared leadership is exhibited when two or more members participate in the leadership of the team with the goal to influence and direct other members to improve the effectiveness of the team (Carson, Tesluk, & Marrone, 2007; Pearce, 2004). Other scholars found that shared leadership also involves an influence process that is dynamic, simultaneous, continuous, and multidirectional (Friedrich, Vessey, Schuelke, Ruark & Mumford, 2009). Bergman, Rentsch, Small, Davenport, and Bergman (2012) additionally studied the process of shared leadership in 45 decision-making teams. The results revealed the probability of a team demonstrating a wide range of leadership behavior increased proportionately to the extent to which multiple team members shared leadership. Decision making teams with shared leadership produced less disputes, increased agreement, and higher trust than teams without shared leadership. Ultimately, the study points out that shared leadership adds to team functioning.

Furthermore, many hospital leadership teams utilize the Plan-Do-Check-Act (PDCA) design to evaluate the effectiveness of executive leadership processes relating to patient outcomes. A consensus among the executive leadership team interviews at the community hospital during the period of May-June, 2016, found that PDCA is utilized as the primary performance improvement measurement model. The PDCA design was first developed by Walter Shewhart and Edward Deming (Best & Neuhauser, 2006). The PDCA design is often referred to as the Deming circle/cycle/wheel, Shewart cycle, or plan-do-study-act (PDSA). The PDCA cycle is a performance improvement tool that helps measure quality indicators and accounts for reevaluations of its components. Furthermore, PDCA is an ideal model for a
community hospital context because it encourages feedback throughout the change process and offers executive leadership teams a blueprint in order to achieve an improvement in patient outcomes (Gill, Leyland, & Reid, 2005).

The focus on quality outcomes in hospitals continues to dominate the news in the healthcare industry. However, several scholars found that although some progress has been achieved in this arena, implementing sustainable clinical best practices has been difficult to realize (Hughes, 2008; Talsma, McLaughlin, Bathish, Sirihorachai, & Kuttner, 2014). Although the PDCA methodology has proven successful in other disciplines (e.g., education, government), it has also been applied to healthcare, with often notable achievements. For example, Randhawa, Roberts-Turner, Woronick, and Duval (2011) reported utilizing the PDCA methodology at a pediatric hospital decreased the rate of cardiac arrest by 31%.

Randhawa et al. (2011) also found the plan-do-check-act (PDCA) methodology can be utilized at the unit and organizational level to produce evidence-based changes in the performance improvement process. Gupta (2006) defined the individual components of the PDCA cycle where the plan step focuses on what areas are in need of improvement. The do step includes the implementation of change identified in the plan phase. Check includes the examination of what was discovered and what did not work well. Act is the step that determines the cost/benefit of moving forward with the current change process. Once a complete cycle of PDCA change has concluded, the process is evaluated and leads to another cycle commencing. PDCA creates a culture where a focused, well strategized process can be used for assessment and ongoing improvement (Dlugacz, Restifo, & Greenwood, 2004).
Wageman, Nunes, Burruss, and Hackman (2008) additionally reported on the fall of the heroic chief executive officer (CEO) or GMT and the rise of the leadership team. Senior leadership teams are not only a sensible means of giving excellent organizational leadership, they are also increasingly vital as the complexity and demands far outweigh the capacity of any individual CEO. The core principle of team leadership is that very few CEO’s can make a leadership team great. However, what the CEO can do is implement certain conditions that will increase the likelihood that a group of senior executives can develop into an outstanding senior leadership team. As a result, there are a growing number of chief executives who are creating teams to assist with leading their organizations. Ultimately, the CEO can draw upon the organizations human capital, which is a rich pool of knowledge, skills, and abilities associated with formal leadership roles and functions. The acquired capabilities from these accomplished senior leaders can assist in making key strategic decisions and is a main reason why organizations protect their human capital (Coleman, 1988; Lepak & Snell, 1999).

Day (2001) also found that leadership development is focused on building a capacity in anticipation of unforeseen challenges within the organization. Leadership development is defined as increasing the collective capacity of organizational members in which to participate in leadership roles and processes (McCauley & Douglas, 1998). Leadership roles exhibit both with and without formal authority, while management development focuses on performance in formal managerial roles. Keys and Wolfe (1998) further defined leadership processes as those that assist groups in working together in purposeful ways toward the pursuit of common goals.

Wageman et al. (2008) further reported there are six processes that foster the effectiveness of senior leadership teams: three essential conditions, which are the building blocks
for team performance; and three enabling conditions, which provide direction towards success
and accelerate the team’s momentum towards the direction. Senior executives form the essential
conditions by creating a real team and not one that is a team in name only; issue the team a clear
and captivating purpose; and supplying the team with participants who demonstrate the
knowledge, skills, and experience required for the team to be successful. The enabling conditions
include ensuring a solid team structure by having the right amount of participants, well designed
tasks, and develop norms of conduct; providing a supportive organizational context by issuing
the right amount of resources needed for the team to perform its work; and include competent
coaching by members of the senior leadership team as well as coaching themselves –to evolve,
learn, and grow.

Hill (2010) found that leadership in organizational groups or work teams is a rapidly
growing area of leadership theory and research. Teams are comprised of organizational groups
and members who are interdependent, share common interests, and coordinate their pursuits in
an effort to accomplish a set of established goals. A few examples of these groups include
project management teams, long-range planning teams, task forces, work units, and quality
improvement teams. Hill developed a team leadership model which is based on the claim that a
leader’s role is to monitor the team and act accordingly to increase team effectiveness. The
model provides a tool or mental road map for helping leaders to understand the complex realm of
team leadership, beginning at the top with opening leadership decisions (e.g., monitor or take
action, task or relational, internal or external), while next moving to leadership actions (e.g.,
task-goal focusing, relational-coaching, environmental-networking); and lastly focusing on the
measurements of team effectiveness (e.g., performance, development). Furthermore, the goal of
the team leadership model is to provide specific actions that leaders can install to improve team effectiveness (LaFasto & Larson, 2001; Zaccaro, Rittman & Marks, 2001).

Furthermore, Abraham Lincoln, the 16th president, wrote the following in a letter to the U.S. Congress on December 1, 1862, one month prior to the emancipation proclamation vote, “The dogmas of the quiet past are inadequate to the stormy present. The occasion is piled high with difficulty, so we must rise with the occasion. So our case is new, we must think anew, and act anew” (Durbin, 2006, p.4). This excerpt is an important reminder for leaders across all disciplines to possess the tools that can lead to effective decision making within their organizations. This is especially important with the complexities that executive leaders face in the current healthcare environment.

Bolman and Deal’s (2008) four frames (e.g., structural, human resources, political, and symbolic) can provide leaders with the ability to reframe or think about situations from a variety of perspectives. Although the four frames have not been endorsed in the literature as a valid and reliable instrument, it does provide leaders with problem solving tools that will help understand complex situations and consider a variety of options and choices. The four frames are important because they can help leaders from misinterpreting, misusing information that can lead to a misdiagnosis of major problems within the organization (Covey, 2004). A misdiagnosis can directly lead directly to “cluelessness” which is self-destructive behavior that ultimately can lead to the demise of the organization.

A good example of cluelessness within an organization was the Kodak Company that was an industry leader in the radiology profession in the 1990s and produced high quality x-ray film. What the executive leaders at Kodak failed to take into account was the shift in the imaging
profession from film to digital images (e.g., computerized). The senior leaders at Kodak failed to recognize and forecast that the digital age in radiology was the future. Kodak continued producing film while many hospitals and imaging centers were converting to digital imaging technology (e.g., Computed Radiography-CR) which did not require the use of x-ray film. Ironically, Kodak held the original patent for CR radiology technology (Rowlands, 2002). To this day, Kodak remains a very small player in the digital radiology market because they sold their CR patent to FUJI who then took full advantage of this huge misjudgment from senior leaders at Kodak.

The structure of the organization is enhanced by increasing efficiency and performance through specialization and a clear division of labor (Taylor, 1911; Weber & Mills, 1946). When the leader establishes clear, well understood goals and effective coordination it improves organizational performance. Also, the relationship between the individual and organization can also improve by offering job security (e.g., good pay, benefits, and promotions). Many scholars also agree on the importance of the individual worker in terms of their energy, talent, skills are important to the organization which can lead the employee to produce more satisfying and meaningful work (Argyris & Schon, 1974; Follett, 1924).

Leaders also need to avoid what Follett (1924) referred to as “bossism” which is another term for micromanagement. Most employees within organizations typically will not function well under this type of leadership approach where they do not possess any autonomy. Leaders also need to recognize that organizations are coalitions whose members have differing beliefs, values and important decisions involve the allocation of scarce resources (e.g., money, staffing) and goals are developed through negotiation among stakeholders. Leaders also have to
understand that power is not negative, but allows for competing groups to express their needs and work to get what they want. Multiple theorists define power as the capacity or potential to influence others (French & Raven, 1959; Northouse, 2010).

According to Bolman and Deal (2008), leaders can improve the culture of the organization through uniting people around shared beliefs and values which sets up the organization for the types of change necessary for long term solvency. Enhancing teamwork is the goal of the leader in the symbolic frame. In other words, to help members find their peace, be a role model, use stories to reinforce group identity, encourage creativity through humor, play, and lift the spirit of the group. The challenge to leaders is to create faith and meaning while inspiring followers to be innovative and productive.

Organizational change is one factor that is constant whether you work in education, healthcare, food industry, retail, or any other field. Burke (2011) reported that most organizational change is unplanned, gradual, and evolutionary. The following are salient skills and dispositions that are integral to leadership promoting change within any organization as outlined in the Burke-Litwin (1992) model: motivation, vision, presentation skills, competence, humility, confidence, charisma, and management skills. The Burke-Litwin model promotes an open systems approach to thinking about leadership and change where the external environment serves as the input factor and the individual/organizational performance is depicted in the output dimension. The model was originally developed as a consequence of trying to understand how to bring about revolutionary change at British Airways in the mid 1980s. What remains clear is leadership needs to possess a set of skills and dispositions that are necessary in order to bring change as evidenced at British Airways or any other organization.
Whetten’s (1989) complete theory is important for leaders across all disciplines because it outlines that an effective organizational theory should consist of the following: what (i.e. constructs), how (i.e. linkages), why (i.e. conceptual assumptions), and the combination of who/where/when. The first element of “what” consists of factors that need to be rationally considered in the change process including: strategy, culture, and performance. The second element refers to “how” the factors in “what” (i.e. strategy, culture, performance) relate to one another. The third element relates to the conceptual assumptions or the logic behind the theory or model which include: fundamental views of human nature, organizational requisites, or societal processes. Last, the fourth element evaluates the range of the theory which includes temporal/contextual influences that determine the conditions in order to generalize.

Lewin (1947) reported that organizations need to follow a 3-step process in order to be successful in the change process: unfreezing, moving, and re-freezing. The first step in the change process includes the organization un-freezing the current level of behavior. A good example in a community hospital setting would include un-freezing the employee behavior of not placing patient safety as their number one priority. The actual un-freezing would be educating community hospital employees that other competing hospitals are providing safer quality healthcare services based on outcomes published by transparent government patient satisfaction surveys (i.e. HCAHPS). The second step would be moving the community hospital employees toward the goal of always providing the safest healthcare services possible on behalf of all patients, physicians and the community. This process might include providing hospital management with the tools they need to monitor and hold employees accountable for the new focus on patient safety or installing new best practices (i.e. bar code scanning of medications)
that will facilitate a patient safety culture among all employees. The re-freezing step provides customary methods to ensure the new employee behavior at the community hospital is insulated against changing back to the previous mode of not focusing on patient safety as their number one priority while providing care to their patients.

Kotter (1995) reported on the success and failure of change efforts across a spectrum of businesses and found that successful change initiatives go through a series of phases that typically take a considerable length of time. Also, bypassing certain phases of the change process creates the illusion of speed and will lead to making critical errors that can produce a catastrophic impact on the organization. The series of eight phase initiatives include: establishing a sense of urgency, form a powerful guiding coalition, create a vision, communicate the vision, empower others to act on the vision, plan for creating short-term wins, consolidate improvements and sustain the momentum for change, and institutionalize the new approaches.

Establishing a sense of urgency usually starts with leadership or other stakeholders noticing a vulnerability within the organization. A good example for the community hospital would be the threat of the VBP program and how poor performance could lead to a decrease in reimbursement and a loss of access to Medicare patients. Also, forming a powerful guiding coalition focuses on change efforts that start with just one or two people, and should grow continually to include more who believe that organizational changes are necessary. This initial group should hold a powerful role within the organization and include between three to five members leading the change effort. A successful transformation relies on snap shot of the future that is relatively easy to communicate and appeals to customers, stakeholders, and employees. A vision helps clarify the direction in which the organization need move. Next, the leadership team
needs to utilize every existing communication channel available to publish the vision (Kotter, 1995).

Empowering others to act on the vision includes allowing members in the organization to make changes in their work areas and allocating a budget toward these change efforts. In short, remove any obstacles there may be to getting on with the change. Furthermore, since real transformation takes time and includes disappointment, leaders need to actively plan and achieve some short-term gains which members will be able to celebrate. This provides proof to the members that their efforts are working and increases their motivation to keep the change effort moving forward. Leaders also need to avoid the declaration of victory too soon. Until changes are deeply sunk into the organization culture new approaches are fragile and subject to regression. Finally, lasting change occurs when it becomes “this is the way we do things around here” (Kotter, 1995).

In conclusion, Longest (2012) found that hospitals in the U.S. are greatly impacted by public policies (e.g., VBP) that affect their operations as evidenced by Medicare and Medicaid initiatives accounting for greater than 50% of the revenue in more than 5000 U.S. community hospitals. Strategic decisions in hospitals are in the purview of senior executives and governing board members who are tasked with establishing the mission of the organization, including markets and product service lines. Strategic decisions reflect what leaders desire to have their hospitals attain and how they want to accomplish it while taking into consideration the external environment. If leaders do not effectively assess their publicly policy environments it can lead to poor strategic decision making and which can be detrimental to hospital operations. This is why
it is important to create more understanding of leadership processes and theories that might point executive healthcare leaders towards effective decision making within a hospital context.
Chapter Three:
Methodology

This qualitative case study examined the perceived effectiveness of executive leadership team response at a community hospital in the Southeastern U.S. in relation to the Value-Based Purchasing (VBP) requirements of the Affordable Care Act (ACA) of 2010, through conducting a document analysis, a review of a repository database (http://www.medicare.gov/hospitalcompare/) for service quality, patient satisfaction, and governmental reimbursement; and structured interviews. A fundamental part of the study was to examine the executive leadership team process as they relate to the VBP policy provisions utilizing Hill’s (2010) team leadership theory. The purpose was to determine what were the executive leadership team processes in terms of leadership decisions, internal leadership actions-task vs relational, external leadership actions-environmental, and ultimately assess to what extent it impacted perceived team effectiveness. The plan-do-check-act (PDCA) performance improvement model was also applied to outline the steps the executive leadership team implemented in attempting to improve service quality levels on behalf of Medicare patients. Additionally, the collection of data from the analysis of documents including policies/procedures, board meeting minutes, memoranda, newsletters; and a repository database, provided further insight into the how the VBP policy provisions affected the community hospital in terms of quality, patient satisfaction (HCAHPS), and Medicare reimbursement. Lastly, the executive leadership team at the community hospital were interviewed in an effort to gain more understanding of what were the main strategic objectives considered as it related to VBP, what
obstacles did they encounter, and ultimately determine whether or not they accomplished their goals.

A thorough review of the literature demonstrated that prior to this current study, no scholar had examined the executive leadership team processes at a community hospital and evaluated their perceived effectiveness in terms of governmental reimbursement for both components of the VBP program relating to quality (e.g., core measures) and patient satisfaction (HCAHPS) scores. This researcher believes that effective senior executive leadership team processes can be critical towards implementing important organizational change that can impact service quality levels for Medicare patients. Hospital leaders at the top levels also possess a responsibility to conduct ethical decision making on behalf of their physicians and patients because hospitals are a vital component of any community because of the special mission of providing routine and urgent healthcare services to the Medicare patients in which they serve. This study was guided toward analyzing several of these senior executive change agents.

The purpose of this research study was to gain a deeper understanding of how the policy provisions of the VBP program, as part of the ACA, specifically impacted the executive leadership team at a community hospital in the southeastern U.S. The objective was to collect and report in-depth, thick descriptions of the executive leadership team processes, how they matured, and determine if they were perceived as effective or not in terms of improving service levels on behalf of Medicare patients. The research question outlined in Chapter One is again presented below:
Research Question

1. What was the perceived effectiveness of the executive leadership team process at an acute care, not-for-profit, community hospital in the Southeastern U.S., as they relate to the Value-Based Purchasing (VBP) policy provisions of the Affordable Care Act (ACA)?

Research Design

For the purposes of this case study, a qualitative design methodology was selected in an effort to provide the answer to the research question. The qualitative data provides the best paradigm in order to investigate the research question because it is a naturalistic design, is descriptive in nature, is inductive (e.g., generates a hypotheses), the researcher is the instrument (e.g., tool), trustworthiness depends on the skill and competence of the researcher, involves the collection of extensive data, and includes discovering/exploring concepts and extrapolations (Roberts, 2010). The appropriateness of the qualitative design for this study was further justified because the researcher met the following purposes for doing qualitative research: the conviction of the researcher was based on experience, the nature of the research problem, to uncover and understand what lies behind any phenomenon about which little is known, to gain novel and fresh slants on things about which quite a bit already is known, and to provide intricate details of phenomena that are difficult to convey with quantitative research methods (Strauss & Corbin, 1990).

This qualitative case study relating to the policy provisions of VBP was orchestrated in two distinct steps. The first phase consisted of performing an analysis of community hospital documents with the goal of uncovering rich, thick, descriptive data that provided the researcher more understanding of what were the leadership processes the senior leadership team
implemented as it relates to the impact of VBP on hospital operations. Next, an analysis of a repository database (http://www.medicare.gov/hospitalcompare/) was conducted in an effort to determine how this community hospital compared to other acute care, community hospitals in terms of reimbursements for the quality of care (e.g., core measures) and patient satisfaction (HCAHPS) for Medicare patients.

The second phase of the study included eight interviews with key senior leadership personnel at the community hospital comprising of both administrative and physician personnel. The interviews were constructed to increase insight into what were the leadership processes the senior leadership team considered and ultimately implemented that would maximize reimbursements as part of the VBP program requirements for both core measures and patient satisfaction. Sample questions that guided the interview procedures can be found in Appendix A. Each of the senior leadership team interviews lasted between 30-55 minutes in duration. The researcher provided the interview questions to the senior leadership team two weeks ahead of the interview date to allow for increased preparation time, to improve the quality of data collected, and to facilitate the time requirements of the interview process. During the data compilation process, it was necessary to contact selected senior leadership personnel in an effort to verify and clarify information relating to certain manifesting issues. Much of this contact was accomplished through electronic Microsoft outlook mail through a secure format, while at times it was also necessary to talk telephonically or by meeting in person.

The researcher applied the principles outlined by Marshall and Rossman (2011) for providing a good argument for utilizing the “research funnel” as a method to help conceptualize the procedures for justification of a qualitative research study within a targeted discipline (e.g.,
healthcare). In terms of research funnels and intellectual flow, it is important that each step in the process is justified by the researcher. The top of the research funnel is the topic area which typically includes professional expertise informed by both knowledge of the literature and experience. Next, the funnel narrows to include what type of knowledge is sought which requires a qualitative approach and ultimately creating the type of “understanding” that is needed in the field. Next, qualitative research questions are developed in an effort to generate the knowledge needed. The research questions are then pared down to one (e.g., bottom of the funnel) with the goal of shaping and refinement to the criteria of a qualitative research study. For the purposes of this study, the research question was related to the perceived effectiveness of the executive leadership team processes at a community hospital to the VBP requirements of the ACA. The researcher developed a high quality research question which was based on intimate knowledge of the extant literature, focused on increasing knowledge in the field, sought to find knowledge important to the healthcare profession; and ensured the question was answerable by using appropriate research methodologies (Scheirer, 2013).

Site Selection: A Community Hospital in the Southeastern U.S.

More than one-hundred years ago, the community hospital under study was the only existing public healthcare facility for 90-miles. The community hospital was founded in the late 1800s with the commitment to meet the healthcare needs of the local residents. In the 1930s, the community hospital was keeping pace with the changing healthcare needs of the local residents and maintained a census of 60-70 admissions per month. In 1943, the average admission rate blossomed to 200 patients per month, including 40 births. The 1970s brought many new physicians in diverse medical specialties to the community hospital (i.e., gastroenterology,
interventional cardiology, interventional radiology, plastic surgery,) which provided patients with new services and opportunities for specialized treatments/therapies. Next, the community hospital moved to a new 75-acre location in 1989 in a response to the growth of local residents to 50,000. The rise in square footage at this new location also came with increased services including: a cancer center, a heart center, an imaging center, a spine center, a women’s health center, and a bariatric surgery center. In 2012, the community hospital was nationally recognized as a leader in patient safety and clinical outcomes as evidenced by the following designations: Top 50 hospitals in the U.S., Magnet Nursing Facility, National Chest Pain Center, Bariatric Surgery Center of Excellence, JCAHO Primary Stroke Center, and National Chest Pain Accreditation (Community Hospital, Internal Document, 2014).

Today, the community hospital is a 335-bed, not-for-profit, acute care hospital located in the Southeastern U.S. whose primary service area to Medicare patients covers six zip codes (Community Health Assessment & Community Health Improvement Plan, 2014). In an effort to place the hospital in context with the local community, according to the Chamber of Commerce (2014), the city draws in approximately 6.5 million visitors annually. Furthermore, because the city settled a few hundred years ago and is considered a popular tourist attraction, the community hospital also services Medicare patients from all across the U.S. who are in need of healthcare services during their brief visit or “snowbirds” who stay for extended periods of time during the winter months.

The community hospital is also a participant in the VBP program as part of the ACA. The researcher received permission to pursue this qualitative case study from the president, chief executive officer (CEO) of the community hospital on December 21, 2015, and which also
included access to documents, public access to a repository database (http://www.medicare.gov/hospitalcompare/), and senior leadership interviews.

The Community Health Assessment & Community Health Improvement Plan (2014) additionally found that the county where the community hospital resides was ranked the healthiest county in the state in the annual County Health Rankings report. Published by the Robert Wood Johnson Foundation and the University of Wisconsin’s Population Health Institute, the County Health Rankings report measures a variety of health indicators that relate to quality and length of life, and serves to illustrate that health is not a solo effort, but is a combined work in progress involving community partners. The community hospital also offers a wide variety of healthcare services, including cardiac, emergency, general surgery, laboratory, radiology, maternity, oncology, orthopedic, neurosurgery, and neonatal intensive care, among others.

Furthermore, emergency room visits totaled 52,458 and 53,819 in 2012 and 2013 respectively. Total inpatient admissions also tallied 10,310 and 10,695 for the same time periods. Lastly, the 2013 payer source summary by percent is Medicare (47%), commercial (40%), and Medicaid (13%). Lastly, the community hospital accounts for eight percent of the total market share among the 14 hospitals in the region which is based on the number of inpatient discharges (HealthLeaders Interstudy, 2014).

Participants

The participants interviewed included eight male and female participants who all reside in the same county where the community hospital resides. The senior leadership experience level of the participants ranged from three to 34 years, which were mostly accrued at the community hospital. In particular, two of the non-physician senior leadership team members have worked at
the community hospital for 34 and 33 years respectively. The education level of the participants ranged from bachelor’s degrees (B.A. Accounting) to doctoral degrees (e.g., M.D.). Six of the senior leadership participants were non-physicians (CAO, CEO, CFO, CNO, COO, VPO) and 2 were physicians (CMIO, CMO). Three of the non-physician senior leadership participants possess a clinical background (e.g., advanced nurse practitioner, physician assistant, registered nurse), while both physician participants prior to their current senior executive leadership roles had practiced medicine for over 20 years in family practice and nephrology respectively.

Participant Selection

The researcher selected eight non-physician and physician senior leadership executives at the community hospital from an organizational chart for the period of 2010-2014, which lead to the pursuit of this disciplined inquiry and study the phenomenon of interest. This pursuit leads directly to selecting information rich cases for in depth study. Cases that are information rich can lead the researcher towards increasing their learning about issues of central importance as it relates to the purpose of the research. For the purposes of this study, the researcher is trying to create in-depth understanding of what was the perceived effectiveness of the executive leadership processes at a community hospital as it related to the VBP policy provisions of the ACA.

Research Protocols/Instrumentation for Interviews

The following research protocols were utilized to describe the medium of how data were collected for this study. First, a questionnaire was developed by the researcher which encompassed 20 open-ended questions with the specific intent to collect data that was meaningful toward answering the research question. Each question was designed to examine the
perspectives of each participant in regards to what were the leadership processes implemented at the community hospital as it related to the policy provisions of the VBP program, as part of the ACA, for the period of FFY 2013-14. The researcher utilized the original 20-questions as a guide while exploring other questions as necessary in order to elicit participant responses that assisted in providing rich data toward the pursuit of answering the research question. The questions covered topics such as how are decisions make within a hospital context, participant background, executive leadership processes, the role of executive leadership in relation to the community, and what were the strategic objectives implemented at the community hospital in addressing the VBP policy provisions of the ACA.

Interview schedules were developed by the researcher and published to the eight participants well in advance of the interview date in an effort to meet the goals of data collection time frames established, as well as decreasing any confusion in terms of when, where, and what time the interviews were to be held. The advanced notice also provided the participants ample time to review the questions and respond thoughtfully in their responses. The researcher conducted the 30-55 minute structured interviews with the eight participants and recorded the responses on an audio receiving device. Next, the interviews were then transcribed by the researcher and a research assistant from an iPhone 6s voice memo recorder into a Microsoft word document which aided the researcher in the data analysis phase of the study. An example of the 20-interview questions can be found in Appendix A.

Patton (2002) purported, in qualitative research the researcher is the instrument and the credibility of the methods to a large degree upon the skill, competence, and rigor of the individual conducting the study. When the researcher is a “tool” or instrument in the qualitative
research process, the research questions are developed through the role of passion, commitment, interest; the role of the “other” (e.g., participants, audience); the level of required knowledge; the contextualizing of knowledge within a broad category such as the VBP policy provisions of the ACA; how they “are” human beings-personal skills, abilities, and preferences; and the perspectives they adopt.

For the purposes of this study, the researcher holds a master’s degree in healthcare administration (MHA) from the University of North Florida, possesses 31-years of hospital leadership experience, having spent the past 16 years as a radiology director working in three Southeastern, U.S. community hospitals. I consider myself a democratic leader who places a great emphasis on the development of the healthcare team within the radiology department: director, assistant director, managers, supervisor, lead technologists and staff. I ensure that each member of my team has a voice in the decision-making process which leads to increasing engagement within their leadership practice. The most valuable leadership skill that I possess is humility. I am very respectful of my employees and treat them like people. My ultimate goal is to build the best managerial/technical staff that will provide the safest and high quality radiological services on behalf of our patients, physicians, and community. The biggest opportunity I have for leadership growth is to practice more patience with my decision-making especially while attempting to solve complex problems affecting operations (i.e. improving patient satisfaction).

Research Protocols for Examining Data

The selection of data sources were critical to this qualitative case study because they provided information rich data for the researcher to be able to determine what were the
leadership processes implemented by the executive leadership team at a community hospital in relation to the VBP requirements of the ACA. The specific data sources included, policies and procedures, board meeting minutes, memoranda, newsletters, medical executive committee (MEC) minutes, ACO meeting minutes, department director minutes, a repository database (http://www.medicare.gov/hospitalcompare/), and structured interviews transcripts.

Policies and procedures were available on the community hospital intranet through an application referred to as Policy Tech. All community hospital employees possess a secure online access to policies and procedures which provided the researcher a reference point for assessing how the community hospital ensures the safety and quality of care provided to their Medicare patients. The community hospital operates both a Board of Trustees which governs over operations and quality; while the Healthcare Foundation, Inc. Board of Trustees comprises the fund raising arm of the operation. The review of both board meeting minutes provided rich, thick data that described the executive leadership processes related to the quality and patient satisfaction requirements of the VBP program as part of the ACA.

Memoranda were another type of media through which senior leadership teams communicate with each other and remaining community hospital stakeholders. Memoranda are utilized to provide directives regarding community hospital initiatives of heightened interest (e.g., projected launch of a new electronic medical record). Additionally, newsletters are also another source of examining data. They are generated by several sources and include information that targets certain members within the organization. For example, the physician newsletter is a forum to update the medical staff on pertinent issues (e.g., medication shortages, ICD-10 training, reimbursement updates, on-call schedules) that impact their medical practices. Also, the
medical executive committee (MEC) is the primary governance committee for the independent medical staff. The MEC, in conjunction with the medical staff, provides important leadership decisions related to medical staff policies, procedures, rules, and with a specific emphasis on quality control and quality improvement initiatives. Performing a document analysis of the MEC minutes was vital in tracking the senior leadership processes related to quality and patient satisfaction.

Furthermore, the community hospital developed an ACO which is a physician hospital organization (PHO) that was formed in May 2013, to promote collaboration among independent physicians and the community hospital in a method that will both increase quality and efficiency of patient centered care. The ACO provides physicians the ability to maintain independence, while also achieving their objectives. A few of these objectives include improved clinical outcomes, adoption of evidenced based standardized healthcare protocols, a reduction of healthcare costs for patients employers and health plans, enhanced coordination of care between all care providers across the continuum of care, assuring the delivery of the right care at the right time in the right setting, and improved reimbursement through demonstration of meeting quality/efficiency targets (CEO Interview, May 23, 2016).

In January 2014, the 188-physician PHO announced an accountable care organization (ACO) agreement with Florida Blue for community hospital members and it was also designated a Medicare Shared Savings ACO by CMS. According to the ACO’s operating agreement, a non-physician entity can be admitted as a member by purchasing membership interests and garnering approval of 75% of the Board and Managers. The community hospital also signed an affiliation agreement in October 2015 with two local health systems which is largely aimed at aligning
resources which will assist with future solvency in a volatile healthcare arena. The operating agreement could allow all three health systems to become part of the ACO and scale up the organization into a major force in the local healthcare market (HealthLeaders InterStudy, 2014).

The senior executive leadership team at the community hospital meets with 30 department heads (e.g., directors) on the last Friday of each month at 10 a.m. in one of the first floor class rooms (Alicia, Osceola, Matanzas) and includes, but is not limited to, the departments of cardiology, radiology, laboratory, emergency department, surgical services, and many more. Each director reports to an officer within the organization and are considered part of the senior leadership team. In an effort to place this meeting in context, the CEO typically begins the initial comments with a visionary update regarding how the community hospital is responding to the governmental policy provisions (e.g., Medicaid reimbursement reduction, VBP) affecting hospital operations.

The Hospital Compare (http://www.medicare.gov/hospitalcompare/) website is a repository database that provides information regarding the quality of care provided at over 3,000 Medicare certified U.S. hospitals (Senot, Chandrasekaran, Ward, Tucker, & Moffatt-Bruce, 2015). The public can utilize “Hospital Compare” data in order to find hospitals and compare the quality of care provided to Medicare patients. The information on Hospital Compare can help U.S. citizens with their decision-making in terms of where they access their healthcare and will also encourage acute care hospitals to improve the quality of care they provide to Medicare patients. Hospital Compare was created through efforts by CMS, in collaboration with organizations representing healthcare consumers, hospitals, doctors, employers, accrediting bodies, and other federal agencies.
Lastly, structured interviews were conducted with eight physician and non-physician senior executives with the explicit goal to learn more about the leadership processes at a community hospital as it related to the policy provisions of the VBP program as part of the ACA and to assist with answering the research question. Each interview consisted of a set of questions that were meaningfully developed with the intent of taking each respondent through a similar sequence. Creswell (2007) expressed the importance of selecting appropriate candidates for qualitative interviews who are willing to share their story openly and honestly. Creswell also recommended to conduct interviews in a comfortable environment where the participants felt unrestricted to share information. Furthermore, Patton (2002) reported that open ended interviews are mainly utilized when the exact instrument used in the evaluation is available for inspection by those who will use the findings of the study; when the interview is highly focused so that interviewee time is used efficiently; and where the analysis is facilitated by making responses easy to find and compare. All three of Patton’s guiding principles were accomplished as part of the data collection process as it related to this study.

*Data Collection*

Data collection began on March 22, 2016 and was completed on June 30, 2016. Data were retrieved from community hospital documents, through the analysis of the Hospital Compare (http://www.medicare.gov/hospitalcompare/) public website, and interviews. The researcher also made several requests to the medical staff office and administration who provided copies of monthly board minutes, memorandums, monthly department director minutes, and other pertinent documents that were vital to the pursuit of this study.
A recruitment letter (Appendix B) was e-mailed to all prospective participants on May 5, 2016, in order to determine the level of interest in participating in this research study. The prospective participants were instructed to contact the principal investigator via e-mail or phone by May 16, 2016, in terms of confirming their participation or opting out of this research opportunity. After confirming all eight research participants via e-mail and telephone, a Microsoft outlook calendar appointment was e-mailed to each research participant that included a proposed interview date, time, and location. The interviews were conducted from May 16, 2016-June 8, 2016. The 20-open ended interview questions were also sent to each participant separately via e-mail which provided them time to review the interview questions ahead of the actual interview, with the explicit goal of increasing the thoughtfulness of their responses. Next, the research participants electronically accepted or declined that the date, time, and location were acceptable or not and the principal investigator received each participant reply through a Microsoft outlook calendar. Informed consent (Appendix C) was obtained prior to moving forward with the interview and all participants were reminded that their participation in the study in terms of confidentiality and anonymity would be preserved. By the end of June 8, 2016, a total of eight open ended interviews had been conducted, which is a 100% completion rate.

Ethical Issues

The Institutional Review Board (IRB) at the community hospital originally approved this study on January 6, 2016. Additionally, an Authorization Agreement (AA) was executed on March 22, 2016, between the community hospital and UNF IRB for graduate and doctoral student research being conducted at this research site. This joint agreement paved the way to move forward with this research study under the guidance of the community hospital IRB. A
request to modify the community hospital IRB application to allow a research assistant to assist with transcribing the executive leadership interview voice memos was also granted on June 20, 2016. All data will be stored in an encrypted format on the UNF server for a period of 3-years after the completion of this study.

Credibility

The researcher adopted rigorous techniques to ensure the quality of the study by making sense of the data and interpreting them accurately, citing research as indicated; and observing all copyright laws. Furthermore, to ensure the credibility and rigor of this qualitative research study a thorough literature review was conducted, the triangulation of several data sources was achieved, transparency was outlined, and the background of the researcher was established. Boote and Biele (2005) further purported a substantive, thorough, sophisticated literature review is a vital component for performing substantive research. The following sections were explored in the literature review and will contribute toward establishing the credibility of performing this qualitative case study: a background on healthcare reform in the U.S., a policy analysis section, a cost vs quality comparison, the impact of the VBP on U.S. hospitals, and a section on leadership and change theories. Next, the triangulation of several data sources (hospital board meeting minutes, executive leadership memoranda, hospital quality sub-committee patient outcome reports) was achieved, methods (qualitative case study, document analysis), and theories (PDCA-Deming Wheel, Hill’s Team Leadership Model) were also adopted in order to increase the rigor of this study.
Trustworthiness

The following methods were utilized in order to strengthen the trustworthiness or validity of this study: triangulation of data sources which included the analysis of managerial meeting minutes, memoranda, newsletters; a review of a repository database; structured interview transcripts; peer debriefing, and member checks that included providing transcripts to the study participants for review and who were prompted if they wanted to continue as part of the research.

Transparency

The researcher performed a data analysis on public Medicare patient data located in the Hospital Compare repository database (http://www.medicare.gov/hospitalcompare/) as reported quarterly by the community hospital as part of the VBP policy provisions the ACA. Lastly, the background of the researcher was made clear to the reader of this study which included they possessed over 31 years of total healthcare experience in government, for-profit, and not-for-profit hospitals in Radiography and has served as director of radiology at three community hospitals in the Southeastern U.S. over the past 16 years.

Transferability

The passing of the ACA in 2010, now gave hope to millions of uninsured Americans who now can access healthcare through the marketplace. However, in 2014, the ACA is also currently having a detrimental effect on the ability of U.S. hospitals to remain solvent due to decreased reimbursements for services, increased Medicaid expansion, employer mandates that has forced a reduction in staffing, increased health insurance premiums for covered employees, pay for performance, and higher taxes. These complex issues that confront healthcare leaders at
over 5700 hospitals, is creating a huge demand for quality decision-making in order for these facilities to survive in the VBP and ACA era (Corbett, 2015).

**Confirmability**

The triangulation of several data sources (hospital board meeting minutes, executive leadership memorandums, hospital quality sub-committee patient outcome reports), methods (qualitative case study, document analysis), and theories (PDCA-Deming Wheel, Hill’s Team Leadership Model) were utilized in an effort to reduce investigator bias. The researcher will confess their beliefs and assumptions relating to this research study. The researcher also recognizes the PDCA performance improvement model may not be effective in all hospital performance improvement activities. The methodology section will be explicit in describing how the research was conducted and which will allow for the integrity of the research results to be scrutinized by others.

**Data Analysis Techniques**

Lincoln and Guba (1985) stressed that in naturalistic inquiry, data analysis is a continuous process which makes the meaningful emergence or unfolding of the design and the subsequent focusing of the study. For the purposes of this study, the researcher adopted Lincoln and Guba’s steps for data analysis which included unitizing, categorizing, filling in patterns, and member checks.

Unitizing refers to information that will serve as the baseline for defining categories. As it relates to this study, information will include internal hospital documents (ACO minutes, MEC minutes, director meeting minutes, memoranda, policies and procedures, physician newsletters), hospital compare data (core measures, patient satisfaction); and thick, rich description from
structured interviews. According to Lincoln and Guba (1985) each unit possesses two main characteristics. First, it must be heuristic which is directed at some type of deeper understanding or at an action the researcher needs to follow. Second, it is the smallest section of information that can stand alone or interpretable in the absence of any further data.

Furthermore, when units were identified by the researcher, they were logged on a legal pad which made the information comprehensible to all other inquirers. During this phase of the study, the researcher adopted an approach of being over-inclusive because it is easier to discard irrelevant units than to reintroduce information that is determined to be relevant, but thrown out at an earlier stage in the study. Next, the legal pad units were transferred to index cards and were coded by the researcher in multiple methods that were useful for this study inquiry. For example, a designation was noted for the source (interview notes, memoranda, MEC minutes) from which the unit derived; a designation for the type of respondent (CEO, CFO, CNO, COO); and a designation for the particular data collection episode (hospital documents, repository database, interviews) in which the unit was collected (Lincoln & Guba, 1985).

Lincoln and Guba (1985) further reported the important tasks related to categorizing are to create provisional categories for those index cards that refer to the same content; to devise rules that describe category properties; and to ensure the category set is internally consistent. The preferred method is one of constant comparison or the continuous and simultaneous collection and processing of data. Operationally, Lincoln and Guba provided 10-steps for the categorization of data which was applied by the individual researcher/analyst. First, the researcher selected the first card in the pile, read it, and noted the contents. This first card depicted the initial entry in the first to be named category. The second card was selected and determined if it was similar to the
first card or whether it represented a new category. The process was continued with successive index cards. After several index cards had been processed in this manner, the researcher placed certain cards in a miscellaneous pile where they were determined to be irrelevant to the developing set. Step five involved the researcher collecting index cards that have accumulated in ample size categories with the goal of determining what properties best characterized the properties of the cards. The properties were then combined into a rule for inclusion which included giving the category a name. In this phase, the researcher was mindful of anomalies, conflicts, and discrepancies that required further analysis. Next, the researcher repeated with steps three and four, and step five, as categories reached a certain critical mass, until the index cards had been exhausted.

Next, the entire category was reviewed to determine if the categories possess any overlap and the set of categories need to be examined for possible relationships among them. Step eight demands that categories may be pursued in subsequent data collection efforts through the strategies of induction, deduction, abduction, and respectively. Step nine required the researcher to ultimately come to a halt of the data collection and analysis phase of the study which is achieved by adopting the following criteria rules: the exhaustion of sources, a saturation of categories, the emergency of regularities (e.g., a sense of integration), and overextension-the sense that new information is far removed from the core data collection categories. Finally, the researcher reviewed the entire category set once again to ensure no data has been omitted (Lincoln & Guba, 1985).

The researcher also performed a retrospective analysis of the Hospital Compare (http://www.medicare.gov/hospitalcompare/) public repository database utilizing Lincoln and
Guba’s (1985) filling in patterns which is the process for the treatment of incomplete data. The goal was to examine VBP scores for the community hospital relating to core measures and patient satisfaction for the FFY period of 2013-2014. The scores were also compared to other acute care hospitals to determine how the community hospital compared nationally. This public data is important to many Medicare beneficiaries because they have the ability to compare which hospitals are outperforming others in terms of quality/patient satisfaction and ultimately can assist in the selection of their healthcare provider. Because the data is publicly reported quarterly by approximately 3000 acute care hospitals who participate in the VBP program, it also is a driver for hospitals to improve the quality of care and which includes financial incentives (Corbett, 2015; Senot et al., 2015).

Lincoln and Guba (1985) also referred to a member check as a method where data, analytic, categories, interpretations, and conclusions are tested with members from where the data originated from. The scholars also considered this to be the most crucial component of establishing credibility of the study. Member checks can occur both informally/formally and is a continuous process. Member checking served a number of important purposes including providing the opportunity to assess their intentions, it provides the participant the opportunity to correct any deficiencies or volunteer additional information, and provides the opportunity to summarize—the first step in the data analysis process.

Lastly, Altheide, Coyle, DeVriese and Schneider (2008) defined a qualitative document analysis (QDA) as a method and research orientation that emphasizes discovery and description, including searching for contexts, underlying meanings, patterns, and processes in lieu of a numerical relationship between two or more variables which are often associated with
quantitative methodologies. The researcher utilized the same approach in this study and performed a document analysis on the following data sources: policies and procedures, board meeting minutes, memorandums, newsletters, medical executive committee minutes, ACO meeting minutes, and department director meeting minutes.

Limitations

Two major limitations of the study are conducting research on only one community hospital and the relatively small amount of data available on the http://www.medicare.gov/hospitalcompare/ website due to the VBP program requirements of 2011 (2016) as part of the ACA in 2010 (2012) being a relatively new legislation. This limited the primary collection period to FFY 2013-2014 data only. Another major limitation of the study was the small sample size (N=8). Time constraints certainly played a role in the data collection process which prevented the inclusion of more participants. Another limitation was the executive leadership experience level of the participants was also very broad (three-34 years). It would have been helpful to only include experienced senior leadership members at a community hospital who possessed the time and experience to provide useful data in terms of a reflective leadership practice. Last, the use of an open interview method increases the risk of interviewer bias.

Summary

This qualitative case study was designed to examine the perceived effectiveness of the executive leadership team response at an acute care, community hospital in the Southeastern U.S. to the policy provisions of the Value-Based Purchasing (VBP) program as a component of the Affordable Care Act (2010). This chapter describes the study research protocols/instrumentation
and validation of the instruments utilized by the researcher. The data collection and subsequent analysis techniques adopted by the researcher are believed to be the most robust methods available for answering the research question. The research methodology searched for what were the executive leadership processes implemented at a community hospital that sought to improve patient satisfaction scores (HCAHPS), core measures (e.g., quality outcomes), and governmental reimbursements for Medicare patients. The study researcher was able to track these variables for the period of FFY 2013-2014, through the analysis of community hospital documents, public access to the Hospital Compare (http://www.medicare.gov/hospitalcompare/) web site where database scores are recorded by all acute care hospitals in the U.S. who participate in the VBP program; and structured interviews.

The analysis of the research question and associated findings are discussed in further detail in Chapter Four. In Chapter Five, the researcher provides both conclusions and recommendations based on outcomes that are extracted from the analyses of data. Chapter Five also includes implications for theory development, further research, practice, and healthcare policy.
Chapter Four:

Data Analysis/Results

Chapter One provided the rationale for the pursuit of this study which was to describe how the VBP program is challenging senior leadership teams at community hospitals around the country to remain solvent in a volatile healthcare arena. In light of this, this research study focused on the perceived effectiveness of how well these executives navigated the new legislation under this new payment model on behalf of Medicare patients. Thus, the purpose of the study was to examine the perceived effectiveness of the executive leadership team response at a community hospital in the Southeastern U.S. in relation to the VBP requirements of the ACA (2010), through a document analysis, a review of a repository database (http://www.medicare.gov/hospitalcompare/) for service quality, patient satisfaction, governmental reimbursement; and structured interviews.

Chapter Two provided an extensive review of the literature that was pertinent to the core of this study and also included the theoretical framework that steered the study design. As discussed in Chapter Three, the methodology for this study included a qualitative design that was best suited for the pursuit of this research study. In Chapter Four, the researcher conducted a rigorous data analysis which provides the reader with germane findings that are relative to the following research question:

1. What was the perceived effectiveness of the executive leadership team processes at an acute care, not-for-profit, community hospital in the southeastern U.S., as it relates to the Value-Based Purchasing (VBP) policy provisions of the Affordable Care Act?
Data Analysis Process

This chapter outlines the data analysis as it related to the research question which is the objective of this study. The starting point for this study was to perform a document analysis which included include community hospital policies and procedures, board meeting minutes, memorandums, newsletters, medical executive committee (MEC) minutes, ACO meeting minutes, department director meeting minutes; and then a review of a repository database (http://www.medicare.gov/hospitalcompare/) website.

The second phase of the study included eight interviews with key senior leadership personnel at the community hospital comprising of both administrative and physician personnel. The interviews were constructed to increase insight into what were the leadership processes among the senior leadership team and other hospital stakeholders, and what actions were implemented that would maximize reimbursements as part of the VBP program requirements for both core measures/patient satisfaction. A fundamental part of this phase of the study was to analyze the executive leadership team processes as it related to the VBP policy provisions utilizing Hill’s (2010) team leadership theory. The purpose was to determine what were the executive leadership team’s processes in terms of leadership decisions, internal leadership actions-task vs relational, external leadership actions-environmental, and ultimately assess to what extent it impacted the perception of team effectiveness. The plan-do-check-act (PDCA) performance improvement model was also applied to outline the steps the executive leadership team implemented in attempting to improve service quality levels on behalf of Medicare patients.

The central themes that emerged after an exhaustive analysis of data are listed in Table 1 and include: team leadership, vision, strategic alignment, PDCA, collaboration, change process
(structure, systems, culture), and community. The purposes or intent and outcomes are also listed in the table in order to provide clarity for the reader of this study. In particular, the researcher found evidence of a strong strategic alignment of the actions outlined by the executive leadership team along with a collaborative effort with other key community hospital stakeholders (hospital board, medical staff, middle management, nurses, hospital staff) towards meeting the goals with VBP for both core measures and patient satisfaction.

Table 1.

Central Themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Purpose/Intent</th>
<th>Outcomes for Leadership/Change Process</th>
</tr>
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<tbody>
<tr>
<td>• Team Leadership</td>
<td>Understanding and attending to the leadership/change processes that impact service levels on behalf of Medicare patients as it relates to the policy provisions of the VBP program.</td>
<td>Improve team effectiveness</td>
</tr>
<tr>
<td>• Vision</td>
<td></td>
<td>Effective problem solving</td>
</tr>
<tr>
<td>• Strategic Alignment</td>
<td></td>
<td>Performance-VBP</td>
</tr>
<tr>
<td>• PDCA</td>
<td></td>
<td>Improve quality &amp; patient satisfaction</td>
</tr>
<tr>
<td>• Collaboration</td>
<td></td>
<td>Inclusion of board/medical staff in decision-making</td>
</tr>
<tr>
<td>• Change Process: Structure-Org. Chart Systems-Policies &amp; Procedures, EBP Culture-(HRO) the way we do things.</td>
<td>Recognize that change is not linear and takes a coordinated, sustained leadership effort in order to be successful. Create understanding of the context where the change takes place.</td>
<td>Improve Efficiency</td>
</tr>
<tr>
<td>• Community</td>
<td>To deepen understanding of the unique role the community hospital plays with regard to providing vital healthcare services to the Medicare patients in the community.</td>
<td>Improve Patient Safety</td>
</tr>
</tbody>
</table>

Moreover, the following criteria for high-quality work also guided this qualitative research study which included adopting associated Howe and Eisenhart’s (1990) five general
research standards which lead to high quality disciplined inquiry: (1) the research question should drive the data collection technique and not vice-versa; (2) the data collection and analysis techniques must be completely applied; (3) linking the research question with data collection techniques and applying them competently does not insure a study will result in warranted conclusions, for studies are judged against a background of extant knowledge; (4) warranted conclusions are drawn after robust and respectable theoretical explanations have been applied to the data (e.g., triangulation); and (5) research is subject to both external (e.g., worthy of research for informing and improving practice) and internal (e.g., relate to research ethics) value constraints.

Professional Expertise

In the field of healthcare, executive leaders need to pay attention to the internal (e.g., culture) and external (e.g., ACA) factors affecting the organization in order to be effective. Healthcare executives also need to be concerned with understanding theories of performance improvement (e.g., PDCA), leadership (e.g., Distributed Leadership, Hill’s Team Leadership, Shared Leadership), and applying them towards improving organizational performance through enhancing the patient experience and quality outcomes. Healthcare executives can rely on their extant knowledge and experience to develop their understanding of the complexities of public policies that affect hospitals which include pay for performance and improving service levels of behalf of Medicare patients.

A major influence in the selection of this research topic was the researcher’s extensive healthcare leadership experience and understanding of how governmental legislations affect community hospitals in the U.S. In particular, my professional resume includes serving on
several of the community hospital committees that impact both core measures and patient satisfaction as part of the policy provisions of the VBP program. This experience has enabled me to gain valuable insights into the intricacies of the VBP program in terms of how it impacts acute care hospitals. It has also deepened my understanding of how to interpret the scores from the repository database (http://www.medicare.gov/hospitalcompare). The researcher was also afforded the opportunity to work with the community hospital executive leaders within a team leadership model towards the pursuit of process improvement (e.g., PDCA) that attempted to impact service levels on behalf of Medicare patients.

Peshkin (2001) reported on the importance of the qualitative researcher being attentive or being prepared to perceive. In other words, the researcher needs to acknowledge the importance of their senses in the data analysis phase of the research and which requires attentiveness. This is important because the researcher applied their healthcare expertise to collect and analyze data to ultimately determine the perceived effectiveness of the executive leadership team processes at the community hospital in relation to the VBP policy provisions of the ACA. The researcher’s extensive healthcare expertise, combined with a thorough review of the literature increased my ability to make sense of the plethora of data.

Literature Review/Theoretical Framework

The researcher’s professional healthcare experience provided a framework for a thorough review of the literature, which discovered that in spite of previous failed healthcare reform efforts in the past, the passing of the ACA legislation in 2010, is viewed as the biggest landmark event since the enactment of Medicare and Medicaid in 1965 (Berenson, 2010; Gruber, 2010; Orszag & Emanuel, 2010). Furthermore, executive leadership teams at U.S. hospitals are
significantly influenced by public policies (e.g., VBP) that affect their solvency because Medicare and Medicaid initiatives account for more than 50% of revenues in over 5000 community hospitals (Longest, 2012). If leaders do not properly assess their public policy environments it could lead to poor decision making that can be disastrous to hospital operations. Thus, the VBP program now motivates hospital executives to improve the service levels of Medicare patients in order to prosper under this new pay for performance model (McHugh et al., 2013; Weissert & Frederick, 2013).

Prior to the enactment of the ACA, at no other time in history have U.S. citizens paid so much for healthcare services, yet with very little return on investment (Levin-Scherz, 2010; Sirgy et al, 2011). Furthermore, because the U.S. healthcare system was based on consumer-directed care or a libertarian/market based model which promotes equal access, it increased the gap between the underprivileged and privileged (Bloche, 2007; DeNavas-Walt, Proctor, & Lee, 2007). The ACA was designed to increase access to quality healthcare for millions of Americans who were not insured, underinsured, or were unable to purchase insurance because of pre-existing medical conditions. A major reason for the large number of uninsured Americans was the high cost for health insurance. However, there continues to be many skeptics of the VBP program in terms of whether it will improve the quality of care delivered to U.S. citizens (Kavanaugh et al., 2012; Weissert & Frederick, 2013).

The combination of the researcher’s healthcare expertise and a thorough review of the literature, provided the basis for the establishment of a theoretical framework that guided the present study. The first component of the theoretical framework included the PDCA model for process improvement which has proven successful in a hospital context and is the preferred
method utilized by the community hospital involved in this study (Gupta, 2006; Randhawa et al., 2011). The second theoretical framework applied was Hill’s (2010) team leadership model which assists in helping leaders to monitor the team and to act accordingly to increase team effectiveness (LaFasto & Larson, 2001; Zaccaro et al., 2001). In the context of this study, it will be utilized to analyze the perceived effectiveness of the executive leadership team processes and actions in relation to the policy provisions of the VBP program, as part of the ACA.

The researcher’s healthcare experience, a thorough review of the literature, and a grounded theoretical framework, all influenced the creation of 20-open ended interview questions for the study participants which can be found in Appendix A. The interview questions were designed to encourage participant responses that were based on their knowledge and experiences within the community hospital context and the healthcare field.

*Data Analysis Strategies*

For the purposes of this study, the adoption of Lincoln and Guba’s (1985) data analysis strategy was informed by my professional healthcare expertise, a review of the literature, and a theoretical framework, with the goal of analyzing qualitative data which provides rich insight into leadership processes and actions. This also supports the data analysis process which allowed the researcher to examine the perceptions and experience of the research participants because qualitative research is increasingly being applied to the social sciences and applied fields like healthcare (Marshall & Rossman, 2011).

Lincoln and Guba (1985) described data analysis as a continuous process which makes the meaningful emergence or unfolding of the design and the subsequent focusing of the study. The four areas of data analysis outlined by Lincoln and Guba include: unitizing, categorizing,
filling in patterns, and member checks. This provided the researcher with the insight to provide thick description of the phenomenon of interest which contributed toward establishing the credibility of this research study. In other words, how congruent were the findings of this study to reality? This is important because Lincoln and Guba (1985) argue that ensuring credibility is a major factor in establishing the trustworthiness or validity of the study.

Lincoln and Guba’s (1985) strategy were applied to provide structure for the data analysis process. This will include a description of the matrices that were used to present the data as well as the coding processes used in order to convert the plethora of data into themes for analysis. This will assist the readers of this study to comprehend how the data were reduced and transformed (Roberts, 2010).

**Analysis of the Data**

The three sources of data for the present study were analyzed in the following sequence: community hospital documents, a repository database ([http://medicare.gov.hospitalcompare/](http://medicare.gov.hospitalcompare/)), and transcriptions from the participant interviews. This sequence enabled the researcher to methodically organize/analyze the data in which to provide thick, rich descriptions of the emerging themes that developed and was instrumental with answering the research question that was central to the pursuit of this study.

According to Bowen (2009), institutional documents have been a prevalent part of qualitative research studies for many years. Moreover, in recent years, there has been a spike in the number of research and journal articles that refer to a document analysis as part of the methodology section. Multiple authors have defined document analysis as the systematic procedure for reviewing and analyzing both printed and electronic documents with the intent to
interpret the data in which to elicit meaning, develop a deeper understanding, and for the development of empirical knowledge (Corbin & Strauss, 2008; Lincoln & Guba, 1985; Rapley, 2007).

**Community Hospital Documents**

The community hospital documents that were included in the document analysis for the present study included the following sources: accountable care organization (ACO) minutes, board meeting minutes, policies and procedures, department director minutes, medical executive committee (MEC) minutes, memoranda, and newsletters. The time period for analysis of documents ranged from 2008-2016, and included several hundred pages of data. This rich data provided the researcher with critical information that assisted with examining what was the perceived effectiveness of the executive leadership team processes at the community hospital prior to, during, and after the implementation of the policy provisions of the VBP program, as part of the ACA.

The first step in applying Lincoln and Guba’s (1985) data analysis strategy was *unitizing* which refers to information that serves as the baseline for defining categories. For the purposes of this study, information included the collection and analysis of community hospital documents. Nearly all requests for community hospital documents were made by the researcher via electronic mail to the various hospital departments which included administration, the medical staff office, and the quality department. The requested documents were delivered to the researcher in a portable document format (PDF) via e-mail and were stored in a secured format on the community hospital server. The one exception to this was the retrieval of community hospital policy and procedures by the researcher via the intranet through a secure software
application referred to as Policy Tech, which is an electronic database that requires a unique log on. The collection of community hospital documents was very straightforward because the researcher is a community hospital employee and possesses access to outlook e-mail and unique log in information that provides access to multiple hospital software applications. The goal of the researcher in the unitizing phase of analysis was focused on gaining a deeper understanding of the phenomenon of interest and to identify the smallest unit of information that can stand alone or can be interpretable in the absence of additional data.

Next, each document was separated into sections (e.g., board meeting minutes, department director meeting minutes) and placed in an inter-department delivery 8” x 11” envelope which assisted the researcher in both referencing and retrieval of the documents. The exterior of the jacket was marked with the name of the community hospital document and a corresponding date range (e.g., 2013-2014). The researcher objectively reviewed each community hospital document over a period of several weeks and used a colored hi-liter to depict areas of the document that included rich data that assisted with answering the research question. Next, after the researcher identified each unit of data it was listed on a yellow legal pad which made the information comprehensible to all inquirers. The number of entries on the legal pad surpassed 150 and included units of information such as the community hospital leadership functions depict all of Bolman and Deal’s (2008) four frames, magnet nursing certification-2012, credentialing of physicians, departmental goals, JCAHO preparation, a plan to improve patient flow in the ED, chest pain accreditation-2013, on-going education of physicians/staff, length of stay (LOS), philanthropy, practitioner peer review, patient rights/responsibilities, and standards of care for physicians. Last, the data units listed on the legal pad were subsequently transferred to
3” by 5” white index cards and were coded by the researcher in multiple forms that were meaningful towards the pursuit of this research study.

Lincoln and Guba (1985) found that the vital part of categorizing, as it pertains to the data analysis process, is creating provisional categories for the index cards that relate to similar content, to develop rules for describing the category properties, and to safeguard that the category is internally consistent. Keeping this in mind, the researcher documented on each index card the designated source (e.g., memoranda) of the unit, the type of respondent (CEO, CFO, CNO, COO), and a designation for the data collection episode (e.g., community hospital document). The researcher continuously cross referenced the data unit with the source, type of respondent, and data collection episode to further expand upon the documentation of the index card. This documentation also included the date of the document, which made the retrieval and analysis of each document much easier. A good example of a coded index card was a community hospital board meeting minutes’ document from 1/25/11, where participant G presented a dashboard on core measures. In order to provide clarity for the board, he stated:

Core measures are the standards of care and required protocols for specific clinical treatments (acute myocardial infarction-AMI). They derive from quality measures based on evidenced based best practices and are reported to CMS, JCAHO, and are publicly viewed on the hospital compare website. (Board Meeting Minutes, Community Hospital internal document, 2011)

The researcher then applied Lincoln and Guba’s (1985) 10-steps for the categorization of data which was also previously outlined in Chapter Three. In step one, the researcher selected each index card individually, read it, and noted the contents. The first card selected was placed in
the broad category of policy analysis which was central to the pursuit of this study. In step two, the researcher selected a second card and determined if it was similar to the first index card or did it fit into a new category. Because of the plethora of data, the researcher identified several additional categories which included leadership, quality, and information technology (IT). Step three included the researcher repeating this process successively. Step four involved processing several index cards and placing those cards that did not fit in a category into a miscellaneous pile. These cards were regarded by the researcher as irrelevant to the study. In relation to this study, the researcher only assigned two index cards to the miscellaneous category.

In step five, the researcher collected index cards from the large categories of policy analysis, quality, leadership, and IT and determined what characteristics best described the properties of the cards. The properties were then combined into a rule for inclusion and included giving the category a name. For the purposes of this study, the new categories created included VBP, core measures, evidenced based practices, governmental reporting and reimbursement, patient satisfaction, PDCA, team leadership, strategic alignment. In this step, the researcher remained cognizant of anomalies, conflicts, and unusual patterns that required further analysis.

In step six, the researcher repeated steps three through five until all index cards were consumed (Lincoln & Guba, 1985).

In step seven, the researcher reviewed the entire category and determined there were many overlaps and relationships between the categories. A good example of this was core measures, which has a relational component for both VBP and quality outcomes. In step eight, the researcher pursued categories via the strategies of induction which is finding new versions of what is already known, deduction which includes intellectual reasoning, and abduction which is
developing meaning creating rules (Lincoln & Guba, 1985; Reichertz, 2004). In step nine, the researcher suspended the data collection and analysis of community hospital documents due to the consumption of data sources, the saturation of categories, and the sense that additional information was not related to the core data collection categories. Last, the researcher reviewed the complete category set to ensure all data has been accounted for.

Repository Database

For the pursuit of this study, the researcher also performed a retrospective analysis of the Hospital Compare (http://www.medicare.gov/hospitalcompare/) public repository database utilizing Lincoln and Guba’s (1985) filling in patterns which is used as a process for the treatment of incomplete data. It assisted the researcher with distinguishing between convergent and divergent themes and provided the understanding in which to explain any discrepancies. Measurement data are available on this Department of Health and Human Services (HHS) website from a variety of sources like Medicare patient surveys, readmissions, complications, mortality rates, as well as timeliness and efficiency measures (Dahlke et al., 2014; Mullins & Pines, 2014). Hospital Compare is not considered a secured web site because it is available to all Medicare beneficiaries and does not report individual data regarding core measures/patient satisfaction. Thus, it does not require any user to have a unique sign-on and password. In light of this, the researcher accessed the Hospital Compare website in an effort to collect data from FFY 2013-14, with the goal of analyzing data specific to community hospital performance on core measures (quality), patient satisfaction (HCAHPS), and governmental reimbursements. The researcher also compared community hospital VBP performance data to participating U.S. hospitals on a national level.
The researcher accessed Hospital Compare numerous times over a five month period which is an official U.S. government site for Medicare. The website is divided into several categories which include: what about Hospital Compare, what information can I get about hospitals, about the data, resources, and a help section. The researcher’s routine practice was to click on Hospital Compare and the webpage displayed a prompt where any member of the U.S. public could type in a zip code and hospital name to display core measure and patient satisfaction performance for any hospital in the country. Again, this publicly reported data is not only important for approximately 3000 acute care hospital executives who are trying to maximize reimbursement rates under this new VBP pay for performance model, but it also provides Medicare beneficiaries with powerful data that can influence their decision in choosing what hospital they will seek their primary and acute care services (Corbett, 2015; Senot et al., 2015).

Next, the researcher routinely accessed the hospital profile section of the Hospital Compare website which included the categories for data mining and analysis: general information (hospital address & phone number), survey of patients’ experiences, timely & effective care, complications, readmissions and deaths, use of medical imaging, and payment and value of care. The researcher performed a data analysis by reviewing information mainly from this section of the Hospital Compare website because the data were rich, as well as reviewing community hospital documents specific to VBP performance. The four domains that were part of this data analysis included the process of care, patient experience of care, outcomes of care, and efficiency.

The researcher analyzed the individual processes of care or core measures categories as part of this study which included the following sub sections: acute myocardial infarction (AMI),
heart failure (HF), pneumonia (PN), surgical care improvement (SCIP), preventative care, and maternity care. All VBP hospitals receive an aggregate score on how well they performed in each performance category. For example, the SCIP-INF-1 core measure for surgical care improvement includes how well the hospital performed and documented if the prophylactic antibiotic was received by the Medicare patient within one-hour prior to surgical incision.

The patient experience (HCAHPS) measures that were analyzed included communication with doctors and nurses, responsiveness of hospital staff, pain management, communication about medicine, cleanliness, quietness, and discharge information. The outcomes of care included the same sub-sections as the processes of care, and reflect how evidenced based best practices impact the patient. The efficiency of care relates to the Medicare Spending Per Beneficiary (MSPB) which is an indicator of how much a hospital spends on an episode of care as compared to all inpatient hospitals nationally (Schumacher & Dobkin, 2014). This section is divided into community hospital performance, U.S. top 10%, and U.S. averages.

Once the categories were complete, it became obvious to the researcher that some categories lacked enough information in which to support any conclusions. This is where the researcher relied on the additional data collected and subsequent analysis of community hospital documents and interview transcripts in which to support any conclusions. Ultimately, the data analysis of the repository database was objective because hospital performance indicators were specific to each measure which left very little room for subjectivity. In other words, the hospital either met the measurement score or not. This assisted the researcher by limiting any convergent or divergent themes because the data were transparent and allowed for a straight forward comparison of the community hospital VBP scores for the period of FFY 2013 and 2014,
respectively. Additionally, the community hospital VBP documents reviewed by the researcher in the document analysis phase were found to be consistent with the data reported on the Hospital Compare website.

Executive Leadership Team Interviews

The researcher interviewed eight senior leaders at the community hospital over a two month period. Each participant interview was recorded digitally utilizing the voice memo application on an Apple iPhone 6s device. All of the interviews were conducted at the convenience of each executive leader and the location was their private office. Each interview transpired behind a closed door in an effort to preserve confidentiality and with the goal of eliciting responses that were thoughtful and meaningful. Throughout this process, the researcher was mindful that textual data alone can never encompass all that takes place during an interview (Kvale, 1996; Mishler, 1986). In light of this, the researcher was mindful of the attitude, body language, level of engagement of each participant, and the artifacts in the room. Additionally, the researcher also recorded hand written notes on the interview guide in an effort to aid the data collection process in the event the digital recording device malfunctioned.

The researcher also acknowledged that because of the type of data collected and the process of how it is analyzed, qualitative research is grounded in a subjective nature (Morrow, 2005; Patton, 2002; Wolf, 1978). For the purposes of this study, I was the instrument in the data collection/data analysis process and also an employee at the community hospital where this study was conducted.

The first step in the coding process was to assign a senior leadership position title (e.g., CAO, CEO) as a unique identifier for each research participant with the goal of preserving
confidentiality. The researcher also self assigned the code of principal investigator or PI for each question asked of the participant. In order to provide clarity for the reader, each question on the typed transcript began with PI and a number (e.g., 3). All questions followed a consecutive order throughout the interview process. For example, PI3 referred to the third question asked by the principal investigator and CEO3 depicted the CEO responding to the third question. This coding process was beneficial because it provided a clear context that assisted the researcher in creating a deep understanding of the participant responses.

Moreover, the researcher assigned a plethora of initial codes or units to the text of each interview transcript document. The researcher hand wrote the units in the margins of the corresponding sections of the text. A few examples of these units included the amount of higher education, total healthcare leadership experience, creating a partnership with community hospital physicians, the largest expense is the hospital cost center, the difference between management and leadership, the birth of VBP, the importance of data reporting to the government, developing core measure teams, and creating a partnership with local community employers. The identification of these units provided the researcher with a robust amount of data in which to analyze and place into a category. Next, the researcher created a list of approximately 40 categories on a yellow legal pad and which included high reliability organization (HRO), consultants, patient voice, PDCA, leadership, coordinated care, and patient safety.

Furthermore, the researcher focused on reducing overlap and redundancy among the categories. A good example of this was condensing the category of performance improvement and assigning it to the broader category of quality. This process was repeated several times until the categories were reduced. This can be important because inductive coding that concludes with
too many major themes may be scrutinized as incomplete (Thomas, 2006). Last, the researcher coded the major theme number and name, participant, and associated text which can be found in Appendix D. This demonstrated a strong consistency of the major themes across the textual data from the interview transcripts. The most important categories or themes and the corresponding sections of the interview transcripts provided the researcher with the ability to data mine in order to provide thick, rich, descriptions of the phenomenon of interest in the results section of this study.

Each research participant was also afforded an opportunity to review the interview transcription as part of ensuring their responses were accurately reflected. Lincoln and Guba (1985) considered this step in the research process as most important in establishing the credibility of any qualitative research study. Each study participant was encouraged to review the transcription carefully and to notify the researcher regarding any changes that needed to be made. In an effort to further preserve confidentiality, the interview transcriptions were typed into a Microsoft word format and e-mailed by the researcher to each study participant individually in a secure format. The eight interview transcriptions were never shared across the study participants. The member check process took several weeks to complete. Ultimately, six out of eight study participants notified the researcher that their perceptions and responses were accurately documented. However, two participants never responded after several attempts by the researcher to clarify their responses.

Results

The research question for this study asked, “What was the perceived effectiveness of the executive leadership team processes at a not-for-profit, acute care, community hospital in the
Southeastern U.S., as it relates to the VBP policy provisions (2011) of the ACA (2010)?” To help answer the research question, the researcher referred back to the data analysis of community hospital documents, the hospital compare repository database, and transcripts from the executive leadership team interviews. This section is dedicated toward answering the research question and is divided into the following categories: leadership processes, actions, outcomes, and a summary.

**Leadership Processes**

Schyve (2009) reported that good leadership is critical to the success of any healthcare organization. Moreover, in order for hospitals to survive in a complex policy landscape, it must also be appreciated as a system, where key leadership groups work together in the pursuit of excellence. The community hospital under study is no exception, where the leadership processes or the relationship between the leader, context, followers, and outcomes include an on-going collaboration between the following three key leadership groups: board of trustees, senior executive leadership team, and the leaders of the medical staff (Jago, 1982; Northouse, 2010). The primary mission adopted by the key leadership groups at the community hospital is “to provide the best patient experience with the best staff”. These key leadership groups recognize that the talents, skills, and knowledge of the employees are the greatest asset in the achievement of this mission. In other words, the workers are the hospital, not the walls, bricks, and mortar. Other goals include maintaining solvency, community service, and conducting ethical business behavior. (Policy & Procedure HR-046, Community Hospital internal document, 2008).

The CAO referred to the key community hospital leadership groups as a three legged stool that possess unique leadership responsibilities (CAO Interview, May 23, 2016). He clarified these roles as follows:
So the three-legged stool around leadership is the medical staff, its board, and administration. Let’s take the three-legged stool—we have various boards and board committees, and we do a number of workshops throughout the year including a leadership board retreat. But the board is there to set governance. The medical staff leadership has oversight into how care is delivered. The role of administration is to set the vision for the organization. (CAO, Interview, May 23, 2016).

Figure 1 provides a diagram of the roles and relationships between the key leadership groups at the community hospital and VBP. Stock, McFadden, and Gowen (2007) defined internal influences (board, medical staff, senior leadership team) as the emphasis on the maintenance and improvement of the existing organization while external influences reflects the emphasis on competition, adaptation, and interaction with the external environment (VBP).

Furthermore, Appendix E illustrates the community hospital organizational chart which outlines the hierarchy of the senior leadership team. Directly under the CEO is the CAO—who the other six senior leaders report through (CFO, CMO, CMIO, CNO, COO, VPO). Furthermore, the order of authority in the absence of the CEO is as follows: CAO, COO, CNO, CFO, CMO, and VPO. (Policy & Procedure MGMT-014, Community Hospital internal document, 2016).
Anning, Entin, and Totten (2011) reported that the governance role of a hospital board means two things: it is what a board does or how it exercises its role; and how the board does its work or the processes used by the board to perform its role. The role of the board at the community hospital is to govern, oversee the affairs of the hospital, and possesses the ultimate oversight and decision-making role. The board members consist of a diverse group of 15 former leadership executives with fortune 500 companies, community business owners, and physicians who practice at the community hospital (Policy & Procedure, MGMT-014, Community Hospital internal document, 2016).

The community hospital board does not take part in the day-to-day operations of the organization because this role is reserved for the CEO and the rest of the senior executive
leadership team. However, the board is responsible for overseeing administration and making key strategic decisions. These decisions include approving significant financial investments, the hiring or firing of the senior leadership team, and ensuring the organization follows their mission and values. Furthermore, the board is also involved with oversight of developing the mission and values of the organization, strategic planning, quality and patient safety, financial and management performance, and risk assessment. A good example of how a board exercises its role and outlines the leadership processes used to perform its work is related to ensuring quality by identifying appropriate performance standards, reviewing hospital and board performance against the standards, and ensuring that administration has appropriate plans in place to address any variances from these standards. (Community Hospital Bylaws, internal document, 2015).

The CEO of the community hospital is appointed by the Board and is vested with the necessary authority and is responsible for the administration of the corporation and all of its departments, subject to the policies enacted and orders given by the Board. The CEO’s duties include, without limitation, setting the vision for the organization, management of the corporation and oversight of the corporation’s assets, information and support systems, recruitment and retention of staff, and administrative leader designations (Community Hospital Bylaws, internal document, 2015).

The community hospital is also made up of physicians and other licensed independent practitioners who are organized into a “medical staff” and the leaders of the medical staff contribute to the leadership of the organization. The aim of the medical staff and its leadership at the community hospital is to strive for quality patient care. While the medical staff must work with and is subject to the ultimate authority of the board, the cooperative efforts and oversight by
the medical staff, administration, and the board are necessary to fulfill the mission of the community hospital in providing quality patient care (Medical Staff Bylaws, Community Hospital internal document, 2016).

Furthermore, the unique role of the medical staff within a hospital context has two important implications for the leadership processes that affect the ability of the organization to accomplish their mission: (1) the licensed physicians cannot be clinically supervised by the majority of most board or senior leadership members because they are not licensed independent practitioners; and (2) clinical decisions that are made by the medical staff about their patients drives the utilization of the resources (laboratory, medications, nursing, radiology) and affect the organization’s ability to provide safe, high quality healthcare services (Schyve, 2009).

The leadership processes among the three leadership groups as they engage in their influence and decision making are as follows: the senior leadership team is responsible for the vision to design and implement of processes (e.g., adopting evidenced based practices in the EMR) within the hospital; the governing body or board exercises governance by encouraging the chief executive to invest in these processes; and the medical staff leadership and clinicians provide oversight that the implemented processes are delivering patient care safely. The governing body, senior leadership team, and the leaders of the medical staff must collaborate because one group without the other, cannot accomplish the complex tasks of adopting a systems approach to patient safety and achieving other goals such as meeting the VBP requirements that impact financial sustainability, and community service (Community Hospital Bylaws, internal document, 2015; Medical Staff Bylaws, internal document, 2016).
Schyve (2009) further purported that it is now recognized that a team delivers patient care in the hospital and there is growing emphasis on the teamwork of the patient care team—the clinical “micro-system”. Even the patient and their families are now recognized as part of the micro-system. Furthermore, teamwork describes the desired state of collaboration among key leadership groups of the hospital and similar to the community hospital under study, include the following by-products of effective leadership processes: shared vision and goals among the members, a shared plan among the members to achieve the goal, clarity of each member’s role, the competence of each member, understanding of other member’s roles, strengths, and weaknesses; effective communication, monitoring other team members functions, conflict resolution, and developing mutual trust. Last, please note that all three variables (e.g., senior leadership team, board, medical staff) are important, but this research mainly focused on studying the senior leadership team change processes at the community hospital as it specifically related to the policy provisions of the VBP program, as part of the ACA.

**Senior Leadership Roles**

In the case of the community hospital under study, it is important for the reader to understand the senior leadership team’s vision of leadership and a clarification of each member’s role in order to provide the context for how the leadership processes work and how decisions were made that affected service levels on behalf of Medicare patients. During the structured interviews with the CEO, which included two sessions of over 50 minutes each, the researcher discovered a real passion for leadership. For example, his response to what was their definition of leadership included 3 ½ single spaced, typed pages of transcript, and over 2400 words. To illustrate his point, the CEO described his leadership role as:
I am the president and CEO and I have been that for 13 years. I am the orchestra conductor. My job is to make sure that I have the best people playing in the orchestra. I look at the piece of music that we need to do, which is the future and I wouldn’t say I do this completely by myself. But then you say where do we want this piece of music to go, and then what you have to do is inspire the players to do it to their best and pull it off. (CEO, Interview, May 19, 2016)

He further described his views on leadership in the following commentary:

I believe that everybody can attack the definition of leadership in a different way, but this has worked for me. You need to have the right person, which is important. It is all uphill if you don’t. Having one leader astray can bring down the ship. In light of this, I had to make some changes at one point because they were not on the same page and it made a big difference because the new leaders are energized. Furthermore, the leader is not the manager. Managing is ensuring that something is done right and a leader consistently does the right thing. (CEO, Interview, May 19, 2016)

The second in command at the community hospital is the CAO or Executive Vice President and who works closely with the CEO on a daily basis. In light of this, it is no accident that the office of the CAO is located directly next to the CEO. He also possesses 24 years of healthcare experience and has worked his way up through the ranks between line and staff roles to reach his current position. He holds a Bachelors degree in Health Administration, and a Masters degree in Business Administration/Industrial Engineering. In terms of his leadership style he said, “I do believe in servant leadership. Especially in the industry we’re in which is
caring for others. You know having a service orientation is key” (CAO, Interview, May 23, 2016). Furthermore, the CAO lightheartedly described his role in the following manner:

[I think a lot of people are asking that] you know the title is Chief Administrative Officer. I am the Executive Vice President. You know really it is the operation and a lot of staff roles report up to me. The office of the CEO has a couple of roles that still report to him, but by and large the day to day and then even a lot of the strategy still reports through me. I have served in this capacity for six years.

(CAO, Interview, May 23, 2016).

The COO possesses 26 years of health care experience and served 22 years honorably in the U.S. Navy as a nurse practitioner. He also possesses a Bachelor of Science in Nursing and a Master’s Degree in Emergency Trauma. The scope of the COO’s role is very large within the hospital as two senior leadership team members (CNO, VPO) directly report through this office which encompasses 20 departments (e.g., emergency department, pharmacy, radiology). The COO also directly administrates over the following nine departments: ambulatory surgery center, decision support, food services, interior design, pharmacy, practice administration, community physicians, behavioral health, and volunteer services (Policy & Procedure MGMT-014, Community Hospital, internal document, 2016). He described his role and responsibilities as follows:

I am the Chief Operating Officer and I have been in this role since 2013. Prior to that, I was the director of our 50-bed emergency department. I am responsible for the day-to-day clinical and facility operations. Even though I have a Vice President of Facility Operations, I am responsible for the day in to day out
operations which include a lot of the clinical care delivery and compliance with our clinical core elements of healthcare delivery. In addition to that I track budgetary operations, special projects-making sure they are delegated to the appropriate authority for action, and then one of the most important and enjoyable is work force development. (COO, Interview, May 17, 2016)

The CNO is a nurse by background and holds a Doctorate in Nursing Practice (DNP) since 2012. She also previously held the title of CNO, and interim COO at a large hospital in the Midwest prior to her employment at the community hospital. She described her role and large span of control in the following commentary:

I have operational responsibility for 43 cost centers. It’s a total of about 1,100 employees and some are nursing specific and some are non-nursing (e.g., respiratory, transport). Conceptually, I have responsibility for nursing services everywhere it is practiced in the hospital. So whether it be a direct patient care type nurse or if it’s a nurse that is functioning in quality management or informatics, anybody who is functioning using their nursing license for practice, I am responsible for what they are practicing. (CNO, Interview, June 8, 2016)

The CFO is another example of the many executives that have been promoted from within as evidenced by spending 10 years in the controller position at the community hospital prior to his promotion in 2014. He possesses a Bachelor of Arts in Accounting and a certified public accountant (CPA) license. He also held positions of leadership in other hospital systems prior to coming to the community hospital in 2002. He described his leadership role as follows:
I am currently the Chief Financial Officer and I have been for over 2 years now. Well, historically the perception of the CFO role is the top bean counter. And for the most part, you are worried about what the finances look like day-to-day and you’re trying to cut costs all the time. However, I have also seen more value in the CFO role which is also becoming a partner with the other executives, specifically the strategy side of things. I work very closely with the CAO and we focus on growth. So it’s not necessarily cost cutting, its growth, its strategy, it’s where we are headed and sort of being that counterbalance between finance and strategy. It’s really being a strategic partner with the other executives in this, all putting in a perspective in where we think we need to go and how do we get there. (CFO, Interview, May 20, 2016)

The VPO has a clinical background in respiratory therapy. He also possesses a Bachelor of Health Science in Respiratory Therapy and a Master of Health Science degree. The following community hospital departments report directly to the VPO: laboratory, radiology, rehabilitation services, plant services, engineering, environmental services, security, and supply chain. He also meets with each department director in these areas once a week in an effort to keep updated with each operation and to provide support when necessary (Policy and Procedure MGMT-014, Community Hospital internal document, 2016). He explained his role and his view of leadership in the following commentary:

My title is Vice President of Operations and I have served in that role for 16 years. Before that I served as administrator of clinical/technical operations and the total amount of service to the hospital is 35 years. I think leadership is
establishing a clear vision, sharing the vision, providing information and
knowledge to allow the organization or group that you are leading to be able to
realize the vision and setting and monitoring measures to be able to measure the
outcomes. (V. P. Operations Interview, May 16, 2016)

The CMIO is a physician who practiced family medicine for 24 years at the community
before moving into his current role. Prior to this he worked as a computer scientist for two large
companies and also possesses a Bachelor of Science degree in Computer Science. His medical
and computer background provided unique experiences and knowledge that assisted with the
executive leadership team response to the policy provisions of the VBP program as part of the
ACA. In particular, the CMIO was instrumental in ensuring a successful transformation to the
new EMR on July 1, 2013. He described his role as the following:

I am the Chief Medical Information Officer for the hospital. I have been here 5
years. Prior to that I was both President of the Medical Staff, Chief of Staff,
Chairman of the Department of Family Medicine, and I have been on the board
for 15 years. I am still serving on the hospital’s investment finance committee for
the past 16 or 17 years. That has certainly given me some insight into hospital
finances and the needs of the hospital. As a family doc you are just trying to get
through the day and solve this problem with the patient, you do not have the
luxury of thinking about how everything works. And seeing that now in a
different light has made a big difference. I think the most important thing the
leadership team does is to set the vision for the hospital and with that vision
comes the culture. (CMIO, Interview, May 23, 2016)
Last, the CMO is also a physician who spent 20 years in private practice in the past. He was educated to the field of quality improvement in Salt Lake City, UT, underneath the tutelage of Brent James, M.D. and is a Fellow of the American College of Physicians (FACP). He provided a description of the CMO role in the following excerpt from the interview:

I have been here for 16 years. I initially was the Vice President of Quality and that changed to Chief Medical Officer about five years ago. My role is to preserve quality through problem solving and to serve as an intermediary between the physicians and administration. Leadership is being on the front line. Being there to solve problems first (CMO, Interview, May 18, 2016).

**Team Leadership**

Team leadership was discovered throughout the data analysis phase of the study. The participant responses were consistent in terms of executive decision making within the community hospital context is a team effort and everyone has a voice. This was not a surprise finding by the researcher because of the aforementioned complexities that are faced by hospital executives in the VBP era where it would be hard for any CEO today to make all of the decisions that affect hospital operations (e.g., GMT). A good example of how to attack this complexity through a team leadership approach was provided by several of the senior leadership team members. Their accounts will provide the reader with context of how team leadership was applied at the community hospital as part of the executive leadership response at the community hospital to the VBP policy provisions as part of the ACA.

First, in the transcript below the CEO again depicts his role within a team-oriented approach as the orchestra conductor which is important because his philosophy promotes a
collaborative decision-making process among the other executive leaders at the community hospital which can enhance team performance. He also provided a good example of the internal task leadership action of maintaining standards of performance by ensuring the senior leadership team members are fulfilling their responsibilities by periodically checking in the following commentary:

So the leadership part is putting people together and getting them to buy into it. Having the right people in the first place and continually monitoring where things are going without getting in people’s way. Encouraging people when they do well, and nudging them when they are off course. So it’s sort of like the conductor. My job as much as anything is to make sure that everybody is doggedly doing that instead of getting off in some other direction. I learned a long time ago that you cannot rely on people doing what you think they are doing because sometimes they are not. Periodically, you have to check. One of the things we do and this helps us all keep working as a team, is we have a meeting once every other week with the senior management team people. And I have one every Monday with a handful of executive leaders and we go around the room and everyone says that where they are with what they are doing, which is useful because sometimes what they’re doing requires my help or from all of us. (CEO, Interview, May 19, 2016)

The CAO also provided his feedback on team leadership in healthcare and which includes a good example of the internal task leadership action of facilitating decision-making (informing) in the following comments:
Well, the way I view healthcare right now it is a team sport. We need to empower our folks to be in a position that they can make decisions at the front line you know as it relates to way that our group works. There is a consensus, but we’re not leaderless armies. There are decisions the CEO makes and we carry it out. I would say is it relates to this leadership team, its one where we are getting much better at exchange and you know really vetting these ideas. Because of the size of our organization, I think we’re much more nimble and you know we meet frequently enough. The key for us is to stay small as we grow in terms of that locust of decision-making power. (CAO, Interview, May 23, 2016)

The CNO explained the process of how decisions are made at the community hospital. This speaks to one of the strengths of the Hill’s (2010) team leadership model where any team member can perform the critical leadership functions to assess team effectiveness and then is empowered to make decisions accordingly. Moreover, she also provides a good example of an external environmental leadership action where the VPO would gather information from the environment and bring it back to the team for discussion/analysis:

I would say it is much more of a team approach. Sort of lending to each group members expertise and borrowing from each other. I feel empowered to make decisions specific to patient care, implementations, policies, and protocols. I will certainly check in and get approval before going down a path but feel that individuals recognize that each leader possesses a content of knowledge that that is specific to their role (e.g. nursing) and all of combined makes us a whole. But I think ultimately it does not feel micromanaged. A good example would be the
VPO bringing back information from the group purchasing meetings and the CAO would weigh in on his thoughts and ultimately the CEO would decide what we are going to do. (CNO, Interview, June 8, 2016)

The COO also described the decision-making process at the community hospital using an analogy that nicely represents an internal task leadership action of structuring for results or visioning. Additionally, the feedback that the CEO provides also illustrates a good example below of the internal task leadership action of maintaining standards of excellence where he ensures the vision is heading in the right direction that benefits the organization:

I think we are blessed here where the CEO sets a vision of where he wants to be and then basically throws a ball up in the air and says catch the idea and now let’s put it in operation. The CEO empowers and basically gives the authority and autonomy to do whatever we would like as long as we are going along with that vision. I think that is a great way to work because he’s always there for feedback and clarification. The neat thing about being here is there is a lot of cross communication and nobody feels like they are in a silo. Everybody has an open door to run ideas by so that we’re not putting somebody down the wrong path. That occurs at all times of the day an even occurs in your department. (COO, Interview, May 17, 2016)

The CFO at the community hospital also illustrates the collaborative leadership process at the community hospital where each senior leadership team member has a seat at the decision-making table and is a good example of an internal relational leadership action (e.g., inclusion, involving):
I think it is very much a team approach. I always provide my opinion. I think everybody is encouraged to speak up. I think over the last couple of years, I’ve seen everybody on the management team speak up more and more. A lot of times what happens even in strategy and things that are going on, you really end up with a lot of your executive team running ideas up through the chain. And that could be me passing an idea off the CAO first, talking to him about it—what do you think? And then end up sitting down and talking to the CEO and see what he thinks and so it’s a collaborative decision-making process. (CFO, Interview, May 20, 2016)

Furthermore, the VPO discussed the team leadership approach is not just for executive leaders, but can be found at all levels within the community hospital staff. This example points to another strength of Hill’s (2010) team leadership model which characterizes leadership as a team in which the leader’s role is to do whatever is necessary to help the group achieve effectiveness. His commentary below also depicts the external environmental leadership action of sharing relevant information with the team in these comments:

We have a very team oriented structure. Different people in the organization certainly have different skill sets and responsibilities and are closer to different areas of the operation so it is important to have the strategic input from the leaders of certain areas of the hospital. Not those leaders alone but because many times decisions that are made in a specific area of the hospital impact other areas. You may have for example a leader that has responsibility for the supply chain area of the hospital and a decision is made in the supply chain area and the availability or purchase of a physician preference item may impact the medical staff, or nursing
staff, or the radiology staff. So again you have to have input from leaders as well as rank and file staff in all these areas. (VPO Interview, May 16, 2016)

Moreover, the CMIO further described the internal relational leadership action of a collaborative decision-making process among the senior leadership team at the community hospital in his commentary below:

It’s a team effort. We have meetings sometimes once a week and sometimes twice a week. Each of us goes around and talks about the things we are doing and about the problems that we face. People chime in and go well why don’t you try this or why don’t you do that or I’ve had the same problem and this worked. And it’s really a team collaboration. (CMIO, Interview, May 23, 2016)

Last, the CMO also referred to the decision making process at the community hospital as a team leadership approach where teams are formed to attack the issues throughout the organization in the following commentary:

Team’s number one and each vice president has projects that we get together and work together and decide on which side to go. The CEO is an experienced leader and puts in his 2 cents when appropriate. It’s a lot of human capital coming together with high levels of experience and varied backgrounds. It’s basically shared leadership. (CMO, Interview, May 18, 2016)

In summary, while the researcher acknowledges Hill’s (2010) model as a theoretical framework for understanding the complexity of team leadership within a community hospital context, it is by no means the only leadership model that can be applied as part of this research study. Rather, Figure 2 depicts the researcher’s conception of how the leadership processes
actually worked at the community hospital under study. The leadership processes begin with the CEO who ensures he has the right people on the senior leadership team. This is vital because having one weak link can significantly impact team effectiveness. Next, the CEO sets the vision for the organization and through a collaborative effort with the other members of the senior leadership team they strategically align the organization for the implementation of high quality objectives. However, before the objectives can be implemented, the senior leadership team initiates an effective change process where the vital components of structure (e.g., organization chart), systems (e.g., adopting evidenced based practices), and culture (e.g., iCARE) have been addressed. The goal of the leadership change process at the community hospital is to improve quality and the vehicle adopted for this performance improvement is the PDCA model. Next, via a team leadership approach, the objectives are implemented with the goal of delivering high quality healthcare services on behalf of the community.

Nadler and Tushman (1977) referred to input as the culture, the resources available to the organization, and the subsequent strategies (e.g., VBP) that are developed and then evolve over time. Strategy refers to how the organization’s resources are best utilized within the culture for optimal organizational performance. While the key components of outputs are system functioning, group behavior, and intergroup relations. With respect to the effectiveness of system functioning the following factors are important to consider: (1) did the organization achieve their desired goals of production, service (e.g., improve quality care), return on investment? (2) how well did the organization utilize its resources; and (3) how well is the organization addressing the changes in its environment over time? Moreover, the Burke-Litwin (1992) model depicts an open systems approach to leadership and change where the external
environment (e.g., VBP) serves as the input factor and the organizational performance (e.g., delivering quality care) represents the output factor.

Figure 2.

Community Hospital Leadership Processes

Leadership Actions (Response)

An effective executive leadership response to any public policy affecting community hospitals that provide service to Medicare patients’, starts with good leadership at the top and throughout the organization. The CEO at the community hospital illustrated this point when he stated, “we have an extremely dedicated, high performing leadership team…everybody understands the mission and their role and every single person is thinking what else can we do” (CEO, Interview, May 23, 2016).
Leadership Vision

An important sub-category within team leadership that was discovered by the researcher through the participant interviews was evidence of the senior leadership team’s vision back in 2008-2009. This was well in advance of the impact of the impending ACA legislation in 2010, and the specific policy provisions of the VBP program which would affect community hospitals who service Medicare patients. Why is leadership vision important for any hospital senior leadership executive? The answer to this question is well addressed by the CEO in his commentary:

One of the big things we needed to address was how to survive in an environment where Medicare reimbursement was being reduced in order to control costs. The key is figure out how to provide good quality, but with cost containment. However, this hospital is not a speed boat, but an aircraft carrier. You cannot address something as complex as healthcare and turn it on a dime. (CEO, Interview, May 19, 2016)

Strategic Alignment

In 2009, the senior executive leadership team also recognized the importance to align with the medical staff and board of the organization towards achieving success which included developing a broader scale prior to when the ACA and VBP began impacting the community hospital. This was vital because Medicare makes up 47% of the total reimbursement for the community hospital and who operates on “razor thin margins” annually (CAO, Interview, May 23, 2016). The CAO further summarized the importance of this alignment planning in these comments:
We began this process in 2009 because we recognized the headwinds coming with the ACA made it important to align regionally with other health systems in order to have scale. Within our community, we believe in preserving the independent practice of medicine so we also created an ACO. The biggest risk associated with value-based purchasing is if you do not provide quality care in an efficient manner, you could lose access to Medicare patients. (CAO, Interview, May 23, 2016)

Furthermore, a community hospital that relies on 47% Medicare reimbursement for their survival, cannot place themselves at the risk of losing patients because it could affect their solvency. To best illustrate this point the CMO bluntly stated: “No money, no mission.” (CMO, Interview, May 18, 2016)

Collaboration

The analysis of data revealed strong evidence of a collaborative approach to decision-making among each of the study participants, medical staff, and board. Collaboration offers members full responsibility for achieving change. By enhancing members roles in governance and decision-making, buy-in to implementation, and the outcomes can be strengthened. A good example of collaboration with the board is outlined by the CMO in his comments below:

All of our board members are part of our external leadership program as well and are informed of the sharing of information at all times. Especially, when it comes to sharing of finances so they know what is going on. They advocate direction for where to put the money, not just how to make it. And they recommend where the community resources are best spent. (CMO Interview, May 18, 2016)
Core Measures

Davies, Nutley, and Mannion (2000) reported that health policy is mainly concerned with improving the quality of healthcare. This focus on quality is what prompted the U.S. government to enact the ACA and VBP in order to shift from pay for volume to a model that is geared towards pay for performance. In other words, the government was no longer willing to reward low performing hospitals who exhibited poor quality and patient satisfaction scores, with the same reimbursement as top performing organizations. In this new payment model, VBP encourages hospital senior executives to focus on improving the service levels of Medicare patients or risk losing vital governmental reimbursement which can impact the solvency of these organizations.

The impact of VBP for the community hospital under study in FFY 2013-14, was significant because during this initial VBP period, up to 2% of Medicare reimbursement annually was at risk or a total of $4M. The CFO confirmed this amount in the following statement: “Medicare is approximately 50% of our business. It’s big, it’s millions. So you are looking at every percent, that’s a couple of million dollars” (CFO, Interview, May 20, 2016).

The participants highlighted that a critical component of being successful in the VBP era was collaboration and alignment with the medical staff. In other words, if the community hospital and physicians work together toward the improvement in core measures there was a higher chance of success versus working independently in this new pay for performance payment model. The CEO outlined the collaborative steps the community hospital did to impact core measures via a team leadership approach in his commentary below:
What we did was run everything through the CMO and the director of quality, who established a work team for each core measure. And for some of them, we also assigned a nurse practitioner in order to spearhead the hardwiring of the documentation in the EMR. Next, the hospital quality & efficiency (HQEP) contract was established through the ACO. This is an agreement between the hospital and physicians to improve quality, utilization, and efficiency. So it was a two pronged thing: we set up teams for each core measure and we identified key ones as part of the HQEP contract; and incentivized the physicians to do that. (CEO, Interview, May 23, 2016)

The participant responses reflect that the community hospital has performed adequately in the VBP policy provision area of core measures. This was an area the participants were proud of because ensuring quality and safety is a primary mission of the community hospital and is central to their executive roles. This was echoed by the VPO who stated, “from our own internal measures we have been highly successful.” (VPO Interview, May 16, 2016)

**Patient Satisfaction**

The participant interviews and the hospital compare data revealed that the community hospital is struggling with ringing the bell in the domain of patient satisfaction. The researcher detected a palpable frustration among the participants that in spite great focus by the executive leadership team in this area, it has not produced favorable results. Part of the difficulty with hospitals scoring well in this area is the subjective nature of patient perceptions of quality. As the CMO explained, “Patients think of hotel functions like were the meals on time, were the people that served them nice, did the nurse respond to them.” (CMO, Interview, May 18, 2016)
A specific strategic objective the executive leadership team implemented in response to the patient satisfaction policy provisions of the VBP program, was contracting with the Studer Group in 2010, an international healthcare consulting expert. The goal was to assist the community hospital with increasing patient satisfaction scores through the implementation of hourly rounding for outcomes on inpatient customers (CEO, Interview, May 23, 2016). The goals of hourly patient rounding were to improve clinical outcomes and increase patient satisfaction through reducing the number of bathroom visits, pain threshold, bed positioning, IV pump alarms, and accidental hits to the call nurse light. Studer coached the community hospital nursing personnel in the following eight key rounding behaviors: using opening key words to reduce patient anxiety; perform scheduled tasks; address the three “P”s (pain, potty, positioning); address additional comfort needs; conduct an environmental assessment; prior to leaving the patient room inquire if the patient is need of anything; inform each patient when you will be back; and document the patient round in the chart. Additionally, in 2010, the community hospital also created a clinical and ancillary team to work on improving patient satisfaction. For example, the clinical team on the 4th nursing floor, targeted pain control and responding to the nurse call bell sooner and which were demonstrating signs of improvement (Directors Meeting Minutes, internal community, August, 2010).

Decision to Install a New EMR (Allscripts)

Another major action that arose from the data analysis phase was the participants expressing how central changing to a new EMR (Allscripts) was to preparing for VBP and the future of the community hospital. The significance of the transition is best illustrated when the CEO stated, “Allscripts is the biggest strategic initiative since moving to the new hospital in
1998. Each director needs to give their full attention to this project because it is critical to our future success” (Directors Meeting Minutes, Community Hospital internal document, September, 2012).

The VPO also purported why a new EMR was important in the following comments:

We had to do some things like bring in a new EMR into the future from where we were. We had a functional EMR system (e.g., Meditech), but it could not meet the standards and measures as part of the ACA into the future. That was a big initiative for us in 2013, with moving forward with a new EMR. (VPO, Interview, May 16, 2016)

The CAO also illustrated the need for a new EMR while answering interview question PI17, where the researcher asked him to describe what best practices did the community hospital adopt that impacted core measures for the period of FFY 2013-14:

As you know healthcare IT is still developing and is more built around the programmer than the physician practice. In order to be relevant going forward we have to better influence the entire care continuum. We have to have visibility and that’s all IT. Within the walls of the hospital we needed a system that will interface with other systems in order to have visibility outside these walls. The old system would not allow us to do that. (CAO, Interview, May 23, 2016)

The study participants revealed that it was no small task for the community hospital in terms of transitioning from one EMR to another. It came with growing pains from an operational standpoint and was also a huge financial investment. The operational difficulty is illustrated in
the comments from the VPO in responding to interview question PI29 relating to the difficult
EMR transition in 2013:

- Was and is. Still four years later we are still building some of the core areas of the
  EMR. Part of that was because in the 2012-13 time-frame, there was not a mature
  EMR option in the marketplace. (VPO Interview, May 16, 2016)

The process for the selection of the new EMR commenced in early 2010, where an IT
committee was formed that included both IT personnel and physicians (Board Meeting Minutes,
Community Hospital Internal Document, July 21, 2011). A major driver in the decision making
process from the IT committee to choose the Allscripts EMR was it exhibited an open
architecture design. This was important because after a thorough review of multiple vendor
EMR’s (Cerner, GE, Epic, Meditech) revealed that most of them would not allow customization.
In other words, you had to live with their design and adopt their associated workflow. This was
clearly not an option for this community hospital and is captured in the following statement from
the CFO:

- The cost of Allscripts was $30M and is considered an open source where you can
  assist with the design of interfaces you need. It’s not letting the company design it
  for you. You can have input and customize that meets the hospital’s needs. So
  that’s ultimately why we chose Allscripts. (CFO, Interview, May 20, 2016)

The open architecture design allowed the community hospital IT department to build
order sets that were specific to each VBP core measure (HF, MI, pneumonia). The order sets are
based on evidenced based practices and were validated based on Zynx software which provided
an extensive library of evidenced based practices and clinical decision support. The CMIO
announced to the physicians at the medical executive meeting on January 25, 2012, that “Zynx software will be utilized as their evidenced based order sets. The order sets are based on literature and evidenced based medicine from 1900 hospitals” (MEC minutes, Community Hospital internal document, 2012). His point was also validated in the following commentary:

Zynx is a California company that employs about 50 physicians who review all the medical evidence, all of the societies, both in the U.S. and all over the world. Then they publish via a website the best practices and evidence that should be considered for core measures. So we used their website to build order sets, not only with evidence, but with the e-link that physicians can access inside the EMR to actually see the evidence associated with that order. (CMIO, Interview, May 23, 2016)

Another advantage to these hardwired practices built into the EMR is the evidenced based order sets are also used in the community hospital sepsis program in order to monitor the health of the patient real time. This is best illustrated by the CMIO when he commented, “So there is a piece of software that kicks off every five minutes and goes through every patient in the hospital. It looks and sees if this patient is likely to be septic based on their vital signs, based on lab reports, based on x-rays, based on cultures. And I think it has brought great value to this hospital because we are anticipating what is going to happen with these patients” (CMIO, Interview, May 23, 2016).

PDCA

Performance improvement measures are at the root of improving the quality of care in a hospital context. The community hospital under study was no exception, where quality is defined
as: “meeting or exceeding our customers’ expectations” (CMO, Interview, May 18, 2016). The commitment to quality was evident from the study participants and is clearly driven from the top of the organization down:

If we tell our hospital staff and physicians here is a way we can do a better job of helping people, they will be engaged in the process. If I tell them this is a way to help make more money, they will tune out. For example, I have never gone to a medical staff meeting and mentioned money. We have always talked about our focus on quality because they are interested in what we are doing benefit the patients. (CEO, Interview, May 23, 2016)

The commitment of the CEO to quality outcomes is also validated in the following statement from the CNO:

It is great to work for a hospital that is truly committed to patient safety and quality. The CEO keeps this focus at the forefront of his thinking and decision making. It is nice that he continuously is driving for this. (CNO, Interview, June 8, 2016)

A main performance improvement tool utilized at the community hospital in improving the quality of care is the PDCA model. For example, seven out of eight participant interviews confirmed that PDCA methodology is routinely utilized in community hospital performance improvement initiatives. The CFO was the only senior leadership member that failed to confirm PDCA during the interview process, but his role is more concerned with ensuring the financial stability of the organization and who does not possess a clinical background (e.g., accounting).
The COO illustrated the use of PDCA and the role of the board in continuous performance improvement via a team leadership approach in the following statement:

We do utilize PDCA as a primary driver of performance improvement. We also develop an annual performance improvement plan that is submitted and ratified by the board of directors. The plan focuses on the top 10-12 performance improvement initiatives throughout the organization that need to be addressed. Once the plan is approved, teams are formed to attack the issues. And throughout the calendar year, there is periodic reporting back to the clinical advisory committee, which is a sub-committee of our board of trustees. (COO, Interview, May 17, 2016)

The CMO’s role within the community hospital is to ensure the highest quality of care is provided to all patients in a continuous performance improvement mode. An advantage for the community hospital is the CMO has received specific training related to performance improvement and PDCA from experts in the field. The CMO eludes to this in the following comments: “and with my quality training in Salt Lake City with Brent James and Donald Berwick….they taught me PDCA” (CMO, Interview, May 18, 2016). Dr. Brent James is currently Chief Quality Officer-Intermountain Healthcare, Harvard School of Public Health and Dr. Donald Berwick, who was the former administrator for CMS, and one of the main authors of the ACA.

A good example of a successful PDCA initiative for the community hospital and spearheaded by the executive leadership team, is the VBP core measure related to heart failure (HF) readmissions which commenced from October, 2013-August, 2014 (PDCA-Heart Failure
Readmissions, Community Hospital internal document, 2014). Lichtman, Jones, Leifheit-Limson, Wang, and Goldstein (2011) reported that Medicare defines a readmission as any patient who has been admitted to a hospital within 30 days of discharge from the original admitting hospital. The main reason the executive leadership team decided to conduct a PDCA is the VBP performance score for the core measure of heart failure was not meeting the target. A major contributing factor for this poor performance was related to the community hospital transitioning to a new electronic medical record (EMR) from Meditech to Allscripts on July 1, 2013. Because of this new EMR system, many of the community hospital processes that had been developed within the Meditech EMR, were now broken and new work flows had to be redesigned with new reports developed to monitor data concurrently. In order to accomplish these many tasks, an informatics department was established and additional financial allocation was given to the clinical decision support department to make it more robust to meet the immeasurable demands that were being placed on it from all throughout the community hospital. Specifically, the heart failure core measure took a hit which was directly attributed to very low compliance on discharge instructions documentation (CEO, Interview, May 19, 2016).

Plan

The main problem identified by the community hospital was the decreasing documentation of left ventricular systolic (LVS) function and HF discharge instructions in the patient medical record which resulted in inconsistent readmission rates. This project was important to study because HF is a major public health issue that affects more than 5.8 million Americans. HF is also the leading cause of hospitalization among adults >65 years of age, which places a
considerable burden on the U.S. healthcare system in the amount of $39 billion annually, as well as high rates of hospitalizations and readmissions (Bui, Horwich, & Fonarow, 2011).

Furthermore, according to Yancy et al. (2013), the national guidelines established by the American College of Cardiology (ACC) reflect that left ventricular (LV) function is the single most important test in evaluating HF and the diagnostic results aid in the selection of appropriate medication regimens. In order for patients to manage their HF they need proper understanding of dietary restrictions, activity recommendations, medication regimens, and the signs and symptoms of worsening HF. The non-compliance with diet and medications is an important reason for the deterioration in the HF patient.

In 2009, CMS also began public reporting of all-cause readmission rates for HF hospitalizations. The ACA established financial penalties for hospitals with the highest readmission rates during the first 30 days after discharge. In 2013, CMS charged a total of 2,213 hospitals approximately $280 million in readmission penalties. Hospitals might lose up to two percent of their Medicare reimbursement if they accrue too many patient readmissions within 30 days of discharge (Mathews, 2015).

A gap analysis was performed in order to provide the community hospital PDCA project team (administration, case management, nursing services, quality management) with a format in which to compare best practices with processes currently in place. It was also helpful in determining the gaps between the community hospital practices and identified best practices nationally. For example, the U.S. national rate of unplanned readmission for HF is 30% (Gheorghiade, Vaduganathan, Fonarow, & Bonow, 2013) and the community hospital scores
were 28.2% for the period of July-September 2013. Additionally, the LVS function
documentation at the community hospital for the period of January-March 2014 was 95%.

The community hospital PDCA team members also identified the following root causes
that can impact HF readmission rates: the lack of consistent documentation of LV function can
delay the proper HF diagnosis and treatment because the lack of data make it difficult for
clinicians to determine if the left side of the heart is affected, a deficit of HF discharge education
and in-hospital teaching, ineffective follow-up of home care services for discharged patients, and
the failure of physicians to identify the HF patient on the problem list.

Check

Next, the community hospital PDCA team members analyzed data utilizing the following
framework: the number of inpatients with documentation of LVS function evaluation either
before arrival, during hospitalization, or is planned after discharge as a percentage of HF
patients; HF patients with complete discharge instructions as a percentage of HF patients
discharged home; and non-elective inpatients returning as an acute care inpatient within 30 days
of date of discharge as a percentage of all inpatient HF discharges.

Act

The community hospital PDCA team members provided the following recommended
solutions:

- Develop a complex case management program to target HF patients from arrival to
discharge.

- Develop a HF program that utilizes a nurse practitioner (NP) for follow-up home visits and
  education of the hospitalized inpatient.
• Trigger social services on admission to determine if there is a social component for the readmission.

• Identify all patients that have had an echocardiogram (e.g. ultrasound study of the heart) during the inpatient visit to the hospital.

• The HF coordinator will identify patients that have been diagnosed with HF and provide and document the education to ensure that LV is reflected in the patient chart- If this is not the case, the coordinator will remind the attending physician to do so.

• The HF coordinator will collaborate with the case management department regarding patient needs and provide documentation in the chart regarding evaluation.

• Develop a query to the physician to add HF to the problem list which would trigger a medical logic module (MLM) to fire at discharge to remind the physician to complete the core measure intervention on the discharge order.

• Create a MLM to remind the physician to utilize the HF discharge order set.

• Revise HF patient discharge instructions to include information about weight monitoring and worsening of symptoms.

• Investigate and correct misfiring MLM trigger to remind physicians to complete the cardiology section of the discharge order set.

• Identify any process breakdowns that allow mandatory fields to be by-passed.

• Explore the possibility of entering the ejection fraction results in a discrete data field in order for it to populate on the HF discharge order set to assist physicians with identifying the appropriate medication.
• Create a report that identifies all patients with elevated troponin levels and b-type
  natriuretic peptide or BNP’s and a report that consists of all patients with a diagnosis of
  HF, congestive HF, or cardiomyopathy.

**Implementation Time Line:**

• Oct. 2012-HF transition to NP commences.
• Feb. 2014-social services began tracking all readmission patients.
• March 2014-case management begins complex case management program.
• May 2014-discharge instructions for weight monitoring and worsening symptoms printed
  at discharge for all HF patients.
• June 2014-HF coordinator commences new identification processes for HF patients.
• July 2014-exit care revised to pre-populate the data of weight gain and diet.
• August 2014-clinical decision nurse will evaluate HF charts 2 days after admission.
• August 2014-augment the “Activity, Follow-up diet” as mandatory data fields on the core
  measure discharge order.
• August 2014-information technology department to identify and rectify any MLM
  misfires.
• Sept. 2014-Create a report that assists the HF coordinator with identifying all HF patients.
• Sept. 2014-name a cardiologist as HF physician champion.
• Oct. 2014-document EF in data field on HF patients.

The community hospital performance measures indicated favorable results for this PDCA
initiative for the period of October 2013-August 2014. First, the number of inpatients with
documentation of LVS function evaluation either before arrival, during hospitalization or is
planned after discharge as a percentage of total HF patients, averaged 99.12%. Next, HF patients with complete discharge instructions as a percentage of HF patients discharged home averaged 74.11%. Last, the non-elective inpatients returning as an acute care inpatient within 30-days of discharge as a percentage of all inpatient HF discharges averaged 21.93%, which was below the national unplanned readmission rate average of 30% (PDCA-Heart Failure Readmission, Community Hospital internal document, 2014).

**Leadership Performance Outcomes**

**VBP- Core Measures**

The aggregate core measures in FFY 2013-14 from the hospital compare website demonstrated the community hospital sustained the same hospital percentile score of 48% in both years (Table 2). The percentile rank indicates performance relative to its peers, where the 100th percentile represents the best performance, and the 1st percentile represents the worst. In this case, the community hospital ranked in the middle of the pack for core measures among approximately 3000 acute care hospitals in the U.S. who participate in the VBP program.
Please also note the domain weight changed from 70% in FFY 2013, to 45% in FFY 2014, because the outcomes of care domain was implemented in FFY 2014 for the first time as part of the VBP program. In order to provide clarity for the reader, the individual processes of care which make up the aggregate core measures scores are listed below:

**Acute Myocardial Infarction (AMI)**
- AMI-7: Fibrinolytic therapy Received within 30-minutes of hospital arrival.
- AMI-8: Primary PCI received within 90-minutes of hospital arrival.

**Heart Failure (HF)**
- HF-1: Discharge Instructions.

**Pneumonia (PN)**
- PN-6: Initial antibiotic selection for CAP in immunocompetent patient.

**Surgical Care Improvement (SCIP)**
- SCIP-INF-1: Prophylactic Antibiotic received within 1-hour prior to surgical incision.
- SCIP-INF-2: Prophylactic antibiotic selection for surgical patients.
- SCIP-INF-3: Prophylactic antibiotic discontinued within 24-hours after surgery end time.
- SCIP-INF-4: Cardiac surgery patients with controlled 6 a.m. postoperative serum glucose.
- SCIP-INF-9: Postoperative urinary catheter removal on post operative day 1 or 2.
- SCIP-CARD-2: Surgery patients on a beta blocker prior to arrival that received a beta blocker during the perioperative period.
- SCIP-VTE-2: Surgery patients who received appropriate venous thromboembolism prophylaxis within 24-hours prior to surgery to 24-hours after surgery.

**Preventative Care**
- IMM-2: Patients assessed with given influenza vaccination.

**Maternity Care**
- PC-01: Elective delivery prior to 39 completed weeks gestation.

**VBP-Patient Satisfaction**

The aggregate HCAHPS patient satisfaction scores for the community hospital for FFY 2013 and 2014 from the repository database revealed that each of the six summary measures, or composites, is constructed from two to three survey questions. Combining related questions into
composites allows consumers to quickly review patient experience of care data and increases the statistical reliability of these measures. The six composites summarize how well nurses and doctors communicate with patients, how responsive hospital staff are to patients’ needs, how well hospital staff helps patients to manage pain, how well the staff communicates with patients’ about medicines, and whether key information is provided at discharge. Additionally, the two individual items address the cleanliness and quietness of patients’ rooms. Publicly reported HCAHPS results are based on four consecutive quarters of Medicare patient surveys.

The community hospital consistently depicted low patient satisfaction scores in the 20th and 33rd percentile (Table 2) when comparing FFY 2013 and 2014 HCAHPS data. The only exception was the overall hospital rating score (72.90%) in FFY 2014 which surpassed the CMS 50th percentile score of 71%. The CMS 50th percentile reflects the median benchmark or 50% of hospitals will score better and 50% will score lower. It is also considered the second quartile out of four. However, the community hospital did demonstrate an incremental improvement in six out of eight measures, and an overall average improvement from 69.59% in FFY 2013 to 69.77% in FFY 2014.

Moreover, the increase in quiet scores from 53.07% in FFY 2013 to 58.87% in FFY 2014, might be attributed to the community hospital forming a quiet task force in 2014 to study this phenomenon, but is unlikely. The VPO purported:

We have given our staff a lot of training and modeling in terms of how to handle patient requests. Strategies were implemented like discontinuing the use of the overhead paging system past 8 p.m. at night, adjusting ring tones on hospital telephones to a lower decibel setting, and encouraging staff to use their inside
voice when conducting hospital operations on the patient floors (VPO, Interview, May 16, 2016).

This is important because a quiet hospital environment promotes sleep, which several scholars report is essential to energy restoration and physical recuperation of patients (Dennis, Lee, Woodard, Szalaj, & Walker, 2010; Huisman, Morales, Van Hoof, & Kort, 2012).

**VBP-Efficiency**

Furthermore, a review of the hospital compare repository database revealed the community hospital scored in the 48th percentile in both FFY 2013 and 2014 for core measures; and exhibited a 20th and 23rd hospital percentile rank in patient experience of care for the same period. Performance on all domains (e.g., process of care, patient experience of care, outcomes of care, efficiency) was combined to calculate a total performance score (TPS) which was used to redistribute contributions under the VBP program. In 2013, the community hospital TPS was 50% which landed in the 37th percentile as compared to the 2014 TPS score of 47%, which escalated to the 52nd percentile. Ultimately, the community hospital demonstrated financial improvement in VBP reimbursement where in 2013 the government withheld an estimated total of ($34,192) versus only ($5,933) in 2014 (Table 2). This demonstrates efficient financial performance during the initial 2013-14 VBP period, given the stakes were high and the community hospital was at risk to lose an estimated $4M annually for demonstrating poor performance (CFO, Interview, May 20, 2016). However, it still would be difficult to correlate the executive leadership response to VBP for any direct improvement in core measures or patient satisfaction scores and subsequent reimbursements.
Accountability

The importance of this community hospital to the patients in this region cannot be overemphasized, especially because the relationship dates back to the late 1800s. Medicare patient’s not only comprise residents outside of the hospital walls, but also includes hospital employees, board members, and physicians who also live in the local community. These factors have created a unique relationship between the residents and community hospital stakeholders which include it is the only facility that resides in the county. A real problem might occur if the community hospital executive leaders do not produce an effective response to the VBP policy provisions of the ACA that can impact the solvency of the organization. This would force local residents to drive 25 miles to the north or south to seek routine and emergent healthcare services. This makes a strong argument that it was vital that the executive leadership team at the community hospital develop a strong response to the VBP policy provisions of the ACA in order to continue to provide healthcare resources that Medicare patients have come to depend upon.

This point is best illustrated in the following CMIO commentary:

This community hospital is essential to the residents of this region. Not only that, but I would go further to say how important is this hospital to the entire country. This is a bold statement, but we have a very unique position because we are not challenged by other hospitals. We have the resources to a lot of great things and were in the process of doing it. (CMIO, Interview, May 23, 2016)

The following commentary also echoes the unique relationship the community hospital has with its residents:
First we have been in business for a long time when the founder endowed the hospital. We are a one hospital county. Because of our long-term relationship with the community and this county has doubled and tripled in size and continues to grow very rapidly that we have a close relationship. We also have a strategic relationship with our local governing board whose members who also live in the community, plus our physicians only practice at this hospital, which creates a lot of synergy that allows us to be successful. (VPO, Interview, May 16, 2016)

The participants were very passionate about their executive leadership roles and responsibilities in terms of providing the highest quality healthcare services to the residents of their community. The CAO made an argument for this when he stated,

This community is our neighbor and these are the neighbors we serve. They put their trust in us and we have an obligation to make sure they come into an environment where we do no harm. And I am very sincere and passionate about this. This is not some bumper sticker for me. (CAO, Interview, May 23, 2016)

The CNO also argues about the accountability the senior leadership team has with the community in the following commentary:

This community hospital plays a different role in the community than other hospitals in the region because we are the only hospital in the county. Because of this we serve a much more integral role of ensuring the health of the community. So we’ve got a different obligation in making sure that we are very well skilled, very capable in delivering care because this is the stopping point for any ambulance and many patients. (CNO, Interview, June 8, 2016)
The risk of not meeting the healthcare needs of the community is losing access to patients and vital revenues. A review of directors meeting minutes from June 25, 2010, outlined this point when the CEO stated, “I am concerned that patient satisfaction scores are low and our goal is having all indicators at exemplary levels. The low patient satisfaction scores could cause insurers to steer patients to other hospital providers. The data is also available to the public on the hospital compare website which may influence Medicare patients to choose their healthcare based on the performance of the hospital in comparison to our peers” (Directors Meeting Minutes, Community Hospital internal document, 2010).

**Team Leadership**

The researcher discovered throughout the data analysis that the executive leadership team at the community hospital adopted many facets of Hill’s (2010) team leadership model in their decision making, actions, and the evaluation of team effectiveness relating to their response to the policy provisions of the VBP program, as part of the ACA. Hill’s (2010) team leadership model mirrored the CEOs role of monitoring the executive leadership team and taking whatever action is necessary in order to ensure team effectiveness. A good example of this was the CEO making personnel changes in the past due to performance issues and a subsequent reduction in team effectiveness. The model also provided a good pathway for creating an understanding of the phenomenon of interest and for describing the leadership processes, actions, and outcomes related to this study because it places the on-going team in an environmental context (e.g., community hospital). In addition, the focus on performance and team effectiveness provides leaders and members with the capability to discover and fix problems that may arise. Overall, Hill’s (2010) team leadership model was a good fit for this study because it provided a guide that
assisted the researcher with the knowledge of how leaders design and maintain effective teams within a hospital context.

Summary

Because the role of the community hospital board is to provide governance and the medical staff is routinely busy with their medical practices; it was abundantly clear that the senior leadership team drove the leadership processes and the routine operation of the hospital on a day-to-day basis. For example, the CEO provided the vision which designed and implemented processes that ensured the care was provided safely. This is accomplished more effectively via a team leadership approach where all senior leadership executives collaborate not only among themselves, but with the board, and medical staff toward meeting the mission of providing the best patient experience with the best staff. Next, the orchestra conductor takes the key strategic decisions mandated by the board and medical staff in terms of quality and patient safety, ensures they have the best people playing in the orchestra, and then takes this piece of music and inspires the players to make it happen.

These actions included the adoption of the iCARE program, implementation of a new EMR, creation of an ACO, affiliating with local hospitals in a network structure that provided scale in the local marketplace, and moving toward the culture of a high reliability organization (HRO).

The type of leadership decisions made by the executive leadership team at the community hospital in terms of taking action to achieve strategic alignment is a good example of applying Hill’s (2010) team leadership model where internal leadership actions relating to task (e.g., goal focusing, structuring for results) and external leadership actions associated with the environment
(e.g., sharing information, negotiating support, advocating) is an important part of overall team effectiveness. Additionally, many educational leaders understand the importance of instructional alignment as a critical component of effective instruction which contributes toward maximizing student learning (Anderson, Krathwohl, & Bloom, 2001; Bransford, Brown, & Cocking, 2000). However, strategic alignment is also a critical component for healthcare leaders who are looking to integrate business strategies with their information technology strategies (e.g., install EMR) to ensure their hospitals survive in the ACA era (Papp, 2001).

A review of board meeting minutes on April 21, 2011, revealed the Vice President of Patient Engagement introducing the iCARE program to the board of trustees at the community hospital. This was an early response from the executive leadership team in terms of preparing the community hospital for the requirements of the VBP program, as part of the ACA. The CEO further endorsed this program by stating, “the purpose of the iCARE program was to further advance an overwhelming culture of caring among our employees that translates into specific behaviors proven to enhance the patient experience and clinical outcomes”. A review of administrative hospital-wide policy and procedure (HR-046) further defined the four components of iCARE (Appendix F) as the following: C= compassionate; A= always listening; R= responsive; and E= empowered. (iCARE, Community Hospital internal document, 2011). In order to reinforce these preferred behaviors in providing excellence in patient care the executive leadership team encouraged employees, physicians, volunteers, patients, and families to nominate individuals for outstanding contributions to the community hospital. iCARE nominees are frequently recognized at employee appreciation luncheons, department director meetings,
town hall meetings, board meetings, in the physician newsletter, and via the community hospital intranet.

Another review of board meeting minutes revealed that on July 21, 2011, the Chief Information Officer (CIO) provided background information outlining what had transpired over the past 18 months in order for the information technology (IT) committee (e.g., administration, physicians, IT personnel, nurses, finance) to make a decision on which vendor had the best EMR for the community hospital. The IT committee was composed of members who were interdependent, shared a common goal—the selection of the EMR, and coordinated activities in order to accomplish this goal. Furthermore, following an extensive evaluation of EPIC, Allscripts, Cerner, GE, and Meditech, the IT committee recommended Allscripts as the best fit for the community hospital. The CEO also purported “that the implementation is extremely complex in order to make this clinical and operational transformation”. Following a discussion, on a motion, second and vote, the board of trustees approved moving forward with the Allscripts EMR product (Board Meeting Minutes, Community Hospital internal document, 2011).

The board minutes on July 18, 2013, also revealed that the CIO provided an update on the recent healthcare transformation the community hospital underwent with the “go live” of Allscripts on July 1, 2013. Furthermore, according to the CEO, CMIO, and VPO, during the executive leadership interviews conducted in May 2016, implementing the Allscripts EMR was a significant step in the response to the VBP program, as part of the ACA. This is because the community hospital needed a reliable method to seamlessly report core measure data electronically to the government in order to keep pace with the VBP requirements and to avoid any delays in receiving vital Medicare reimbursement. Allscripts also provided the infrastructure
to build order sets (e.g., chest pain, pneumonia, congestive heart failure) via Zynx that are tied to evidenced based practices which are medical guidelines tested by research that if followed, will lead to better patient outcomes (Houser, 2012).

A document analysis of medical executive committee (MEC) minutes from August 22, 2012 discovered the CEO at the community hospital providing his vision of the future when he stated:

Medicare will eventually be capitated at some level. As a result, the hospital will need to work toward finding a way to survive under these pending circumstances. This includes the formation of a Clinical Integration Committee and has been condoned by the board. The committee was composed of physicians with the intent to find ways to deliver quality patient care while being exceptionally mindful of available resources. (MEC minutes, Community Hospital internal document, 2012)

In recognition of this, the executive leadership team developed another response to the policy provisions of the VBP program by implementing a strategic plan to closely align the hospital with independent community physicians in an effort to meet the challenges and opportunities that come with this type of transformation. A direct by-product of these efforts was the formation of an ACO in May 2013, and keeping the principles of quality, value, service at the forefront in this clinical integrated network (CIN) model. A CIN is the lean infrastructure needed to support clinical integration among community providers. The CIN also develops a governance structure through which these providers come together to decide on protocol development,
implementation, performance measurement, and formulas for rewarding performance (Physician CIN Committee Recommendation, Community Hospital internal document, 2014).

A review of community hospital board minutes on January 16, 2014, revealed the CAO providing information on the hospital quality and efficiency program (HQEP) to the board of trustees when he stated, “this is a strategy that will support efforts of the community hospital and the ACO to prepare for a value-based payment environment”. A HQEP is a performance based agreement between a hospital and a CIN to improve quality, utilization, and efficiency. The hospital and CIN share in the savings they are able to achieve over a one to three year window. Payments and targets are defined in advance and if achieved are allocated back to the CIN for distribution to network physicians. Significant opportunities exist to improve performance in utilization and quality at the community hospital through the HQEP. These initiatives must be jointly vetted and prioritized by the community hospital and the ACO (MEC Minutes, Community Hospital internal document, 2014).

A further response was the decision to participate in a partnership with two local health systems to explore clinical and cost savings opportunities. The researcher also confirmed this point by a consensus among the participants which was obtained from analyzing the transcripts of the executive leadership team interviews from May-June, 2016. This affiliation was also made known to the public on November 4, 2013. A review of MEC minutes from July 23, 2014, also confirmed a non-binding letter of intent was signed by all three entities. This partnership provided scale opportunities for the community hospital in terms of having more leverage to negotiate better reimbursement through insurance contracts, group purchasing opportunities, and strategize how to improve patient outcomes. A good example of a clinical improvement
implemented in 2014, were all pediatric electrocardiograms (ECGs) performed at the community hospital were sent electronically to a pediatric cardiologist for interpretation at a local children’s hospital. This is a best practice because while the community hospital does provide limited pediatric services, its primary function is providing routine and acute care to an adult patient population (MEC Minutes, Community Hospital internal document, 2014).

A final strategy from the executive leadership team was discovered while the researcher was performing a document analysis of department director’s minutes from January 24, 2014, (Appendix G) was moving the community hospital towards a change in culture towards a high reliability organization (HRO). The COO explained that an “HRO” is where individuals work together in high acuity situations who face a great potential for error and disastrous consequences are consistently able to deliver care and positive results with minimal error” (Directors Meeting Minutes, Community Hospital internal document, 2014). Weick and Sutcliffe (2007) also discussed that the five essential traits of HRO’s include: sensitivity to operations, reluctance to accept “simple” explanations for problems, pre-occupation with failure, deference to expertise, and resilience.

Chassin and Loeb (2013) further reported that hospitals that move their organizations in the direction of high reliability establish codes of behavior that are routinely practiced by leadership (e.g., administration, nurses, physicians,) who support endeavors to eradicate intimidation and encourages/rewards the reporting of patient safety issues. A good example of this at the community hospital was the executive leadership team implementing the HRO safety huddle in 2014. The CMO described the safety huddle as “a meeting held twice a week with hospital administration and directors to cover any current safety issues at the hospital” (CMO
Interview, May 18, 2016). He further explained why hospital employees should not be inhibited to provide feedback that affects patient safety:

There are no repercussions for anybody who attends this meeting and reports a safety issue. Afterwards, teams are assigned to tackle any of the safety issues discussed with the goal of solving them as soon as possible. (CMO, Interview, May 18, 2016)

After an extensive analysis of all study data and taking into consideration the perceptions and responses of the study participants; the researcher has verified a very strong collaboration between administration, board, and medical staff toward the successful implementation of high quality VBP leadership actions throughout the organization via a team leadership approach. As a result, the researcher has determined the executive leadership team processes at this community hospital were perceived as effective in response to the policy provisions of the VBP program, as part of the ACA, for the time period of FFY 2013-14.

The focus of this chapter was to provide a description of the data analysis, report the associated results, and was organized by emerging themes associated with the research question. The analysis included the examination of the executive leadership team response in relation to the VBP policy provisions of the ACA, which included collecting and comparing data for core measures, patient satisfaction, and governmental reimbursements for FFY 2013 and 2014. Chapter Five presents a summary of the study, conclusions and recommendations. Also included in this chapter are implications for theory development, further research, practice, and healthcare policy.
Chapter Five:

SUMMARY, FINDINGS, CONCLUSIONS

Summary

The purpose of this qualitative case study was to examine the executive leadership response at a community hospital to the VBP requirements of the ACA through an analysis of documents/repository database relating to service quality, patient satisfaction, and governmental reimbursements; and structured interviews. This chapter will present a summary of this study, findings, limitations, implications for theory development/research/practice, reflexivity, suggestions for future research, policy recommendations, and a conclusion.

Findings Related to the Literature

The theoretical framework that guided this study consisted literature related to Hill’s (2010) team leadership model which outlines the process of how executive leadership teams work together to make decisions that impact the solvency of their organizations and the PDCA model and its impact on performance improvement within a hospital context. The review of literature also connected how prior healthcare reform efforts laid the foundation for the development of the current VBP program; a description of policy analysis as a field of study; an analysis of how increased cost does not necessarily equate to an increase in quality for U.S. healthcare consumers; an overview of how the VBP program impacts U.S. acute care hospitals; and an examination of multiple leadership/change theories.

Team Leadership

After conducting interviews (N=8) with the executive leadership team at the community hospital between May-June 2016, the researcher confirmed through the participants that team
leadership (Hills team leadership model, shared leadership, distributed leadership) is the approach to accomplish its organizational work. For example, the following teams have been formed throughout the community hospital to attack quality issues and who report to the hospital board in the leadership departmental report: quality improvement team, ambulatory surgery center team, diabetes performance improvement team, transfusion safety team, six-sigma sepsis team, critical alarm management team, and multidisciplinary antimicrobial therapy team (Board Minutes, Community Hospital internal document, 2014). This finding confirms the results of prior research who confirm the fall of the heroic CEO (e.g., Great Man Theory) and the rise of the senior leadership team (Wageman, et al., 2008). This is due to the complexity faced by hospital leaders today, like the policy provisions of the VBP program, as part of the ACA, far outweigh the talents and abilities of any individual CEO. As a result, CEO’s today need to rely on their senior leadership team within the organization, who collectively possess different skill sets, responsibilities, and are closer to specific areas of operation which make it vital to consider their strategic input on key hospital initiatives.

**Performance Improvement and PDCA Model**

Quality improvement efforts are commonplace today at U.S. acute care hospitals where pay for performance is at the root of the VBP program which affects Medicare reimbursement for both core measures and patient satisfaction (Chassin, Loeb, Schmaltz, & Wachter, 2010; Jha, Joynt, Orav, & Epstein, 2012). Connecting financial incentives to hospital performance is gaining widespread acceptance as an approach to improving the quality of healthcare (Greenberg, Dudley, & Ferris, 2010; Lee, Berenson, & Tooker, 2010; Rosenthal, Landon, Normand, Frank, & Epstein, 2006). The practice of linking financial incentives to quality
improvement on the surface seems like a prudent strategy. In other words, paying for better healthcare should translate into improvements in quality and lead to excellent patient outcomes. However, the literature is still unclear in terms of whether pay for performance will lead to better outcomes for Medicare patients who are serviced at U.S. acute care hospitals who participate in the VBP program (Miller, Doherty, & Nadash, 2013; Weissert & Frederick, 2013; Winborn, Alencherril, & Pagan, 2014).

Thus, research related to PDCA and Hill’s (2010) team leadership model, particularly as it relates to a hospital context, was applied in the theoretical framework of this study in order to examine the executive leadership response at a community hospital to the VBP policy provisions of the ACA. It was understood that the community hospital context variables included in this study-specifically implementing a patient safety culture (HRO, iCARE program), adopting evidenced based clinical practices through a new EMR, and a commitment from executive leadership toward continuous quality improvement (CQI) might have a positive effect on core measures and patient satisfaction on behalf of Medicare patients.

**Patient Safety Culture**

The community hospital’s mission is “to provide the best patient experience with the best staff” and can only be achieved by creating a patient safety culture. The findings of this study maintain that hospital executive leaders who adopt evidenced based practices and support continuous quality improvement initiatives will have an effect on improving patient outcomes, and validates prior research which suggests it is still unclear if a patients’ report of their hospital experience reflects the quality of care provided (Manary, Boulding, Staelin, & Glickman, 2013). For example, the community hospital patient satisfaction scores (20th, 33rd percentile) which
were consistently low in all eight dimensions were not a good predictor of the consistent core measure scores (48th percentile) witnessed for the reporting period of FFY 2013-2014. In an effort to move VBP scores upward, the senior leadership team implemented the iCARE (compassionate, always listening, responsive, empowered) program in 2011, with the goal to further advance an overwhelming culture of caring among employees that translates into specific behaviors proven to enhance the patient experience, satisfaction, and clinical outcomes (Policy & Procedure HR-046, Community Hospital internal document, 2011). Unfortunately, the consistency in core measure scores did not correlate with soaring patient satisfaction scores (Board Meeting Minutes, Community Hospital internal document, April 21, 2011).

Many hospital organizations attempt to change in order to survive in a very competitive market. Executive leaders need to recognize that it is imperative to react to the internal (i.e. culture) and external (i.e. JCAHO, VBP) environmental factors affecting the organization. However, multiple authors reported that most organizations fail at change efforts due to the following factors: change is hard, poor leadership, lack of monitoring, a failure to focus on employee behavior first versus efforts geared towards changing the culture; and leader’s knowledge about how to implement change is limited (Burke, 2011; Burke & Litwin, 1992).

**Evidenced Based Practices**

A second example of how the community hospital utilized a PDCA model to implement evidence based clinical practices which assisted in reducing catheter associated urinary tract infections (CAUTIs) occurred in 2014 (PDCA-CAUTI, Community Hospital internal document, 2014). During this period, the CEO was frustrated by the current rate of CAUTI infections and decided to focus on eradicating this untoward outcome for patients by his commitment to this
initiative by stating: “There is no reason in this world we are giving people urinary tract infections from catheters. That is just wrong. We need to stop doing that” (CEO, Interview, May 23, 2016).

The main problem identified for CAUTI was the lack of consistency from 2012-13, in terms of the timely removal of a post-operative Foley catheter and documentation for the indication for continuance. Multiple sources confirm the daily risk of patients developing a CAUTI is 3-7% and bacteria will develop in 26% of patients after 2-10 days of catheterization (Lo et al., 2014; Society for Healthcare Epidemiology America, 2014). The findings of this study confirmed this data because the community hospital CAUTI rates fell within the national average at 3.39% in November 2012. This PDCA project was important because urinary tract infections are considered the most common hospital acquired infection nationally (Davis, et al., 2014; Lee et al., 2012; Saint, et al., 2008). Furthermore, because CAUTIs are considered a VBP core measure, CMS is monitoring whether Foley catheters are being removed by U.S. hospitals in a timely measure after surgical procedures and will not reimburse the hospital if this secondary diagnosis develops.

The analysis time frame for the PDCA performance improvement initiative was January-September 2014. As a result of implementing the Act component of PDCA below, the community hospital reduced their CAUTI’s from 3.39% in November 2012 to 0% in September 2014, by removing 100% of Foley catheters either on post operative day one or two for the period of July-September 2014:

Act
• Create a medical logic module (MLM) in the electronic medical record that
notifies the attending physician every two days while a patient has a catheter in
place. This reminder creates an order to either continue or to discontinue the
Foley catheter.

• Concurrent review by a designated coordinator to verify that an initial Foley
catheter order has been placed correctly or that it exists.

• Weekly meeting of Core Measures task Force-CNO, quality management, and
nursing staff.

• Continue with physician rule letters reminding them of the importance of this core
measure initiative (PDCA-CAUTI, Community Hospital internal document,
November, 2014).

**Continuous Quality Improvement (CQI)**

Edwards, Huang, Metcalfe, and Sainfort (2008) defined continuous quality improvement
(CQI) as a philosophy that encourages all healthcare providers to continually ask: “How are we
doing?” and “Can we do it better? More specifically, can we do it more efficiently, effectively,
timely? Continuous improvement begins with the culture of improvement for the patient, the
practice, and the population in general.

The community hospital executive leadership team made a landmark commitment to CQI
by implementing a new electronic health record (EHR) called Allscripts on July 1, 2013, which
confirm the findings of this study because many hospitals are adopting (EHRs) as a method to
improve patient safety and quality improvement (Burwell, 2015; Silow-Carroll, Edwards, &
Rodin, 2012). This is accomplished through the use of checklists, alerts, and predictive tools;
inherent clinical guidelines that encourage standardized, evidenced based practices; electronic orders that reduce errors and redundancy; and specific data fields that promote the use of performance dashboards and compliance reports. In addition to the benefits reported in previous studies, EHRs also provide a foundation that facilitates quality improvement in healthcare. While CQI is increasingly being applied to healthcare, it depends heavily on having reliable data on key structure, process, and outcomes measures.

*Implications for Theory Development, Research, Practice*

It is important for leaders across all disciplines to possess a tool set that can lead to effective, ethical decision making within their organizations. This is especially important with the complexities (e.g., navigating VBP legislation) that executive leaders face in the current healthcare arena and would be a good topic area for theory development for scholars going forward. A good example of a tool set is Bolman and Deal’s (2008) four frames (e.g., structural, human resources, political, and symbolic) which provide leaders with the ability to reframe or think about situations from a variety of perspectives. Although Bolman and Deal’s (2008) four frames has not been endorsed in the literature as a valid and reliable instrument, this framework can provide leaders with problem solving tools that will help understand complex situations and consider a variety of options. The four frames can be helpful to hospital executives because they can assist leaders from misinterpreting or misusing information that can lead to a misdiagnosis of major problems within the organization and subsequently keeping their organizations solvent in a volatile marketplace.

Another justification for why businesses across all spectrums should be investing their efforts in leadership development and consequently what are the roots of their ethical decision
making, is our society needs leaders who safeguard their best interests. This is especially important for U.S. hospitals where local citizens rely on senior executive leaders to make decisions that will act in the best interest of the communities in which they serve in terms of consistently providing high quality routine and acute care healthcare services. The negative trend of corporate scandals and subsequent loss of confidence from the U.S. public, combined with the complexities faced by leaders today, highlights a real need for leader development and subsequently more research dedicated to this phenomenon.

The researcher’s radiology career started in the U.S. Navy from 1985-1991, where they served the entire enlistment in San Diego, CA. The researcher graduated from the Naval School of Health Sciences (NSHS) in 1987 with an A.S. degree in Radiologic Technology from George Washington University. Next, the researcher received formal educational training from the NSHS to be a clinical instructor in the radiologic technology program and subsequently completed their enlistment in 1991 in this capacity. The researcher was responsible for teaching x-ray students both in the didactic and clinical phases of the program between the NSHS and Naval Hospital San Diego (NHSD), CA.

It was in this educational setting that the researcher came to appreciate the complexities that educational leaders face in their routine job functions. The NSHS program in radiologic technology admitted members from all service branches (e.g. Air Force, Army, Coast Guard, Navy) and ranks (e.g. E-4 to E-6) and who would ask for certain favors of the researcher including: adding points to didactic exams because of their advanced time-in-service (TIS) as compared to their junior class mates; assigning higher ranked students to the easiest clinical rotations at NHSD; not reporting a student for failing to report for their clinical x-ray rotations;
issuance of free passes for not completing assigned course work; and frequent offers to fraternize with the radiologic technology students well knowing this was against NSHS regulations for a clinical instructor. The researcher was able to navigate through these dilemmas through grounded decision making because not only did their career depend on it, but were held accountable to the Uniformed Code of Military Justice (UCMJ) which is the foundation for military law for the armed services.

In this complex educational setting, the researcher applied Bolman and Deal’s (2008) 4 frames to assist in the decision making process. First, the researcher applied the structural frame by clarifying the goals of the radiologic technology program and by enforcing the rules uniformly. A good example was not giving any student added points to their exams just based on their longevity in the military or advanced rank. Second, the researcher applied the human resources frame by treating the students as human beings and not numbers. Support was also provided to the students when they needed some encouragement or needed assistance. For instance, the researcher would frequently stay late to assist struggling students in the x-ray lab with anatomy review and positioning of exams. Third, the researcher adapted the political frame by using their power as a clinical instructor carefully among the radiologic technology students by taking control of the class room setting with confidence. The researcher also set clear expectations for the students early on in the program and outlined their role as an educator in great detail. The researcher did this in an effort to avoid any future conflict and looked to appeal to the self-interest of the students. Last, the symbolic frame was applied by being visible, energetic, and displayed great respect for the students in a class of all ranks and branches of service.
Reflexivity

Senge (1990) reported that learning organizations require a new view of leadership. The hospital under study was a good example of a learning organization where leaders are designers, stewards, and teachers. The senior hospital leadership at the community hospital promotes and supports the Leadership Academy, which is a 6-month leadership development program for directors and managers (Directors Meeting Minutes, Community Hospital internal document, 2009). The leadership academy is a highly successful program that requires each student to work collaboratively on a strategic initiative (e.g., developing a new hospital orientation program), as well as building on their communication, decision-making, organization, financial, and leadership skills. Candidates for the program are nominated by senior hospital leadership and are comprised from various hospital departments ranging from nursing to ancillary services (e.g., laboratory, radiology). The researcher believes the collaboration exercise is the most important component of the leadership academy because it takes a team with a shared vision and working together, to solve the types of problems (e.g., increasing service levels to Medicare patients) faced by leaders in a complex healthcare market. The leadership academy also provides a connection to educational leadership where shared decision making is gaining momentum because of the complexity facing leadership in schools today.

A positive side outcome of the leadership academy are the relationships and the alliances the participants make during the course of this training that can be utilized in the future. A good example would be collaborating with other leaders to find solutions to difficult hospital issues. The leadership academy is a glaring reason why the community hospital in the Southeastern U.S. continues to be a leader in providing quality healthcare to residents of their community as
evidenced by winning the 2015 Healthgrades Award for being one of the Top 50 hospitals in America and the Leapfrog safety award. It can be very inspiring to be a part of a hospital organization where senior leadership promotes and practices the vision of a learning organization where safe, quality healthcare is delivered consistently on behalf of their patients, physicians, and community.

Suggestions for Future Research

Because the VBP policy provisions of the ACA are still early in the adoption phase for executive leaders at U.S. acute care hospitals, it provides the foundation to study this legislation in greater detail in the future. Future research may provide vital insight for senior healthcare executives in terms of providing a blueprint to assist in successfully navigating the VBP policy provisions for both core measures and patient satisfaction, while maximizing reimbursements for the Medicare patients they serve. This is especially important because U.S. senior healthcare executives today need every advantage possible because they are continually challenged with a plethora of complex issues. A few examples of these complexities include decreasing government reimbursements, increasing regulation (e.g., JCAHO), pay for performance, increasing cost of technology, decreasing leverage in negotiating insurance contracts, increasing number of liability claims, and the impact of healthcare reform. If senior healthcare executives do not account for these complexities in their decision making it can affect the solvency of their hospitals in terms of keeping their doors open to Medicare patients who depend on vital healthcare services provided by their local community, acute-care hospital.

The first area the researcher would target for future research is the poor implementation of the VBP program for many U.S. hospitals which negatively impacted their reputations and
Medicare reimbursements. This is a very important research area because many U.S. hospitals exhibit only a profit margin of between one to five percent annually and the governmental financial penalties levied for poor performance on core measures and patient satisfaction are devastating for these facilities. The playing field has significantly changed as U.S. acute care hospitals are all fighting for governmental reimbursement based on performance and some will ultimately be left out in the cold. The target of this future research will be to provide a rubric to assist senior healthcare executives in the successful implementation of the VBP policy provisions. This will lead to improvements in the processes of care, patient experience of care, outcomes of care, and efficiency of care that will maximize Medicare reimbursements for the patients they service.

The second area of focus for future research is team leadership because this is the method in how leadership decisions are made within the community hospital under study. Because team leadership can be a catalyst for team effectiveness, more study of this phenomenon might help other senior healthcare executives at community hospitals to navigate the intricacies of the VBP policy provisions by creating more understanding of how teams work together to make effective decisions that positively impact service levels on behalf of their Medicare patients. As a result, CEO’s can now benefit from a team leadership approach that gives all executives a seat at the decision-making table and who bring unique skill sets and experience to the group. Ultimately, the success of any policy provision (e.g., VBP) affecting hospital operations will be linked to the quality of the executive leadership team and their ability to work together toward effective decision-making.
Policy Implications

Because the policy provisions of the VBP program are still in their infancy, what remains clear is there is no panacea for leadership/change processes that executive leadership teams can adopt at U.S. acute care hospitals that will maximize governmental reimbursements by increasing service levels (e.g., core measures, patient satisfaction) provided to Medicare patients. However, as Rosenbaum (2011) reported, the ACA will fundamentally alter the policy landscape in which public health is practiced. The policy provisions of this legislation will be implemented over several years and it is still too early to understand what this means for the future of hospitals. A central question remains, “How do public health practitioners and policymakers seize the opportunities presented by this seminal change in policy while also working with others to rise to its challenges?” (Rosenbaum, 2011).

Conclusion

This qualitative case study examined the executive leadership team response at a community hospital in the southeastern U.S. in relation to the Value-Based Purchasing (VBP) requirements of the Affordable Care Act (ACA) of 2010, through a document analysis, a review of a repository database for service quality, patient satisfaction, governmental reimbursement; and structured interviews. Through a qualitative design methodology, it was determined that the executive leadership response at the community hospital was perceived as effective in relation to the VBP requirements of the ACA. Although the community hospital HCAHPS patient satisfaction scores were not impressive, they made up for this deficit in core measure scores, and were able to maximize reimbursements as part of providing quality service levels to Medicare patients for FFY 2013 and 2014, respectively.
Last, it is commonplace to hear reports in the media from policymakers regarding the unstable future of the ACA, especially in a presidential election year, like 2016. However, executive leadership teams at U.S. acute care hospitals who participate in the VBP program, cannot be concerned with this speculation and must turn their attention toward increasing service levels to Medicare patients where up to two percent of Medicare reimbursement is at risk by 2017 (Gilman et al., 2015). A good example that outlines the complexity faced by hospital executives today lies within the fact that it is not enough to only provide outstanding clinical services on behalf of Medicare patients, but reimbursement is also tied to their satisfaction. As a result, hospital executives must implement effective strategies that will assist in meeting the VBP financial incentives in order to achieve their mission of remaining solvent and continuing to provide vital healthcare services to Medicare patients all across the U.S.
References


Congressional Budget Office. *CBO’s May 2013 estimate of the effects of the Affordable Care Act on health insurance coverage*. [Http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareAct](http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareAct)


Joint Commission primary stroke center-certified and noncertified hospitals. *Stroke, 42*(12), 3387-3391.


Imaging Management, 6-7.


White, J. (2013). Cost control after the ACA. Public Administration Review, 73(S1), S24-S33.


Additional References


*Community Health Assessment & Community Health Improvement Plan, October 2014.* Retrieved at stjohns.floridahealth.gov on August 17, 2016.


APPENDIX A

Interview Questions

1. Can you briefly describe your background which includes your highest attained degree and previous healthcare leadership experience?

2. What is your executive leadership role at the hospital and how long have you served in this capacity?

3. Can you please describe what is the mission of the hospital as it relates to residents of this region?

4. Can you please describe the strategic vision for the hospital over the next 5 years?

5. What is your definition of leadership?

6. Can you please explain the process of how executive leadership decisions are made within in a hospital context?

7. What factors do you consider throughout the executive leadership decision-making process?

8. Describe the internal leadership actions that need to be considered which include task (e.g., goal focusing, structuring for results, facilitating decisions, training, and maintaining standards) versus relational (coaching, collaborating, managing conflict, building commitment, satisfying needs, and modeling principles)?

9. Describe the external leadership actions that need to be considered which include networking, advocating, negotiating support, buffering, assessment, and sharing information?

10. How do you measure team effective effectiveness (e.g., performance, development)?
11. What impact did the Affordable Care Act (ACA) of 2010 have on the hospital?

12. Prior to the implementation of the Value-Based Purchasing (VBP) program in 2013, how did the executive leadership team prepare the hospital for the impact of this new legislation that impacts Medicare reimbursement?

13. What performance improvement tool does the hospital utilize to ensure peak performance of all quality of care and patient satisfaction initiatives?

14. Describe what best practices were implemented that impacted core measures?

15. Describe what leadership strategies were implemented that impacted patient satisfaction (e.g., HCAHPS)?

16. What is the most significant strength that the hospital possesses that will ensure survival in the VBP era?

17. What is the biggest opportunity for the hospital as it relates to the VBP program?

18. What is the largest threat for the hospital as it relates to the VBP program?

19. What is the greatest weakness for the hospital as it relates to the VBP program?

20. What is your perceived effectiveness of the executive leadership response at FH as it relates to the VBP policy provisions of the ACA (2010)?
Appendix B

Recruitment Letter

Date:

Name of potential participant

Re: Value-Based Purchasing Research Study conducted by Lawrence R. Smith

Dear <<insert name>>:

You are invited to participate in a research study, conducted by UNF doctoral student Lawrence R. Smith, about the executive leadership response at a community hospital to the Value-Based Purchasing (VBP) requirements of the Affordable Care Act (ACA) of 2010. This study will examine the executive leadership response at a community hospital to the VBP requirements of the ACA through structured interviews and an analysis of documents and a repository database (http://www.medicare.gov/hospitalcompare/) relating to service quality, patient satisfaction, and governmental reimbursements.

I obtained your contact information by reviewing the community hospital organizational structure chart for the period of 2010-2015 and you were listed as a member of the senior leadership team. This makes you eligible to participate in this research study. Your agreement to be contacted or a request for more information does not obligate you to participate in this study. Participation in this study is voluntary, will not provide any compensation for your time, and will include an interview. However, if you decide to participate in this research study all data will be stored in the UNF encrypted server and will remain confidential at all times. Please respond to this letter by Monday, May 16, 2016, by either calling or e-mailing indicating you would like to
participate or opt out of this research opportunity. If I do not receive a response by May 16, 2016, I will send a reminder e-mail asking for your reply to participate or not.

Thank you for your consideration and timely reply.

Respectfully,

Lawrence R. Smith  
Principal Investigator  
University of North Florida
Appendix C

Informed Consent Document

Hi my name is Lawrence R. Smith and I am a doctoral student at the University of North Florida. We are conducting a qualitative research study in order to examine what was the executive leadership response at a community hospital to the Value-Based Purchasing requirements (VBP) of the Affordable Care Act (ACA) (2010).

If you take part in my project, you will be asked to respond to twenty open-ended questions in a structured interview relating to leadership processes and strategies that were considered and implemented in preparation for the impact of the VBP program at the community hospital for Medicare patients. We expect that your participation in this study will take approximately one-hour of your time. Your responses will be digitally recorded and will remain confidential. Only authorized personnel will have access to your responses.

Although there are no direct benefits to or compensation for taking part in this study, others may benefit from the information we learn from the results of this study. Additionally, there are no foreseeable risks for taking part in this project. Participation is voluntary and there are no penalties for deciding not to participate, skipping questions, or withdrawing your participation. You may choose not to participate in this research without negatively impacting your relation with the University of North Florida or the community hospital.

If you have any questions or concerns about this project, please contact me or my professor if appropriate. A copy of this form will be given to you to keep for your records.

If you have questions about your rights as a research participant, or if you would like to contact someone about a research-related injury, please contact the community hospital IRB.

Thank you for your consideration.

Sincerely,

Lawrence R. Smith                                    Luke M. Cornelius, Ph.D, J.D., Chair

Phone: ____________________________ Phone: (904) 6______________
Email: ____________________________  Email: _______________________

I _________________________________ (print name) attest that I am at least 18 and agree to take part in this research study.
Signature: ____________________________ Date: _______________________
## Appendix D

### Transcript Coding Method

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**Codes:**  
Part. = Participant  
P = Page  
L = Line (s)
### Administrative Hospital-wide Policy and Procedure

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Order of authority in absence of president:
1. Executive Vice President / Chief Administrative Officer
2. Chief Operating Officer
3. Chief Nursing Officer
4. Chief Medical Officer
5. Chief Financial Officer
6. Vice President of Operations

* CNO has primary authority and responsibility for all standards of nursing practice across
### Administrative Hospitalwide Policy and Procedure

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Policy: iCARE STAR RECOGNITION PROGRAM

OBJECTIVE:
Hospital’s mission is to provide the best patient experience with the best staff. We recognize that the talents, skills and knowledge of our employees and affiliates are the greatest asset we have in achieving our mission. The iCARE Star Recognition Program has been developed to encourage and reward employees and affiliates of Hospital for their participation in iCARE and in enhancing patient-centered care. The concept behind iCARE is simple: To further advance an overwhelming culture of caring among our employees that translates into specific behavior proven to enhance patient experience, satisfaction and clinical outcomes. The iCARE Star Recognition Program recognizes and reinforces excellence in patient care by encouraging employees, physicians, volunteers, patients and families to nominate individuals for their outstanding contributions to Hospital. The Patient-Centered Care Group Leaders, a multidisciplinary team facilitated by the Hospital Human Resources and Marketing Departments. The program consists of two components which include the iCARE Star Card Award and the iCARE Five-Star Award.

PROCEDURE:
A. iCARE STAR CARD AWARD:
All Hospital employees, physicians, volunteers, patients and families are eligible to present iCARE Star Cards. All Hospital employees, physicians and volunteers are eligible to receive iCARE Star Cards. Blank iCARE Star Cards are available in specifically designated areas in each Hospital department. Employees, physicians, volunteers, patients and families are encouraged to identify specific outstanding behaviors and to recognize employees, physicians, and volunteers by presenting them with a completed iCARE Star Card. The employee, physician and/or volunteer receiving an iCARE Star Card must present it to their respective director and/or supervisor for validation. The completed iCARE Star Card is given back to recipient once approved and documented. Each month, one star card will be randomly selected by an automated system to win $100.00. The winner’s name along with the names of the other recipients will then be published on the intranet and in the hospital newsletter. Directors and/or supervisors must send the names of each person who received an iCARE Star Card(s) to Marketing in order to participate in the monthly drawing. Only the names sent from directors will be eligible. If an employee receives more than one iCARE Star Card within a month, the director and/or supervisor must specify the number of cards obtained by that employee. For each iCARE Star Card earned, the individual is eligible for a separate entry in the monthly drawing. Recipients may also exchange them for the recognition rewards below.

When employees, physicians, and/or volunteers reach a specific iCARE Star Card Award level as delineated below, they may choose to exchange their iCARE Star Cards for the recognition rewards that are available in the Human Resources Department. iCARE Star Cards are valid only during the fiscal year in which they are presented to the employee, physician and/or volunteer.

Recognition rewards are subject to applicable taxes.
- 20 iCARE Star Cards for $50.00 cash prize
- Invitation to the “Employee Appreciation Luncheon”
Policy: iCARE STAR RECOGNITION PROGRAM

B. iCARE FIVE-STAR AWARD:
Any employee, physician, volunteer, patient and/or family member can submit an iCARE Five-Star Award nomination to a Department Director. Any employee, physician and/or volunteer are eligible to be nominated for an iCARE Five-Star Award. Hospital Department Directors and the Senior Management Team are exempt from this award. Nominations for the iCARE Five-Star Award must be submitted to the Hospital Department Directors. The will then submit nominations to the Patient-Centered Care Group Leaders Committee that will confidentially review all eligible nominations and may select winner(s) on a monthly basis.

Nominations and selection criteria for the iCARE Five-Star Award are focused on recognizing exemplary performance in any or all of the following four elements that iCARE stands for:

1. Compassionate
2. Always Listening
3. Responsive, and
4. Empowered

And in any or all of the following eight dimensions of patient-centered care:

1. Respect for Patient’s Values/Preferences and Expressed Needs
2. Coordination and Integration of Care
3. Information/Communication and Education
4. Physical Comfort
5. Emotional Support and Alleviation of Fear and Anxiety
6. Transition and Continuity
7. Access to Care, and
8. Involvement of Family and Friends
Appendix G

MINUTES OF DEPARTMENT DIRECTORS MEETING-JANUARY 24, 2014

HIGH RELIABILITY ORGANIZATION (HROs)

XXXXXX explained function of HRO as institutions where individuals work together in high acuity situations facing great potential for error and disastrous consequences consistently deliver care and positive results with minimal error. He noted there are five essential traits of HROs:

- Sensitivity to operations
- Reluctance to accept the “simple” explanations for problems
- Pre-occupation with failure
- deference to expertise
- Resilience

He discussed challenges identified in hospitals pursuing high reliability. Crew Resource Management (CRM) was discussed and included elements of CRM which are: Briefings, conflict resolution and performance review will be the key two teachers for HRO and training will begin in March 2014. There will be benefits with HRO and CRM under the quality pillar.

Note: Transcribed by the Principal Investigator on 3/22/17 from the January 24, 2014 actual Minutes from the Department Directors Meeting.
Date: 1/5/2016

To: Larry Smith (Principal Investigator)

From: [Name] (Chairman, IRB) [Signature]

Protocol: A Case Study: The Executive Leadership Response At A Community Hospital To The Value Based Purchasing Requirements Of The Patient Protection And Affordable Care Act

Please be advised, your research protocol was reviewed by the IRB and approved on 1/5/2016. The IRB is recommending the following:

☑ Approved via Expedited Process, please be advised of the following:
  • It is your responsibility to immediately (at the time of the occurrence) notify the IRB of any significant adverse event.
  • A copy of the approved informed consent must be given to each person enrolled in your trial.
  • It is your responsibility to submit changes to the protocols and/or consents, to the IRB for approval, before they are implemented.
  • An outcomes report notifying the IRB the conclusion of your study.
  • The anticipated expiration date of your study is: 1/5/2017

☐ Approved, contingent upon:
  • Once the contingency is met, the IRB will issue a letter of approval, noting you have met the standards outlined above, under the approved section.

☐ Not Approved, based on the following:

If you have any questions or comments, please contact [Name] [Name]
MEMORANDUM

DATE: March 24, 2016

TO: Mr. Lawrence Smith, M.H.A.

VIA: Dr. Luke Cornelius
      Leadership, School Counseling & Sports Management

FROM: Dr. Jennifer Wesely, Chairperson
      On behalf of the UNF Institutional Review Board

RE: Project Withdrawal for IRBNet# 848323-1: “A CASE STUDY: THE EXECUTIVE
      LEADERSHIP RESPONSE AT A COMMUNITY HOSPITAL TO THE VALUE BASED
      PURCHASING REQUIREMENTS OF THE AFFORDABLE CARE ACT.”

Date Fully Executed Authorization Agreement Established with Hospital IRB: 03/21/2016

Thank you for notifying us of your intent to withdraw your project “A CASE STUDY: THE EXECUTIVE
LEADERSHIP RESPONSE AT A COMMUNITY HOSPITAL TO THE VALUE BASED PURCHASING
REQUIREMENTS OF THE AFFORDABLE CARE ACT.” An Authorization Agreement (AA) was established
with the Hospital IRB that allows the Hospital IRB to be the IRB of record for UNF graduate
and doctoral student research when all research activities will be conducted at Hospital or with Hospital patients or employees. This AA was fully executed on 03/21/2016 and is applicable to this project.
Based on that fully executed AA and the request for withdrawal submitted by Mr. Smith on 03/22/2016, the UNF IRB application for the project identified above has been officially withdrawn as of the date of this memo. If you would like to submit a proposal for a new project you can do so by completing a new protocol via IRBNet.

Should you have questions regarding your project or other IRB business, please contact the research integrity unit of the Office of Research and Sponsored Programs by emailing IRB@unf.edu or calling (904) 620-2455. A copy of this letter will be retained within UNF’s records.
VITA

LAURRENCE SMITH

EXPERIENCE: COMMUNITY HOSPITAL
Director of Radiology
October 2007-Present
Duties: Administrate over the daily operations of the hospital Radiology Department and one satellite imaging center (80 FTE’S). Accountable for the following cost centers: Cat Scan, Diagnostic Radiology, Mammography, M.R.I., Nuclear Medicine, Special Procedures, Ultrasound, and Imaging Center. Direct Report to the V.P. of Professional Services. Responsible for the safe delivery of >140,000 annual Radiology procedures, including >190M in gross revenues.

Highlights:
Transitioned from Analog to Digital Mammography (2008)
Passed MQSA surveys (2008-2014)
Installed over $10M capital equipment (2007-2014)
Imaging Center patient satisfaction 99th percentile (2008-2014)
Spearheaded several GE PACS upgrades (2008-2014)
Employee turn-over rates <5% (2008-2014)
Installed Mammography Reporting System (2014)

COMMUNITY HOSPITAL
Director of Radiology
April 2003-October 2007
Duties: Administrate over the daily operations of the hospital Radiology Department and one imaging center (85 FTE’s). Responsible for eight cost centers including: Cat Scan, Diagnostic Radiology, Fleming Island Imaging Center, Mammography, MRI, Nuclear Medicine, Special Procedures and Ultrasound. Direct report to the Chief Operating Officer, and V.P. Ancillary Services. Responsible for implementing initiatives of the hospital strategic plan, ensuring quality of care, business analysis, monitor productivity targets, development of management team skills, enforce policy and procedure, monitor employee/patient satisfaction, and JCAHO readiness. Planned and installed >$7M of imaging equipment: in the following modalities: CT, Diagnostic Radiology, Mammography, M.R.I., PACS, Special Procedures and Ultrasound. Annual Radiology volume >125,000 procedures.

Highlights:
Volume growth >5% at Imaging Center (2004-2006)
Successful MQSA surveys (2004-2007)
Successful Florida DOH surveys (2004, 2006)
Successful JCAHO survey (2005)
PACS installation (2007)
Increased OP Hospital Radiology volume >5% (2003-2006)
Employee turn-over rates < 5% (2004-2006)

COMMUNITY HOSPITAL
Director of Radiology
January 2001-April 2003
Duties: Directly accountable for the efficient administration of inpatient and outpatient Radiology services. Primary function was to serve as liaison between C.E.O., C.O.O.,
Radiology Group, and staff technologists. Duties included administrating over one-hundred five (105) FTE’s at the hospital and three satellite imaging centers. Implemented a $6.5M CAMS project that included the planning and installation of key imaging equipment (Cat Scan, M.R.I., Nuclear Medicine, Ultrasound). Passed the following surveys with zero violations: JCAHO (2002), Florida DOH (2002), and MQSA (2001-2003). Annual Radiology volume > 165,000 procedures.

EDUCATION: 
University of North Florida U.S. - Jacksonville, Florida  
Master of Health Administration  
Graduated: December 1998

Associate Science-Radiological Sciences  
Graduated: January 1990

Ithaca College U.S. – Ithaca, New York  
Bachelor of Science- Physical Education  
Graduated: May 1984

PROFESSIONAL:  
State of Florida Radiologic Technologist (CRT 28612)  
American Registry of Radiologic Technologists (#237719)  
Member of American Healthcare Radiology Administrators (AHRA)


