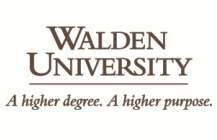
View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by Walden University



Walden University
ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies Collection

2019

Strategies to Improve Customer Care Services in Urgent Care Businesses

Marcus Ellis Caster
Walden University

Follow this and additional works at: https://scholarworks.waldenu.edu/dissertations

Part of the Health and Medical Administration Commons, and the Nursing Commons

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Management and Technology

This is to certify that the doctoral study by

Marcus Caster

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

Review Committee
Dr. Gwendolyn Dooley, Committee Chairperson, Doctor of Business Administration Faculty

Dr. Charles Needham, Committee Member, Doctor of Business Administration Faculty

Dr. Peter Anthony, University Reviewer, Doctor of Business Administration Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2019

Abstract

Strategies to Improve Customer Care Services in Urgent Care Businesses

by

Marcus Caster

MS, University of Phoenix, 2013

BS, University of Mobile, 1998

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

Walden University

June 2019

Abstract

Healthcare industry owners who have unsatisfactory customer care services may experience a financial risk and create dissatisfied patients. The purpose of this case study was to explore customer care strategies that managers of urgent care businesses used to improve customer care services and patient satisfaction. The target population consisted of 1 urgent care manager from 3 separate urgent care clinics with the highest customer satisfaction ratings in Alabama. The urgent care managers were knowledgeable about effective customer care strategies that improved customer care services and patient satisfaction. Customer loyalty theory with emphases on customer behavior, customer attitude, repeat patronage, and loyalty was the conceptual framework for the study. Semistructured interviews and patient survey forms were the data sources. Data were analyzed using thematic analysis which identified similar codes, patterns, and themes. The 3 primary themes that emerged from thematic analysis were patient-focused care, social media outreach, and employee engagement. The implications of this study for positive social change include the potential to enhance the quality of healthcare experiences, which may empower individuals to seek medical care. The patients might become trusting of healthcare providers and become collaborators in responding to medical care requests by medical staff to improve their quality of life.

Strategies to Improve Customer Care Services in Urgent Care Businesses

by

Marcus Caster

MS, University of Phoenix, 2013

BS, University of Mobile, 1998

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

Walden University

June 2019

Dedication

I dedicate this doctoral study to my deceased grandparents Mr. Minto Caster, Mrs. Mary Lee Caster, Mrs. Dorothy Love, and Mr, George Love Sr. In addition, I dedicate this study to my aunts (Hihwather L. Caster-Stewart, Violet Caster-Fields, Robin Caster-Bradley, Sylvia Caster-Reed, Rachel Caster, Gloria Love, and Shelia Love. To my siblings (Mario P. Caster, Marlon D. Caster, Marvell L. Caster, Dominique J. Colzie, Rachel N. Taylor, Marshanda N. Colzie and the baby Malcolm T. Colzie), I am proud of you all. Last but not least, I thank my Mom (Doris M. Caster-Colzie), my Dad (George E. Love Jr.), and my uncles (Eric Caster, Thaddeus Caster, Jack Adams, Donald R. Love, Arvester Love, Anthony Love, Stevie Love, and Eric Love) and finally my "Boys" (Ladetric Hayes, Derrek Brown, Phillip Breech, Andre Love, Michael Greene, and Cory Griffin). Each one of you made it possible for me to be here and accomplish this tremendous goal. To my special uncle Lennie Caster, I will always remember the time you invested in me to make me become a better basketball player and a man. I will never forget May 27, 1987 when you left this earth. This day holds a special place in my heart for motivation, endurance, and perseverance. To my three late cousins Latywen G. Caster, Lezerrious "Big Zeek" Creagh, and Josh Creagh, you will never be forgotten, may you all RIP.

Acknowledgments

I thank God for my beautiful wife LaTunja Adams Caster, my kids Peyton Marcus Caster, Mackenzy Ellis Caster, and Micah Logan Caster for being understanding, supportive, and uplifting when times were tough. I would also like to thank my mother and father in law Mr. William Adams Jr. and Mrs. Nina Mae (Westry) Adams. This journey has had a major impact on my life, as well as my family. I thank you all for your forgiveness when I wasn't able to make it to some of your events and special moments. I hope you all understand that Daddy was trying to make history and lay a solid educational foundation for our family, and future generations. There was a time when our people weren't allowed to read books or embark on any type of educational journey. I want it to be acknowledged that I took advantage of every educational opportunity that existed for people of color. I would like to thank all my colleagues at JIS, in particular, Ursula Rozier (Greatest Phys. Ed. Teacher in the World), and to the best principal, Mrs. Gwendolyn Wheeler. Moreover, I would like to thank Walden University, my chair Dr. Gwendolyn C. Dooley, my SCM Dr. Charles Needham, my URR Dr. Peter Anthony, and finally Dr. Rya Carter, Dr. Chantell Beaty, Dr. Dorie Maahs, and Dr. Lisa Burnside.

Table of Contents

List of Tables

List of Figures

Section 1: Foundation of the Study

UCMs are responsible for providing high quality care to ensure patient satisfaction. Dissatisfied patients reduce the financial stability in HC facilities (Ferrand et al., 2016). Therefore, patient satisfaction is of interest to business managers and owners in the HC industry. I explored a customer care service business problem that UCMs encounter when trying to improve patient satisfaction. I discussed the gap in the literature as well as the background of the problem. In addition, Section 1 includes information pertaining to the background of the problem, problem statement, purpose statement, and nature of the study. In the review of the academic professional literature, I explored Dick and Basu's CLT, as well as three other theories that support and contradict the primary conceptual framework. In addition, this section included the purpose statement, which included the population of the study, methodology, and social change implications. I explored strategies in the literature and collected data that may contribute to the management of the overall customer care experience.

Background of the Problem

Patient dissatisfaction with urgent care clinics (UCCs) can increase the need for better customer care services for patients demanding satisfaction from UCCs in the HC industry. With increasing patient expectations, this burden raised the demand for better community-based health care facilities (Loewenson & Simpson, 2017). Managers of UCCs claimed that a third of customers that visited their HC facility were unhappy when receiving care (Mercieca, Cassar, & Borg, 2014). Moreover, some business leaders lacked the knowledge to sustain financial performance in the HC industry. Business

leaders in the HC industry compete in branding and marketing for sustainability, while improved customer services remain essential to the extension of a business brand (Askariazad & Babakhani, 2015). Competition is high in HC facilities, and leaders understand that patients are demanding satisfactory customer care services (Pflueger, 2016). According to Pflueger (2016), the two measures managers place on HC are (a) patient care, and (b) quality of customer care. Business managers that redirect their organizational focus to marketing and branding as opposed to customer satisfaction may lack knowledge on improving patient satisfaction. Therefore, I explored customer care strategies that UCMs use to provide a positive experience that may contribute to the improvement of patient satisfaction in the HC industry.

Problem Statement

Financial stability of HCCs decreased because patients are dissatisfied with services (Ferrand et al., 2016). Some healthcare managers (HCMs) reported that 71% of patients are dissatisfied with emergency room (ER), urgent, and traditional physician care (Mercieca et al., 2014). The general business problem was that some urgent care leaders experience financial risks when implementing new customer care strategies, with no guarantee of success in improving patient satisfaction. The specific business problem was that some UCMs lack customer care strategies to improve patient satisfaction.

Purpose Statement

The purpose of this qualitative embedded single case study was to explore customer care strategies UCMs used to improve patient satisfaction. The target population consisted of three UCMs within one HCC organization with less than 500

employees located in Alabama that improved the quality of patient satisfaction. The study results may contribute to positive social change by helping UCMs provide a higher quality of customer care services, which could benefit local communities by decreasing illnesses and improving patient satisfaction in HCCs.

Nature of the Study

Three research methods are available to a researcher to conduct a research study. The quantitative method requires the development of mathematical models, theories, or hypotheses regarding a phenomenon (Steele & Rawls, 2015). The quantitative method did not align with my study because of the lack of mathematical models, theories, or hypotheses. Mixed methods research includes both qualitative and quantitative methods (Berger, 2015). Mixed methods research was not appropriate for this study because my intent was to explore specific strategies used by UCMs to improve the quality of patient services, and not test hypotheses about the relationships among variables. The qualitative method is for exploratory research, useful for interviews, and is effective in human data collection (Sandelowski, 2015). The qualitative research method is a combination of data codes, interviewing, and textual understanding from the participants (Berger, 2015). For the study, I used the qualitative method to explore strategies that UCMs used to improve the quality of patient services and satisfaction.

I used a qualitative embedded single case study research design for this study. Ethnography and phenomenological designs were some possible approaches to the study. Ethnographers conduct field studies exploring groups' cultures (Silverman, 2016). Case, Todd, and Kral (2014) indicated that the use of an ethnographic research design is

unnecessary to explore strategies in applied research. Therefore, the ethnography design approach was irrelevant to the study. Yin (2017) indicated that the phenomenological design is for researchers who want to explore the meanings of participants' lived experiences with a phenomenon. A phenomenological design was inappropriate for this study because I was not exploring the meanings of participants' lived experiences. Gathering information through stories is narrative design (Tong, Raynor, & Aslani, 2014). There was not a way to ascertain if a story is a fact or fiction. Therefore, the narrative design was not applicable to my research. A case study design is applicable to studies where exploring a phenomenon exists (Lewis, 2015). Therefore, I used a single case study design to explore customer care strategies UCMs used to improve the quality of patient satisfaction.

Research Question

What customer care strategies do UCMs use to improve patient satisfaction?

Interview Questions

1. What customer care strategies do you use to improve patient satisfaction?
2. How do you describe customer care strategies and patient satisfaction?
3. What assessment instruments do you use to determine if customer care strategies improve patient satisfaction?
4. What assessment instruments do you use to determine if patients are satisfied with the customer care strategies?
5. What other data sources do you use to develop or change customer care strategies based on organizational outcomes?

6. How do you engage customers and staff members' feedback when considering, implementing, or changing customer care strategies to improve patient satisfaction?
7. How do you measure the costs of customer care strategies to improve patient satisfaction targets?
8. What other information will you share as it relates to the successful customer care strategies you have developed and implemented to improve patient satisfaction?

Conceptual Framework

The conceptual framework for this qualitative study was the CLT by Dick and Basu. Dick and Basu (1994) introduced the theory to examine customer loyalty tendencies individuals use when patronizing specific organizations. Dick and Basu argued that it is important for managers to determine the customers' attitude and influence on the organization. In addition, Dick and Basu also discussed four relationship implications that managers may encounter while using the CLT: (a) comparative loyalty relationships through competitors' offerings, (b) consequences of recognizing pertinent customer relations antecedents, (c) determining the antecedent impact, and (d) detecting shortcomings from competitors and how new inventions can affect loyalty. Organizational leaders use the CLT as a framework to develop effective marketing and customer service strategies to retain customer loyalty (Wang et al., 2017). Customers who provide repeat business typically have a positive attitude toward the brand and are loyal customers (Bowen & McCain, 2015). Researching customer care strategies UCMs used to improve customer care and satisfaction aligned with the purpose of the CLT.

Operational Definitions

In this section, I provide words and definitions that may not be common to the reader. Marshall and Rossman (2016) indicated that operational definitions and phrases promote clarity. By making these terms clear for the reader, there may be a deeper understanding of the study topic. The following are definitions used in this study.

Business Sustainability: Business sustainability assures all processes, products, and manufacturing activities address current environmental concerns while maintaining a profit (Borim-de-Souza, Balbinot, Travis, Munck, & Takahashi, 2015).

Customer Care: Customer care is the process of using products and services to ensure the proper satisfaction of customers (McMahon, Tipirneni, & Chopra, 2016)

Patient Satisfaction: Patient satisfaction is determining the quality of service patients receive at health care clinics (Kamimura, Ashby, Myers, Nourian, & Christensen, 2015).

Urgent Care Centers: UCCs are HC facilities where patients can walk in for treatment, with more affordable costs than emergency room care (Albert, 2015).

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions include unsubstantiated statements or facts that researchers use to validate a research study. Leedy and Ormrod (2013) stated assumptions were research facts that may be true and accepted without verifying the information. I assumed that the participants would give honest and factual responses. I met the assumption by creating a relaxing environment that made the participants feel comfortable to answer questions

openly and honestly. A second assumption was the inclusion and criteria selection of the participants. I assumed by including UCMs, that they would have the knowledge and experience to answer the interview questions and help in the findings of the overarching research question. The final assumption was assuming that a qualitative embedded single case study was the appropriate approach for answering the overarching research question. Future researchers can expand on the study by using strategies to support increased customer loyalty and improve patient satisfaction.

Limitations

Limitations of a study relate to occurrences out of control of the researcher and may affect the results or conclusions of the study. Limitations are the uncontrollable boundaries and constraints that have a direct influence on research results (Brutus, Aguinis, & Wassmer, 2012). The first limitation involved using the qualitative method for research. When a researcher selects certain methodologies and designs, they accept inherent limitations over which he or she may have little control (Simon & Goes, 2013). Certain methodologies and designs may limit the researcher in terms of control and collecting viable data (Simon & Goes, 2013). I accepted that I may encounter inherent limitations by selecting the qualitative method because qualitative research occurs in a natural setting and relates to a specific phenomenon. Another limitation was using a single case study design to explore customer care strategies UCMs used to improve the quality of patient satisfaction. The single case study explored customer care strategies of three UCMs and may not reflect similar results of other UCCs.

Delimitations

Certain delimitations are encountered when performing research studies. Delimitations are objectives that bound the scope and set restrictions for research studies (Leedy & Ormrod, 2013). The first delimitation was only exploring three UCMs in the same organization and geographical region. The second delimitation was using purposeful selection. Purposeful selection is nontransferable to a larger scope (Marais, 2012). The third delimitation involved requesting archival company internet survey results. The final delimitation is that I only explored customer care strategies UCMs used to improve patient satisfaction. Excluded in the study are other business strategies UCMs may use in business that are not directly relevant to the purpose of this study. Future researchers may expand on this topic by having a larger sample size, perform multiple case studies, and explore employee satisfaction rather than patient satisfaction.

Significance of the Study

Contribution to Business Practice

The findings of this study may be of value to business managers in terms of how UCMs can provide customer care services to improve patient satisfaction. Managers using successful guidelines associated with sustainability can retain their current customers, which increases repeat business (Srivastava & Kaul, 2016). UCMs may experience higher quality performance and efficiency in UCCs by increasing customer loyalty. Acknowledging the importance of patient perceptions in HC supports a positive customer care environment and may foster economic growth and stability (Al-Abri & Al-Balushi, 2014). The improvement of customer care services can enhance business

sustainability in UCCs. Some HCMs noticed the value of considering the patient's customer care perception and started incorporating patient-centered care in their mission statements (Al-Abri & Al-Balushi, 2014). Practicing good strategies for improving patient satisfaction may have positive implications on social change.

Implications for Social Change

The study results may contribute to positive social change by helping UCMs provide a higher quality of customer care services, which could benefit local communities by decreasing illnesses and improving patient satisfaction in HCCs. Patient satisfaction is a major concern for HCMs in Alabama and members of the local community. Beausejour et al. (2015) said that the inclusion of HCCs in communities helps develop relations and bridges the gap between management and community members. By increasing the quality of customer care services, the findings of the study may result in more patient satisfaction and provide positive engagement from members of the local community. Collaboration between HC officials and community stakeholders advances population health and increases developmental activities (Carlton & Singh, 2018). Therefore, the implication of positive social change for UCC community members could be higher quality in patient care and overall higher quality of health for people in these communities. A potential increase in overall patient satisfaction could mean people would be healthier.

A Review of the Professional and Academic Literature

The review of the literature consisted of issues pertaining to improving customer satisfaction for UCMs. Additionally, information regarding the components of Dick and

Basu's CLT is present, which served as the conceptual framework for the review. I selected articles from scholarly journals, dissertations, and academic books. Most of the articles were from peer-reviewed journals and the work of seminal authors.

The organization of the literature review extensively includes strategies used to improve customer care services and patient satisfaction. The literature review section contains a critical analysis and synthesis of the CLT and customer loyalty two-dimensional findings. Also included is a critical analysis with supporting and contrasting theories for the CLT and a critical analysis and synthesis of literature pertaining to patient satisfaction. Additional information includes theories on the conceptual framework, and related content on HC services, HC communication barriers, duties of HCMs, concepts regarding UCCs, and the Patient Protection Affordable Care Act (Obamacare). Finally, content on consumer assessment, customer care services, strategies to increase patient satisfaction, and HC sustainability concludes the literature review section. Moreover, I compare different points of view and the relationship of the study to previous research. The content in the literature review supports the research question and enhances the reader's understanding of how UCMs improve customer care services and patient satisfaction.

Strategies for Searching the Literature

I searched the literature using multiple databases and government websites. The databases included (a) Business Source Complete, (b) Emerald Insight Advanced, (c) Sage Premier, Google Scholar, (d) ProQuest Central, (e) Science Direct, and (f) ABI/Inform. The keywords I used to explore research strategies UCMs may use to

improve customer satisfaction were *urgent care centers*, *patient satisfaction*, *customer care*, *healthcare*, *business sustainability*, and *affordable care*.

Frequencies and Percentages of Peer-Reviewed Articles and Dates Published

I calculated the frequency of articles in the literature by topic. In addition, approximately 50% of the article were on customer loyalty and patient satisfaction strategies. In addition, 25% of the articles reference business sustainability and another 25% reflect customer repeat business. I reviewed 257 references consisting of scholarly peer-reviewed articles, books, and dissertations published between 2011 and 2018. Eighty five percent of articles reviewed were peer-reviewed articles, with 155 of those peer-reviewed articles included in the literature review. Ninety-four percent of the references reviewed met the requirement of publication within the past 5 years and met the 85% requirement for Chief Academic Officer approval (see Table 1).

Table 1

Literature Review Source Content

Literature Review Content	Total #	Sources less than five years old (since 2014)	% Total peer-reviewed less than five years (since 2014)
Peer-reviewed Journals	120	114	7
Books	8	7	1
Non peer-reviewed Journals	0	0	0
Older Articles	0	0	0
Total	128	121	8

Applications to Applied Business Problem

The purpose of this qualitative embedded single case study was to explore customer care strategies UCMs used to improve patient satisfaction. This section contains

a critical analysis and synthesis of literature pertaining to the conceptual framework CLT and a critical analysis with supporting and contrasting conceptual models for the CLT. In addition, I include in this section a critical analysis and synthesis of literature pertaining to strategies UCMs used to improve patient satisfaction. Furthermore, I compare different points of view and the relationship of the study to previous research and findings. This section includes a comprehensive critical analysis and synthesis of the literature on the research topic of customer care strategies UCMs used to improve patient satisfaction.

Customer Loyalty Theory

The customer care model that explores cognitive customer behavior and attitudes to improve marketing strategies is CLT. Dick and Basu (1994) introduced the customer loyalty two-dimensional system which identifies customer behavior and attitudes. Business leaders analyze the two-dimensional system to develop marketing and customer care strategies for retaining customer loyalty and improving satisfaction. Managers have an enormous challenge in order to gain loyalty from customers. Customer loyalty is complex, and a direct reflection of the atmosphere formulated by the customer (Babin, Boles, & Griffin, 2015). Maintaining customer satisfaction requires the knowledge to persuade customers to be loyal. The CLT, often referred to as brand loyalty theory, provided the analytics of conceptualization in this study. Moreover, exploring the behavior and attitude components of CLT can impact customer care and customer satisfaction by providing a model to improve customer loyalty. Kotler (2015) argued that the cost to interest new customers is far greater than retaining current customers. Kotler noted five tenets to customer loyalty: (a) attaining current customers to reach new

customers, (b) existing customers tend to patronage more, (c) regular customers are more predictable in their services, which is less expensive, (d) existing satisfied customers is free marketing, and (e) existing customers are prone to pay prices at a premium. The tenets by Kotler support methods UCMs can use to improve customer care strategies and patient satisfaction.

The two-dimensional system includes components of customer behavior and attitudes that UCMs may use to enhance customer loyalty. Dick and Basu (1994) maintained that customer loyalty is a two-dimensional system comprised of relative attitude and repeat patronage. In response to the two-dimensional systems of CLT, managers claim competition will do three things: (a) decrease the visual aid on the main brand, (b) increase the value on attitude-driven products and services, and (C) manipulate the customer through situational factors (Dick & Basu, 1994). Negative and positive experiences will cause a customer to either repeat patronage or take their business somewhere else (Komarov & Avdeeva, 2015). Good leadership strategies can influence the customer to remain loyal and develop relations between the patient and UCC to improve customer care services.

Leadership strategies involving the two-dimensional system may strengthen customer loyalty and minimize customers patronizing other businesses. Dick and Basu (1994) argued the importance of managers determining the attitude and influence on the customer. Dick and Basu also discussed four implications on loyalty that managers may encounter while using the CLT: (a) comparative loyalty relationships through competitors' offerings, (b) consequences of recognizing pertinent customer loyalty

antecedents, (c) determining the impact of customer loyalty, and (d) detecting shortcomings from competitors and how new inventions can affect loyalty. Dick and Basu noted managers should focus on positive organizational values to prevent customer dissatisfaction. Multiple authors shared strategies that UCMs can use to retain existing customers and build customer care services to improve patient satisfaction.

Various outcomes of research are from multiple sources on Dick and Basu's (1994) CLT. Using the CLT two-dimensional system, Muthukrishnan's (2015) argued that habits increase customer loyalty behavior and customer satisfaction in his brand loyalty theory (BLT). Muthukrishnan posited that customer loyalty is more of a habitual behavior rather than emotional behavior. Muthukrishnan stated there were four components of brand loyalty which include (a) persistence stems from the preferred business, (b) persistence is derived from the lack of change, (c) persistence from brand attachment, and (d) persistence from life experiences. In addition, Andajani, Hadiwidjojo, Rahayu and Djumahir (2015) posited that the future of customer behavior is dictated through observing negative and positive customer care services from the perception of the customer. Moreover, Chahal and Dutta (2014) maintained that managers are reluctant to adopt the customer perception and behavior model due to conflicting views on customer care services and brand loyalty. Despite having contrasting views on customer habitual behaviors and customer perception, managers who develop customer loyalty are more likely to succeed in business (Chanal & Dutta, 2014; Muthukrishnan, 2015). UCMs can use these contrasting views on customer persistence and perception to enhance brand loyalty, and to improve care strategies and patient satisfaction in UCCs.

Positive managerial strategies are a concern for most business managers and organizations. Ngobo (2016) tested four components of the CLT to establish leadership strategies on how managers can become more effective in grocery stores. The four components of the study were (a) no customer loyalty, (b) true customer loyalty, (c) latent customer loyalty, and (d) spurious customer loyalty. Ngobo agreed that managers should focus their attention on true customer loyalty, latent customer loyalty, and spurious customer loyalty due to the high intensity of customer behavior. However, Ngobo stated that spurious loyalty is a risk for managers due to a customer's psychological weakness on using the services. In addition, Zhibin and Bennett (2014) stated that managers should have strategies on customer loyalty programs to enhance the customer's commitment and improve customer satisfaction. According to Grosso and Castaldo (2015), managers that offer discount, incentives, and reward programs, improve customer satisfaction. The majority of these managerial strategies supported Dick and Basu's CLT in relations to a customer's behavior and the impact it has on loyalty programs and marketing to improve customer satisfaction. UCMs can implement these strategies on customer loyalty to entice customers to become more true loyal customers, which may lead to better patient satisfaction in UCCs.

Customer satisfaction and repeat business yield wavering effects on branding and customer care strategies in an attempt for managers to reach organizational goals. According to Neupane (2015) a business achieves customer satisfaction when they appease the expectations of a customer with their products or services. A satisfied customer may develop a positive attitude and continue to patronize the business and

become loyal customers. Repeat customers have a positive attitude toward the brand and are loyal customers and satisfied customers (Bowen & McCain, 2015). The four components of CLT repeat business are (a) higher the attitudes increase repeat business (b) low loyalty attitudes decrease repeat business), (c) latent loyalty attitudes decrease repeat business, and (d) spurious loyalty decreases attitudes and increase repeat business. Customer satisfaction and repeat business can be measured by observing a customer's attitude and loyalty (Porral & Levy-Mangin, 2014). Repeat business may be consistent with customer loyalty, and the willingness of an organization to show transparency and have good ratings from the consumer. According to Srivastava and Kaul (2016), good business ratings are favorable to the customer, and organizational transparency impacts repeat purchases. UCMs can use these strategies on customer satisfaction and repeat business to improve patient satisfaction and retain patients, which may improve customer care services in UCCs.

Business leaders tend to think gaining new customers will help sustain their organizations. Recruiting new customers will not guarantee long term success for a company, especially when the company cannot retain its customers (Thaichon, Lobo, & Mitsis, 2014). A 2% increase in the client retention rate is equal to a 10% decrease in the cost of customer acquisition in the service industry (Thaichon et al., 2014). Therefore, keeping a loyal customer is more profitable than gaining new customers. Thaichon et al. (2014) described how improving service quality can aid small business owners in retaining existing customers and increasing customer loyalty through brand building. Business owners can increase sustainability by using data from existing customers and

develop relationships to maximize profits (Ramaj & Ismaili, 2015). According to Ramaj and Ismaili (2015), organizations have access to permeable information by storing data from the customer and keeping up with social media feedback. Through the access of data and technology, organizational managers can appeal to their customers' needs, increase repeat business, and improve profitability (Peppers & Rogers, 2016). UCMs can use these technology strategies to enhance their customer data base, build customer relationships, and retain existing customers in UCCs.

Maintaining positive relationships between managers and customers builds organizational performance. Relationship marketing is a strategy that managers use to entice loyal customers by building customer relationships to optimize organizational performance (Kim & Kim, 2014). The customer manager relationship affects organizational performance, new business, and customer satisfaction. Organizational performance is affected through the reduction of profitability, negative feedback, and dissatisfied customers (Agnihotri, Dingus, Hu, & Krush, 2016). Organizations need positive and loyal relationships to increase customer retention and improve performance (Matis, 2014). When manager and customer relationships succeed, they both experience positive emotions that can enhance organizational performance and customer loyalty (Kim & Kim, 2014). Organizational loyalty aligned with the fulfillment of self-oriented values and customer loyalty. In addition, UCMs who value customer relations, can increase patient retention and improve customer care services in UCCs.

Consumers tend to repeat patronage if they have an emotional attachment to a certain purchase or organization. O'Brien, Jarvis, and Soutar (2015) noted that

organizations continuously try to create an emotional attachment to brands and products. Dick and Basu (1994) expressed that a customer's repeat patronage and loyalty behavior are determined by the way managers communicate socially, and the structure of the organization. Social engagement and organizational structure are important to customers. Therefore, organizations rely on customer engagement systems as drivers to improve customer loyalty in the services industry (O'Brien et al., 2015). Moreover, the interaction between business owners and the customer can determine the level of repeat patronage to improve customer care services in UCCs.

Strategies to retain customers remain a major concern for businesses. Customer loyalty programs are a primary source for business owners and organizations (Kursunluoglu, 2014). With consistency and treating everyone fairly, the consumer may gain trust and loyalty from the customer (El-Manstrly, 2016). Iqbal (2014) stated retaining present customers is more cost effective than recruiting new customers. According to El-Manstrly (2016), loyal customers tend to spend more, forgive organizational failures, turn down offers from competitors, and generate higher profits. Organizations attract new customers with preconceived marketing strategies. In addition, some organizations retain new customers with loyalty programs. Business owners in the United States spend $48 billion per year in repeat purchase programs (Melnyk & Bijmolt, 2015). McMahon et al. (2016) posited that business leaders focus on customer loyalty programs to increase repeat customers. When organizations eliminate loyalty programs such parking vouchers or early appointments, customers often lose faith in the organization or business owner. When customers receive incentives as part of a loyalty

program, they may develop a positive behavior and refer other customers to the organization. Dick and Basu (1994) argued that rewards lead to word-of-mouth marketing. Customers in loyalty programs provide positive referrals, enhancing customer base and revenue (McMahon et al., 2016). Provision of loyalty programs allow direct financial benefit to customers, and discounts could stimulate customer repeat business. However, the same programs increase customer sensitivity to deals and may force them to patronize elsewhere (Melnyk & Bijmolt, 2015). Customers of all ages and genders realize business leaders have an obligation to offer rewards and promote customer care strategies to improve patient satisfaction.

To improve customer care services, UCMs should examine situational factors and demographics to attract new customers. Repeat business behaviors varied in terms of individual characteristics, like gender, age, and levels of income and education. Customer loyalty varies from the service received by men and women (Giovanis, Athanasopoulou, & Tsoukatos, 2015; Gounaris & Boukis, 2013). Some men feel customer loyalty derives from physically helping the customer, while some women feel emotions resonate with the customer. The overall business goal to increase customer loyalty is for both men and women to commit to the organization (Almutawa, Muenjohn, & Zhang, 2016). Dick and Basu (1994) argued that repeat business and loyalty is determined by (a) social norms, (b) situational factors, (c) expectations, (d) moods, and (e) switching behaviors. These personal characteristics regarding customer satisfaction and behavior demonstrate an impact on loyalty, including the intention to repurchase services and willingness to pay more. The behavior of customers and their repeat business varies in terms of different

genders and income. For example, women tend to shop more than men, and low-income individuals tend to stay at home (Dick & Basu, 1994). The personal characteristic of each customer may encourage UCCs to improve customer care services and promote satisfaction and loyalty.

Comparative Theories

Provided in the study is a critical analysis of three supporting theories of leadership and customer satisfaction. In this section, I included three supporting theories that may support customer care strategies and improvement in patient satisfaction. These theories are the bureaucracy theory (BT), customer satisfaction management system (CSMS), and transformational leadership theory (TLT). Leadership encompasses gratitude and servitude but is not easily defined (Burns, 1978). Each theory has a unique position in determining the effectiveness of a leader. Although each model and theory differ, they benefit from improving organizational performance. However, neither theory supported strategies to improve customer satisfaction.

BT. Weber (as cited by Byrkjeflot, 2018) indicated that managers and owners should focus on organizational goals and the consumer. Since 1985, governments have implemented postcolonial development programs based on BT. BT is an administrative management approach whereby managers presented disciplinary rules for the organization based on a hierarchy and bureaucratic structure (Khorasani & Almasifard, 2017). The components of BT include (a) precise job descriptions, (b) accurate work documentation, (c) hire a qualified individual, and (d) maintain appropriate work relations (Byrkjeflot, 2018). Business owners can apply the bureaucracy theory and top-

down leadership approach (Ahmad, Talib, & Abu, 2015). Managers that display top-down leadership often lack customer care strategies and may push customers away through unapproachable tactics.

A major aspect of customer satisfaction is approachable leadership. Weber (as cited in Byrkjeflot, 2018) suggested that management should act firm and stick to organizational goals. The drivers of BT are more suitable for improving leadership, management, and organizational performance. Although BT suggested leadership strategies managers could use to improve customer satisfaction, the straightforward components of the theory make the customer feel the business is too authoritative (Byrkjeflot, 2018). Therefore, BT is not an appropriate conceptual framework to improve customer care services and patient satisfaction.

Customer satisfaction management theory. Associating management and customer satisfaction can appear difficult. In 2012, Kobylanski and Pawlowska established CSMS to measure customer care services and patient satisfaction policyholders in the life insurance industry. CSMS suggested that customer satisfaction can be transformed into a competitive advantage for business sustainability. Unlike customer loyalty two-dimensional systems of attitude and customer loyalty, CSMS is a one-dimensional system that emphasizes business sustainability. Kobylanski and Pawlowska (2012) argued that organizations must act (a) oriented in the organization, (b) willing to take a competitive advantage, (c) focus on continuous improvement, and (d) control systematic management. Álvarez-García, Río-Rama, & Simonetti (2017) noted positive managerial strategies derive from customer satisfaction and organizational

productivity. Moreover, organizational sustainability measures customer satisfaction (Ioppolo, Cucurachi, Salomone, Saija, & Shi, 2016). Lack of customer care strategies may lead to a dissatisfied patient and affect the sustainability of the organization. Many organizations risk sustainability over profit gain. According to Jianu (2015), large companies have two major goals which are profit and sustainability. Researchers who used business sustainability theory, measure and trace data to generate accurate information for decision making (Pádua & Jabbour, 2015). Customers often undermined the credibility of the sustainability reporting process (Jones, Hillier, & Comfort, 2016). Although all organizations should have goals, the customer is more concerned about service and satisfaction. CSMS theory appears applicable to customer satisfaction; however, the theory suggests leadership strategies that support organizational priorities over customer care services and the improvement of patient satisfaction in the HC industry.

TLT. The characteristics of good organization performance rely on strong leadership. In 1978, Burns introduced the TLT to share how leaders and followers could support one another. Burns (1978) suggested that both parties should move forward to a higher level of organizational performance. The key tenants of TLTs framework include (a) challenges leaders to rise above their immediate needs, (b) emphasizes organizational culture, (c) empower and mentally stimulate subordinates, (d) reassure leader to employee communication, and (e) immediate benefits for the organization (Burns, 1978). The tenants listed in the study are all relevant for positive leadership, and not intended to improve customer satisfaction. The intent of the study is to find leadership strategies to

supplement customer satisfaction. Although TLT may be applicable to business leaders and organizational sustainability, it lacked customer care strategies that UCMs could use to improve patient satisfaction. Either model potentially could support the conceptual framework; however, CLT better supports the overall research topic on improving customer care services and patient satisfaction.

Analysis of the Literature in Relation to Patient Satisfaction

The components of CLT include (a) customers continue to buy from a specific organization (b) organization leaders can develop effective marketing and customer service strategies to retain customer loyalty, and (c) business leaders employ loyalty programs rewarding customers for repeat business. Based on these schemes, I presented literature topics relating to patient satisfaction. The topics include (a) health care services, (b) HC Communication Barriers, (c) duties of HCMs (d) concepts of UCCs, (e) Patient Protection and Affordable Care Act (PPACA/Obamacare), and (f) consumer assessment, (g) customer care, (h) strategies to increase patient satisfaction, and (i) health care sustainability.

HC Services

Patients are seeking lower cost and better health care services from frontline employees. The quality of customer care service is on the decline, while the cost is increasing (Wells, Semple, & Lane, 2015). Stock and Bednarek (2014) wrote that customer demands happen at the service interface and include behaviors like hostility and complaining about frontline employees. Customers need emotional support, and they subtlety demand it during interactions with frontline employees (Stock & Bednarek,

2014). Cao, Jiang, and Wang (2016) wrote that structural relationships among customers and the influence factors researchers embrace consist of structural equation models. By reducing the adverse effect of data collected from the structural equation model, business owners can predict customer demand. Tracking customer behavior and showing organizational transparency builds relationships (Hopkins & McCarthy, 2016). Lack of transparency and severed relationships may cause patients to become dissatisfied. The HC industry is competitive, and managers realize patients are demanding better quality care and services (Pflueger, 2016). Lokdam, Kristiansen, Handlos, and Norredam (2016) stated the importance of health care is increasing throughout borders because of globalization, and the mobility of patients. Of 44 countries in Europe, 18 of the countries implemented strategies to regulate health care quality (Prakash, 2015). In addition, the private sector controls over 83% of the HC facilities, which has a major impact on GNP (Prakash, 2015). Despite major overhauls in HC, many customers are still confused between the quality of customer services and patient care.

Scrutiny exists between a HC facilities' wait time, customer care services and patient satisfaction. A customers' attitude derives from their perception of waiting, and the quality of goods and services (S, Mitra, & Sahoo, 2015). The perception of patient care generates from nurse care, wait time and cost efficiency (Antinaho, Kivinen, Turunen, & Partanen, 2017). According to Turan & Bozaykut-Bük (2016), perceived quality varies from individual to individual, service quality is measured through satisfaction, whereas patient care is measured through attitude. HC service providers have a duty to treat their patients with care.

Patients treated with care show a commitment to the organization despite recruitment from competitors. Commitment is the core of brand relationships and may lead to important marketing outcomes such as customer loyalty and repeat purchases of a brand over time (Kemp & Poole, 2017). Askariazad and Babakhani (2015) described how competition in the HC industry force many business managers to focus on branding and marketing for sustainability as opposed to the simple needs of the customer. However, Sharma (2017) evaluated factors influencing patient satisfaction and brand loyalty at a HC facility in India and found the improvement of health care services is determined by total relationship management and total quality management. In addition, Sharma (2017) noted strategies that include customer input may benefit organizational branding. Moreover, Askariazad and Babakhani (2015) suggested that strategies in contrast to brand loyalty and relationship management, such as customer loyalty improve the quality of management.

HC Communication Barriers

Proper communication in HC is conducive to the quality of customer care services provided to patients. Communication barriers can cause stress for patients when there is a lack of communication between HC workers and patients concerning procedures (Research Triangle Institute International, 2016). Common barriers that impede communication include (a) mental health morbidity, (b) wait time, (c) ineffective strategies, and (d) unqualified employees. Some HC providers lack collaboration due to busy schedules and social support, which can cause mental health morbidity (MHM) (Eklof, & Ahlborg, 2016). According to Eklof and Ahlborg (2016), MHM is an acute

psychological disorder often present in hospitals, which causes disorganization in HC staff teamwork. Also, Eklof and Ahlborg defined social support as having reliable feedback and support from an employee's supervisor. Often, MHM is a hidden diagnosis present in nurses and HC staff workers, which may cause resistance and communication problems that can impact patient satisfaction. UCMs that look for hidden MHM symptoms in their employees may intervene on issues that could prohibit their ability to improve customer care services.

To improve patient satisfaction, HCCs must communicate important medical information to the patient promptly. Patients that have to wait on extended communication regarding diagnosis become dissatisfied with their customer care services (Mehra, 2016). Dissatisfied patients are reluctant to communicate with their HC provider if they feel their needs are not met due to a lack of communication (Platonova, Qu, & Warren-Findlow, 2019). According to Mehra (2016), 33% of patients that lack communication with their HC provider suffer increased effects and medical complications. Moreover, HCCs must research and develop more tools and strategies to alleviate any potential patient from being dissatisfied. UCMs that share medical information promptly and encourage effective communication can improve their efforts on patient satisfaction.

Effective tools and strategies can eliminate poor communication within HCCs. According to O'Lawrence and Poyaoan-Linzaga (2018), communication between the HC provider and patient is a great intervention tool that can increase the quality of customer care services. Also, investing in patient-centered preparation courses can increase trust

from the patient, and enhance communication levels with members of the staff (Platonova, Qu, & Warren-Findlow, 2019). According to Platonova et al. (2019), to assure adequate communication is practiced in HCCs, managers should train staff members to (a) encourage listening, (b) display sincerity and interest, (c) encourage patients to share true medical history, (d) explain the procedures in simple language, (e) engage the patient on a resolution, (f) check for clarification on treatment selections, (g) accept patient feelings, and (h) show empathy and reassure great care. UCMs can improve their customer care services by implementing these strategies to eliminate poor communication barriers and train qualified employees to improve patient satisfaction.

All HC employees must be qualified in order to have effective communication within an organization. Unqualified employees can form disengagement and cause communication barriers in an organization (Chochinov et al., 2015). HCMs must find qualified employees that will compliment an environment conducive to effective communication and employee engagement. According to Marrelli (2015), good HC providers can resolve communication issues, and play a key role communicating clinical issues concerning their patients. UCMs must eliminate disengaged employee behavior and recruit employees who are qualified, and willing to provide effective communication to improve patient satisfaction in their UCC.

Duties of HCMs

HCMs play a vital role in managing customer care services to improve patient satisfaction. According to Holton and Grandy (2016), managers are responsible for maintaining and applying strategies to encourage their employees to complete specific

tasks. Also, HC facility owners place managers where they can be more effective for the organization (Oldenhof, Stoopendaal, & Putters, 2016). HCMs should strengthen relations with staff members to enhance employee engagement. According to Davenport (2015), managers that establish a bond with their employees encourage a high performance of customer care services. Moreover, HCMs can recognize key factors that contribute to satisfactory employee performance and customer care services (Dainty & Sinclair, 2017). Therefore, UCMs can learn to identify satisfactory employee performance to establish an environment that will satisfy their patients.

The demand and expectations from HCCs and patients have increased the leadership role of HCMs. HCMs are required to implement training, resources, and innovative strategies to encourage employees to be more effective (Engle et al., 2017). High expectations should be the center dynamics of every HCC to improve performance and customer care services. HCCs may experience growth and positive feedback from patients by employing a firm and positive HCM. HCMs must provide emotional support, schedule meetings, and advise their employees (Engle et al., 2017). The multiple roles of HCMs are not limited and can provide strategies for UCMs who oversee employees in UCCs. Expectation strategies can help UCMs provide effective leadership to improve customer care services and extend services to the community.

Education status and social factors affect the job satisfaction of HCMs. Many HCMs become stressed due to heavy workloads experienced at work and in the community. According to Lampinen, Viitanen, and Konu (2015), HCMs with higher education are more satisfied with their jobs, while HCMs with lower education are less

satisfied. HCMs with a higher education receive better benefits and support from their superiors and co-workers (Lampinen, Viitanen, & Konu, 2015). HCMs with less education feel pressure to establish a presence within their organization and community (Lampinen, Viitanen, & Konu, 2015). Some social factors that HCMs face indicate that community members, family, and friends rely on HCMs for minor health checkups. The lessons that can be learned by UCMs include (a) obtain a higher level of education, (b) reduce the workload, (c) refrain from unrelated work procedures, and (d) obtain the support of the community. UCMs that follow these strategies and tools can help their organization maintain sustainability, improve customer care services, and learn key concepts to ensure patient satisfaction in UCCs.

Concepts of UCCs

UCCs changed the modern day treatment of patients. In the early 2000s, walk in UCCs phenomenon began as an alternative to expensive and time consuming options such as hospital emergency rooms and physician office visits (Hermanson, Berkshire, Leaming, & Piland, 2013). Most were identifiable by four characteristics including location within a big box retail store or pharmacy, a limited menu of services which did not require imaging or laboratory services, nurse practitioners, and affordable pricing structures (Wright, 2017). Visibility and accessibility attract more customers to the business.

Individuals seeking to bring change to the HC model own and operate UCCs. Minority small business owners also capitalized on this market (Hermanson et al., 2013). By identifying costs associated with local health care, UCMs can capitalize on

competitive advantages to make UCCs more successful. Patient visits, leadership commitment, marketing, staffing, and location were the most cited factors as the key determinants of repeat sales (Beausejour et al., 2015). More opportunities existed for patients and individuals seeking small business ownership. Beausejour et al. (2015) stated within the regular source of care, communities could see relational, informational, and management continuity with the inclusion of UCCs in their community.

Having a regular source of medical attention reduces uncoordinated contacts with multiple health care providers. Patients were relevant stakeholders in the development of medical services (Mercieca et al., 2014). Historically, HC delivery has not met patient expectations (Mercieca et al., 2014). With the inclusion of UCCs in remote communities, patients will have access to care promptly and avoid worsening of medical symptoms. Service providers needed to obtain patient health care perspectives to ensure services were built around patient needs, which created a business opportunity for those who were interested in providing space for those providers to operate (Mercieca et al., 2014). Economic resources for HC facilities became more prevalent.

The model for UCCs has become an underground success. Arthur, Fisher, Shoemaker, Pozniak, and Stokley (2015) posited that rapid growth is occurring in UCCs in the United States. Most UCCs were not affiliated with a larger HC system but owned by entrepreneurs and small business owners. In 2015, owners and leaders of UCCs were responsible for 70% of preventative HC (Arthur et al., 2015). In nonphysician owned UCCs, evidence from Lelli, Hickman, Savrin, and Peterson (2015) showed a link between job satisfaction and the practice settings of nurse practitioners (NPs). Moreover,

stakeholders devoted to the development of UCCs may influence retention and turnover rates amongst NPs; therefore, increasing organizational strategies on customer care services.

Shopping conveniences contributed to the many UCCs opening in stores. Win (2016) found major pharmacies such as CVS, Walgreens, and Rite Aid also used the UCC model. Part time physicians use the UCC to provide care for simple acute conditions. In big box stores (i.e. CVS, Walgreens, Rite Aid), UCMs do not reduce visits to emergency rooms (Win, 2016). However, small business owners who own UCCs have reported a 10% rate of patients go on to ER visits (Lelli et al., 2015). Although UCCs are important, patients still visit emergency rooms for care. Patients continue to go to UCCs once they are available in their neighborhood (Hassmiller & Quinn, 2015). Patient satisfaction with UCCs illustrated an increased need for the services provided by UCCs in this industry. Grube, Cohen, and Clarin (2014) emphasized consumer-driven HC is sensitive to the market. The HC market expanded throughout other countries because of a variety of chronic illness.

Many high and middle-income countries share many individuals with chronic diseases. The demographics, political, and social expectations impact the delivery quality of HC services (Martin, Weaver, Currie, Finn, & McDonald, 2012). Business owners performed risk assessments for strategic development practices in HC (Wright, Paroutis, & Blettner, 2013). With increasing patient expectations, this burden raised the demand for community-oriented innovation in health care (Loewenson & Simpson, 2017). Early first contact and continuity of primary care (PC), PC coordination of referral, and team

approaches supported comprehensive approaches. Each approach contributed to financial factors in pharmacies and UCCs.

Certain products or services can impede or grow revenue in an organization. Richardson (2015) noted that CVS executives decided to discontinue tobacco sales in their United States pharmacies to focus on UCCs. The CVS case was indicative of strategic issues to address the nonfinancial factors that affected HC. For UCCs, a broad array of costs were in management decision making, contingent costs, reputational costs, and social costs that affect repeat business (Richardson, 2015). Keevy and Perumal (2014) posited that promoting transparency in retail clinics emphasizes creating a sustainable competitive advantage. UCMs may increase competitive advantages by offering multiple services to consumers. As retailers face a demand for knowledge and the ability to train, retail leaders could build leaders internally (Keevy & Perumal, 2014). TLT is a great model for UCMs wanting to develop better emotional leadership to improve customer care services and patient satisfaction in UCCs.

In the model of TLT, the three tenants were experience, critical reflection, and emotional development (Keevy & Perumal, 2014). Leaders with expertise could integrate with the assumption of learners bringing a reservoir of experience to learning intervention. Critical reflection is the principle of learning and self-direction. Self-directed leadership skills allow managers to be better at solving problems (Keevy & Perumal, 2014). This type of reflection processes a higher level of thinking, deliberation, and networking with others. In addition, components of the TLT model may result in

individuals changing their perception of how UCMs may improve customer care services and patient satisfaction.

Patient Protection Affordable Care Act. In March 2010, Congress passed a law expanding the guidelines for Americans to accept health care coverage, and regulate policies offered by insurance companies. The PPACA of 2010, better known as Obamacare, awarded incentives to HC leaders for improving performance and patient services. Many Americans not insured were able to enroll either individually, or their entire family in Obamacare. Prior to Obamacare, many Americans were without HC because of excessive premium cost (Skinner, 2014). The Center for Medicare and Medicaid Services (CMS, 2014) created several programs to increase patient services in the HC industry. Value-based programs (VBP) reward health care providers with incentives based on the quality of service performed (Dupree, Neimeyer, & Mchugh, 2014). According to CMS (2015), the three major components of VBP include (a) better patient care, (b) improve the health in the population, and (c) affordable cost. More than 100 million Americans are enrolled in some type of Medicare or Medicaid program operated by the CMS (CMS, 2015). Consequently, the CMS takes full control over ensuring patient satisfaction by demanding HC organizations provide quality customer care services to their patients.

It is important that legislation provide affordable care to citizens to ensure adequate health care services. Despite government efforts to provide a high quality of health care services to all Americans, many Americans rejected affordable care because of the name Obamacare (Mendoza, 2016). Political predisposition and bipartisanship

have a key role in the attitudes of many Americans, hence the reason why many Americans rejected the program (Cooper, Feldman, & Blackman, 2018). When legislation passed the bill, they were hoping younger healthier adults would sign up for coverage to subsidize payments for elderly individuals. However, after the news media created a frenzy amongst political parties, many young Americans decided to opt out of the program. According to Wojcieszak, Bimber, Feldman, and Stroud (2015), this type of rhetoric is not logical and can cause a sobering effect on HC reform. To improve customer care services in the HC system, managers will have to put aside their differences and unite for the betterment of society.

Consumer assessment and patient satisfaction. Systematic accountability may improve the quality of customer care services and patient satisfaction. The hospital consumer assessment of health care providers and systems (HCAHPS) is an assessment model used to measure and evaluate health care providers on the patient (CMS, 2014). According to Iannuzzi et al. (2015), the HCAHPS has seven components that measure patient satisfaction (a) communication, (b) response time, (c) pain management, (d) new medicine, (e) facility cleaning (f) patient discharge, and (h) post-op knowledge. After the patient leaves the HC facility, within 48 hours the HCAHPS will send out a random survey. According to the HCAHPS, the primary section of the survey consists of 21 questions asking the patient to evaluate their visitation. The surveys from the HCAHPS provide data beneficial to both the patient and the manager to improve satisfaction.

Feedback from individuals associated with the organization can be a positive sign management is moving in the right direction. Managers in the HC industry are required to

include customer feedback and their staff on developing strategies to improve patient satisfaction (Hilton & Sherman, 2015). Often overlooked at times, patients can add value to an organization through their vision (Sharan, Millhouse, West, Schroeder, & Vaccaro, 2015). Quality HC delivery systems require a higher level of collaboration and new advanced ideas to improve service quality (Wutzke et al., 2016). Therefore, doctors, nurses, and patients are all responsible for contributing to improving the quality of customer care services and patient satisfaction in health care.

Customer care. Organizations have an obligation to ensure high quality customer care to individuals patronizing their establishment. Mohebifar, Hasani, Barikani, and Rafiei (2016) suggested that properly equipped, clean and customer friendly facilities attract customers. Competition exists in HC facilities, and managers understand patients are demanding satisfactory customer care services (Pflueger, 2016). According to Pflueger (2016), in 1985 the two efforts placed on health care included (a) measure of health care and (b) quality of customer care. The efforts determined the quality of customer care services and government price control. During governmental price control, judging and checking customer care services can be difficult. Pflueger (2016) argued that nurses and acting physicians measured customer care services, leaving the customer without any input on services given. Therefore, UCMs can learn from this by allowing customer input to improve customer care services and patient satisfaction.

Trustworthiness and honest is a major concern in the HC industry. Patients often feel HC professionals are dishonest people (Pflueger, 2016). Dishonesty makes patients feel overlooked and underappreciated. According to officials from CMS (2015), HC

officials argue the testing of customer care is unfair, and patients receive the correct information. The division of customer care quality and HC professionals forced the HCAHPS and CMS to administer surveys and create measurement programs (CMS, 2015). Consequently, UCMs and HC professionals should make adjustments to build better customer care relations to improve patient satisfaction in the HC industry.

Strategies to increase patient satisfaction. UCMs should take strategic steps to guarantee all their patients are satisfied with their customer care services. Saadat, Panah, and Noroozi (2017) indicated that 72% of patients are satisfied with the quality of customer care services they receive from HC professionals. Therefore, 28% of patients feel they received dissatisfactory customer care services. Key factors such as positive managerial strategies and quality customer care can increase patient satisfaction. Both HC professionals and patients have responsibilities in ensuring patient satisfaction. Schaufeli (2015) suggested that leaders of HC facilities can engage employees by paying competitive wages and offering rewards to their employees. Rewarding employees for their service can help UCMs increase employee engagement. Engaged employees can offer a positive environment that welcomes new or repeat patients in their UCC. Schiff et al. (2016) argued that HC professionals waste millions of dollars each year on wrongful and unwanted examines.

HC Sustainability

Few organizations invest in practices targeting sustainability. Family ties to future generations within transgenerational succession could change as the adoption of sustainable practices change (Delmas & Gergaud, 2014). Transgenerational framing

strategies may improve patient satisfaction and increase sustainability through concept innovation. Fleiszer, Semenic, Ritchie, Richer, and Jean-Louis (2015) noted sustainability benefit from the endurance of innovation related benefits, as well as continued development of innovation over time. Sustainability educators (SE) proposed the definition should integrate all three characteristics of the business model (Wyness, Jones, & Klapper, 2015). Sustainability is a descriptive analysis research tool used to measure and balance sustainable strategies against competing interests (Starik & Kanashiro, 2013). When managers of UCCs use guidelines associated with sustainability, they increase their chance of having a competitive advantage and repeat business (Srivastava & Kaul, 2016). Additional sustainability benefits include increased repeat business and new business development because customers tend to conduct business with real branded companies. Wyness et al. posited that the inclusion of sustainability into entrepreneurial activity remains a niche topic within the entrepreneurship literature. Many sustainability theory research articles were about environmental sustainability and business sustainability. Steinmeier (2016) noted the situation was not clear whether small businesses possess the required time to follow the type of sustainability processes and guides available. Sustainability theory scholars encourage appreciation of the interconnectedness of the world's systems and processes, therefore lacking strategies to improve customer care services and patient satisfaction.

Organizational sustainability should include leaders willing to accept new innovations. Herrera (2016) wrote that innovation could enhance corporate performance and create a social impact. Business leaders can increase social impact by targeting

systemic factors using business culture and sustainability for inclusive growth. Stakeholder engagement increased opportunities to enable business model innovation through knowledge gathering and creation. Strengthening and aligning organizational elements enhance the likelihood of improving corporate performance (Herrera, 2016). UCMs that implement sustainability strategies in their organizational goals could improve customer care services and patient satisfaction with effective business practices.

HC facility managers should remain aware of situations that may arise with upper management. Some business owners exploit sustainability for personal gain (Steinmeier, 2016). In addition, some companies make sustainability a priority because of performance targets. The lack of understanding is how managers use organizational innovations to develop capacities to ensure high quality practices, contribution to overall performance, and responding to customer demands (Fleiszer et al., 2015). The rationale for further developing the knowledge base about how organizational programs were sustainable given achieving these fundamental institutional functions. Steinmeier discussed the bonus incentives for sustainable businesses, such as security in their jobs, or advancement in their careers. As such, the notion to act fraudulently increased amongst small business owners. Therefore, UCMs should be aware of fraud and network with other managers to eliminate causes that can impede improving customer care, and that may prevent sustainability in UCCs.

Networking with colleagues or other organizations can foster growth and sustainability. Avery (2015) wrote sustainable businesses often form relationships with many conglomerates. Entity collaboration from different regions brings awareness of

political and social issues to large businesses, which increases sustainability (Avery, 2015; Symons & Lamberton, 2014). Sustainable partnerships remain equally important to small business owners (Avery, 2015; Symons & Lamberton, 2014). The business case for sustainability confirmed a focus on the expected economic impacts of a shift towards sustainability (Symons & Lamberton, 2014). The relevancy of sustainability for business performance and goals remain more complex than a single dimensional economic perspective. If UCMs fail to meet sustainability and performance goals, the difficulties of improving customer care services and patient satisfaction may increase.

Management is a key component in the success of an organization. Operational efficiencies associated with management strategies and employment practices in the use of business sustainability theory (Mrope & Bangi, 2014). The association between sustainability factors and management promote financial and operational performance (Sharma & Rani, 2014). According to Jianu (2015), large companies have two objectives which include profit and sustainability. Researchers use business sustainability concepts to measure and trace data to generate information for decision making (Pádua & Jabbour, 2015). Stakeholders often undermine the credibility of the sustainability reporting process (Jones et al., 2016). However, systematic articulation of a sustainable framework enables sustainability reporting and design of new data models (Nyerges, Roderick, Prager, Bennett, & Lam, 2014). Therefore, UCMs that perform proper reporting and documentation build credibility and sustainability for their UCC, which may lead to effective strategies in improving customer care services and patient satisfaction.

Business sustainability may enhance and improve the longevity of organizations. Eugenio, Laurenco, and Morais (2013) stated some researchers use the concept of sustainability to motivate legal and political initiatives that resolve economic problems (Eugenio et al., 2013). Business owners and stakeholders continuously assessed strategies to integrate sustainability concepts into their business decisions and best practices to ensure not only transparency but also sustainability assessments. For example, manufactured goods consist of a sequence of processes ensuring sustainability (Olinto, 2014). Concerted efforts between business owners and stakeholders strengthen the possibility for future generations; however, the model lacks strategies that UCMs can use to improve customer care services and patient satisfaction.

Following company regulations and policy is a standard practice every organization should enforce. Aigner and Lloret (2013) determined compliance status is the gap between the regulatory standard and an organization's cost minimizing propensity. Environmental management had a strong, independent effect on compliance, even when business implemented controls exist. In developing countries, programs of environmental management training provided a useful complement to uncertain conventional enforcement (Aigner & Lloret, 2013). Almost 92.5% surveyed by Aigner and Lloret stated the adoption of sustainability practices improved the overall standards of the organization (Aigner & Lloret, 2013). Although organizational standards increase the sustainability of an organization, UCMs must implement these standards to improve customer care services.

Relationship of the Study to Previous Research and Findings

Researchers found a distinguished difference between the elements of loyalty and customer satisfaction. Satisfaction and loyalty elements align with the perception generated by the customer, and each element may increase organizational leadership (Babin et al., 2015). Similar relationships between customer attitudes and behaviors increase customer satisfaction and demand for quality (Sahin Dölarslan, 2014). Satisfaction affects the consumer's willingness to pay for the service and is an impact on a company's financial performance; however, the relevancy to improving customer care services and patient satisfaction remains absent in UCCs.

Although statistical differences exist in customer loyalty, researchers identified demographic factors as the major concept of the model. Demographic changes, such as age, marital status, children in the household, and changes in economic situations altered customers' evaluations of a product or service (Lariviere, Keiningham, Cooil, Aksoy, & Malthouse, 2014). In addition, younger customers are more loyal to branding and staying faithful to a company over their lifetime more than adults over 30 years of age. Klopotan, Vrhovec-Zohar, and Mahic, (2016) proposed a four-stage customer loyalty model that encompasses a customer's belief, affect intentions, brand loyalty and action. Business managers who use the four-stage loyalty model may experience negative feedback from older customers, however, they can gain loyalty from younger customers in the demographic region. Despite many similarities of CLT, the model lacks customer care strategies to improve patient satisfaction.

Big data was a phenomenon that allowed business owners to know their customers through algorithms. The four defining characteristics of big data were the data was unlikely in one place, the data was unlikely owned by one organization, the data maintenance was not a traditional database tool, and the data was vast (Andonova, 2013). Bahmani-Oskooee and Ghodsi (2016) posited that in business, mixed reports were found from businesses that increased data power, utilized panel test and data. Changes in the fundamentals of data had symmetric effects on prices. Quarterly data from each of the states in the United States showed that variations in the fundamentals had asymmetric effects on prices, in the short and long run. Big data allowed small business owners to offer custom offers and target advertisements (Andonova, 2013). In addition, big data can lead to businesses offering a better quality of products and services. However, big data fails to provide strategies to improve customer care services and patient satisfaction.

High quality products and good customer care services can attract new customers to UCCs. Customer-related quality may be determined by the fulfillment and interactions with the service provider (Srivastava & Rai, 2014). Quality was the competency of the small business owner in returning restitution on investment for their client and was a core service in financial planning. Functional quality was the interaction of the service provider with the customer. Srivastava and Rai (2014) asserted functional quality covered the processes dealing with delivering service. The overall quality of a product or customer care service influences the satisfaction of the customer. UCMs that invest in high quality of customer care services can attract new customers for the organization.

Although quality is important, other factors may contribute to a lack of customer satisfaction. Researchers (Klopotan et al., 2016; Lariviere et al., 2014) noted some aspects of customer satisfaction reflected one's loyalty, attitude, and behavior. Other researchers (Andonova, 2013; Bahmani-Oskooee & Ghodsi, 2016; Sahin Dölarslan, 2014; Srivastava & Rai, 2014) focused on price, data, and quality as influencing factors of satisfaction among consumers. The focus of this qualitative embedded single case study is customer care strategies UCMs used to improve patient satisfaction. However, by relating this research to other research and findings, researchers may determine how to improve overall patient satisfaction.

Transition

In Section 1, I introduced information regarding the background and foundation of the study. I also explored the conceptual framework and how to view the study through the lens of Dick and Basu's 1994 CLT which explain strategies to enhance customer loyalty and repeat patronage. Additionally, I explored the following nine components which include (a) problem statement, (b) purpose statement, (c) research question, (d) interview question, (e) operational definitions, (f) assumptions, (g) limitations, (h) delimitations, and (i) significance of the study. In the review of professional literature, I provided information on three supporting and contrasting theory is pertaining to the research question. In Section 2 I describe the research process and plan for protecting participants' information. I explain my role as the researcher, how I collected, interpreted, and analyzed data as the primary instrument in the study. In addition, I elaborate on the qualitative research method, share my data collection procedures, and provide

information pertaining to the ethics of the researcher. Section 3 concludes this study with themes that emerged from the data analysis process. Information in Section 3 provides a practical analysis of the findings and results of this research study.

Section 2: The Project

My goal for this study was to explore customer care strategies UCMs in Alabama used to improve patient satisfaction. In Section 2, there is an overview of the research design, method, data collection, analysis, and participant criteria. This section includes the methodology used to answer the research question. The primary subsections are the purpose statement, role of the researcher, participants, population and sampling strategies, and ethical research. Also included is a plan to contact the respondents, a description of the population sample, and data analysis strategies including external factors that may affect reliability and validity issues present in this study.

Purpose Statement

The purpose of this qualitative embedded single case study was to explore customer care strategies UCMs used to improve patient satisfaction. The target population was three UCMs within one HCC organization with less than 500 employees located in Alabama that improved the quality of patient satisfaction. The implications for positive social change include strategies UCMs can use to provide a higher quality of customer care services, which could benefit local communities by decreasing illnesses and improving patient satisfaction in HCCs.

Role of the Researcher

My role for this qualitative research study was to be the primary instrument and data collector. Yin (2017) suggested the role of the researcher is to collect, organize, and interpret data. In addition, the researcher is responsible for conducting interviews, recording participants, validating themes and concepts, and analyzing and transcribing

the data (Sherry, 2013). As the primary instrument for data collection, I collected data from managers of UCCs using open-ended questions and semistructured interviews. Moreover, I reviewed archival company internet survey forms pertaining to improving patient satisfaction.

I am currently an educator in the public school system with no interaction with managers of UCCs in Alabama. In my role as an educator, I interact with managers of education and children in K-12 grades. My job requires me to build character in kids, coach physical education, and increase community development. My current background eliminates any personal or professional relationship with managers in UCCs. The only affiliation I have with the research topic is my personal visits to UCCs in Alabama. Although I have little interaction with UCCs, I educated myself on the inner workings of the organization. Yin (2017) suggested that researchers should become familiar with the subject matter before performing the study. I used bracketing when I collected the data and performed interviews. Chan, Fung, and Chien (2013) said bracketing is a strategy that researchers use to eliminate prior knowledge of the subject. My acquired knowledge of UCCs and experience as an educator enabled me to comply with the Belmont Report (BR) on ethical behavior.

The National Commission for the Protection of Human Services of Biomedical and Behavioral Research introduced the BR to protect human subjects during research. The three basic principles outlined in the BR are respect for participants, member beneficence, and justice (Bromley, Mikesell, Jones, & Khodyakov, 2015). The responsibility of the researcher is to act ethically, and to respect the participants based on

the principles and requirements stated in the BR. I was able to comply with these requirements by maintaining an open communication with prospective members, gather data from UCMs, and abide by the Institutional Review Board (IRB) guidelines for the DBA program of study. In addition, I relied on my assigned committee members for feedback to help alleviate any ethical challenges.

Most ethical challenges are obtaining informed consent, mitigating bias, and protecting the privacy of the participant. I offered an informed consent form to the participants, and requested they reply in email, "I consent." In ethical research, researchers are required to inform participants of the potential risks and obtain authorization of consent (Sanjari, Bahramnezhad, Fomani, Shoghi, & Ali Cheraghi, 2014; Winter, 2017). I explained in detail the protocol and procedures to the participants. To mitigate any biased judgments in a study, researchers should engage in a state of epoche (Moustakas, 1994). According to Moustakas (1994), epoche is the suspension of judgement, and having the attitude of noninvolvement. I alleviated research bias through epoche and my ability to restrain from expressing my opinions throughout the interview process. In addition, I removed any preconceived thoughts of the study results, obtained the proper consent, and protected the privacy of the UCMs that participated in the study. I followed up with each participant with a summary of their responses to perform member checking. I verified with participants my interpretations of their responses to the interview questions to ensure I gained their perspectives. Member checking is interpreting a participant's data and checking for any misinterpretations (Strauss & Corbin, 2015). Checking interviews with participants is a process that ensures accuracy

from the researcher (Koelsch, 2013). Finally, I had a professional demeanor and avoided sounding emotional, judgmental, or biased.

I had an interview protocol for this research. To validate the scientific rigor of qualitative inquiry, researchers should have an interview protocol (Sarma, 2015). An interview protocol is a substantive practice used to gather information for qualitative inquiry (Sarma, 2015). The interview protocol (see Appendix B) contains information on the pre interview, interview, and post interview stage. By following proper procedures during the data collection process, I had a protocol in place to ensure the academic soundness of research in academic inquiry. I performed semistructured interviews with open-ended questioning. Qualitative research requires interview protocols (Yin, 2017). Researchers should consistently remain professional throughout semistructured interviews (Strauss & Corbin, 2015). I had a list of questions (see Appendix A) to ask participants during the interview process. The semistructured interviews I performed consisted of eight open-ended questions, enabling participants to openly talk about the research topic. I ensured academic soundness by following a descriptive interview protocol (see Appendix B). In addition, I used semistructered interviews and archival company internet survey results to collect data for this qualitative embedded single case study.

Participants

Participants in the study were three UCMs from Alabama who used customer care strategies to improve patient satisfaction. The three participants worked at different UCCs; however, each UCC fell under the same organizational franchise. Participants

should have working knowledge of the subject matter (Yin, 2017). The eligibility criteria for study participants were that they were UCMs who had improved patient satisfaction. Participants chosen for the study resided on the gulf coast in Alabama. Working relations were established to gain access and trust with the participants. Researchers gain access to participants through their communication and networking skills (Booyens, 2014). After gaining IRB approval from Walden University, I called, text, emailed, and visited the participants to establish clear access and open communication. I provided the participants with procedures and a sample of the interview questions for familiarity. I encouraged participants to call, email, or text me if they had any questions pertaining to their role as participants. According to Lancaster (2016), research preparation can be done prior to interviews through conversations with key individuals. Through these techniques, I was able to work on my relationships with the participants.

I developed a working relationship with participants by communicating with them about the interview process. Establishing bonding relations between the researcher and the participant is imperative to obtain quality results (Patton, 2015). I was positive, honest, and encouraging to the participants in the study. Marshall and Rossman (2016) posited encouragement in the interview process help build working relationships between the researcher and interviewee. To ensure confidentiality and proper ethical behavior, I briefly explained the BR to the participants. By explaining and abiding by the BR, I was able to establish trust, beneficence, and a working relationship with the UCMs who were improving customer care services and patient satisfaction.

Research Method and Design

In this section, I explore strategies UCMs used to improve customer care services and patient satisfaction in UCCs. I continue the discussion of the qualitative study method and how it applied to this research. The overall research question and business problem were imperative in the foundation of this research study. This section consists of a comparison of two primary research methods, qualitative and quantitative, as well as mixed methods research. A summary of the research methods and designs concludes this section.

Research Method

Three research methods are available to researchers to conduct a research study. Researchers can select qualitative, quantitative, or mixed methods (Yin, 2017). The qualitative method is exploratory research, useful for interviews, and is effective in human data collection (Sandelowski, 2015). The qualitative research method is a combination of data codes, interviewing, and textual understanding from participants (Berger, 2015). The qualitative method is used in business studies for business leaders to share their experiences (Dağhan & Akkoyunlu, 2014). Theories are developed when researchers observe and interpret reality in qualitative studies (Merriam & Tisdell, 2015; Newman & Benz, 2006; Strauss & Corbin, 2015). Testing human subjects in quantitative and mixed method research designs justify using qualitative methods (Yin, 2017). After reading and analyzing other research designs for the study, I decided to use a qualitative research method for this study. The qualitative research study method was more

appropriate for the research question which requires a thorough exploration of strategies managers used to improve customer care services and patient satisfaction.

The quantitative method is relevant when the intent of the research begins with a hypothesis or theory to test for disconfirmation or confirmation of the hypothesis (Newman & Benz, 2006). The quantitative method requires the development of mathematical models, theories, or hypotheses concerning a phenomenon (Steele & Rawls, 2015). Qualitative research tests real life experiences, whereas, a hypothesis is tested through quantitative research (Yin, 2017). Quantitative researchers ignore the substantive reasons for decision making (Parker, 2014). Both quantitative and mixed methods study incorporate numerical responses (Bryman & Bell, 2015). Mixed methods research requires a researcher to conduct both qualitative and quantitative analysis, and combine them into one study (Arris, Fitzsimmons, & Mawson, 2015). This study excluded variables and hypothesis; therefore, mixed and quantitative methods were irrelevant to this study. The qualitative method is relevant in inductive approaches and using a subjective perspective from the interpretivist model (Bryman & Bell, 2015). Based on this analysis, I was able to validate reasoning for using the qualitative method over the quantitative and mixed study method to conduct exploratory research on how UCMs improve patient satisfaction.

Research Design

I used an embedded single case study design for this qualitative research study. To understand the complexity of a social phenomenon, researchers perform case studies (Merriam & Tisdell, 2015; Stake, 2010; Yin, 2017). Researchers consider a case study

design when the focus of the study is answering how and why questions, and when the study involves human behavior (Yin, 2017). In addition, a case study may be used when the researcher plans to cover contextual conditions that are relevant to the phenomenon and context (Koopman, 2015). The focus of this study was to explore a complex social phenomenon involving UCMs and customer care strategies to improve patient satisfaction.

I considered other research designs for this study such as narrative, ethnographic, and phenomenological. Gathering information through stories is narrative design (Tong, Raynor, & Aslani, 2014). There was not a way to ascertain if a story is a fact or fiction. Therefore, the narrative design was not applicable to my research. Ethnographic researchers acquire an understanding of a phenomenon by studying the structure and behavior of a group (Koopman, 2015). Ethnographers desire to understand group actions from the group's perspective (Henry, Rivera, & Faithful, 2015). I was not studying groups; therefore, an ethnographic design was not applicable to the research. Phenomenologists seek to understand conscious experience such as emotions, judgments, and perceptions, rather than traditional data (Henry et al., 2015). Phenomenological researchers decline objective reasoning through a method known as phenomenological epoche (Koopman, 2015). I was not interested in emotions, perceptions, or judgmental behavior. I was seeking to understand a complex social phenomenon, and strategies UCMs used to improve customer care services; thus, the phenomenological design was not appropriate for this study.

Reaching data saturation is imperative qualitative research studies. Data saturation is achieved when sufficient information is available to duplicate the study (Fusch & Ness, 2015). According to Marshall, Cardon, Poddar, and Fontenot (2013), data saturation occurs when no new information emerges from the interview process. Additionally, researchers achieve data saturation when no new themes and the information collected becomes redundant (Burda, van den Akker, van der Horst, Lemmens, & Knottnerus, 2016). Therefore, I repeated the process of going over additional information with the participants until the data collection provided no new themes, insights, perspectives, or new information. I collected enough information to replicate the study.

To achieve data saturation, I conducted in depth interviews and included a data sharing and interpretation process called member checking. Member checking entails sharing data and interpretations with participants (Marshall & Rossman, 2016). I shared the interpreted data with participants by following a member checking procedure suggested by Marshall and Rossman, which has the following three components that include (a) conducting the initial interview, (b) interpreting what the participant shares, and (c) sharing the interpretation with the participant for validation. After I shared the data and interpretations with participants following the member checking procedure suggested by Marshall and Rossman, I performed a follow up interview by email with an additional process of member checking until I achieve data saturation.

In the member checking process, I typed each interview question into a Word document and summarized the participant's response in a concise manner after each question. I then shared a copy of each interview question and summary response with the

participant through email. The participants read the email and checked to see if the interpretations aligned with their original responses. In addition, the participants checked to see if any additional information needed to be added. Finally, I repeated the process of adding additional information with the participants until the data collection provided no new themes, insights, perspectives, or information.

Population and Sampling

The population for this study included three UCMs in Alabama who used strategies to improve customer care services and patient satisfaction. I used purposeful sampling to select the participants for the study. Purposeful sampling is widely used in qualitative research for the identification and selection of information rich cases related to the phenomenon of interest (Palinkas et al., 2013). According to Apostolopoulos and Liargovas (2016), researchers should select participants with relative knowledge of the research subject. Leaders of organizations are great for purposeful sampling (Nicol, Mohanna, & Cowpe, 2014). Some situations require managers, or other key individuals to be the primary source of data collection (Yin, 2017). Purposeful sampling requires access to key participants in the field who can help in identifying information rich cases (Suri, 2011). I was interested in participants sharing information to support the research topic.

The population for this qualitative embedded single case study consisted of three UCMs who used strategies to improve customer care services and patient satisfaction. The three participants worked at different UCCs, however, each UCC fell under the same organizational franchise. The three UCMs provided three separate collections of data. Participants for the study were strategically selected based on their knowledge of

customer care services and patient satisfaction. In a qualitative study, the researcher defines the population sample (Bryman & Bell, 2015). Additionally, a sample size of three to 20 individuals is appropriate for qualitative research (Stivala, Koskinen, Rolls, Wang, & Robins, 2016). Once a participant identifies individuals in the snowball, the researcher may request respondents refer others in the same demographic that may be interested in the research study (Morse, 2015). A sample from the larger population is ideal, however, 15 UCCs are in this scope, therefore I chose a snowball sample size of three.

I ensured the sample size of participants reached data saturation. Researchers reach data saturation when enough information is collected to replicate the study (Fusch & Ness, 2015). According to Marshall et al. (2013), data saturation occurs when no new information emerges from the interview process. Additionally, researchers achieve data saturation when no new themes and the information collected becomes redundant (Burda et al., 2016). The justification for selecting a few participants for this embedded single case study analysis was to obtain an in depth interview with each participant until I reached a data saturation point of no new information or perspectives. Data saturation is achieved when the collected information can duplicate the study (Fusch & Ness, 2015). I ensured reaching data saturation by interviewing the participants and reviewing archival company internet survey forms until data replication occurred.

Participants for the study met certain eligibility requirements. In HC research some participants practice gatekeeping to meet eligibility criteria for validation (Tromp & Vathorst, 2015). According to Tromp and Vathorst, gatekeeping is meeting certain

criteria to allow access to HC professionals. The eligibility criteria for study participants included (a) the individuals were UCMs operating a UCC and (b) they were improving customer care services and patient satisfaction. The qualifying criteria for inclusion as a participant were (a) willing to participate, (b) had to be over the age of 18, (c) had to be a UCM in a UCC in Alabama, and (d) used strategies to recruit trained medical professionals.

Participants in the study felt comfortable with the location of the interview. The location should be secluded to protect the individual rights of the participant (Johnson & Esterling, 2015). The interview location was secure to ensure privacy, protection, and no distractions. The interview environment was closed off and confidential to only the participant and researcher. Harris, Boggiano, Nguyen, and Pham (2013) stated the location must be private to protect the participant's responses. There was a mutual agreement on the interview site location. Herring (2013) suggested that participants tend to give more honest answers when they are comfortable with their interview environment. Therefore, the participants felt comfortable to answer the research questions openly and freely.

Ethical Research

I conformed to the ethical standards of Walden University IRB process and the BR. Bromley et al. (2015), states the BR includes principles of ethical research which include respect for the person, beneficence, and justice. In defining the informed consent process, one must adhere to the requirements of ethical research (Smith-Merry & Walton, 2014). The informed consent form for a study is a set of two rules intended to respect a

participant's autonomy; and protect members from harm (Tam et al., 2015). I sent each participant a copy of the consent form, as well as all my personal contact information. Each participant was responsible for reviewing the consent form and sending me an email with the words "I consent" before any tangible information was collected from the interview process. The internationally accepted standard is to obtain written consent or a documented statement of "I consent" from participants before enrollment in a study.

Acute situations can arise causing discomfort or risks to the participant. Protecting researchers and respondents from harmful situations is paramount to qualitative inquiry. According to Nguyen (2015), the participant can remove themselves from the interview process at any time. The respondent procedures for withdrawing from the study consisted of them stating at any time during the interview process "I will no longer participate." Participants did not receive any pay, compensation or incentives for contributing to the study. If incentives are part of a study, respondents may involve themselves due to the stimulus (Sarma, 2015). To ensure I practiced good ethical behavior, I informed the participant of my training. I participated in the National Institutes of Health (NIH) series to certify I would ethically and morally, protect participants from both known and unknown risks. The informed consent letter sent through email was the only document that had the participants' name and identification.

To ensure no one could identify the participants either directly or indirectly, I used a coding system. Ranney et al. (2015) stated a system of coding can protect the identities of the participants. I developed a unique identifier (code) for each participant and referred to those codes in the study. To assure the ethical protection of participants,

data will be kept in a locked fireproof safe in my home for a minimum of 5 years. In collecting responses anonymously from the participants, labels interviewee one, interviewee two, and interviewee three (P1, P2, P3), maintained the privacy of any personally identifiable information. Protecting the names of individuals or organizations is to keep the participants and organizations confidential (Tansley, Kirk, & Fisher, 2014). Protected participants provide accurate data for collection. Transcribed interviews and themes that emerged from the data is stored on a password protected hard drive for a minimum of five years to protect participants from any loss of privacy. Electronic files were stored on the researcher's password protected computer and backed up on a password-protected hard drive. The organizations where the UCMs do business will not be part of this study. The Walden IRB approval number for this study is 01-31-19-505963, and it expires on January 30th, 2020.

Data Collection Instruments

I was the primary data collection instrument in this qualitative research study. In qualitative studies, the primary data collection instrument is the researcher (Yin, 2017). Additionally, Marshall and Rossman (2016) stated the researcher is the primary instrument in data collection. The second instrument was a set of interview questions included in Appendix A. I conducted semistructured interviews to collect data from UCMs implementing customer care strategies to improve patient satisfaction.

The method for data collection included eight opened ended face to face semistructured interview questions with three UCMs. The face to face interview method emulates the needs of the researcher by garnering as much information as possible (Comi,

Bischof, & Eppler, 2014). Clarity is established by the researcher through the semistructured interviewing technique with open-ended questioning (Harvey, 2015; Marshall & Rossman, 2016; Strauss & Corbin, 2015). I used a digital voice recorder to document the interview for accuracy. Upon completion of the recording, I then transferred the collected data to my laptop, and then I used audio transcription (Voicea) software to transcribe the data. I searched for key meanings; organized the data to look for codes and common phrases collected from the interviews.

I followed a case study protocol. A case study protocol is vital for a case study design and will aid researchers in keeping the focus on their topic and assist them in enhancing reliability (Yin, 2017). A case study protocol consists of (a) an overview of the case study, (b) data collection procedures, (c) the data collection questions, and (d) a guide for the case study report (Yin, 2017). It was important to organize all the data collected in the interview process.

The interview protocol for this qualitative case study is in Appendix B. There should be plans and protocols prior to conducting an interview (Baškarada, 2014). I followed a detailed interview protocol (see Appendix B) with a guideline ensuring I gathered all necessary information and documents in an organized manner. The interview protocol includes information on the pre-interview, actual interview, and the post interview process. I used the same protocol in each of the participant's interview. Additionally, I checked with the participant to make sure the information is accurate.

I enhanced the reliability and validity through a process called member checking. Member checking increases the reliability and validity of a study (Marshall & Rossman,

2016). Member checking is interpreting a participant's data and checking for any misinterpretations (Strauss & Corbin, 2015). Marshall and Rossman (2016) posited three tenants for member checking: (a) conducting the initial interview, (b) interpreting what the participant shares, and (c) sharing the interpretation with the participant for validation. Participant data validation strengthens the credibility in research (Caretta, 2015). Therefore, I recorded the interview, interpreted the answers and check with the participants to validate their responses.

Data Collection Technique

I collected data using semistructured face to face interviews with open-ended questioning. Semistructured interviews enable the researcher to maintain research consistency and collect rich data in the interviews (Strauss & Corbin, 2015). Some participants may not be overly talkative during the interview and especially in unstructured interviews (Rowley, 2012). I performed semistructured interviews with open-ended questioning that enabled participants to openly talk about the research topic. I had an interview protocol to ensure the academic soundness of research in academic inquiry. Sarma (2015) stated validation of research is achieved through scientific qualitative inquiry and interview protocol. Additionally, an interview protocol is a substantive frame used to gather information for qualitative inquiry (Sarma, 2015). Some business owners create company websites providing academic information for the general public. Therefore, my fourth source of data collection came from company internet survey forms.

I used archival company internet survey forms from UCCs websites that gave patients an opportunity to rate their physician and visit. Archival company data is a supplementary source of data collection researchers use (Gibbons, 2015). According to Hopper and Uriyo (2015), the best place to find comments on physicians and data relating to patient satisfaction is on the World Wide Web. Additionally, several company websites let patients share their customer care experiences. For example, anyone concerned with selecting the best physician with good ratings can visit www.ratemds.com. In addition, they can also find out which physician or facility offers the least desirable customer care services.

The interview location should be free of noise and distractions. Secluded areas protect the privacy and individual rights of the participant (Johnson & Esterling, 2015). Harris et al. (2013) stated the participant's responses are protected by the location. Additionally, Herring (2013) argued that participants tend to give more honest answers when they are comfortable with their interview environment. There was a mutual agreement on the interview site location. Moreover, the interview location was secure to ensure privacy, protection, and no distractions. In addition, the interview environment was closed off and confidential to only the participant and researcher.

Several advantages and disadvantages are present when using semistructured interviews. The advantages of using semistructured interviews include (a) clarity on data collection, (b) flexibility and location, (c) provide quick data, and (d) provides descriptive information (Baškarada, 2014). Additionally, another advantage to using the qualitative semistructured interview method is open-ended questions allow for conversations to

happen (Humphrey, 2014). I capitalized on the advantages by having immediate access to the data and ensuring clarity with the participant before concluding the interview. The disadvantages of using semistructured interviews include (a) subjectivity and interpreting the data; (b) participants' information is the data, and it cannot be validated statistically; (c) time consuming; and (d) interviewee overestimating the actual problem (Yin, 2017). To minimize some disadvantages, I let the participants give me time for the interview, and I collected accurate data.

Following the interview, I conducted member checking. Member checking entails sharing interpreted data with participants (Marshall & Rossman, 2016). Member checking is interpreting a participant's data and checking for any misinterpretations (Strauss & Corbin, 2015). I shared the interpreted data with participants by following a member checking procedure suggested by Marshall and Rossman that has the following three components which include (a) conducting the initial interview, (b) interpreting what the participant shares, and (c) sharing the interpretation with the participant for validation. Participant data validation strengthens the credibility in research (Caretta, 2015). Moreover, I typed each interview question into a Word document and summarized the participant's response. An interpreted copy was sent through email asking participants to read the email checking to see if the summary represented their original response. The process was repeated to see if the participant wanted to share additional information. Member checking concluded when no new information, insights or perspectives occurred.

Data Organization Technique

Organizing and storing multiple sources of data is important in qualitative research. Carter, Bryant-Lukosius, DiCenso, Blythe, and Neville (2014) suggested that data organization is imperative when a researcher collects multiple sources of data. I developed a labeling system to track data and emerging themes collected from the participants. I used a labeling system separating the individuals using the following codes (a) interviewee one (P1), (b) interviewee two (P2), and (c) interviewee three (P3). I then gathered similar themes from the data and highlighted them using the same color codes. Coding is for researches to decipher underlying information while keeping the names of participants confidential (Qayyum, 2015). Coding and storing data ensured confidentiality. In addition, coding participant's information protects their identity (Ranney et al., 2015). After the indepth interviews and notes were on the computer, I formatted the data for analysis in NVivo. I used NVivo software to organize the collected data and ensure reliability. Woods, Paulus, Atkins, & Macklin (2016) stated that NVivo software is best for coding, comparison, and checking for reliable consistency. I stored each participant's raw data on separate USB flash drives and locked the information in a fireproof safe for a minimum of 5 years, per university policy.

Data Analysis

Collecting data from multiple sources is important in qualitative research. Applying multiple sources in research clarifies the understanding and interpretation of data accuracy (Yin, 2017). Researchers achieve triangulation through multiple sources of data collection (Yin, 2017). According to Denzin (2012), four quadrants are present in

triangulation which include (a) data source triangulation, (b) investigator triangulation, (c) methodological triangulation, and (d) theory triangulation. I used methodological triangulation to gather information from multiple data collections. According to Yin, methodological triangulation is used by researchers seeking to understand a phenomenon through multiple sources. Additionally, the use of triangulation adds to the depth of validity and understanding by having multiple sources for verification (Hoque, Covaleski, & Gooneratne, 2013). I used semistructured interviews, archival company data, and observations as part of the methodological triangulation for this qualitative embedded single case study on customer care services. Methodological triangulation provides a researcher with a more comprehensive picture than using only one type of data (Denzin & Lincoln, 2011; Heale & Forbes, 2013; Marshall & Rossman, 2016). I provided interview data from three UCMs, and archival company website surveys to enhance methodological triangulation.

I used a logical sequential process to analyze the data collected from the participants. All participants' information and archival company survey data were collected and organized with qualitative data organizing software. Software designed for qualitative data analysis and data organization is called NVivo (Castleberry, 2014). After I collected the data from the three UCMs and archival company internet survey forms, I organized the data to look for codes and common phrases collected from the sources. Next, I transcribed and interpreted the information and then dismissed irrelevant material. I then checked with the participants to ensure the interpreted responses were accurate and free of errors. Member checking is the process of sharing interpreted data with

participants to ensure the accuracy of the information collected (Marshall & Rossman, 2016). Following the interview protocol and member checking process, I then analyzed my sources of collected data.

I used NVivo software to organize the data collected from the UCMs and archival company internet survey forms. NVivo software is used in HC research and multiple organizations to organize data. According to Woods et al. (2016), research on NVivo, proved HC organizations use the software more than any other organization to organize data. NVivo software is a great source for coding and creating relational pairing for grouping and sourcing (Kotula, Ho, Dey, & Lee, 2015). According to Houghton, Casey, Shaw, and Murphy (2013), NVivo is a great software to use in a case study analysis. Woods et al. argued that NVivo software is best for coding, comparison, and checking for reliable consistency. I uploaded the participant's interviews and archival company internet survey forms into NVivo. I saved the information as P1, P2, P3 and company survey results. Any related information was grouped into nodes before coding. After reviewing the generated data, I extracted all relevant material and presented the findings in the results section.

I analyzed the data searching for relative information. I searched and read all relative data and looked for comparisons. Data from the study was then analyzed and coded with labels. Koopman (2015) indicated that researchers examine codes and themes through the process of thematic analysis. I used Yin's thematic analysis process to analyze the data. Yin (2017) stated thematic analysis is good for the following: (a) interpreting data, (b) deductive and inductive methods, (c) analyzing two different

processes, and (d) coding and pattern recognition. Using thematic analysis, I emerged the themes and interpreted the data. I looked for corroborating themes relating to recently published studies. The key themes identified in the literature included (a) theories to support the conceptual framework, (b) patient satisfaction, (c) HC services, (d) concepts of UCCs, (e) Patient protection affordable care act (Obamacare), (f) consumer assessment and patient satisfaction, (g) customer care, (h) strategies to increase patient satisfaction, and (i) HC sustainability. In comparison to new research, CLT emphasizes four categories of attitude and behavior, Oliver (as cited by Alraimi, Zo, & Ciganek, 2015) focused on post perception, customer expectation, and satisfaction. Customer care services, perception, and satisfaction are likely to improve in HC if managers implement these strategies. Expectation confirmation theory place emphasis on customer satisfaction, therefore it is possible to improve customer care services and satisfaction in the HC industry. For additional information, I focused on the themes and compared those ideas to the literature and the conceptual framework of CLT for this study.

Reliability and Validity

Researchers use reliability and validity to test the measurement of research. Researchers increase the integrity of data collected through reliability and validity (Barry, Chaney, Piazza-Gardner, & Chavarria, 2014). According to Noble and Smith (2015), validity and reliability practices support research standards by addressing the research instrument, and the overall research measurement consistency. However, these research standards are often overlooked and need to be verified using qualitative methods such as member checking and triangulation (Marshall & Rossman, 2016). Member checking is

interpreting a participant's data and checking for any misinterpretations (Strauss & Corbin, 2015). Methodological triangulation provides the researcher using multiple data collection techniques with a more comprehensive picture (Marshall & Rossman, 2016). I provided detailed information on the research design, research methods, participants, data collection procedures, data analysis, and data organization to enhance the reliability and validity of the study.

Reliability

Reliable and dependable information can be duplicated. The consistency of data collection instruments increases dependability in qualitative studies (Munn, Porritt, Lockwood, Aromataris, & Pearson, 2014). Research is deemed dependable when proper documentation and member checking are performed (Marshall & Rossman, 2016). I ensured dependability by using proper data collection protocols in the interview process. A constant data collection protocol allows future researchers to replicate the study and find comparable outcomes (Jacob & Furgerson, 2012). I also performed member checking with each participant. Member checking is sharing interpreted interview data with the participant for accuracy and validation of their responses (Strauss & Corbin, 2015). Additionally, I audio recorded the participant interviews and then transcribe the recorded audio. I ensured dependability and reliability by summarizing the interview data and then having the participant review a summary of the transcripts through email to look for any discrepancies or errors for validation. In addition, I synthesized the data results by utilizing NVivo, a qualitative data organizing software. Through data transcription,

member checking, and the use of NVivo data software, I enhanced the dependability of my study results.

Validity

Credibility, transferability, and confirmability will serve as the basic construct to validate the data. The specific criteria that validate a study for qualitative research include (a) dependability, (b) creditability, (c) confirmability, and (d) transferability (Houghton et al., 2013). Researchers maintain credibility by verifying differences between the information collected and the interpretation of the participants' responses (Munn et al., 2014). The primary researcher (instrument) is responsible for collecting rich and accurate data to ensure credibility.

I was the primary data collection instrument in this qualitative study; therefore, I collected data from three sources to ensure credibility. I collected data from face to face interviews with three UCMs from three different UCCs, archival data from company internet surveys, and observations. The three UCMs managed three separate clinics within the same organization, giving me three sources of data collection. In addition, I collected data from another source generated from online archival company data survey forms. Collecting data from multiple sources of data is a process called methodological triangulation (Carter et al., 2014). Triangulation of data sources will enhance the credibility of study results (Marshall & Rossman, 2016).

Following the interview process, I member checked the data with the participants for accurate interpretation. I shared the interpreted data with participants by following a member checking procedure suggested by Marshall and Rossman (2016) that has the

following three components which include (a) have a preliminary interview, (b) inferring participants' responses, and (c) share interpreted information with the participant to establish validation. Additionally, member checking is giving the interpreted information collected and transcript reviews to the participants for validation and accuracy (Strauss & Corbin, 2015). I member checked the data by typing each interview question into a word document summarizing the participant's responses. A copy of the summary was then sent through email to the participants, encouraging the participants to check if the summary represented the participant's original responses, or if additional information needed to be added. I repeated the process of adding additional information with the participant until the data collection provided no new information, insights, or perspectives.

A reader can determine transferability through the results of a study. If the results of a study can apply to the setting of the reader, the data is transferable. Transferability is when data results are applicable and can transfer in an alternative setting or context (Elo et al., 2014). Additionally, transferability is when research results can be replicated beyond the boundaries of the study (Houghton et al., 2013). I provided the research setting, research methods, data collection instruments, and tools for future research. To enhance the transferability of my study, I provided the reader with a thick and rich detailed description of my findings which include research information from the participants and archival company survey data. According to Morse and McEvoy (2015), lack of comprehensive information presented in the research can prohibit data transferability. I took detailed notes and provided an interview protocol for an investigator wanting to apply this study to their setting. In addition, I included direct

quotes from participants and provide information on the population and setting for future researchers to replicate. The information provided in the study is applicable and may transfer to future studies.

Research is valid when data can be transferred and confirmed. Confirmability is like dependability in the processes for establishing both are alike (Houghton et al., 2013). Biased free research is confirmability (Merriam & Tisdell, 2015). Furthermore, confirmability consists of precise information collected (Patton, 2015). To establish confirmability, I refrained from objectivity, and I documented the entire research process. In addition, I established the confirmability of the data by establishing frequencies of words and themes using NVivo software for organizing.

I performed open-ended semistructured interviews with the participants until no new responses or information was presented. A researcher achieves data saturation when the evidence is replicated (Fusch & Ness, 2015). Data saturation may be associated with the stage when a further collection of evidence provides little in terms of further themes, insights, perspectives or information in a qualitative research synthesis (Suri, 2011). I ensured reaching data saturation through three in depth participant interviews and archival company survey data on patient satisfaction.

Transition and Summary

Section 2 included the literature review, purpose, statement of the problem and nature of the study. The information presents empirical research on how UCMs own or operate UCCs using strategic tools to improve customer care services and patient satisfaction. Section 2 of this study included how data was collected, analyzed, and

validated. I presented why a qualitative case research study was the correct approach compared to using mixed or a quantitative analysis method. Section 3 consist of the results that emerged during the interview process, company survey forms, and the themes drawn from the raw data. The presentation of the findings, implications for social change, and suggestions for future research will conclude Section 3.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative embedded single case study was to explore customer care strategies UCMs used to improve patient satisfaction. Purposeful sampling was used to select participants for the study, who all worked at UCCs in Alabama. Data collected for the study came from semistructured interviews with UCMs and archival company internet survey results. The findings showed strategies that the UCMs used to improve customer care services and patient satisfaction in UCCs. Study results from the interviews indicated that UCMs looking to improve patient satisfaction in UCCs should advocate for patient-focused care, perform followup callbacks, have a social media presence, and encourage employee engagement to increase patient satisfaction. Findings from the company internet survey results indicated that UCCs looking to improve customer care services should have an easy registration process, have friendly front desk staff, practice good physician and nurse bedside manner, clarify communication, and have adequate visit times. I was able to conduct methodological triangulation and achieve reliability by collecting data from three semistructured interviews and 10 company internet survey results that included patient feedback regarding customer care services. By collecting data from multiple sources, I was able to have a clear and in-depth understanding of the strategies UCMs used to improve customer care services and patient satisfaction in UCCs.

Presentation of the Findings

This section contains user information pertaining to the emerging themes from the interviews, participant identification codes, and interview protocols. I used an interview protocol (see Appendix B) to explore the overarching research question: What customer care strategies do UCMs use to improve patient satisfaction? Dick and Basu's CLT was the conceptual framework of this study. To ensure the privacy of my three participants and their data, I assigned each participant a personal identifying code (P1, P2, and P3). In addition, the identifying codes for data collected from the 10 company internet survey results from the patients are codified as PS1, PS2, PS3, PS4, PS5, PS6, PS7, PS8, PS9, and PS10.

I used data from semistructured interviews and company internet survey results for this study. The three participants responded to interview questions sharing their knowledge and strategies on how they provide customer care services. In addition, I analyzed 10 company internet survey results from patients who visited the UCC. There were four themes that derived from the analysis: patient-focused care, followup callbacks, social media outreach, and employee engagement.

Theme 1: Patient-Focused Care

HC leaders rely on quality measurement programs to ensure patient-focused care is achieved. According to the data analysis, patients are satisfied with customer satisfaction, and UCMs place emphasis on customer care services. Each participant shared placing the needs of their patients first and shared the motto that the customer is always right. Consequently, managers and HC professionals improved customer care

services by working to build programs to strengthen relations with their customers. P1 indicated that the primary focus of the UCC is for the patient to feel free to express their concerns to the administration. In addition, P1 stated that their organization had a drop box program. The drop box is where a patient can leave a note or message in the front office to share their experience, suggestions, or any concerns they may have. In addition, P1 stated:

> Every person that comes into the clinic leaves their email. They [patients] receive a review survey sent to them through email from Google or Facebook (FB). Most of the time it is through Google review. The patient can go in on Google to leave comments either positive or negative.

P2 stated, "UCCs are more beneficial to the customer because of the wait time." In addition, P2 stated:

> We believe in greeting every patient that comes to our clinic. Every patient that comes to the clinic will be acknowledged, and we let them know we saw them come in, and that they have been seen and recognized. We introduce ourselves to the patient and reach out to them with a few questions such as (a) who you would like to see, (b) would you like something to drink, and (c) would you care for a treat bag. We also let them know the approximate wait time and our procedures. We try to make their wait time and visit as short as possible but ensuring them that we pay attention to their needs and medical care.

Each participant indicated that they were committed to keeping their patients satisfied, as well as remaining aware of the sustainability of their organization. P3 stated:

> You have to be mindful that we are trying to do the best for the patient, so we are trying to make them happy, but at the same time, we are a medical facility, so the patient doesn't always get the treatment that they want. Sometimes they come in and say "I want this, and I want that", but we must do what's in the best interest of the patient, and at the same time try to keep the patient happy, so it's kind of a hard thing to try to keep your patient satisfied, and do correct medicine.

In addition, P3 stated, "There is a fine line between trying to meet the patients' wants and offering them the proper medical care they need." In addition, P3 also stated, "each patient should be treated with proper care and given the best quality of services that can be offered," and Similarly, P2 stated, "after each visit to the clinic, there is follow up callback process to check on the patient." As indicated in Figure 1, patients who visit this UCC are satisfied with the quality of patient-focused care they receive from their nurses and physicians. Results from the survey showed that PS2, PS4, PS5, PS7, and PS9 each rated patient-focused care 10 out of 10. Data results from PS1 and PS6 showed that their patient-focused care rating is .5 lower than the other patients but still rated high at 9.5. Findings from the surveys indicate that patients rated their bedside manner with the physician at 9.7, and nurse bedside manner at 9.2. The overall rating for patient-focused care is 9.8 for the physicians and 9.1 for the nurses. In triangulating the data from interviews and survey results, the data collected from the survey results supported data collected from the interviews on patient-focused care.

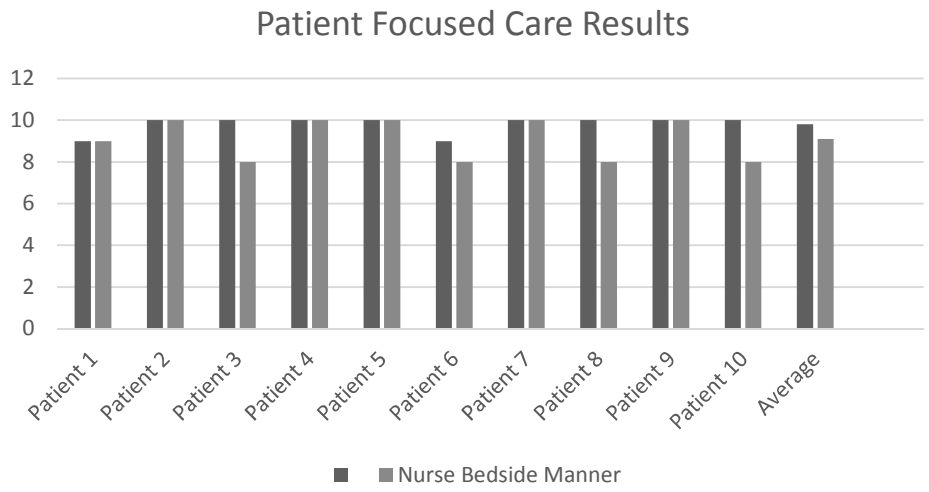


Figure 1. Nurse and physician patient-focused care results from internet survey forms.

Theme 2: Follow up Callbacks

The second theme that emerged from the participants was patient callback. Follow up procedures are important to patients in the HC industry. According to my analysis, the followup callback system is innovative, and it allows physicians and nurses to call patients after their visit, and effectively communicate them on a personal level. Each participant believed they should let the patient know they care about their wellbeing by way of a phone call. P3 stated that the companies' followup calls are made for various reasons ranging from lab work to checking up on patients. P1 stated:

> If you were a patient, we attempt to call the number that you've left as a follow up, uh, within one to three days. Often times we try the next day or the second day and just to make sure the patient is fine, having any issues or anything like that. We attempt to callback on everyone just to see how everything's going. It's kind of the big three things that we use.

Similarly, P2 stated:

> One of the biggest things we do is callbacks. Every single patient that comes in here, every single one is called back within anywhere from two to four days after their initial visit. We call them, we check on their visit, we see how they're feeling. If they're [patient] feeling better, if there's anything they need to change, you know, is the medicine not working, or they not getting better and feeling worse. We also want to know how was their visit. We like to get it straight from them and there's no better person to ask than the patient.

In addition, P3 stated,

> I think one of the main things that we've tried to do to improve patient satisfaction is we always do a callback after their visit. We check on them to see how they're doing it, to see if the treatment that we did is improving their symptoms. If the patient says no, then the front desk transfers it to a nurse and from there we can kind of direct the patient to continue their antibiotics or if they're not feeling better, come back in.

Various strategies in the HC field may ensure patient satisfaction. Each participant indicated that they were not part of a large franchise and needed to have a personal relationship with their patients. Therefore, they use inexpensive strategies to reach out to their patients. Follow up calls and social media strategies are ways that the organization can reach out to their patients at a relatively low cost.

The survey results did not address information on physician or nurse follow up calls. However, results from the company internet survey forms showed that patients

were able to follow up with the physician or nurse to get results and do follow up reviews. In triangulating the data from the interviews and survey results, the findings from the survey results supported the interview data on the follow up callback system, and extended knowledge on research to improve customer care services in UCCs.

Theme 3: Social Media Outreach

The third theme that emerged from my data analysis was social media outreach to increase customer care services and patient satisfaction. Social media has become a strategic instrument for businesses reaching out to current and potential customers. My analysis of the data indicated that positive feedback and comments on social media promote engagement between UCMs and patients. Each participant agreed that using FB and their company website were great tools for ensuring proper communication with their patients. All participants mentioned their patients appreciate the open communication and rewards offered on social media. P1 stated, “Data ratings posted on social websites capture the experiences of a systematic controlled organization. P2 stated, “we use FB to help our clinic gain credibility in our community.” In addition, P2 stated,

> We like to use social media. You would be surprised how fast you can put the word out, and that makes a difference. We’ve actually tweeted stuff before. When we put stuff on FB, within minutes people are coming in and mentioning things about it. So I mean it's instantaneous.

Similarly, P3 stated,

> We do a lot of social media with Google reviews, and we have FB marketing where patients can leave their reviews, and if anytime a patient does have a

> negative view or have a bad experience, we do try to contact that patient and see what went wrong, what we did wrong, and what we could do better in the future to improve. We need to understand how we can satisfy our clients and know how to handle situations. So we always try to go back and see when patients leave comments, whether they be positive or negative, I mean a lot of times if we get a positive comment we try to share that with the staff because I feel like that also boosts morale for people to treat people better. So I think by having the comment boxes and doing the whole review system, I think that kind of help to increase patient satisfaction.

All comments from patients were not complimentary reviews. P3 stated, "they feel that it is important to receive all types of feedback whether it be positive or negative." Evidence collected from participants found that social media increases and strengthens relationships between businesses and the customer. Social media interaction within an organization can cultivate positive employee engagement.

The company internet survey forms did not address any organizational information on social media. Therefore, I cannot confirm nor disconfirm that social media outreach improved customer care services and patient satisfaction at the UCC. However, the patients were able to offer reviews from the survey and make comments on the company's FB page. Data collected from the participants concerning feedback and comments on their FB page confirm that strategies to increase feedback and comments on their social media outreach improved customer care strategies at the UCC. By triangulating the data from the interviews and internet survey results, I was able to find

evidence that the patient feedback and comments on the UCCs FB page extended knowledge on data collected from the interviews.

Theme 4: Employee Engagement

The fourth theme that emerged from the data collected was employee engagement. Employee engagement is important in creating a culture conducive to satisfaction. According to my data analysis, employee engagement strengthens relations with staff members, and create a positive environment for customer care services and patient satisfaction. All three participants agreed that informing employees on patient feedback is important to the growth of their organization. P2 stated, "we asked the staff a lot of times, what do you think we should do differently if things are slow?" P2 stated,

> A lot has to do with the staff, and we try to hire good staff. All staff should be nice and friendly to people. You should always have a nice person that greets them (patient) and talks to them. You want them to ask the patient how are you doing? When they see the nurses, they do the same thing. When they leave, we tell them, hope you feel better when they walk out the door. You will be surprised at how a little bit goes a long way. I always say kill them with kindness.

Similarly, P3 stated,

> We tried to teach the employees to be respectful to the patient and to kind of treat the patients as they would their family members, and how they would want their family members to be taken care of. I feel like it's all in the training of your staff. It's not really cost that you have to put into it. It's more of an in house thing where you make sure that you're hiring the right people and people that are actually

> genuinely wanting to care for other people. I feel like that is more valuable than spending money on I guess outside resources. I feel like we just try to hire the right staff and the right people to deal with the customers. I feel like that is, you know, really an invaluable resource and you don't really have to spend a lot of money on it.

Creating an environment that is conducive to a positive work culture is important to employee engagement. P3 stated, “Employees work better in a friendly work environment.” Engaged employees are more likely to be dedicated, trustworthy, and friendly to their customers, which can strengthen organizational outcomes and professional practices. As indicated in Figure 2, the findings confirm that the patients were satisfied with employee engagement and gave the UCC a 9.5 score rating. The findings show that eight of the patients that visited this UCC rated the registration process a 10 out of 10. In addition, the findings show that PS1-PS10 rated the friendliness of staff engagement at 9.2. Survey results indicate that PS3 and PS5 both had identical score ratings of 10.0 and 8.0 on employee engagement from their visit to the UCC. Moreover, additional evidence from the surveys shows that PS6, PS7, and PS9, each rated the UCC a 10 on satisfactory employee engagement, ranking them the highest among the patients. After reviewing the data from the interviews and internet survey results on employee engagement, I was able to confirm that employee engagement improved customer care services and patient satisfaction. Data from the interviews were supported by data collected from internet survey results on employee engagement.

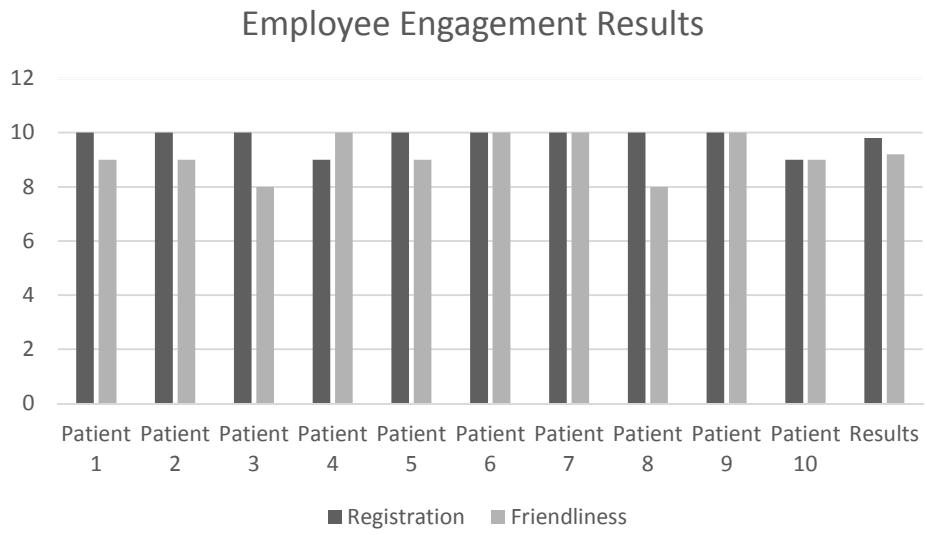


Figure 2. Employee engagement results from internet survey forms.

Company Survey Forms Review

Patient-centered company internet surveys are welcomed at the participating UCC. According to Gibbons (2015), archival company data is a supplementary source of data collection researchers use. In addition, Hopper and Uriyo (2015) posited that the best place to find comments on physicians and data relating to patient satisfaction is on the World Wide Web. After reviewing 10 anonymous patient internet survey forms, results show that the facility received 9.4 out of 10 score rating with their patients on satisfaction, and services offered (see Figure 3).

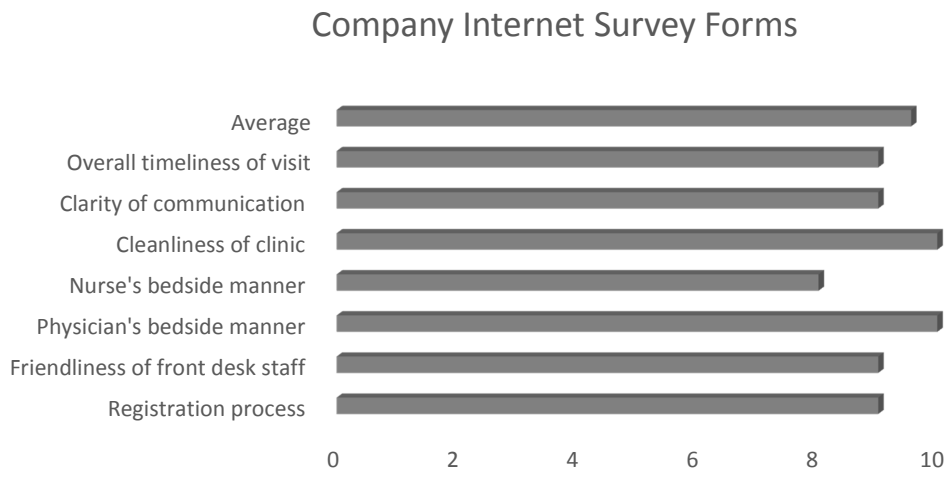


Figure 3. Overall patient survey feedback from UCC.

The 10 company internet survey forms served as another source of data collection. Each form had a rating score of 1-10 with 1 being the lowest and 10 being the highest. There were seven key components on the survey forms which included (a), registration process, (b) friendly of front desk staff, (c) physician bedside manner, (d) nurse bedside manner, (e) clarity of communication, and (f) overall timeliness of visit. The highest rating of the data was the cleanliness of the clinic and physician's bedside manner with a score of 9.8 out of 10. Patients that visited this UCC facility felt that the facility was clean, and the physicians tended to them with care. The median of the group was overall timeless of visits, clarity of communication, friendliness of front desk staff, and registration process averaging a score of 8.9. Evidence from the surveys showed that the overall wait time was sufficient, their procedure was communicated with them accurately, and the staff's demeanor and registration process was adequate. The lowest of the scores was nurses' bedside manner scoring an 8.2 out of 10, which is still extremely high. Nurses have a daunting task to draw blood, collect culture samples, and still must

convince the patient on customer care and patient satisfaction. The overall score from all seven groups was 9.4 out of 10. The scores from the study indicate that this facility is doing an outstanding job ensuring their staff members, doctors, and nurses practice a high quality of customer care services.

Findings Related to Literature

Data findings from the literature indicated that the UCMs was making considerate efforts on patient-focused care, follow up callbacks, social media outreach, and employee engagement to improve customer care services. My findings related to Pflueger's (2016) theory on leadership and the measurement of customer care services. According to Pflueger (2016), the two leadership efforts placed on HC are (a) measure of HC and (b) quality of customer care. Therefore, business leaders that redirect their business focus on patient care may improve patient satisfaction. Participants in the study indicated the importance of placing the needs of the patients first. In addition, the participants shared the motto that the customer is always right. The findings from the participants confirm that patient-focused care increases patient satisfaction. According to (Sharma, 2017), patient satisfaction and brand loyalty are determined by the improvement of health care services, total relationship management, and total quality management. P1 indicated that the primary focus is for the patient to feel free to express their concerns to the administration. Klopotan, Vrhovec-Zohar, and Mahic (2016) suggested that leaders should focus on the satisfaction and beliefs of the customer. Results from the internet survey forms confirm that patients are satisfied with the care they received at the facility, and they rated satisfaction a 9.1. Moreover, the findings from P2 supported previous

literature by Antinaho, Kivinen, Turunen, and Partanen's (2017) perception of the patients' belief system in patient satisfaction, and how it improved customer care services.

Follow up procedures are important to the patient and organization in the HC industry. Results from the interviews showed that business leaders that use creative marketing strategies such as follow up calls can entice customer feedback and gain new customers. According to Askariazad and Babakhani (2015), business leaders in the HC industry that emphasize marketing remain essential and gain valuable feedback from their customers. This finding relates to previous research by Kuhn and Brown (2015), which indicates that a more positive patient outcome exists when HC professionals perform follow up calls. Each participant in the study indicated they should let the patient know they care about their wellbeing by way of a phone call. According to Hoffman and Pelosini (2016), patient telephone conversations increase patient satisfaction. The findings from the internet survey results on patient callbacks extended the knowledge of data collected from the interviews. Previous research indicates that using technology and new innovations is a creative tool for organizations. Herrera (2016) wrote innovation could enhance corporate performance and create a social impact. Therefore, the follow up callback system confirms Herrera's (2016) theory on using innovation to enhance organizational performance. The media is important in improving customer care services and gathering pertinent information to improve customer care services.

Social media can appear as a strategic instrument for businesses reaching out to current and potential customers. Participants in the study suggested that FB and their

company website was a great tool for ensuring positive communication with their patients. This finding relates to Men and Tsai (2015), which posited that social media communication encourages positive and negative behavior; however, the dialogue is more important. In addition, each participant mentioned their patients appreciate the open communication and rewards offered on social media. P2 stated, "we use FB to help our clinic gain credibility in our community." This aligns with previous research by Shen, Chiou, Hsiao, Wang, and Li (2016) which states, having a positive and informative social media impact can add credibility to a business. These findings align with Go and You (2016), who stated through the use of social media, users can comment, offer suggestions, and stay current on reviews with members of the community. According to Goi (2014), clients and customers tend to follow FB posts to get relative information about a business. This form of communication can strengthen and engage social interaction between employees, business owners, and customers.

Employee engagement is important in creating a culture conducive to satisfaction. Employees that work together in a healthy work environment create better patient care (Logan & Malone, 2017). These findings relate to Döös, Vinell, and von Knorring (2017) which states, HC administrators that work along with their staff in a positive manner help nurses alleviate potential problems. All three participants in the study indicated that positive administration support and engagement is important to the growth of their organization. My findings relate to Schaufeli (2015) in that, administrators that support and provide a positive service climate increase employee work engagement. Findings in

the literature related to previous research from other authors and aligned with Dick and Basu's (1994) theory of customer loyalty.

Findings in Relations to Customer Loyalty Theory

The research findings for this study is grounded from Dick and Basu (1994) CLT. I used CLT to find managerial strategies that identify customer behaviors and attitudes to improve customer loyalty and satisfaction. According to Dick and Basu, managers have to identify the four types of loyalty characteristics and behavioral attitudes. Components of CLT consists of complete loyalty, low loyalty, latent loyalty, and sporadic loyalty. Bowen and McCain (2015) posited that repeat customers have a positive attitude toward the brand and are loyal customers. Each participant expressed they had true loyal customers that spread their satisfaction experience about their clinic to other members of the community. P2 stated, "If a customer had a bad experience, we reach out to them immediately so that we can address any negative feelings that might exist." P3 noted, "We accept walk in patients that come in sporadically. They are welcomed with open arms and seen by a team member in adequate time." The evidence showed that each of the participants was delivering on their organizational goals to ensure loyalty and satisfaction toward the customer. The themes that emerged from the data support managerial strategies based on CLT. Participants in the study identified behaviors and attitudes to improve organizational goals on loyalty, satisfaction, and patient-focused care.

Efforts made by the participants on patient-focused care to develop a high attitude of customer loyalty aligned with CLT. The drop box program implemented by the UCMs

strengthened the relationship with the customers, as well as showed the patient that the organization cared about their thoughts and feedback. P1 stated, “We do this program to gain valuable feedback, we also do it to gain trustworthy and loyal customers that will continue to come back to our clinic.” Each participant agreed that customer loyalty is a key component in measuring the retainment of current customers and obtaining new customers. The measurement of patient satisfaction is confirmed from the positive survey reviews and responses from follow up calls to patients.

Some businesses use a follow up callback system to check on patients, remind them of their visit, and to share results. Each participant used the drop box program and follow up callback system to gauge the attitudes and behavior of their customers. This system aligns with CLT because managers and staff are using protocols that show that they care about reaching out to the patient. Patients are more satisfied when their HC provider reaches out to them (Lopez et al., 2011). P3 stated, “We must be persistent on our efforts to attract new customers to visit our clinics, we also want to ensure our patients we have their best interest at heart.” This method the participants practiced aligned with other theories that stated the behavioral attitude of customers stems from the persistence of the organization, brand loyalty, and behavioral attitudes (Dick & Basu, 1994; Kotler, 2015; Muthukrishnan, 2015). These creative methods in technology helped the participants’ transition into social media for patient outreach.

Social media outlets can be a great tool for businesses with a limited budget for advertising and looking to reach out to loyal or latent customers. This is a new and affordable tool small business owners can use to increase engagement and satisfaction.

There is a considerable amount of value placed on social media from the perception of the customer, which is confirmed with other research that suggests social media is valuable, increases patient satisfaction, and supports loyalty (Chang, Yu, & Lu, 2015; Lacoste, 2016; Yadav et al., 2015). Social media aligned with CLT because the managers used FB as an outlet for positive and negative feedback behaviors from their patients. The managers realized they would receive comments and suggestions that may cause comparative loyalty relationships from competitors' offerings and face potential consequences through negative feedback from non-loyal, latent, and sporadic customers. A statement by P3 on positive and negative feedback on social media supports previous research by Men and Tsai (2015) which stated that social media communication encourages positive and negative behavior; however, the dialogue is more important. Despite the risks, the participants concluded that social media has increased their presence in the community, helped them obtain more true and loyal customers, and foster better employee engagement.

Employee engagement aligned with CLT because the managers were able to create a friendly and positive work environment to monitor the behavior of their patients. The UCMs determined that engaging with one another and their patients increased loyal attitudes. According to Bowen and McCain (2015), managers must survey customer employee relationships to measure their demands. In addition, each participant agreed that working together shows unity, a positive work culture, and trust to their patients. This evidence extends findings from new research on engaging employees in HC. According to Logan and Malone (2017), a healthy patient-centered work environment is

created when employees collaborate for the betterment of the customers. UCMs that were successful at engaging and interacting with their customers were able to retain and attract new and loyal customers and have an effective business.

Findings Related to Effective Business Practice

Findings in the study supported the efforts of the UCMs' strategies on improving customer care services and patient satisfaction. The customer care strategies they shared are imperative to effective business practices. UCCs are new, which presented a challenge comparing and disputing the findings in the study due to the lack of research done on this topic. However, in comparison to previous research on customer care services and customer loyalty, there was limited information on reward programs that offer discounts or incentives to the consumer. The participants in this study noted that to have an effective business practice, the organization must rely on positive word of mouth from the customer. They felt that it is more sustainable for the organization to do a lot of "personal legwork" than rely on spending thousands of dollars on marketing. P1 stated, "We're not going to spend $50,000 on something that doesn't work, we like to keep it simple." In addition, the participants stated they are a "Mom and Pops Clinic", which rely on a lot of community engagement to attract new customers. The results of this study indicated there were effective business strategies on customer care services that can be applied to improve patient satisfaction.

Applications to Professional Practice

The most interesting result found in this study that is relevant to the application of professional practice was the focused patient care initiative to improve patient

satisfaction. Data collected from face to face interviews and company internet surveys provided results displaying several effective strategies UCMs used to improve customer care services and patient satisfaction. The results of the study may help existing and future HCCs on developing strategies that could lead to a higher quality of customer care. Participants in the study were UCMs that strive to increase positive communication through focused patient care, follow up callbacks, social media outreach, and employee engagement to improve patient satisfaction strategies for their organization. Existing HC UCMs and future HC UCMs may use these strategies for daily customer care services in UCCs, hospitals, primary care, and walk in HCCs. Final study results indicated that the participants were using successful customer care strategies to improve patient satisfaction. In addition, results from company internet survey forms showed that the patients are highly satisfied with the customer care services they receive. Implementing the proposed strategies can fill the gap between disgruntle customers and staff members at not just UCCs, but any type of HC facility that serves patients.

Organizational leaders can take information from the patient survey forms to strengthen the relationship between business leaders and managers to ensure sustainability for the organization. HC business leaders compete for sustainability, improved customer care services, and patient satisfaction (Askariazad & Babakhani, 2015). Organizational leaders understand that patient satisfaction is in high demand from customers (Pflueger, 2016). Therefore, the strategies from the study are important to the professional business practice applications to organizations in the HC business. Strategies

from the study can be applied to strengthen existing and future organizations and have an impact on the implications of social change in surrounding communities.

Implications for Social Change

The purpose of this qualitative embedded single case study was to explore the strategies UCMs used to improve customer care services and patient satisfaction. Customer care services and patient satisfaction in health care are major concerns for business leaders and community members. Adequate customer care services have a direct impact on customer loyalty and repeat business from community members. Community members refer friends and family members to organizations that have a large and diverse group of satisfied customers (Costanza & Finkelstein, 2015). The study results may contribute to positive social change by helping UCMs provide a higher quality of customer care services, which could benefit local communities by decreasing illnesses and improving patient satisfaction in HCCs.

Recommendations for Action

The results of this study could impact existing and future businesses in HC. My recommendations are for business leaders, HC organizations, patients, and community members. My specific recommendations for action on improving customer care services and patient satisfaction consists of (a) focus on the patient, (b) implement programs to receive feedback, and (c) create a friendly environment. Participants in the study emphasized the importance of focusing on the patient and providing proper medicine.

Organizational leaders in HC can better understand what their patients are seeking through patient-focused care. Leaders in HC are aware that patients realize the

importance of the organization paying attention to their needs. Leaders must focus on making each patient feel they are a priority and provide quality medical care. Priority is important in satisfying a patient and practicing good customer care services. Providing high quality services can support the organization even if the patient feels as if their wants and needs were not met. Therefore, organizations should implement programs in case an acute situation may arise.

I recommend HC organizations have programs to listen to feedback from their patients. Three programs that can be implemented are a drop box, callback system, and internet survey program. The drop box program is a way that patients can leave anonymous comments at the facility pertaining to their experience or make a recommendation. The second program is a callback system to check on the patient after their visit or remind them of an appointment. The third and final program is an internet survey review form where patients can anonymously comment on their experience with a particular physician, nurse, or staff member. These three programs can be implemented to increase customer care services.

My third recommendation is to create a friendly positive work environment. Each participant indicated they enjoy going to work and meeting new patients. A positive friendly work environment can ease the tension on a patient and make them feel more comfortable. A patient with less stress is more treatable. Therefore, the symptoms of the patient may decrease, reducing the cost to the patient and the organization. These methods can create a better relationship between the patient and the organization.

Each individual or group can generate confidence and strategies to improve business and customer relations with one another. Business leaders in HC can benefit from this study by having effective customer care strategies to improve their business or organization. UCMs can gain insight on strategies to oversee their staff and provide them with ideas to improve customer relations with their patients. Managers can benefit from this study by having strategies to ensure a sustainable future. Customers and the general community can benefit from the results of the study by seeing positive actions taken to improve customer relations and a positive growing organization in their community.

Recommendations for Further Research

Research will always be at the core existence of science either to improve, contradict, or confirm previous research. The findings from my study derived from three interviews, and 10 company internet survey results. A small amount of my study came from limited information from previous research studies on UCCs. There were several limitations in gathering information, resources, and data for this study. Moreover, I used a qualitative embedded single case study to collect data. In addition, I only collected data from Alabama, and only used one organization, which was a limitation.

Therefore, I recommend for future research to expand the geographical region beyond the scope of Alabama. Alabama is a small and rural state lacking many resources to conduct a study. Larger and more diverse states have more HC facilities, which means more information can be collected. Neighboring states such as Florida and Georgia have both UCCs and Walk In Retail Clinics, which can be another source of data collection for future research.

Another recommendation for future research is to expand the number of participants, research multiple organizations, and use the patients as participants. More participants will offer a larger amount of data for collection. In addition, there may be more strategies and suggestions on improving customer care services and patient satisfaction. My final recommendation for future research is to expand the research design by conducting a multiple case study.

Reflections

I explored the customer care strategies UCMs used to improve patient satisfaction in UCCs. I collected data through semistructured interviews and company internet survey forms. As I stated earlier in the document and to the participants in the study, any biased activity or thoughts were eliminated. As the primary researcher, my job was only to collect data and not share any personal thoughts or judgments.

There was a preconceived notion pertaining to the size of the organization. I thought by having six respected UCCs, the organization was considered to be a large franchise business. After listening to the participants, I was told that they are a small "Mom and Pops" organization. Another preconceived notion I had was communicating with the owner. I thought it would be difficult to talk with someone in such a well-organized business; however, the owner and all the participants were very accessible and willing to take part in the study.

This study enabled me to talk with the participants and document strategies on customer care services to improve patient satisfaction. Prior to the study, I thought people just made vague and blanket statements concerning society. After completing this study, I

now value the importance of science and research. Looking back on this long and rigorous journey, I can now see the value of all my instructors and my entire committee.

Conclusion

Patient dissatisfaction is a major topic for managers, resulting in a need for better customer care services in the HC industry. With increasing patient satisfaction expectations, the demand for better community-based health care facilities has become extremely important. The findings from the study indicated that UCMs used the following strategies to improve patient satisfaction (a) patient-focused care, (b) follow up callbacks, (c) social media outreach, and (d) employee engagement. UCMs can take strategies from this study to help their UCC remain sustainable, retain new loyal customers, and enhance a customer care model to improve patient satisfaction in their community.

References

Ahmad, M. S., Talib, N. B., & Abu. (2015). Empirical investigation of community empowerment and sustainable development: Quantitatively improving qualitative model. *Quality and Quantity, 49*, 637-655. doi:10.1007/s11135-014-0014-y

Agnihotri, R., Dingus, R., Hu, M. Y., & Krush, M. T. (2016). Social Media: Influencing customer satisfaction in B2B sales. *Industrial Marketing Management*, *53*(1), 172-180. doi:10.1016/j.indmarman.2015.09.003

Aigner, D. J., & Lloret, A. (2013). Sustainability and competitiveness in Mexico. *Management Research Review, 36*, 1252-1271. doi:10.1108/MRR-06-2013-0138

Al-Abri, R., & Al-Balushi, A. (2014). Patient satisfaction survey as a tool towards quality improvement. *Oman Medical Journal, 29*(3), 3-7. doi:10.5001/omj.2014.02

Albert, D. J. (2015). Primary care is not urgent care, and we need more urgent care. *British Medical Journal***,** *350*, 2218-2218. doi:10.1136/bmj.h2218

Almutawa, Z., Muenjohn, N., & Zhang, J. (2016). The effect of human resource management system on employees' commitment: The mediating role of the AMO model. *The Journal of Developing Areas, 50*(6), 17-29. doi:10.1353/jda.2016.0147

Alraimi, K. M., Zo, H., & Ciganek, A. P. (2015). Understanding the MOOCs continuance: The role of openness and reputation. *Computers & Education, 80*, 28-38. doi:10.1016/j.compedu.2014.08.006

Álvarez-García, J., María De La Cruz Del Río-Rama, & Simonetti, B. (2017). Quality management and customer results: The tourist accommodation sector in Spain.

International Journal of Quality & Reliability Management, 34, 701-719. doi:10.1108/ijqrm-05-2015-0084

Andajani, E., Hadiwidjojo, D., Rahayu, M., & Djumahir, (2015*).* Customer experience model: Social environment, retail brand and positive WOM. *Research in Business and Management*, *2*(1), 25-27. doi:10.5296/rbm.v2i1.5823

Andonova, Y. (2013). Loyalty 3.0: How big data and gamification are revolutionizing customer and employee engagement. *Journal of Marketing Analytics, 1*, 234-236. doi:10.1057/jma.2013.19

Antinaho, T., Kivinen, T., Turunen, H., & Partanen, P. (2017). Improving the quality of registered nurses' working time use data. *Journal of Clinical Nursing, 26*, 3031-3043. doi:10.1111/jocn.13650

Apostolopoulos, N., & Liargovas, P. (2016). Regional parameters and solar energy enterprises: Purposive sampling and group AHP approach. *International Journal of Energy Sector Management, 10*, 19-37. doi:10.1108/IJESM-11-2014-0009

Arris, S. M., Fitzsimmons, D. A., & Mawson, S. (2015). Moving towards an enhanced community palliative support service (EnComPaSS): protocol for a mixed method study. *BMC Palliative Care*, *14*(1), 1-8. doi:10.1186/s12904-015-0012-4

Arthur, B. C., Fisher, A. K., Shoemaker, S. J., Pozniak, A., & Stokley, S. (2015). Business models, vaccination services, and public health relationships of retail clinics: A qualitative study. *Journal of Healthcare Management*, *60*, 429-440. Retrieved from https://journals.lww.com

Askariazad, M. H., & Babakhani, N. (2015). An application of European customer

satisfaction index (ECSI) in business to business (B2B) context. *The Journal of Business & Industrial Marketing, 30*, 17-31. doi:10.1108/JBIM-07-2011-0093

Avery, G. C. (2015). Key corporate sustainability drivers: Engaged boards and partnerships. *Strategy & Leadership, 43*(3), 44-48. doi:10.1108/SL-02-2015-0015

Babin, B. J., Boles, J. S., & Griffin, M. (2015). The moderating role of service environment on the customer share customer commitment relationship. In *New meanings for marketing in a new millennium* (pp. 266-271). Cham, Switzerland: Springer.

Bahmani-Oskooee, M., & Ghodsi, S. H. (2016). Do changes in the fundamentals have symmetric or asymmetric effects on house prices? Evidence from 52 states of the United States of America. *Applied Economics*, *48*, 2912-2936. doi:10.1080/00036846.2015.1130795

Barry, A. E., Chaney, B., Piazza-Gardner, A. K., & Chavarria, E. A. (2014). Validity and reliability reporting practices in the field of health education and behavior: A review of seven journals. *Health Education & Behavior*, *41*, 12-18. doi:10.1177/1090198113483139

Baškarada, S. (2014). Qualitative case study guidelines. *Qualitative Report, 19*(1), 1-25. Retrieved from https://www.tqr.nova.edu

Beausejour, M., Goulet, L., Debbie, E. F., Roxane-Borges, D. S., Pineault, R., Rossignol, M., & Labelle, H. (2015). Pathways of healthcare utilisation in patients with suspected adolescent idiopathic scoliosis: A cross-sectional study. *BMC Health Services Research, 15*, 2-12. doi:10.1186/s12913-015-1152-1

Berger, A. A. (2015). *Media and communication research methods: An introduction to qualitative and quantitative approaches*. Thousand Oaks, CA: Sage.

Booyens, M. (2014). A Student's Experience of Gaining Access for Qualitative Research. *Notes from Practice/Uit Die Praktyk*, *1*, 146-151. doi:10.15270/50-1-17

Borim-de-Souza, R., Balbinot, Z., Travis, E. F., Munck, L., & Takahashi, A. R. W. (2015). Sustainable development and sustainability as study objects for comparative management theory. *Cross Cultural Management, 22*(2), 201 doi:10.1108/CCM-02-2013-0027

Bowen, J. T., & McCain, S. C. (2015). Transitioning loyalty programs. *International Journal of Contemporary Hospitality Management, 27*, 415-430. doi:10.1108/IJCHM-07-2014-0368

Bromley, E., Mikesell, L., Jones, F., & Khodyakov, D. (2015). From subject to participant: Ethics and the evolving role of community in health research. *American Journal of Public Health, 105*, 900-908. doi:10.2105/AJPH.2014.302403

Brutus, S., Aguinis, H., & Wassmer, U. (2012). Self-reported limitations and future directions in scholarly reports analysis and recommendations. *Journal of Management, 39*(1) 48-75. doi:10.1177/0149206312455245

Bryman, A., & Bell, E. (2015). *Business research methods*. New York, NY: Oxford University Press.

Burda, M. H. F., van den Akker, M., van der Horst, F., Lemmens, P., & Knottnerus, J. A. (2016). Collecting and validating experiential expertise is doable but poses

methodological challenges. *Journal of Clinical Epidemiology, 72*, 10-15. doi:10.1016/j.jclinepi.2015.10.021

Burns, J. M. (1978). *Leadership*. New York, NY: Harper and Row.

Byrkjeflot, H. (2018). The Impact and Interpretation of Weber's Bureaucratic Ideal Type in Organisation Theory and Public Administration. *Comparative Social Research: Vol. 33*. *Bureaucracy and Society in Transition* (pp. 13-35). doi:10.1108/s0195-631020180000033006

Cao, J., Jiang, Z., & Wang, K. (2016). Customer demand prediction of service-oriented manufacturing incorporating customer satisfaction. *International Journal of Production Research*, *54*, 1303-1321. doi:10.1080/00207543.2015.1067377

Caretta, M. A. (2015). Member checking: A feminist participatory analysis of the use of preliminary results pamphlets in cross-cultural, cross-language research. *Qualitative Research, 16*(3), 305-318. doi:10.1177/1468794115606495

Carlton, E. L., & Singh, S. R. (2018). Joint community health needs assessments as a path for coordinating community-wide health improvement efforts between hospitals and local health departments. *American Journal of Public Health, 108*, 676–682. doi:10.2105/ajph.2018.304339

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum, 41*, 545-547. doi:10.1188/14.ONF.545.547

Case, A. D., Todd, N. R., & Kral, M. J. (2014). Ethnography in community psychology: Promises and tensions. *American Journal of Community Psychology, 54*, 60-71. doi:10.1007/s10464-014-9648-0

Castleberry, A. (2014). NVivo 10. Version 10. *American Journal of Pharmaceutical Education*, *78*(1), 25. doi:10.5688/ajpe78125

Centers for Medicare & Medicaid Services. (2014). HCAHPS: Patients' perspectives of care survey. Retrieved from http://www.cms.gov/Medicare/Quality-Inititives-Patient-Assessment-Instruments/Hospital Quality Inits/HospitalHCAHPS.html

Centers for Medicare & Medicaid Services. (2015). The HCAHPS Survey – Frequently asked questions. Retrieved from http://www.cms.gov

Chahal, H., & Dutta, K. (2014). Conceptualizing customer experiences: Significant research propositions. *The Marketing Review*, *14*(4), 361-381. doi:10.1362/146934714X14185702841280

Chan, Z. C. Y., Fung, Y., & Chien, W. (2013). Bracketing in phenomenology: Only undertaken in the data collection and analysis process? *The Qualitative Report*, *18*(30), 1-9. Retrieved from https://nsuworks.nova.edu/tqr/

Comi, A., Bischof, N., & Eppler, M. J. (2014). Beyond projection: Using collaborative visualization to conduct qualitative interviews. *Qualitative Research in Organizations and Management, 9*, 110-133. doi:10.1108/QROM-05-2012-1074

Costanza, D. P., & Finkelstein, L. M. (2015). Generationally based differences in the workplace: Is there a there there? *Industrial and Organizational Psychology, 8*, 308-323. doi:10.1017/iop.2015.15

Cooper, J., Feldman, L. A., & Blackman, S. F. (2018). Influencing republicans' and democrats' attitudes toward Obamacare: Effects of imagined vicarious cognitive dissonance on political attitudes. *The Journal of Social Psychology, 158,* 1-6. doi:10.1080/00224545.2018.1465023

Dağhan, G., & Akkoyunlu, B. (2014). A qualitative study about performance based assessment methods used in information technologies lesson. *Educational Sciences: Theory & Practice*, *14*, 333-338. doi:10.12738/estp.2014.1.2005

Dainty, K. N., & Sinclair, D. (2016). A critical qualitative study of the position of middle managers in health care quality improvement. *Journal of Nursing Care Quality, 32*, 172-179. doi:10.1097/ncq.0000000000000224

Davenport, T. O. (2015). How HR plays its role in leadership development. *Strategic HR Review, 14*, 89-93. doi:10.1108/SHR-04-2015-0033

Delmas, M. A., & Gergaud, O. (2014). Sustainable certification for future generations the case of family business. *Family Business Review*, *27*, 228-243. doi:10.1177/0894486514538651

Denzin, N. K. (2012). Triangulation 2.0. *Journal of Mixed Methods Research, 6,* 80-88. doi:10.1177/1558689812437186

Denzin, N. K., & Lincoln, Y. S. (2011). *The Sage handbook of qualitative research* (4th ed.). Thousand Oaks, CA: Sage.

Dick, A. S., & Basu, K. (1994). Customer Loyalty: Toward an integrated conceptual framework. *Journal of the Academy of Marketing Science, 22*, 99-113. doi:10.1177/0092070394222001

Döös, M., Vinell, H., & von Knorring, M. (2017). Going beyond 'two-getherness': Nurse managers' experiences of working together in a leadership model where more than two share the same chair. *Intensive and Critical Care Nursing, 43*, 39-46. doi:10.1016/j.iccn.2017.04.009

Dupree, J. M., Neimeyer, J., & Mchugh, M. (2014). An advanced look at surgical performance under medicares hospital-inpatient value-based purchasing program: Who is winning and who is losing? *Journal of the American College of Surgeons, 218*, 1-7. doi:10.1016/j.jamcollsurg.2013.09.017

Eklof, M., & Ahlborg Jr, G. (2016). Improving communication among healthcare workers: A controlled study. *Journal of Workplace Learning, 28*, 81–96. doi:10.1108/jwl-06-2015-0050

El-Manstrly, D. (2016). Enhancing customer loyalty: Critical switching cost factors. *Journal of Service Management*, *27*, 144-169. doi:10.1108/josm-09-2015-0291

Elo, S., Kaariainen, M., Kanste, O., Polkki, T., Utriainen, K., & Kyngas, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE Open, 4*(1), 1-10. doi:10.1177/2158244014522633

Engle, R. L., Lopez, E. R., Gormley, K. E., Chan, J. A., Charns, M. P., & Lukas, C. V. (2017). What roles do middle managers play in implementation of innovative practices? *Health Care Management Review, 42*, 14-27 doi:10.1097/hmr.0000000000000090

Eugenio, T., Laurenco, I., & Morais, A. (2013). Sustainability strategies of the company Timorl: Extending the applicability of legitimacy theory. *Management of*

Environmental Quality, 24, 570-582. doi:10.1108/MEQ-03-2011-0017

Ferrand, Y. B., Siemens, J., Weathers, D., Frendendall, L. D., Yunsik, C., Pirrallo, R. G., & Bitner, M. (2016). Patient satisfaction with healthcare services: A critical review. *Quality Management Journal*, *23*, 6-22. Retrieved from https://asq.org

Fleiszer, A. R., Semenic, S. E., Ritchie, J. A., Richer, M., & Jean-Louis, D. (2015). An organizational perspective on the long-term sustainability of a nursing best practice guidelines program: A case study. *BMC Health Services Research, 15*, 2-16. doi:10.1186/s12913-015-1192-6

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report, 20,* 1408-1416. Retrieved from https://nsuworks.nova.edu/tqr/

Gibbons, K. B. (2015). *Small seasonal business strategies to increase profits through community collaboration*. (Doctoral dissertation). Retrieved from https://scholarworks.waldenu.edu

Giovanis, A., Athanasopoulou, P., & Tsoukatos, E. (2015). The role of service fairness in the service quality - relationship quality - customer loyalty chain. *Journal of Service Theory and Practice, 25*, 744-776. doi:10.1108/JSTP-11-2013-0263

Go, E., & You, K. H. (2016). But not all social media are the same: Analyzing organizations' social media usage patterns. *Telematics and Informatics, 33*, 176-186. doi:10.1016/j.tele.2015.06.016

Goi, C. L. (2014). The impacts of social media on the local commercial banks in Malaysia. *Journal of Internet Banking and Commerce, 19*(1), 1-10. Retrieved

from http://www.arraydev.com

Gounaris, S., & Boukis, A. (2013). The role of employee job satisfaction in strengthening customer repurchase intentions. *Journal of Services Marketing, 27*, 322-333. doi:10.1108/08876041311330799

Grosso, M., & Castaldo, S. (2015). How store attributes impact shoppers' loyalty: Do different national cultures follow the same loyalty building process? *International Review of Retail, Distribution and Consumer Research*, *25*(5), 503-515. doi:10.1080/09593969.2015.1088460

Grube, M. E., Cohen, A. S., & Clarin, D. (2014). Preparing to succeed in a retail healthcare environment. *Healthcare Financial Management*, *68*(11), 53-62. Retrieved from https://www.hfma.org

Harris, L. M., Boggiano, V., Nguyen, D. T., & Pham, L. H. (2013). Working in partnership with interpreters: Studies on individuals affected by HIV/AIDS in Vietnam. *Qualitative Health Research, 23,* 1408-1418. doi:10.1177/1049732313506964

Harvey, L. (2015). Beyond member-checking: A dialogic approach to the research interview. *International Journal of Research & Method in Education, 38*, 23-38. doi:10.1080/1743727x.2014.914487

Hassmiller, S. B., & Quinn, W. V. (2015). How nurse leaders can fix our healthcare system. *Nurse Leader*, *13*(2), 31-35. doi:10.1016/j.mnl.2015.01.008

Heale, R., & Forbes, D. (2013). Understanding triangulation in research. *Evidence Based Nursing, 16*, 98-98. doi:10.1136/eb-2013-101494

Henry, M., Rivera, J., & Faithful, G. E. (2015). The four principles of phenomenology. *Continental Philosophy Review, 48,* 1-21. doi:10.1007/s11007-014-9313-1

Hermanson, P. M., Berkshire, S. D., Leaming, L., & Piland, N. (2013). Retail health clinics: Sustain or close? A case study. *Journal of Management Policy and Practice, 14*(6), 37-41. Retrieved from http://www.na-businesspress.com

Herrera, M. E. B. (2016). Innovation for impact: Business innovation for inclusive growth. *Journal of Business Research*, *69*, 1725-1730. doi:10.1016/j.jbusres.2015.10.045

Herring, A. D. (2013). Oral history and dalit testimonies: From the ordeal to speak to the necessity to testify. *South Asia Research, 33,* 39-55. doi:10.1177/0262728013475542

Hilton, N., & Sherman, R. O. (2015). Promoting work engagement: One medical center's journey. *Nurse Leader, 13*(6), 52-57. doi:10.1016/j.mnl.2015.03.013

Hoffman, J., & Pelosini, L. (2016). Telephone follow up for cataract surgery: feasibility and patient satisfaction study. *International Journal of Health Care Quality Assurance, 29*, 407–416. doi:10.1108/ijhcqa-08-2015-0096

Holton, J. A., & Grandy, G. (2016). Voiced inner dialogue as relational reflection-on-action: The case of middle managers in health care. *Management Learning, 47,* 369-390. doi:10.1177/1350507616629602

Homisak, L., & Baum, N., M.D. (2015). Patient satisfaction: What we can learn from other industries. *The Journal of Medical Practice Management, 30*, 294-298. Retrieved from https://www.greenbranch.com/store/index.cfm/product/4_15/the

journal-of-medical-practice-managementsupregsup.cfm

Hopper, A. M., & Uriyo, M. (2015). Using sentiment analysis to review patient satisfaction data located on the internet. *Journal of Health Organization and Management, 29*, 221-233. doi:10.1108/jhom-12-2011-0129

Hoque, Z., Covaleski, M. A., & Gooneratne, T. N. (2013). Theoretical triangulation and pluralism in research methods in organizational and accounting research. *Accounting, Auditing & Accountability Journal, 26*, 1170-1198. doi:10.1108/AAAJ-May-2012-01024

Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigor in qualitative case study research. *Nurse Researcher*, *20*, 12-17. doi:10.7748/nr2013.03.20.4.12.e326

Humphrey, C. (2014). Qualitative research - Mixed emotions. *Qualitative Research in Accounting and Management, 11*, 51-70. doi:10.1108/QRAM-03-2014-0024

Iannuzzi, J. C., Kahn, S. A., Zhang, L., Gestring, M. L., Noyes, K., & Monson, J. R. (2015). Getting satisfaction: Drivers of surgical hospital consumer assessment of health care providers and systems survey scores. *Journal of Surgical Research, 197*, 155-161. doi:10.1016/j.jss.2015.03.045

Ioppolo, G., Cucurachi, S., Salomone, R., Saija, G., & Shi, L. (2016). Sustainable local development and environmental governance: A strategic planning experience. *Sustainability, 8*(2), 1-16. doi:10.3390/su8020180

Iqbal, A. (2014). Effect of relationship quality on customer loyalty. *International Journal of Information, Business and Management, 6*(2), 41-52. Retrieved from http://ijibm.elitehall.com

Jacob, S. A., & Furgerson, S. P. (2012). Writing interview protocols and conducting interviews: Tips for students new to the field of qualitative research. *The Qualitative Report*, *17*, 1-10. Retrieved from https://nsuworks.nova.edu/tqr/

Jianu, I. (2015). Sustainability reporting and consumers' protection. *Journal of Applied Quantitative Methods*, *10*(3), 96-111. Retrieved from http://www.jbepnet.com

Johnson, E. I., & Esterling, B. A. (2015). Coping with confinement: Adolescents' experiences with parental incarceration. *Journal of Adolescent Research, 30*, 244-267. doi:10.1177/0743558414558593

Jones, P., Hillier, D., & Comfort, D. (2016). Sustainability in the hospitality industry: Some personal reflections on corporate challenges and research agendas. *International Journal of Contemporary Hospitality Management*, *28*, 36-67. doi:10.1108/IJCHM-11-2014-0572

Kamimura, A., Ashby, J., Myers, K., Nourian, M. M., & Christensen, N. (2015). Satisfaction with healthcare services among free clinic patients. *Journal of Community Health*, *40*, 62-72. doi:10.1007/s10900-014-9897-8

Keevy, Z., & Perumal, J. (2014). Promoting transformational leadership practices of retail managers. *The Journal of Management Development, 33*, 919-931. doi:10.1108/JMD-05-2012-0057

Kemp, E., & Poole, S. M. (2017). What's love got to do with it? Investigating consumer commitment in health care. *Health Marketing Quarterly, 34*, 113-127. doi:10.1080/07359683.2017.1309210

Khorasani, S. T., & Almasifard, M. (2017). Evolution of management theory within 20

century:A systemic overview of paradigm shifts in management. *International Review of Management and Marketing, 7*(3), 134-137. Retrieved from http://www.econjournals.com/

Kim, J., & Kim, J. (2014). Making customer engagement fun. *Journal of Fashion Marketing and Management, 18*, 133-144. doi:10.1108/JFMM-04-2013-0050

Klopotan, I., Vrhovec-Zohar, K., & Mahic, E. (2016). Impact of income on customers' loyalty: Are customers with higher income more loyal? *Business Systems Research, 7*(1), 81-88. doi:10.1515/bsrj-2016-0006

Kobylanski, A., & Pawlowska, B. (2012). Managing customer satisfaction: A conceptual framework. *The Business Review, Cambridge, 20,* 33-41. Retrieved from http://www.jaabc.com/brc.html

Koelsch, L. E. (2013). Reconceptualizing the member check interview. *International Journal of Qualitative Methods, 12*, 168-179. doi:10.1177/160940691301200105

Komarov, M., & Avdeeva, Z. (2015). Customer experience management for smart commerce based on cognitive maps. *Procedia Computer Science, 55*, 970-979. doi:10.1016/j.procs.2015.07.106

Koopman, O. (2015). Phenomenology as a potential methodology for subjective knowing in science education research. *Indo - Pacific Journal of Phenomenology, 15*(1), 1-10. Retrieved from https://www.nisc.co.za

Kotler, P. (2015). The founding father. *Conversations with marketing masters*. (pp. 6-23). doi:10.1002/9781119209256.ch1

Kotula, M., Ho, W., Dey, P. K., & Lee, C. K. (2015). Strategic sourcing supplier

selection misalignment with critical success factors: Findings from multiple case studies in Germany and the United Kingdom. *International Journal of Production Economics, 166*, 238-247. doi:10.1016/j.ijpe.2014.12.039

Kuhn, D., & Brown, C. (2015). Exploration of factors associated with hospital readmissions in patients with chronic heart failure: A pilot study. *Professional Case Management, 20*, 106-109. doi:10.1097.NCM.000000000000086

Kursunluoglu, E. (2014). Shopping centre customer service: Creating customer satisfaction and loyalty. *Marketing Intelligence & Planning, 32*, 528–548. doi:10.1108/mip-11-2012-0134

Lacoste, S. (2016). Perspectives on social media and its use by key account managers. *Industrial Marketing Management, 54*, 33-43. doi:10.1016/j.indmarman.2015.12.010

Lampinen, M.-S., Viitanen, E. A., & Konu, A. I. (2015). Sense of community and job satisfaction among social and health care managers. *Leadership in Health Services, 28*, 228–244. doi:10.1108/lhs-09-2014-0067

Lancaster, K. (2016). Confidentiality, anonymity and power relations in elite interviewing: Conducting qualitative policy research in a politicised domain. *International Journal of Social Research Methodology, 1*, 1-11. doi:10.1080/13645579.2015.1123555

Lariviere, B., Keiningham, T. L., Cooil, B., Aksoy, L., & Malthouse, E. C. (2014). A longitudinal examination of customer commitment and loyalty. *Journal of Service Management, 25*, 75-100. doi:10.1108/JOSM-01-2013-0025

Leedy, P. D., & Ormrod, J. E. (2013). *Practical research: Planning design* (10th ed.). Upper Saddle River, NJ: Pearson Education.

Lelli, V. R., Hickman, R. L., Savrin, C. L., & Peterson, R. A. (2015). Retail clinics versus traditional primary care: Employee satisfaction guaranteed? *Journal of the American Association of Nurse Practitioners*, *27*, 514-520. doi:10.1002/2327-6924.12220

Lewis, S. (2015). Qualitative inquiry and research design: Choosing among five approaches. *Health promotion practice*, *16*, 473-475. doi:10.1177/1524839915580941

Loewenson, R., & Simpson, S. (2017). Strengthening integrated care through population-focused primary care services: International experiences outside the United States. *Annual Review of Public Health*, *38*, 413-429. doi:10.1146/annurev-publhealth-031816-044518

Logan, T. R., & Malone, D. M. (2017). Nurses' perceptions of teamwork and workplace bullying. *Journal of Nursing Management, 26*, 411-419. Retrieved from https://onlinelibrary.wiley.com/journal/13652834

Lokdam, N., Kristiansen, M., Handlos, L. N., & Norredam, M. (2016). Use of healthcare services in the region of origin among patients with an immigrant background in Denmark: A qualitative study of the motives. *BMC Health Services Research, 16*, 1-10. doi:10.1186/s12913-016-1346-1

Lopez, C., Valenzuela, J. I., Calderon, J. E., Velasco, A. F., & Fajardo, R. (2011). A telephone survey of patient satisfaction with telemedicine in a rural community in

Columbia. *Journal of Telemedicine and Telecare, 17*, 83-87. doi:10.1258/jtt.2010.100611

Marais, H. (2012). A multi-methodological framework for the design and evaluation of complex research projects and reports in business and management studies. *Electronic Journal of Business Research Methods*, *10*, 64–76. Retrieved from http://www.ejbrm.com/main.html

Marrelli, T. (2015). *Hospice and hospice care handbook: Quality, compliance, and reimbursement*. St. Louis, MO: Elsevier Mosby.

Marshall, B., Cardon, P., Poddar, A., & Fontenot, R. (2013). Does sample size matter in qualitative research: A review of qualitative interviews in IS research. *Journal of Computer Information Systems, 54*(1), 11-22. doi:10.1080/08874417.2013.1164566

Marshall, C., & Rossman, G. B. (2016). *Designing qualitative research* (6th ed.). Thousand Oaks, CA: Sage.

Martin, G., Weaver, S., Currie, G., Finn, R., & McDonald, R. (2012). Innovation sustainability in challenging health-care contexts: Embedding clinically led change in routine practice. *Health Service Management Research, 25*, 190-199. doi:10.1177/0951484812474246

Matis, C. L. (2014). Customer relationship management in the insurance industry. *Procedia Economics and Finance*, *15*, 1138-1145. doi:10.1016/s2212-5671(14)00568-1

McMahon, L. F., Tipirneni, R., & Chopra, V. (2016). Health system loyalty programs:

An innovation in customer care and service. *Jama*, *315*, 863-864. doi:10.1001/jama.2015.19463

Mehra, P. (2016). Outpatient clinic waiting time, provider communication styles and satisfaction with healthcare in India. *International Journal of Health Care Quality Assurance, 29*, 759–777. doi:10.1108/ijhcqa-02-2016-0017

Melnyk, V., & Bijmolt, T. (2015). The effects of introducing and terminating loyalty programs. *European Journal of Marketing, 49*, 398-419. doi:10.1108/EJM-12-2012-0694

Men, L. R., & Tsai, W.-H. S. (2015). Infusing social media with humanity: Corporate character, public engagement, and relational outcomes. *Public Relations Review, 41*, 395-403. doi:10.1016/j.pubrev.2015.02.005

Mendoza, R. L. (2016). Which moral hazard? Health care reform under the Affordable Care Act of 2010. *Journal of Health Organization and Management, 30*, 510–529. doi:10.1108/jhom-03-2015-0054

Mercieca, C., Cassar, S., & Borg, A. A. (2014). Listening to patients: Improving the outpatient service. *International Journal of Healthcare Quality Assurance, 27*, 44-53. doi:10.1108/IJHCQA-03-2012-0033

Merriam, S. B., & Tisdell, E. J. (2015). *Qualitative research: A guide to design and implementation*. San Francisco, CA: Wiley.

Mohebifar, R., Hasani, H., Barikani, A., & Rafiei, S. (2016). Evaluating service quality from patients' perceptions: Application of importance–performance analysis method. *Osong Public Health and Research Perspectives, 7*, 233-238.

doi:10.1016/j.phrp.2016.05.002

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, *25*, 1212-1222. doi:10.1177/1049732315588501

Moustakas, C. (1994). *Phenomenological research methods*. Thousand oaks, CA: Sage.

Mrope, G., & Bangi, Y. (2014). Examining the influence of management practice and attitudes on employee turnover: A case of Kibaha district council. *The International Journal of Business & Management, 2*(9), 11-18. Retrieved from www.theijbm.com

Munn, Z., Porritt, K., Lockwood, C., Aromataris, E., & Pearson, A. (2014). Establishing confidence in the output of qualitative research synthesis: The ConQual approach. *BMC Medical Research Methodology, 14*. 1-7. doi:10.1186/1471-2288-14-108.

Muthukrishnan, A. V. (2015). Persistent preferences in market place choices: Brand loyalty, choice inertia, and something in between. *Foundations and Trendsin Marketing, 9*, 1-82. doi:10.1561/1700000040

Neupane, R. (2015). The effects of brand image on customer satisfaction and loyalty intention inretail supermarket chain UK. *International Journal of Social Sciences and Management*, *2*(1), 9-26. doi:10.3126/ijssm.v2i1.11814

Newman, I., & Benz, C. R. (2006). *Qualitative-quantitative research methodology: Exploring the interactive continuum*. Carbondale, IL: Southern Illinois Univ. Press.

Ngobo, P. V. (2016). The trajectory of customer loyalty: An empirical test of Dick and

Basu's loyalty framework. *Journal of the Academy of Marketing Science*, *45*, 229-250. doi:10.1007/s11747-016-0493-6

Nguyen, D. M. (2015). A new application model of lean management in small and medium sized enterprises. *International Journal of Simulation Modelling (IJSIMM)*, *14*, 289-298. doi:10.2507/IJSIMM14(2)9.304

Nicol, E. D., Mohanna, K., & Cowpe, J. (2014). Perspectives on clinical leadership: A qualitative study exploring the views of senior health care leaders in the UK. *Journal of the Royal Society of Medicine, 107*, 277-286. doi:10.1177/0141076814527274

Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence Based Nursing*, *18*, 34-35. doi:10.1136/eb-2015-102054

Nyerges, T., Roderick, M., Prager, S., Bennett, D., & Lam, N. (2014). Foundations of sustainability information representation theory: spatial–temporal dynamics of sustainable systems. *International Journal of Geographical Information Science*, *28*, 1165-1185. doi:10.1080/13658816.2013.853304

O'Brien, I. M., Jarvis, W., & Soutar, G. N. (2015). Integrating social issues and customer engagement to drive loyalty in a service organisation. *The Journal of Services Marketing, 29*, 547-559. doi:10.1108/JSM-02-2015-0085

O'Lawrence, H., & Poyaoan-Linzaga, M. (2018). Effective communication provides early intervention among Medicare patients. *International Journal of Organization Theory & Behavior, 21*(2), 52–61. doi:10.1108/ijotb-03-2018-0018

Oldenhof, L., Stoopendaal, A., & Putters, K. (2016). Professional talk: How middle

managers frame care workers as professionals. *Health Care Analysis, 24*(1), 47-70. doi:10.1007/s10728-013-0269-9

Olinto, A. C. (2014). Vector space theory of sustainability assessment of industrial processes. *Clean Technologies and Environmental Policy, 16*, 1815-1820. doi:10.1007/s10098-014-0729-4

Pádua, S. I. D., & Jabbour, C. J. C. (2015). Promotion and evolution of sustainability performance measurement systems from a perspective of business process management. *Business Process Management Journal, 21*, 403-418. doi:10.1108/BPMJ-10-2013-0139

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2013). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research, 42*, 533-544. doi:10.1007/s10488-013-0528-y

Parker, L. (2014). Qualitative Perspectives: Through a methodological lens. *Qualitative Research in Accounting and Management, 11*, 13-28.

Patton, M. Q. (2015). *Qualitative research, & evaluation methods*. Thousand Oaks, CA: Sage.

Pflueger, D. (2016). Knowing patients: The customer survey and the changing margins of accounting in healthcare. *Accounting, Organizations and Society, 53*, 17-33. doi:10.1016/j.aos.2016.08.002

Platonova, E. A., Qu, H., & Warren-Findlow, J. (2019). Patient-centered communication: Dissecting provider communication. *International Journal of Health Care Quality*

Assurance, 32, 534–546. doi:10.1108/ijhcqa-02-2018-0027

Porral, C.C., & Levy-Mangin, J.P. (2014). Do store image and price perception matter to store brand equity? *Journal of Food Products Marketing*, *21*(1), 102-122. doi:10.1080/10454446.2013.843486

Prakash, G. (2015). Steering healthcare service delivery: A regulatory perspective. *International Journal of Health Care Quality Assurance, 28*, 173-192. doi:10.1108/ijhcqa-03-2014-0036

Qayyum, Z. U. (2015). Image retrieval through qualitative representations over semantic features. *Multimedia Tools and Applications, 74*, 1935-1959. doi:10.1007/s11042-013-1731-2

Ranney, M. L., Meisel, Z. F., Choo, E. K., Garro, A. C., Sasson, C., Gutrie, K. M., & Arthur, N. (2015). Interview-based qualitative research in emergency care part II: Data collection, analysis and results reporting. *Society for Academic Emergency Medicine, 22,* 1103-1112. doi:10.1111/acem.12735

Research Triangle Institute International. (2016). *Delivering the promise of science for global good*. Retrieved from https://www.rti.org/

Richardson, A. J. (2015). CVS/Caremark: The costs and strategy of a tobacco-free pharmacy. *Accounting Perspectives*, *14*, 71-85. doi:10.1111/1911-3838.12042

Rowley, J. (2012). Conducting research interviews. *Management Research Review, 35*, 260-271. doi:10.1108/01409171211210154

S, S., Mitra, A., & Sahoo, D. (2015). The impact of customer's perceived service innovativeness on image congruence, satisfaction and behavioral outcomes.

Journal of Hospitality and Tourism Technology, 6, 288-310. doi:10.1108/jhtt-10-2014-0061

Saadat, M., Panah, A. D., & Noroozi, F. (2017). Evaluating relationship between the implementation of healthcare reform and patient satisfaction in health care centers of Yasuj. *World Family Medicine Journal/Middle East Journal of Family Medicine, 15*(10), 157-161. doi:10.5742/mewfm.2017.93155

Sahin Dölarslan, E. (2014). Assessing the effects of satisfaction and value on customer loyalty behaviors in service environments. *Management Research Review*, *37*, 706-727. doi:10.1108/MRR-06-2013-0152

Sandelowski, M. (2015). A matter of taste: evaluating the quality of qualitative research. *Nursing Inquiry*, *22*, 86-94. doi:10.1111/nin.12080

Sanjari, M., Bahramnezhad, F., Fomani, F. K., Shoghi, M., & Ali Cheraghi, M. (2014). Ethical challenges of researchers in qualitative studies: The necessity to develop a specific guideline. *Journal of Medical Ethics & History of Medicine, 7*(2014), 1-6. doi:10.1177/0969733007086018

Sarma, S. K. (2015). Qualitative research: Examining the misconceptions. *South Asian Journal of Management, 22*, 176-191. doi:10.1732041530

Schaufeli, W. B. (2015). Engaging leadership in the job demands-resources model. *Career Development International, 20*, 446-463. doi:10.1108/cdi-02-2015-0025

Schiff, G. D., Nieva, H. R., Griswold, P., Leydon, N., Ling, J., Biondolillo, M., & Singer, S. J. (2016). Addressing ambulatory safety and malpractice: The Massachusetts PROMISES Project. *Health Services Research, 51*, 2634-2641. doi:10.1111/1475-

6773.12621

Sharan, A. D., Millhouse, P. W., West, M. E., Schroeder, G. D., & Vaccaro, A. R. (2015). Managing the delivery of health care. *Journal of Spinal Disorders and Techniques, 28*(7), 254-257. doi:10.1097/bsd.0000000000000308

Sharma, M., & Rani, L. (2014). Environmentally sustainable consumption: A review and agenda for future research. *Global Journal of Finance and Management, 6*, 367-374. Retrieved from http://www.ripublication.com

Sharma, V. (2017). Patient satisfaction and brand loyalty in health-care organizations in India. *Journal of Asia Business Studies,11*, 73-87. doi:10.1108/JABS-09-2015-0157

Shen, G. C. C., Chiou, J. S., Hsiao, C. H., Wang, C. H., & Li, H. N. (2016). Effective marketing communication via social networking site: The moderating role of the social tie. *Journal of Business Research, 69*, 2265-2270. doi:10.1016/j.jbusres.2015.12.040 0148-2963

Sherry, E. (2013). The vulnerable researcher: Facing the challenges of sensitive research. *Qualitative Research Journal, 13*, 278-288. doi:10.1108/QR J-10-2012-0007

Silverman, D. (Ed.). (2016). *Qualitative research*. Thousand Oaks, CA: Sage.

Simon, M. K., & Goes, J. (2013). *Dissertation and scholarly research: Recipes for success.* Seattle, WA. CreateSpace Independent Publishing Platform.

Skinner, D. (2014). Health care and the disembodied politics of American liberalism. *Studies in Law, Politics and Society*, 107–136. doi:10.1108/s1059-433720140000065004

Smith-Merry, J., & Walton, M. (2014). Research governance as a facilitator for ethical and timely research? Learning from the experience of a large government-funded multisite research project. *Australian Health Review, 38*, 295-300. doi:10.1071/AH13173

Srivastava, M., & Kaul, D. (2016). Exploring the link between customer experience–loyalty–consumer spend. *Journal of Retailing and Consumer Services*, *31*, 277-286. doi:10.1016/j.jretconser.2016.04.009

Srivastava, M., & Rai, A. K. (2014). An investigation into service quality-customer loyalty relationship: The moderating influences. *Decision, 41*(1), 11-31. doi:10.1007/s40622-014-0025-5

Stake, R. E. (2010). *The art of case study research*. Thousand Oaks, CA: Sage.

Starik, M., & Kanashiro, P. (2013). Toward a theory of sustainability management: Uncovering and integrating the nearly obvious. *Organization & Environment*, *26*, 7-30. doi:10.1177/1086026612474958

Steele, J. M., & Rawls, G. J. (2015). Quantitative research attitudes and research training perceptions among master's-level students. *Counselor Education and Supervision*, *54*(2), 134-146. doi:10.1002/ceas.12010

Steinmeier, M. (2016). Fraud in sustainability departments? An exploratory study. *Journal of Business Ethics, 138*, 477-492. doi:10.1007/s10551-015-2615-3

Stivala, A. D., Koskinen, J. H., Rolls, D. A., Wang, P., & Robins, G. L. (2016). Snowball sampling for estimating exponential random graph models for large networks. *Social Networks*, 47, 167–188. doi:10.1016/j.socnet.2015.11.003

Stock, R. M., & Bednarek, M. (2014). As they sow, so shall they reap: Customers' influence on customer satisfaction at the customer interface. *Academy of Marketing Science Journal, 42*, 400-414. doi:10.1007/s11747-013-0355-4

Strauss, A., & Corbin, J. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal, 11*, 63–75. doi:10.3316/qrj1102063

Symons, C., & Lamberton, G. (2014). Building a social case for business sustainability. *Journal of Economic and Social Policy, 16*(2), 1-22. Retrieved from https://epubs.scu.edu.au

Tam, N., Huy, N., Thoa, L., Long, N., Trang, N., Hirayama, K., & Karbwang, J. (2015). Participants' understanding of informed consent in clinical trials over three decades: Systematic review and meta-analysis. *World Health Organization. Bulletin of the World Health Organization, 93*, 186-198. doi:10.2471/BLT.14.141390

Tansley, C., Kirk, S., & Fisher, C. (2014). Navigating the ethical maze through design action research. *European Journal of Training and Development, 38*, 456-482. doi:10.1108/EJTD-08-2013-0087

Thaichon, P., Lobo, A., & Mitsis, A. (2014). Achieving customer loyalty through service excellence in internet industry. *International Journal of Quality and Service Sciences, 6*, 274-289. doi:10.1108/IJQSS-03-2014-0024

Tromp, K., & Vathorst, S. V. (2015). Gatekeeping by professionals in recruitment of pediatric research participants: Indeed an undesirable practice. *The American Journal of Bioethics, 15*(11), 30-32. doi:10.1080/15265161.2015.1088978

Turan, A., & Bozaykut-Bük, T. (2016). Analyzing perceived healthcare service quality on patient related outcomes. *International Journal of Quality and Service Sciences, 8*, 478-497. doi:10.1108/ijqss-04-2015-0042

Wang, Z., Singh, S. N., Li, Y. J., Mishra, S., Ambrose, M., & Biernat, M. (2017). Effects of employees' positive affective displays on customer loyalty intentions: An emotions-as-social-information perspective. *Academy of Management Journal, 60*, 109-129. doi:10.5465/amj.2014.0367

Wells, M., Semple, C. J., & Lane, C. (2015). A national survey of healthcare professionals views on models of follow up, holistic needs assessment and survivorship care for patients with head and neck cancer. *European Journal of Cancer Care, 24*, 873-883. doi:10.1111/ecc.12285

Win, A. Z. (2016). The changing face of pharmacies in America: Retail clinics. *Perspectives in Public Health*, *136*, 130-131. doi:10.1177/1757913916638237

Winter, R. (2017). The idea of equality and qualitative inquiry. *Qualitative Inquiry, 23*, 27-33. doi:10.1177/1077800416657102

Wojcieszak, M., Bimber, B., Feldman, L., & Stroud, N. J. (2015). Partisan news and political participation: Exploring mediated relationships. *Political Communication, 33*, 241-260. doi:10.1080/10584609.2015.1051608

Woods, M., Paulus, T., Atkins, D. P., & Macklin, R. (2016). Advancing qualitative research using qualitative data analysis software (QDAS)? Reviewing potential versus practice in published studies using ATLAS.ti and NVivo, 1994–2013. *Social Science Computer Review, 34*, 597-617. doi:10.1177/0894439315596311

Wright, A. L., Wahoush, O., Ballantyne, M., Gabel, C., & Jack, S. M. (2016). Qualitative health research involving indigenous peoples: Culturally appropriate data collection methods. *The Qualitative Report*, *21*, 2230-2245. Retrieved from https://nsuworks.nova.edu/tqr/

Wright, R., Paroutis, S., & Blettner, D. (2013). How useful are the strategic tools we teach in business schools? *Journal of Management Studies, 50*, 92-125. doi:10.1111/j.1467-6486.2012.01082.x

Wright, W. L. (2017). New Hampshire Nurse Practitioners Take the Lead in Forming an Accountable Care Organization. *Nursing Administration Quarterly*, *4*, 39-47. doi:10.1097/NAQ.0000000000000205

Wutzke, S., Benton, M., & Verma, R. (2016). Towards the implementation of large scale innovations in complex health care systems: Views of managers and frontline personnel. *BMC Research Notes, 9*(1), 1-7. doi:10.1186/s13104-016-2133-0

Wyness, L., Jones, P., & Klapper, R. (2015). Sustainability: What the entrepreneurship educators think. *Education & Training, 57*, 834-852. doi:10.1108/ET-03-2015-0019

Yin, R. (2017). *Case study research: Design and methods* (6th ed.). Thousand Oaks, CA: Sage.

Zakaria, I., Rahman, B. A., Othman, A. K., Yunus, N. A. M., Dzulkipli, M. R., & Osman, M. A. F. (2014). The relationship between loyalty program, customer satisfaction and customer loyalty in retail industry: A case study. *Procedia-Social and Behavioral Sciences*, *129*, 23-30. doi:10.1016/j.sbspro.2014.03.643

Zhibin, L., & Bennett, D. (2014). Examining retail customer experience and the moderation effect of loyalty programmes. *International Journal of Retail & Distribution Management*, *42*(10), 929-947. doi:10.1108/IJRDM-11-2013-0208

Appendix A: Interview Questions

The following interview questions are for this qualitative embedded single case study. Question 1 is the initial research question. Questions 2-7 pertain to the tenets of the CLT. Question 8 is to ensure depth of interview:

1. What customer care strategies do you use to improve patient satisfaction?
2. How do you describe customer care strategies and patient satisfaction?
3. What assessment instruments do you use to determine if customer care strategies improve patient satisfaction?
4. What assessment instruments do you use to determine if patients are satisfied with the customer care strategies?
5. What other data sources do you use to develop or change customer care strategies based on organizational outcomes?
6. How do you engage customers and staff members' feedback when considering, implementing, or changing customer care strategies to improve patient satisfaction?
7. How do you measure the costs of customer care strategies to improve patient satisfaction targets?
8. What other information will you share as it relates to the successful customer care strategies you have developed and implemented to improve patient satisfaction?

Appendix B: Interview Protocol

1. Introduce myself to the participant(s).
2. Turn on the audio recording device.
3. Follow the procedure to introduce participant(s) with a pseudonym and coded identification; note the date and time.
4. Begin interview with question number 1; follow through to the final question.
5. Follow up with additional questions and collect company documents.
6. End interview sequence; discuss member checking with the participant(s).
7. Thank the participant(s) for taking part in the study.
8. Reiterate contact numbers for follow up questions and concerns from participants.