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Strategies Healthcare Leaders Use to Improve Patient Satisfaction

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This is to certify that the doctoral study by

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Abstract

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MBA, Cleary University, 2012

BBA, Cleary University, 2010

Doctoral Study Submitted in Partial Fulfillment

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Abstract

For all healthcare leaders, patient satisfaction plays a key role in healthcare; poor patient satisfaction within healthcare organizations can lead to poor patient health outcomes, decreased revenue, and poor employee engagement. Grounded in Mayeroff's theory of caring, the purpose of this qualitative single case study was to explore strategies healthcare leaders use to improve patient satisfaction. The participants consisted of five healthcare leaders in metropolitan Detroit, Michigan, who implemented strategies that improved patient satisfaction. Data was collected using semistructured interviews, archival document review, and data from the Centers for Medicare and Medicaid Services (CMS) Hospital Compare database. Yin's five-step process was used to analyze data. Four themes emerged: caring for patients through communication, patient-centered care, compliance through CMS patient satisfaction processes, and leadership. A key recommendation for healthcare leaders is to create an environment built on communication amongst staff, patients, and their family members, ensuring that everyone involved in the patients' care understands the expectations of the patients' outcome. Implications for positive social change include potentially improving patient care experiences through communication and education by healthcare leaders and healthcare workers, resulting in improved health outcomes within the local communities in metropolitan Detroit, Michigan.

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Dedication

Through this study, I have had the opportunity to grow and learn so much about myself and my capabilities. This study challenged me to the fullest and allowed me to see how strong my faith was when tested. I could have given in so many times, but I refused to give in because this degree was for me. By the grace of my God, I carried out this goal, and I cannot be more delighted and grateful. Obtaining this degree was put on my heart several years ago to obtain, and I did it. Thank you, Jesus!

Acknowledgments

I dedicate this study to my loving and supportive mother and father; it was with your strength and guidance that I could accomplish this goal. You taught me the importance of a strong work ethic and keeping my word, and I could not thank you more, as this journey brought many highs, lows, and everything in between. Thank you for allowing me to dream and become anything that I wanted to be. Thank you for being you and loving me more than enough.

I dedicate this study to my friends and staff who supported me when this thing got the best and worst of me. Your support was what I needed to stay focused and keep pushing. Your faith in me and God's blessings was the charge that reminded me consistently of who I am and whose I am. Thank you all with my whole heart.

With your insight and monthly check-in calls, Dr. Hay, you helped push me through to the finish line. Speaking with you kept me accountable to the goals that I set for myself. I am thankful for your support and your guidance. I appreciate you.

Dr. Diala, thank you for your patience with me and your support. Thank you so much for believing in me and pushing me through this program. I am grateful for your leadership as with you, I have completed this journey. You have been a blessing to me, and I thank you so very much.

Thank you to my classmates who have completed the program before me and who will complete the program after me. Your post and support helped tremendously. Thank you to my 2nd committee chairs and URRs; I appreciate your feedback. Dr. Land, thank you for your patience and support.

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Section 1: Foundation of the Study

Patient satisfaction is a critical element in the delivery of healthcare. As technology advances in healthcare, patients have become more knowledgeable about individualized care and the role of patient satisfaction. Healthcare leaders are accountable for patients' experiences and satisfaction with the care received based on a patient's perception when patients complete a patient satisfaction survey, the Consumer Assessment of Healthcare Providers and Systems (CAHPS), implemented by the Centers for Medicare and Medicaid Services (CMS). In this qualitative single case study, I explored strategies healthcare leaders use to improve patient satisfaction in a healthcare organization.

Background of the Problem

The Patient Protection and Affordable Care Act (PPACA) of 2010 includes strong recommendations for healthcare leaders to improve patients' perceptions of healthcare. The PPACA initiated the requirement for healthcare leaders to restructure or create provisions that include improving patient satisfaction and quality of care (Pascual, 2021). Hospital reimbursement is affected by patients' perceptions of care and services received (Pascual, 2021). It includes accountability measures to aid healthcare leaders in maintaining fiscal viability (Pascual, 2021). In healthcare, lack of accountability corresponds with poor customer service experiences (D. L. Leonard, 2017). As patient satisfaction plays a significant role in healthcare, healthcare leaders are increasingly accountable for ensuring patients are satisfied with the care received.

Many healthcare leaders have established patient satisfaction organizational goals to ensure higher levels of care and service. Healthcare leaders who have not implemented strategies to improve patients' perceptions of care and service are at risk of market share loss resulting in healthcare consolidation (DeVore & Champion, 2011; Vizzuso, 2015). Nationally, many healthcare leaders have improved patient satisfaction; however, some still lack strategies to make necessary adjustments (Mann et al., 2016). Patient satisfaction is a vital component of the financial longevity of healthcare organizations, requiring healthcare leaders to establish strategies to improve patient satisfaction. Greater satisfaction, in turn, could increase inpatient referrals and insurance reimbursements.

Problem Statement

Healthcare leaders who fail to deliver quality patient experiences are under pressure to improve patient satisfaction, placing them at financial risk (Mahoney et al., 2017). In July 2017, 14% of U.S. healthcare leaders publicly reported patient satisfaction scores through 3.1 million completed CAHPS surveys, while 86% of healthcare leaders did not (CMS, n.d.). A decrease in patient satisfaction could negatively affect hospital profitability by 25% (CMS, n.d.). In addition, the PPACA includes a core measure for the reimbursement for services provided by healthcare providers based on patient satisfaction (Pascual, 2021). The general business problem is poor patient satisfaction within healthcare organizations puts hospitals in the U.S. at financial risk. The specific business problem is some healthcare leaders lack strategies to improve patient satisfaction.

Purpose Statement

The purpose of the proposed qualitative single case study was to explore strategies healthcare leaders used to improve patient satisfaction. The targeted population included leaders of a healthcare organization located in metropolitan Detroit, Michigan who successfully implemented strategies that improved patient satisfaction. Findings may influence the ways healthcare leaders address patient satisfaction and how patients perceive service quality, resulting in improved service outcomes for patients and their families.

Nature of the Study

I selected a qualitative approach for the study. Researchers use qualitative methods to study characteristics of a population through focus groups and interviews that produce data reflecting personal experiences, perspectives, and cultural backgrounds (Anyan, 2013). The qualitative method was appropriate for this study as I explored participants' perceptions. By contrast, researchers use quantitative methods to evaluate studies using hypotheses, nonpurposeful sampling, measures, and randomization standards in changing contexts of real-world settings (Balasubramanian et al., 2015). The quantitative approach was not appropriate for this study because I did not examine relationships or differences among variables in real-world settings. Another option was the mixed methods approach, which researchers use to integrate qualitative and quantitative research (Pluye & Hong, 2014). Mixed methods research was not appropriate for this study because there were no quantitative components to the study.

Several qualitative designs are available to researchers, including case studies, ethnography, and phenomenology. For this study, I used the case study design. Researchers use the case study design for an empirical exploration of a phenomenon within a real-world context bounded by a unit of analysis, generally time (Yin, 2018). The case study design is appropriate for exploring the depth of a single phenomenon specified over time. The ethnographic design, which researchers use to describe a culture or act to understand another way of life (Spradley, 2016), was not appropriate for this study because my intent was not to describe groups' cultures or understand a way of life. Researchers use the phenomenological design to describe, interpret, or embrace the essence of lived experiences of a group of people involving a specific phenomenon (Valentine et al., 2018). Exploring a specific phenomenon of a group of people was not the goal of my study; the phenomenological design was therefore not appropriate.

Research Question

One central question guided this research: What strategies do healthcare leaders use to improve patient satisfaction in healthcare?

Interview Questions

1. What strategies did you use to improve patient satisfaction?
2. What strategy did you find worked best to improve patient satisfaction?
3. How did you measure the success of the strategies used?
4. What were the key barriers to implementing the strategies for improving patient satisfaction?

5. How did your organization address the critical barriers to improving patient satisfaction?
6. How did patients respond to your strategies to improve patient satisfaction?
7. What else would you like to share that you did not address regarding the strategies used to improve patient satisfaction?

Conceptual Framework

The conceptual framework for this study is Mayeroff's theory of caring. The theory of caring involves the process of relating to someone, understanding their needs, and committing to their well-being (Houghton et al., 2014; Mayeroff, 1971). Mayeroff's (1971) theory of caring is the process of helping another grow and satisfy another person's needs to actualize oneself through transformational qualitative relationships. The act of caring includes observing and assessing responses to needs and concerns of another person as well as expressions of compassion, empathy, and respect (Smylie et al., 2016). Caring is a crucial function in multiple institutions that affects the lives of those in need, as well as human services enterprises such as healthcare (Smylie et al., 2016). Caring for individuals is the primary function of healthcare and a significant aspect of ensuring the wellbeing of patients through listening, responding, and empathizing with each patient.

The theory of caring has evolved. The tenets of this theory include knowing a person's needs, limitations, patience, honesty, humility, hope, and courage (McAfee, 2016). The theory of caring has become a core training method for nurses since 1991. Such training accelerates and expands to clinical and nonclinical roles within healthcare organizations (Watson & Smith, 2002). Researchers use the theory of caring to focus on

relationships and behaviors, demonstrating consideration for the needs of others (McAfee, 2016). Individualized care for patients involves the provision of care based on addressing each patient's unique needs and problems (Cheraghi et al., 2017). Continued training and education focusing on the theory of caring and how to provide care to patients individually can effectively strengthen the overall perceptions of the healthcare organizations from patients' perspective.

Tenets of the theory of caring can facilitate healthcare leaders' understanding of patients' needs to develop and deploy strategies. Mayeroff's theory of caring requires a commitment to wellbeing of others by supporting and encouraging specific behaviors (Houghton et al., 2014). This was a suitable foundation for understanding strategies used to improve patient satisfaction in healthcare.

Operational Definitions

Centers for Medicare and Medicaid Services (CMS): Is a U.S. government division of the Department of Health and Human Services that administers Medicare and Medicaid health insurance coverage for seniors, individuals with disabilities, children, low-income adults, and pregnant women (CMS, n.d.).

Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CGCAHPS): This is a standardized healthcare survey tool used to measure patients' perceptions of care provided by physicians in office settings (CMS, n.d.).

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): This was the first national standardized healthcare survey tool used to measure a patient's perception of hospital care (CMS, n.d.). *Meaningful Use:* Meaningful use requires

healthcare leaders to develop an electronic patient portal for improving patients' healthcare (CMS, n.d.).

Patient Protection and Affordable Care Act of 2010 (PPACA): An act enacted by the U.S. 111th Congress and signed into law by President Barak Obama on March 23, 2010, expanding healthcare coverage for all Americans and reducing the number of uninsured American's and healthcare costs (Healthcare.gov, n.d.).

Value-based healthcare: The healthcare payment and delivery model which rewards value over quantity based on patients' perceptions of care (CMS, n.d.).

Assumptions, Limitations, and Delimitations

Assumptions

Three assumptions guided this study. Assumptions are the researcher's unproven assertions necessary to conduct the investigation (Marshall & Rossman, 2016). The first assumption was that healthcare leaders responded to interview questions truthfully by sharing their expertise and specific details about strategies used to improve patient satisfaction. Second, I assumed that expanding healthcare leaders' knowledge of improving patient satisfaction would lead to action that will improve patients' perceptions of care, thereby improving CGCAHPS and HCAHPS results and financial stability of the healthcare organization. The third assumption was that strategies provided by participants contributed to overall patient satisfaction ratings of the healthcare organization as reported through the CGCAHPS and HCAHPS results.

Limitations

Limitations are constraints or weaknesses beyond the researcher's control and may affect the outcome of the study (Theofanidis & Fountouki, 2019). Limitations of the study included potential biases of healthcare leaders during interviews and limited documentation for data collection. During interviews, participants had the ability to limit the amount of information shared or withdraw from the study. The study was focused on a single healthcare organization. Therefore, strategies may not help all healthcare leaders. The focus of the study was specific to strategies used to improve patient satisfaction. With a qualitative single case methodological design, other researchers can duplicate and test study results in different demographic and geographic locations where healthcare leaders improved patient satisfaction.

Delimitations

Delimitations are boundaries or challenges of the researcher's shortcomings in the assumptions of a study forcing the researcher to better evaluate the assumptions (Theofanidis & Fountouki, 2019). The first delimitation of the study was that the sample population was limited to healthcare leaders who implemented and improved patient satisfaction processes for a healthcare organization. The second delimitation of the study was the sample population of healthcare leaders were delimited to one health system located in metropolitan Detroit, Michigan. The third delimitation of the study was my choice to interview healthcare leaders who implemented and improved patient satisfaction within the healthcare organization; therefore, I did not interview healthcare

leaders who did not implement and improve patient satisfaction within the healthcare organization.

Significance of the Study

The findings of this study offer potential value to healthcare leaders because improving patient satisfaction has a strong influence on patients' behavior and wellbeing. Patients' perceptions of the care and service provided within a healthcare organization determines the patients' satisfaction with the clinician and the healthcare employees (D. L. Leonard, 2017). High patient satisfaction scores as resulted through the CGCAHPS and HCAHPS, are associated with increased reimbursement rates from insurers (Shirley & Sanders, 2013); in turn, financial performance is a critical success indicator for healthcare organization leaders (Akingbola & van den Berg, 2015). According to Anderson and Wilson (2011), the results of the CGCAHPS and HCAHPS allow insurers to provide up to 30% in reimbursements or deductions for services rendered based on patients' experience, and up to 70% reimbursement or deduction based on clinical care patients receive within healthcare organizations. In addition to reimbursement rates tied to patient satisfaction, the PPACA includes a core measure for the evaluation and pay of healthcare providers based on patients' perceptions of quality of care and services received (Tsai et al., 2015). Healthcare leaders who create processes focused on patient improvements and perceptions may have higher reimbursement rates, compared to the previous year, based on patients' feelings regarding the care received within the healthcare organization.

Contribution to Business Practice

This study may contribute to healthcare leaders' improvement of business practices. Healthcare leaders seek alternative methods to ensure patients are satisfied with services received by healthcare employees. Patient satisfaction may aid leaders in creating effective ways to empower and create innovative process improvements in healthcare organizations. Further, improved patient satisfaction may aid in terms of organizational sustainability and improved patient health outcomes.

Implications for Social Change

Improving patient satisfaction in healthcare can directly affect positive social change by contributing to overall patient wellbeing. U.S. Government leaders set forth quality standards outlined in the PPACA that include strategies needed to achieve positive patient experiences. Healthcare leaders who implement effective communication practices within healthcare organizations can improve patients' health, safety, and overall satisfaction (Burgener, 2020). Study results may contribute to positive social change. Revisions to patient satisfaction through patient-centered and respectful and responsive care is necessary to achieve universal healthcare for all (Larson et al., 2019). Improving quality of care from patients' perspectives may promote improved health outcomes and wellbeing for patients regardless of age, demographics, race, or ethnicity.

A Review of the Professional and Academic Literature

This literature review includes strategies used by healthcare leaders to improve patient satisfaction. I present the theory, research problem, and studies on the topic. The literature review addresses five strategies to improve patient satisfaction in healthcare: (a)

applying the theory of caring, (b) sustaining a culture of patient-centered care, (c) understanding patient needs, (d) ensuring compliance, and (e) employing dedicated leadership skills.

Sources reviewed included journals, government sources, and websites that provided detailed information to address the research problem as well as findings from scholars who have studied similar concerns. I used the following databases: Google Scholar, National Center for Biotechnology Information (NCBI), Science Direct, PubMed, and EBSCOHost, to retrieve peer-reviewed articles published between 2017 and 2021. Keywords searched were *patient satisfaction in healthcare*, *HCAHPS, PPACA*, *CMS, CGCAHPS, theory of caring, hospital compare, press ganey, patient satisfaction*, *CMS star rating, customer service in healthcare, value-based care, organizational leadership, transformational leadership, and culture of caring*. I reviewed prior scholarship on patient satisfaction strategies and improving patients' perception of care. The literature review consisted of 92 sources, 74 of which came from peer-reviewed journals, with 85% published between 2017 and 2021 (see Table 1).

Table 1

Literature Review Source Content

Reference Type	Total	<5 Years (2017 to 2021)	>5 Years (Prior to 2017)	%Total <5 Year
Peer-reviewed journals	82	74	8	85%
Books	1	0	1	0%
Websites	2	2	0	100%
Non-peer reviewed journals	7	1	6	1%
Total	92	80	15	87%

The purpose of the proposed qualitative single case study was to explore strategies healthcare leaders used to improve patient satisfaction. I first discussed the conceptual framework, which was the theory of caring. Next, I explained sustaining a culture of patient-centered care, understanding patients' needs, ensuring compliance, and employing dedicated leadership skills. The strategies identified are among several that healthcare leaders may consider implementing based on the needs of patient populations. The review concludes with a consideration of healthcare leaders and improving patient satisfaction.

Theory of Caring

The conceptual framework for this study is Mayeroff's theory of caring. According to Mayeroff (1971), caring is the process of relating to someone to understand the person's needs while being fully committed to his or her wellbeing. Mayeroff's theory of caring is a foundation for understanding strategies to improve patient satisfaction. Caring requires a commitment to the wellbeing of others through hope and courage (Bagnall et al., 2018). Leaders who implement a culture of caring create healthcare providers with caring attributes and behaviors (Wei et al., 2019). Establishing a healthcare environment with a primary focus on caring for each patient leads to a culture of caring.

Healthcare providers who deliver care and support to their patients can create a culture of caring by listening to patients' needs and treating them with dignity and respect. Caring is a natural phenomenon (Arman et al., 2015). The theory of caring framework involves the context of caring for life with a commitment and devotion for

wellbeing (Létourneau et al., 2017). In healthcare, the theory of caring is fundamental in terms of providing patients with the care they deserve and aiding each patient with healing and improved outcomes.

Healthcare leaders who encourage the theory of caring build a thoughtful environment focused on improving patient care and wellbeing by applying personalized treatment and creating a shared approach to patient care. This approach allows patients to take part in their healthcare and make decisions with care teams, creating a foundation for individualized care (Bokhour et al., 2018). There are three tenets of the theory of caring: (a) knowing and understanding another's needs, (b) adjusting behaviors to reduce mistakes, (c) patience with growth and development (Bagnall et al., 2018). The three tenets of the theory of caring may enhance patient satisfaction, resulting in an overall improvement in patient outcomes.

Practicing the tenets of the theory of caring allows healthcare teams to understand patients' needs and vulnerabilities. Proper training and education involving compassionate care and theory of caring principles positively affects patient experiences (Saab et al., 2019). Creating a patient-centered environment is the most critical factor for healthcare leaders who emphasize value and care for every patient (Bruno et al., 2017). Creating a healthcare environment that allows patients to feel cared for and respected while developing higher standards of perceptions of care improves outcomes of patients and healthcare organizations.

Helping patients grow and develop through support and encouragement is a means of caring for another human (Houghton et al., 2014). Caring is a process that

provides meaning, creates harmony and order, and inspires individuals to heal and grow (Bailey, 2009). Caring behaviors within healthcare organizations are about patient satisfaction (Ellina et al., 2020). Through the theory of caring, healthcare leaders who create environments built on caring for patients may improve patient satisfaction and wellbeing.

The theory of caring is essential to the process of caring and improving the health of others. Having skills and knowledge to implement the theory of caring allows healthcare providers to focus on each patient as an individual, stimulating growth and healing. The theory of caring provides the foundation for creating a comprehensive approach to patient care, specifically in healthcare (Bailey, 2009). This holistic approach focused on the health and care of each patient shows the importance of accountability through caring. Fostering the tenets of the theory of caring and creating a patient-centered culture enhances care provided through attention and education for all patients.

Theory of Caring and Related Theories

Ten theories fall within the context of Mayeroff's theory of caring. The 10 theories are: (a) Watson's transpersonal caring theory, (b) Swanson's middle range theory of caring, (c) Leininger's theory of culture care, (d) Gaut's theoretical description of caring, (e) Knowlden's communication of caring in nursing, (f) Halldorsdottir's theory of caring and uncaring encounters within nursing and healthcare, (g) Boykin and Schoenhofer's nursing as caring theory, (h) Ray's theory of bureaucratic caring, (i) Sister (Sr.) Roach's human mode of being, and (j) the Geropalliative caring model. These theories all pertain to aspects of caring for other human beings and provisions of care.

Of the 10 theories, three are most relevant to improving patient satisfaction: Halldorsdottir's theory of caring and uncaring, Ray's theory of bureaucratic caring, and Roach's theory of caring as the human mode of being. Each of these theories includes tenets that improve patient satisfaction in healthcare organizations: communication with patients and their families, care for whole patients physically, emotionally, and spiritually, and responsibility for patients.

Halldorsdottir's Theory of Caring and Uncaring

Applied to nursing and healthcare encounters, Halldorsdottir's theory of caring and uncaring emphasizes the importance of creating professional and caring relationships with individuals who seek care. The tenets of Halldorsdottir's theory include connecting with patients by developing communication plans during episodes of care and reducing lack of communication or negative communication toward patients. Communication and building relationships are the foundation of patient-centered care (Söderman et al., 2018). Theory of caring can assist in identifying subjective experiences of individuals who need or receive care from clinicians (Halldorsdottir, 1996). Professional care and communication between the clinician and the patient create a positive health outcome for the patient

In healthcare, clinicians providing care to patients have a responsibility to ensure that patients feel safe and cared for while under the care of healthcare providers. Patients who have negative or unpleasant interactions in healthcare organizations may have adverse health outcomes that prevent them from healing (Halldorsdottir, 2007). Caring requires a commitment to the wellbeing of others by supporting and encouraging specific

behaviors (Houghton et al., 2014). The provision of care can positively or negatively affect patients; Halldorsdottir's theory of caring and uncaring involves identifying the importance of caring for patients as individuals with respect and dignity. The Halldorsdottir's theory of caring and uncaring relates to this study through the theory of caring and the importance of establishing relationships and open communication with every patient.

Ray's Theory of Bureaucratic Caring

Ray's theory of bureaucratic caring centers on caring from a spiritual and ethical perspective. The theory is associated with giving and charity specific to services for homebound individuals who require well-trained and balanced clinicians to provide care, comfort, and fulfillment (Johnson, 2015). Tenets of the theory of bureaucratic caring include spiritual wellbeing and clinical education and social elements of care relative to the patient population, such as access to medication (Bailey, 2009). Through Ray's theory of bureaucratic caring, clinicians can contribute to wellbeing through improved safety measures and assurance of patients' adherence to treatment plans.

Healthcare providers offer support to individuals who are homebound and need medical assistance. Healthcare employees provide more resources for patients and their families to ensure improved quality of life using technical aspects, such as educating the patient about the details of the disease and care provided, legal aspects, such as access to fair and equitable care, or economic aspects, such as access to affordable medication, of patient care and wellbeing (Johnson, 2015). Individualized managed care allows patients

to participate in their treatment and play a supportive role in terms of quality of care received.

According to Wagner et al. (2001), patient care is the responsibility of the entire health team. In conjunction with the bureaucratic care model, the chronic care model involves quality improvements for patients, clinicians, and healthcare leaders by implementing quality measures allowing patients to rate the quality of care received from healthcare teams (Wagner et al., 2001). Through these ratings, healthcare leaders gain insight into what healthcare teams experience while caring for patients.

To improve healthcare outcomes, the healthcare effectiveness data information set measures patient care outcomes, created by the National Quality Council (Potter & Wilson, 2017). Healthcare effectiveness data tool supplies metrics focused primarily on the patient's behavior, thus placing some responsibility on the patient to improve healthcare outcomes (Potter & Wilson, 2017). Through these measures, patients receive education to maintain wellness plans in order to address individual responsibility of quality of care.

The chronic care model functions through an organized delivery system connecting resources of healthcare organizations to patients within the community, creating pathways to equitable care. To effectively use the chronic care model, an organized delivery system with valuable resources, such as pamphlets and educational sessions, that the local community can use outside of healthcare organizations should exist (Wagner et al., 2001). Healthcare leaders who use community outlets, such as community centers and social service organizations, provide patient education as a

community partner, building bridges to patient education about chronic health conditions and the available treatments within a health system (Wagner et al., 2001). The community partners act as a coach, providing essential information to aid patients with quality care and improving perceptions of care for healthcare organizations.

The chronic care model includes a framework to improve outcomes of patients with chronic diseases. The chronic care model involves six elements of care that support constructive feedback and planning from the perspective of the people within the community, the patients', and the leaders of the healthcare organization (Llewellyn, 2019). Components of the chronic care model include (a) community resources, (b) self-care management support, (c) organization of healthcare (OHC), (d) delivery system design (DSD), (e) clinical decision support (CDS), and (f) computer information systems (CIS) (Llewellyn, 2019). Chronic care model elements work together simultaneously to achieve desired outcomes involving improvement of patients' overall experience and health (Llewellyn, 2019). Patients establish support and guidance within healthcare organizations and communities, jointly fostering an environment of care.

Resource leaders advocate for healthcare organizations and patients by providing available resources to patients. Resources include peer groups, counseling, and outreach for specific research trials available to the local community (Llewellyn, 2019; Wagner et al., 2001). Self-management support involves (a)collaborative goal setting, (b) routine assessments of health management, and (c) problem-solving and planning of health outcomes. Self-management provides education culturally tailored to the patient's lifestyle and disease (Llewellyn, 2019; Wagner et al., 2001). Self-management allows

patients to maintain independence and responsibility for their own wellness and care, supporting patients to improve health outcomes.

The health system-organization of healthcare (OHC) is the third element of the chronic care model. The OHC is a review of the culture within a healthcare organization. Through the OHC, the mechanics and culture of health systems require senior leadership intervention in terms of creating a top-down leadership approach for health system changes and initiatives (Llewellyn, 2019). Through motivation and support of senior leadership, healthcare leaders may improve chronic illness care improving patient outcomes and preventions. The OHC reflects the need for support by senior leadership to implement changes such as the culture and the mechanics of the healthcare organization to improve patient satisfaction while engaging employees.

The delivery system design (DSD) is the fourth element of the chronic care model. Using the DSD, leaders define roles of healthcare workers and create standards and expectations to provide quality patient care (Wagner et al., 2001). Through these standards, healthcare leaders can create a culture of caring focused primarily on patients and improving health outcomes.

The fifth element of the chronic care model, the clinical decision support (CDS) element, functions with patient-centered care guidelines that work to improve patient care and outcomes. The CDS element is the most effective element, with established patient-centered guidelines that define the goals and expectations of care (Wagner et al., 2001). Creating a care plan for each patient and goals for patient care may play a key role in patient-centered care and wellbeing of overall patients.

The sixth element of the chronic care model, the clinical information system (CIS), the CIS element highlights the technological aspects of patient care. The CIS is an electronic communication tool that healthcare providers use to ensure communication between patients and providers. This involves collecting and organizing patient data, including feedback and reminders for patients and providers (Llewellyn, 2019). The elements of the chronic care model, combined with Ray's bureaucratic care model, served as a guide for healthcare organizations to improve patient outcomes centered around better patient care.

Roach's Theory of Caring, the Human Mode of Being

Roach's theory of caring, the human mode of being, reviews the moral aspect of caring for oneself and others. Roach's theory of caring, the human mode of being, focuses on the holistic way of caring for self and others as a moral endeavor for everyone (Villeneuve et al., 2016). Roach developed a caring practice, defining six tenets that align with the human mode of being on a spiritual level. The six tenets are (a) compassion, (b) competence, (c) confidence, (d) conscience, (e) commitment, and (f) comportment offer deeper moral reasoning for caring for another (Villeneuve et al., 2016). Through these attributes, clinicians can create a culture of caring for every patient, enabling an environment for patients to improve their health outcomes.

The first attribute, compassion, highlights the awareness of a relationship with all living creatures. The second attribute reflects individuals who show competence by providing their skills and expertise to deliver professional, responsible care to others (Villeneuve et al., 2016). The third attribute indicates an individual who displays

confidence in fostering a quality relationship with another (Villeneuve et al., 2016). The reflection of conscience, the fourth attribute of Roach's theory, is when a person cares for another; one must have a conscience that directs the behaviors and thoughts toward an ethical outcome (Villeneuve et al., 2016). The fifth attribute is a commitment to provide quality care for another regardless of whether the care is a choice or an obligation (Villeneuve et al., 2016). The sixth attribute, comportment, entails accepting others and their beliefs (Villeneuve et al., 2016). Roach's theory has served as a model for the transformation of caring in healthcare and the development of character among care providers (Villeneuve et al., 2016). Practicing Roach's theory of caring improves the quality of care provided by the clinician and the patient's perception of the care received.

Sustaining a Culture of Patient-Centered Care

Patient-centered care involves the patient and enhanced patient satisfaction. The physician and the patient work together as a team for a better outcome for the patient's well-being, establish human-to-human caring, align with the theory of caring tenets and create moments of caring with the patient (Delaney, 2018). Patient-centered care increases the patient's involvement in the care received to improve health outcomes, with the physician honoring the patient's wishes (Olson, 2019). Patient-centered care empowers the patient to become involved with and responsible for improving health outcomes, quality of life, and best practices to avoid recurring health issues.

Patient-centered care comprises five tenets. The tenets are: (a) the bio-psychosocial perspective when the doctor appreciates the entire health problem from a social, psychological, and biomedical perspective; (b) the doctor as a human being, who

expresses sensitivity toward the patient and the health condition; (c) the patient as a human being, where the doctor is concerned about the health condition and the patient; (d) sharing power and responsibility, as the doctor and the patient are involved in the decision-making process; and (e) therapeutic alliance, when the doctor and patient establish a personal and professional relationship to enhance the patient's experience and improve the initial health condition (De Boer et al., 2013). Patient satisfaction is pivotal to the existence of healthcare organizations (Ellina et al., 2020) and the development of patient-centered care practices. Patient-centered care is an essential function in improving patient outcomes and perceptions, as the care received focuses on the patients, making them a part of the healthcare team.

Patient-centered care in healthcare organizations across the United States and abroad is transitioning to the essential evolution of care, to establish best practices. Providing patient-centered care under any caring theory requires a commitment by clinicians to offer ethical, safe, and supportive treatment to patients and their families (Lee, 2019). Clinicians are responsible for caring behaviors to meet patient-centered care (Ellina et al., 2020). The commitment and responsibility of clinicians to provide patient-centered care encompass the ability to address each patient's unique needs, providing care and education on an individual level.

To create a culture focused on patient-centered care, clinicians need to establish and maintain a healthy, caring relationship with patients. Healthcare organizations with a focus on patient centered care have the potential to create a tailored care experience for individual patients (Kuipers et al., 2021). Caring is the factor that distinguishes clinicians

from other professionals because caring is the essence of a clinician's daily regime (Afaya et al., 2017). Caring occurs when the clinician attends to another and genuinely wants to provide care (Nicholson & Kurucz, 2017). Patient-centered care enhances the relationships between clinicians and patients (Nurse-Clarke et al., 2019). Being aware of caring behaviors and providing personalized care to each person is the embodiment of caring.

Caring for the whole person leads to relationships with the patient and the patient's family. It is critical for the healthcare provider to understand the experiences of the patient and the patient's family; to ensure that the care provided is patient and family centered care (Sorra et al., 2021). The caring relationship creates a fundamental human connection improving the perceived attitudes and activities (Nicholson & Kurucz, 2017). Patient-centered care is intrinsically vital to the quality-of-care outcomes (Larson et al., 2019). Through patient-centered care, the patient is the focal point, involved in the services received at every step of the treatment plan.

The delivery of care has changed vastly as the U.S. population has begun to age and become increasingly ill. The demand for high-quality, fundamental patient-centered care is at the core of patient care and satisfaction (Ellina et al., 2020). The clinician can only achieve patients' cultural needs and requirements through understanding and communication (Lee, 2019). Engaging in a relational and reflective process of education through conversation supports the development of patient care and welfare and improves the clinician's, leaders, and other healthcare employees' overall effectiveness (Nicholson & Kurucz, 2017). Leaders who support patient-centered care value an environment that

encourages improved patient care and patient perception. With continued awareness and leadership, providers can manage the health and well-being of the aging population through personalized care for each patient.

Physicians and nurses who practice patient-centered and fundamental care can influence a patient's attitude toward the care provided. Including patients in co-creation, sensitive care decisions with clinicians play a pivotal role in improving patient care and satisfaction (Lee, 2019). As an approach to patient-centered care, clinicians focus on what is of value and necessary to the patients and their families (Delaney, 2018). Patient-centered care as a practice always puts the patient at the center of healthcare to provide individualized treatment and improve as many outcomes as medically possible.

As healthcare leaders seek to implement a patient-centered care model to improve patient care and organizational financial outcomes, leaders establish a culture that reflects the theory of caring and influences patients' perception of care (Afaya et al., 2017). Building patient-centered care environments empower patient-provider relationships that enhance the goals of patient health outcomes (Bokhour et al., 2018). Healthcare providers who establish relationships with patients and the patient's family build a foundation of trust. Patient-centered care improves the patient's satisfaction and drives improved patient care and experiences and clinician accountability (Bokhour et al., 2018). Patient involvement is increasingly important to ensure proper delivery of care that meets the patients' needs (Seeralan et al., 2021). Including the whole patient in the care provided creates trust between the patient and the clinical team. Developing open communication

and involving the patient in decisions implies a culture of caring for the well-being of all patients.

Establishing professional, caring relationships with patients allows the patient to develop a bond and trust with the healthcare provider and the environment. Fostering patient-centered care invites the patient to participate in the care provided, creating a perception of caring and quality-driven healthcare (Boysen et al., 2017). Four elements of accessing good care are (a) humanistic care, or empowering patients' care, (b) relational care, or providing patients with communication that the patient can understand, (c) clinical care, or knowledge and skills required to provide clinical care; and (d) comforting care or providing a respectful environment and listening to the patient's needs (Kuis et al., 2014). Patients perceive clinicians as caring, responsive individuals. Practicing the elements of good care ensures the patient is the focus of the care given, guiding the patient to an improved health outcome.

Mayeroff's theory of caring provides the rationale for the conceptional framework for the study. The theory of caring indicates the ideals of delivering patient satisfaction by providing compassionate care to every patient. The theory of caring can empower clinicians with the knowledge and legitimacy of practicing patient care (Lee, 2018). Creating a culture of caring requires the clinicians to focus on the patient as an individual when providing care (Awdish, 2017). Establishing a culture of patient-centered care built on the foundation of the theory of caring within a healthcare organization improves patient trust and meaningful care.

Understanding Patients' Needs

Identifying and understanding the needs of patients through patient feedback is the second strategy healthcare leaders use to improve patient satisfaction. Patient satisfaction is a broad term that encompasses personal feelings relative to the care received in a healthcare organization. The patient's experience may positively or negatively impact a healthcare organization based on the emotional consequences of a patient's perception of the care received (Arboleda et al., 2018). Negative patient experiences affect the patient and the organization greater than the positive patient experiences (Ling et al., 2021). According to Lee (2019), the measurement of patient experiences is related to the interactions and communication with the clinician. Compiling the individual feedback results regarding patient satisfaction with healthcare experiences could indicate deficits in the services provided.

In healthcare organizations, HCAHPS and CGCAHPS serve as tools to identify and address areas of concern as voiced by individual patients. Through the CAHPS, patients provide feedback to healthcare leaders regarding the experiences encountered at specific healthcare facilities (CMS, n.d.). The results of the CAHPS allow for reimbursement or deduction for services rendered based on the patients' experience (Onukogu, 2018), which could have a negative financial impact on healthcare organizations. With the changes in Medicare reimbursement policies, patient satisfaction is a large portion of the reimbursement to healthcare organizations (Chen et al., 2020). Implied in the use of CAHPS is that healthcare leaders will implement the 2appropriate measures to ensure that every patient receives a satisfactory visit.

The PPACA outlines the requirements for healthcare leaders to create provisions that include improved patient satisfaction and quality reporting. Measurement sets rely on clinician communication, technology, type of care and services, and patients' engagements with staff (Lee, 2019). Patient satisfaction ratings guide quality improvement efforts by holding healthcare leaders accountable to the patients and communities served (Larson et al., 2019). Patient experience measures and reporting give patients a voice regarding the care received to improve patient and actionable physician feedback (Golda et al., 2018). The CAHPS provides healthcare leaders with direct insight into the patients' experience and may offer recommendations to improve service, quality, and care.

CAHPS, supplies feedback to leaders, usually related to service, quality, care, and facility appearance. The CAHPS is a way to solicit patient involvement to make improvements and keep a significant patient base. CMS originally developed the HCAHPS, a national standardized patient satisfaction tool used to incentivize value-based care and patient satisfaction (Dottino et al., 2019). The CGCAHPS, created later, measures the quality of healthcare from the patients' perspective based on personal experiences with the physicians and clinical staff (CMS, n.d.). The CAHPS follows principles that reliably access patient experiences based on standardized questions and protocols to ensure that data are comparable across diverse healthcare settings. The CAHPS is CMS's effort to improve healthcare in the U.S., and healthcare leaders use the data to ensure a better quality of care from the moment the patient enters the healthcare organization.

CMS uses the CAHPS to survey patients about a recent healthcare experience, randomly. Patient's perception of care influences reimbursement for clinicians (Lindsay, 2017). Clinicians who demonstrate high patient satisfaction through patient-centered care receive reimbursement from CMS at a higher rate for improved performance (Lindsay, 2017), making healthcare more patient-centered with a value-based, incentivized performance for physicians. Through the CAHPS, healthcare leaders can facilitate reflections and opportunities to improve patient care in addition to reinforce behavior changes amongst healthcare employees and physicians (Spinnewijn et al., in press). To practice healthcare transparency, to increase patients' participation by making the best decision for care, CMS publicly shares patient ratings of healthcare organizations and clinicians.

Through the CAHPS, patients now have a voice in healthcare to impose change and become active in the care received. Since the implementation of the Hospital Value-Based Purchasing (VBP) program, quality of care and patient satisfaction helps to determine reimbursement rates based upon using the results of the CAHPS (Lindsay, 2017). The CGCAHPS monitors patient satisfaction with healthcare visits (Adhikary et al., 2018), allowing individuals to rate the level of service received. Healthcare leaders and physicians seek the most efficient way to deliver quality care and patient satisfaction and improve outcomes to remain competitive (Lee, 2019). Poor patient satisfaction may create financial risk for healthcare leaders, increasing the need to improve patient satisfaction.

CAHPS are patient-reported outcomes, measured by experiences or perceptions toward the care and concern received. Many healthcare leaders have altered the organization's culture to supports individualized patient care and patient participation in care (Lee, 2019). Providing patient-centered care is essential to a high-quality healthcare system; therefore, establishing strategies that enhance patient experiences creates value for the healthcare organization (Lee, 2019). Healthcare leaders ask for patient reviews to change the organization's culture, thus meeting patient's need and keeping a high-level reputation for satisfaction, quality, and care.

The value-based program rewards healthcare providers with incentives for providing quality care to patients with Medicare to support improved care for individuals. Through the value-based program, clinicians receive incentives to provide better care for patients and communities and decreased costs to patients (CMS, n.d.). The value-based program allows for payments to providers based on the quality-of-care patients received instead of the number of patients the provider has seen (CMS, n.d.). Transitioning the focal point of a healthcare visit to the actual patient instead of the number of patients the physician sees may improve the patients' overall outlook of healthcare.

The CMS website shares the results of the CAHPS, allowing consumers and patients to review hospital ratings. The results of the CAHPS affect a percentage of the PPACA's hospital value-based purchasing program. A percentage of the program reimbursements results from the CAHPS scores, and these scores predict the compensation disbursed to healthcare organizations (CMS, n.d.). In addition to the value-based purchasing program, CMS currently withholds a percentage of Medicare payments

to healthcare organizations (CMS, n.d.). As CMS enhances the value-based purchasing program payments, healthcare leaders seek strategies to improve patient satisfaction to enhance the competitive advantage in healthcare (Lee, 2019). With the now continuous review of payments, the withholding of reimbursements will increase year after year. CAHPS results could affect the overall finances for healthcare organizations, including physicians' reimbursement through CMS. Physicians who provide average performance will not experience a change in pay, while physicians who perform below standards; or worse than average; will receive a decrease in payment. CMS shifted its reimbursement from the quantity of care to quality of care to lower costs for healthcare organizations and maintained sustainability (CMS, n.d.). The most significant bonus payment allowed to clinicians is equivalent to a percentage of Medicare fees (CMS, n.d.). The incentive is a method to improve patient care and quality, with better results for the healthcare organization.

CMS provides reimbursement for the number of services given to patients, and the quality of the service provided based on the patients' perception of care. Determining the quality of services given includes a review of the clinician, the administrative team, and the use of patient experience to determine reimbursement (CMS, n.d.). It uses the value-based payment system to reward healthcare providers for excellent care, with payments adjusted based on the patients' perceived quality of care (CMS, n.d.). Reimbursement for services provided aligns with the value-based payment system, indicating that patient visits must meet or exceed the patients' expectations if organizations receive maximum payments.

Through CMS reporting, healthcare leaders measure and evaluate how often a provider gives the best treatment and results. Healthcare leaders can assess the department's performance and implement changes to improve patient satisfaction using the results of the CAHPS. CAHPS findings also allow consumers to compare services and physicians using the CMS hospital compare website (CMS, n.d.) or Physician Compare website, and other hospital and academic health centers' websites made available for the public audience (Golda et al., 2018). The review of clinicians and services provides healthcare transparency for individuals to make healthcare decisions based on patients' perceptions of care received.

CMS launched the Hospital Compare database in 2005. Consumers use the database to inform consumers and patients about individual physicians and the healthcare organizations in which the physicians work through patient reviews and feedback as reported through the CAHPS (CMS, n.d.). CMS encourages and empower patients to make patient care decisions using Medicare's compare tools (CMS, n.d.). The site provides information to consumers on the quality-of-care patients received from specific providers and support staff. Consumers can access the information they need to make informed decisions about healthcare and physicians (CMS, n.d.). The website also allows individuals to review information about patients' experiences, quality of care, complications, readmissions, deaths, and the value of care (CMS, n.d.). Healthcare leaders can draw upon patient reviews to ensure that individuals receive adequate care at every visit.

Many patient's perceptions begin the moment they enter the healthcare facility. Others develop positive assessments of quality service through ongoing communication with healthcare workers, who keep patients abreast of all aspects of treatment (P. Leonard, 2017). Patient's reported communication expectations show differences in how healthcare providers keep them informed (Grocott & McSherry, 2018). Research shows that an overwhelming proportion of patient complaints are related to interpersonal communication (Stewart, 2018). Patient feedback aids in understanding the needs and concerns of patients and improves communication between the patient and the clinician (Thornton et al., 2017). Addressing patient's concerns and providing adequate feedback in a prompt and efficient manner may improve the patient's perception of the healthcare organization.

Patient satisfaction is an intended result of the care patients receive at every visit. With the increase in awareness of CAHPS results, healthcare leaders are adopting transformational and innovative processes to improve patient satisfaction (Delaney, 2018). Healthcare is evolving into patient-centered care, improving patient outcomes while holding healthcare leaders and clinicians accountable for quality services. Continuous improvement to patient satisfaction must include all aspects of the healthcare organization, which could otherwise result in poor reviews for the healthcare organization.

Compliance

The third strategy healthcare leaders use to improve patient satisfaction is to ensure compliance with CMS patient satisfaction regulations, thus minimizing financial

risk. To achieve compliance and reduce financial hardship, healthcare leaders look to build sustainable, resilient, cost-efficient, and value-based organizations. Insurers are enforcing physicians and other providers to deliver on the growing demand for value-based care and provide safe, high quality, and affordable care to every patient (Padilla, 2017). Value-based healthcare aligns with patient-centered care, patient satisfaction, and positive perception of care.

Value-based care has created a shift in healthcare delivery to patients, creating an environment of quality, safety, and transparency. Healthcare leaders acknowledge the need to shift delivery to a value-based system (Kanters & Ellimoottil, 2018). Value-based care allows for optimal use of resources that enabling physicians to improve healthcare outcomes at the patient, population, and care levels (Jani et al., 2018). Healthcare leaders who identify the interventions needed to increase value base care reflect a reduction in cost and an improvement in the quality of care (Xu et al., 2020). Value-based care ensures the patient is involved in healthcare decisions creating an environment of transparency.

Healthcare reform has created challenges for healthcare leaders. Under the PPACA, the healthcare culture has adapted to declining reimbursement rates, reduced research funding, and expectations of lower cost, higher quality from payers and insurers (Itri et al., 2017). The rising cost of healthcare creates ambiguity in the relationship between the quality of care and healthcare spending, resulting in an urgent need to strategize efficient payment methods that align with quality care and value (Resnick, 2018). The U.S. government is the largest healthcare insurance payer, providing coverage

to over 71 million individuals in the Medicare and Medicaid programs (Resnick, 2018). The goal of the Department of Health and Human Services is to have 90% of Medicare's fee-for-service payments linked to quality or value while favoring a transition to alternative payment models.

Various factors affect healthcare spending increases, and those factors include multiple factors associated with technology, spending, and quality of care. According to the Organization for Economic Cooperation and Development (n.d.), the estimated average annual expenditure on healthcare is $10,000 per U.S. citizen. Healthcare in the United States is the most significant expense in household consumption (Organization for Economic Cooperation and Development, n.d.). Reasons for the rising U.S. healthcare costs include medication cost, physician reimbursement, and a fragmented care delivery system (Owaid, 2017). The increase in Medicare enrollments contributes to the rise in healthcare spending sponsored by the federal, state, and local governments, with an expected increase of 47% by 2027 (CMS, n.d.). As the population grows, the citizens age and face illness; thus, the increasing cost of care could decrease patient care.

The need for healthcare insurance continues to rise as patients develop health issues and emergencies. Healthcare per capita cost in the United States is the highest among industrialized nations, Medicaid state spending in 2017 increase to 29%, up from 20.5% in 2000 (Emanuel, 2018). Access to health insurance is available to individuals who are employed (private insurance or marketplace), low-income (Medicaid), or over the age of 65 years (Medicare). Medicaid is a state-funded benefit with an inflation rate higher than any segment of the state budget (Emanuel, 2018). When an uninsured patient

seeks a physician's care, the healthcare organization may have to cover the cost of care. Although a patient with Medicare or Medicaid insurance receives care, healthcare reimbursement covers only a portion of the cost. Because many patients lack insurance coverage, healthcare leaders must rely on patients with private insurance to balance spending and investments for a sustainable fiscal model (Sowers, 2016). However, depending primarily on private insurance could create additional financial risk for healthcare organizations.

Improved incentive programs are a method to deliver safe, quality patient care by providing incentives to physicians. The Hospital Quality Incentive Demonstration, a voluntary CMS program from 2003 to 2009, became the model for the hospital value-based purchasing program established after the PPACA (Bonfrer et al., 2018). The hospitals that took part in the Hospital Quality Incentive Demonstration received financial incentives to improve quality, providing those hospitals with a competitive advantage (Bonfrer et al., 2018). Early evidence suggests that the hospital value-based program has had minimal impact on patient outcomes, including the hospitals that volunteered for the Hospital Quality Incentive Demonstration program (Bonfrer et al., 2018). Value-based care is a way to improve patient perceptions through the quality of care, healthcare transparency, and healthcare safety.

To transition to a value-based care plan, the Department of Health and Human Services moved most Medicare fee-for-service payments to other payment models. The moved models included bundled payments, accountable care organizations, and changing fee-for-service reimbursement based on patient experience, harm, and quality (Francis &

Clancy, 2016). Half of the payments made are through alternative payment models, such as accountable care organizations or bundled payment arrangements (Arnold, 2017). The implementation of the PPACA included many financial changes. The Medicare Disproportionate Share Hospital funding became available for uncompensated care payments after reducing in the percentage of uninsured patients in 2014 (CMS, n.d.). As the number of uninsured patients grows, the need for uncompensated care payments increases.

The fee for service compensation metric provides payments to physicians for services rendered for patient care. Using a value-based compensation metric, CMS makes payments based on the value of care each patient receives. The compensation metric for physicians replaces the volume of patients with the value of care provided to patients (Miller & Mosley, 2016). In 2019, Medicare implemented a replacement formula for physician payments (CMS, n.d.). The new method requires physicians to choose one of two ways to participate in the Medicare payment system (Miller & Mosley, 2016): the merit-based incentive payment system (MIPS) or the advanced alternative payment model (APM). Providers must participate in one of the programs in the performance year 2018 or will be subject to a 5% penalty in the payment year 2020 (Copeland & Woo, 2018). If the provider chooses not to participate in one of the programs in a performance year, the physician is subject to a payment penalty 2 years later (Woo et al., 2018). The method holds the physician accountable for participation and payments in providing safe and quality care to every patient, regardless of the number of patients seen.

The first value-based option includes MIPS which combines the physician quality reporting system and meaningful use into one program to provide physicians with a quality score. The higher the quality score, the higher the reimbursement rates. If the quality score stays at the set average, there will be no adjustment; if the quality score is below the set average, the Medicare payment will be subject to reduction or elimination (Miller & Mosley, 2016). Thus, value-based compensation metrics pose a further financial risk to the healthcare organization if their physicians do not meet the quality scores.

The MIPS uses a scoring system from 1 to 100. Physicians with scores between 3.76 and 14 will receive a negative payment adjustment of five percent in 2020 for the performance year 2018 (Woo et al., 2018). A score of 15 does not include a change. In contrast, a score of 16 to 69 earns a positive five percent adjustment and scores 70 and above qualify for an outstanding performance adjustment of a shared $500 million bonus among all exceptional performers (Woo et al., 2018). Four component categories make up the final score: (1) Quality of service provided equals 50% of the score, (2) advancing care information is 25% of the score, (3) Improvement activities are 15% of the score, and (4) Cost management is the remaining 10%. Each category is weighted and calculated differently and individually to the performance year 2018 and all performance years after that (Woo et al., 2018). The 2018 performance scores reflected an adjustment to the Medicare Part B payments in 2020 (Woo et al., 2018). 2019 was the first payment year for MIPS, bonuses or penalties were paid up to 4% to participating U.S. healthcare providers, by 2022 the payments will be adjusted up or down by 9% (Johnston et al.,

2020). As healthcare leaders adjust to the outcome of the adjusted annual payments, there may be a continuous change in the delivery of healthcare due to these requirements.

The second choice, the alternate payment model (APM), includes a medical group of physicians who take a lump sum of money to care for a specific group of patients. If the physicians provide care for the patient and meet specific quality metrics, the physicians can keep any money remaining from the lump-sum payment as set by the APM. The APM aligns with high-value services (CMS, n.d.). Participants in this model will receive a 5% bonus each year from 2019 to 2024, equal to the Medicare Part B payments (Opelka et al., 2018). In 2026, physicians will qualify for a 0.75% increase in payments every subsequent year (Miller & Mosley, 2016). The payment model can be beneficial to the healthcare leaders who support higher quality scores and patient satisfaction through the physicians' commitment to delivering quality care to every patient.

Like MIPS, the APM payments depend on reported quality measures with at least one outcome measure. The outcome measure includes 50% usage of a certified electronic medical record within the healthcare organization; if healthcare organizations cannot meet quality measures, they will assume the financial risk of monetary loss (Kuebler, 2017). Healthcare organizations with a productive population health model could achieve ample cost savings resulting in more increases in physician payments (Ali & Dinizio, 2018). The details of the APM model are still in the planning stages to ensure the APM model is fair for all clinicians and physicians.

Consumers' perception of the care received affects financial incentives for healthcare organizations. The CMS hospital compare website presents the results of patient experiences allowing consumers and patients to review the hospitals they are considering for care. The PPACA's hospital value-based purchasing program bases reimbursement on CAHPS scores, leading to unfavorable compensation or favorable reimbursement. In addition to the value-based purchasing program, CMS currently withholds three percent of the Medicare payments.

As CMS enhances the value-based purchasing program for payments, healthcare leaders seek strategies to improve patient perceptions of care. To adapt to the continuous changes of healthcare, healthcare leaders need to continuously pursue innovative processes to maintain sustainability (Persaud & Murphy, 2020). The value-based program rewards healthcare providers with incentives for providing quality care to patients with Medicare supporting improved care, better health for patients and the communities they live in, and decreased patient costs (CMS, n.d.). The value-based program allows for payments to providers based on the quality of the care patients received instead of the number of patients seen (CMS, n.d.). The value-based program provides incentives for physicians to focus more on preventative care and spending more time with patients.

Dedicated Leadership Skills

The fourth strategy named is the healthcare leader's role in improving patient satisfaction through dedicated leadership skills. Strong leadership plays a significant role in improving and supporting a patient-centered healthcare organization. As healthcare leaders adjust to healthcare reform, training and educating solid and dedicated leaders is

equally important to improve patient satisfaction and organizational financial health. Through solid leadership skills, the benefits of employee engagement and patient satisfaction may be limitless (Rotenstein et al., 2019). Hospitals with the highest performance levels have used transformational leaders who empower employees, build staff engagement in decision-making processes, and create an evenly distributed leadership team (Lee et al., 2019). Through transformational leadership, healthcare leaders may have the opportunity to foster new and improved processes and procedures for engaging employees and patients.

The healthcare industry is undergoing significant transformations through healthcare reform and the PPACA. Leaders need to develop practical skills to ensure a robust, teamwork-based foundation through those transformations, grounded on the principle that improving patient care and satisfaction is the organization's primary organizational goal. The greatest need is for healthcare leaders who are dedicated quality clinical care delivery (Kelly, 2021). To maintain validity, healthcare organizations must adjust to various elements of patient demand, including changes in leadership structure, culture, and goals (Peng et al., 2021). Transformational leadership has become a prevalent style across many industries, especially healthcare (Giddens, 2018). A transformational leader can positively influence change and job satisfaction, thus reducing clinical errors and creating an optimal workplace (Seljemo et al., 2020). Through the changes set forth by the PPACA, leaders with a strong focus on patient care and patient outcomes are allies in improving patient satisfaction, having the ability to lead the healthcare organization to improved patient satisfaction and financial stability.

Interest in transformational leadership has increased as the need for dedicated and focused leadership has grown and developed in diverse organizations, especially healthcare. Transformational leadership in healthcare influences organizational and individual outcomes to achieve the organization's goals through inspiration and excitement (Alqatawenah, 2018). As the healthcare industry faces ongoing reform, the organization's success relies on the capacity for change implementation (Spaulding et al., 2017). Healthcare requires providers to put the patient first while leadership requires providers to make decisions based on the business of healthcare (Bronson & Ellison, 2021). Creating a healthcare environment with a primary focus on the patient requires change agents with a record for improving service, care, and teamwork to meet the needs of all patients, as required by the PPACA.

Through the required healthcare reform changes, creating a strong leadership culture focused on patient perceptions and care is key to maintaining a solid healthcare organization. Engaged and robust leadership are invaluable traits in healthcare and crucial to the changes necessary for quality improvement. Transformational leaders establish trust with employees and emphasize the organization's goals creating an atmosphere empowered through growth and development (Asif et al., 2019a). Communicating and listening are the core of effective leadership, leaders with these skills can articulate the vision and goals of the organization to every employee within the organization, regardless of the position title (Sacks & Margolis, 2021). Healthcare leaders should clearly explain the goals; for change and the rationale behind those goals, launch a clear, concise vision of how the change will improve patients' overall care. The American

Institute of Medicine recommends transformation leadership as a leadership style used to create the highest-level work environment that focuses on patient safety and employee engagement (Seljemo et al., 2020). Leaders' and physicians' commitment to strengthening and improving patient care is critical to the healthcare organizations' initiatives (Bokhour et al., 2018). Leaders play a pivotal role in serving as a model for organizational goals and initiatives. Engaged healthcare leaders help to strengthen employees, which results in improved patient outcomes. Shared experience through open dialogue between leaders and employees further engages the employees and sets an example of transformational leadership.

In healthcare, the primary leadership styles are transformational and ethical leadership. Transformational leaders play a significant role in effecting the changes needed to improve patient satisfaction in healthcare organizations, exhibiting engagement and relationships with employees while encouraging to improve processes. Ethical leaders also contribute significantly to improving patient satisfaction by using employee's creativity to engage and employ teamwork methods. Leaders serve as role models of expected behaviors and encouragement within the healthcare organization (Walumbwa et al., 2017). The healthcare organization's success depends on the leader's ability to engage employees to meet or exceed the organization's goals. Leaders enable followers to work toward a results-driven goal, despite the challenges (Gilson & Agyepong, 2018). Through those challenges and uncertain conditions, and exemplary leadership, leaders gain a better insight into the healthcare organizations' areas of improvement. Engaged healthcare leaders contribute to improved patient satisfaction (Bruno et al., 2017).

Employees reach a sense of empowerment in learning, leading to a better outcome for the healthcare organization.

Leaders who exhibit transformational leadership skills fall into one of four dimensions, befitting the title of a transformational leader. The four dimensions of transformational leaders are leaders with influence, individualized or supportive leaders, inspirational leaders, and leaders who provide intellectual stimulation (Jambawo, 2018). Transformational leaders positively influence the work environment and reduce adverse clinical events (Seljemo et al., 2020). Leading by example, motivation, and empowerment to work toward organizational goals is a hallmark of this leadership style. Transformational leaders show the skills needed in healthcare to implement and change processes, cultures, and patient care to improve patient satisfaction and the financial well-being of the healthcare organization.

Transformational leadership promotes employee engagement as a tool to meet organizational goals. Transformational leadership is an instrumental skill in healthcare. Crucial for boosting employee satisfaction, recognizing near-miss patient errors, and successful conflict resolution (Lee et al., 2019). Transformational leaders can encourage, convince, and motivate followers to challenge the current processes or usual ways of enriching innovative behaviors (Ng, 2017). Change is constant in healthcare; as such, leaders play a vital role in assuring employee engagement and quality patient care.

Another essential leadership skill often used by healthcare leaders is ethical leadership, promoting moral and equitable behaviors, employee creativity, and innovation (Duan et al., 2018). The characteristics of ethical leadership include fostering principled

and respectful practices for human dignity (Barkhordari-Sharifabad et al., 2017). Ideally, a leader who exhibits both transformational and ethical leadership skills ensure adherence to the people aspect of the organization. The practice of ethical leadership improves overall confidence in leaders and employees, thus increasing patient satisfaction and employee engagement. Healthcare warrants ethical leadership to empower employees to reduce conflict and misconduct with one another and patients (Walumbwa et al., 2017). Ethical leaders ensure the highest moral behaviors while implementing accountability tools to improve patient satisfaction and employee engagement.

Understanding the importance of transformational and ethical leaders and what these leaders can provide a healthcare organization is crucial for building a strong organization with positive results. Support for transformational and ethical leaders is vital for healthcare organizations to ensure that every patient and employee receives, has access to, and provides quality healthcare (Jambawo, 2018). Under the PPACA recommendations, leaders must develop and expand teamwork and support a robust, healthy work environment to continuously improve patient care and optimize performance (Geraghty & Paterson-Brown, 2018). With transformational and ethical leaders, employees engage in patient care and have a sense of responsibility to the healthcare organization to meet the needs of patients. Employees should be familiar with the leader's leadership styles and feel trusted and valued while supporting the needs of the organization and the leader (Purwanto et al., 2020). Establishing a culture of transparency builds trust among the teams, and a commitment to the leaders and the overall goal of the organization. Transformational leadership styles positively affect the

organization's performance (Purwanto et al., 2020). Top leaders (e.g., Chief Executive Officers) influence employee job satisfaction and improved job performance to implement change initiatives (Asif et al., 2019a). Transformational leaders lead with change through influence and engagement; ethical leaders lead through sincere beliefs and behaviors that promote creativity and risk-taking (Duan et al., 2018). Both styles of leaders focus on engaging employees, either through influence or creativity, supplying support and guidance for employees to be part of the organization's overall goal, either through creative ideas or engagement through personal development.

The American Nurses Credentialing Center of the American Nurses Association Magnet designation recognizes transformational leadership as a key leadership principle in guiding and improving healthcare leadership. The recognition of transformational leadership as a principal part of nursing and healthcare leadership encourages leadership in the reform of healthcare (Lee et al., 2019). Healthcare leaders who invest in the clinical team and quality service receive Magnet designation recognition, showing the highest level of nursing care quality (Tubbs-Cooley et al., 2017). Leaders who create and promote a supportive, professional, innovative Magnet designation environment foster quality improvements and healthcare excellence (Pabico & Graystone, 2018). The prestigious Magnet designation further supplies advanced quality measures that reflect the healthcare organization's status for leadership and quality throughout the United States.

Quality improvement plays a significant role in the changes in healthcare, allowing patients to feel confident in the treatment received. Effective leadership must

continuously learn through adaption and innovation in the changing environment (Persaud & Murphy, 2020). Patient safety, clinical effectiveness, and patient satisfaction are critical components of quality healthcare (Kumar & Khiljee, 2016). Leaders who focus on quality seek to improve upon and learn the most effective methods for quality improvements tailoring the changes to the needs and resources of the organization (Sandberg, 2018). Patient satisfaction has started a charge in healthcare leadership as a partnership with patients and building and encouraging employees a call to action in healthcare organizations (Wolf, 2017). Through strong quality measures and accountability practices, leaders can keep patient care as a primary focus for all employees.

Through dedicated leadership, healthcare leaders can create better health outcomes for patients by engaging physicians and patients jointly to improve the quality of care of every individual. Understanding the needs of patients means including patients in the decisions related to their care. Embracing patient satisfaction in healthcare is a critical indicator of the need to set up strategic plans and goals to provide a better quality of care by understanding the needs of patients (Batbaatar et al., 2017). Implementing patient satisfaction interventions may improve patient perceptions through compassionate care and dedicated healthcare leaders who seek quality improvements and financial stability for the organization.

The purpose of this qualitative single case study was to explore the strategies healthcare leaders use to improve patient satisfaction. Researchers have presented consistent information relative to the CAHPS and quality care, with many scholars

addressing patient satisfaction worldwide (Batbaatar et al., 2017). There is a need for more rigorous research to identify effective interventions to improve patient satisfaction in healthcare.

Transition

In Section 1, the goal of this study was to explore strategies healthcare leaders used to improve patient satisfaction. Section 1 of this study included (a) the Foundation of The Study, (b) the Research Questions, (c) the Assumptions, Limitations, and Delimitations, and (d) the Significance of The Study. In the literature review, I explored the theory of caring, sustaining a culture of patient-centered care, understanding patients' needs, ensuring compliance, and supporting dedicated leadership skills. The foundation of the literature review included a discussion about the changes implemented by the creation of the PPACA and the role that patient satisfaction plays in healthcare organizations' financial viability. The problem statement and purpose statement included introducing the business problem and the case for further research. The literature review includes evidence that patient satisfaction in healthcare affects physicians and healthcare organizations. Further research will aid in the exploration of strategies to care for the whole patient, reduce healthcare costs, and improve patient satisfaction in healthcare.

In Section 2, I describe my role as the researcher. I focus on the methodology and design of the study, the participants, population and sampling, and ethical research. I will conduct a single case study by interviewing healthcare leaders who have successfully implemented strategies to improve patient satisfaction. My data collection and analysis plan include using interview data and reviewing one healthcare organization's archived

documents. The archived documents include patient satisfaction survey scores, leaders' notes, reports, standard operation procedures, reporting methods, training plans, and other documents related to improving patient satisfaction. I used software to support my findings and documentation.

In Section 3, I include a detailed description of the presentation of the findings, application to professional practice, and social change. The implication for social change includes investigating healthcare leaders' practices to improve patient satisfaction in healthcare. Healthcare leaders can use the findings from this study to improve patient satisfaction and the financial performance of healthcare organizations. The results of this single case study may create an awareness of the need to establish effective strategies to improve patient satisfaction in all healthcare organizations. I close Section 3 with recommendations for action for further research and reflections of the study.

Section 2: The Project

In Section 2, I describe the data collection process for the project. I discuss the purpose of this single case qualitative study, the role of the researcher and participants, and the research method and design. I reviewed data collection, data organization, and data analysis processes. Section 2 concludes with the importance of ethical research and steps I took to ensure reliability and validity of the study.

Purpose Statement

The purpose of the proposed qualitative single case study was to explore strategies healthcare leaders used to improve patient satisfaction. The target population included leaders of a healthcare organization located in metropolitan Detroit, Michigan who have successfully implemented strategies that improved patient satisfaction. The study could influence the way healthcare leaders address patient satisfaction and patients' perceptions of service quality, resulting in improved outcomes for patients and their families.

Role of the Researcher

In my role as the researcher, I selected participants and established relationships with them, worked to eliminate internal personal bias, and conducted interviews, reviewed archival documents, and reviewed databases for data collection. My role was to act as the primary data collector, ensuring validity, reliability, and prevention of any bias that hindered honest and fair data collection (van den Berg & Struwig, 2017). As the researcher and primary data collector, it was my responsibility to collect data to ensure reliability and validity. I had a limited professional networking relationship with each

participant as well as work experience within a healthcare organization. Because of healthcare networking events, limited preexisting relationships with each potential participant existed. I expected each participant to provide information about implementing successful strategies to improve patient satisfaction.

As the researcher, I am knowledgeable about patient satisfaction because I am a leader within a healthcare organization that has implemented strategies to improve patient satisfaction. As a leader, it is my responsibility to ensure that every patient receives quality care and service at every visit. I am also familiar with the topic because of my previous work experience within a healthcare organization that implemented strategies to improve patient satisfaction. Improved patient satisfaction is a daily commitment because decreased patient satisfaction based on the CGCAHPS and HCAHPS results can harm the profitability of healthcare organizations not meeting established targets. Inspired by my background in this study, I sought to understand healthcare organizations' social and financial obligations and the role that patient satisfaction has. My work involving patient satisfaction has led to the development of the research question.

Applying ethical standards in research is the researcher's responsibility, as is upholding honesty and transparency in the study (Cumyn et al., 2018). As the researcher, I did my best to eliminate bias and ethically collect and report data that aligns with *The Belmont Report*. *The Belmont Report* provides guidance for researchers to follow and ensure the ethical treatment of human participants (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). To ensure that I acted according to the tenets of *The Belmont Report*, I ensured respect for each

participant by providing informed consent forms, assessing risks and benefits of the project, and ensuring that each participant received fair treatment during research. To protect participants, I followed guidelines in the National Institutes of Health training course Protecting Human Research Participants.

To ensure the validity of the study, I developed processes to mitigate potential bias. Implementing implicit and explicit bias mitigation techniques is essential to mitigate bias (Babcock et al., 2016). Bias can directly and adversely impact quality of the study, as results of an investigation can be invalid if the researcher does not account for potential biases (Dunn et al., 2016). To mitigate bias, I acknowledged and set aside my perceptions and opinions regarding the topic.

I avoided viewing data using a personal lens via my data collection practices and member checking. Member checking is a necessary process used by researchers to help mitigate bias (Birt et al., 2016). Researchers use member checking to ensure that data reflects participants' views (Fusch & Ness, 2015). To mitigate bias, I audio-recorded interviews, transcribed interview responses, and then followed up with participants using member checking. Throughout interviews, I used an interview protocol to facilitate discussions and reduce bias.

I used an interview protocol to mitigate personal bias. An interview protocol can strengthen the reliability and quality of collected data from participant interviews (Castillo-Montoya, 2016). Interview protocols use core components to ensure that the collection of data is consistent. The core components of interviews include (a) establishing rapport with interviewees, (b) establishing ground rules for the interview,

and (c) using open-ended questions (Navarro et al., 2019). I used this interview protocol to collect data consistently and avoid bias (see Appendix). I established a neutral disposition during interviews with participants to ensure mitigation of bias.

Participants

The study included individuals who successfully implemented strategies to improve patient satisfaction. To gather meaningful data, researchers choose participants with knowledge of the research topic (Grafton et al., 2016; Newton, 2017). Identifying effective recruitment processes enables efficient and prompt data collection (Marks et al., 2017). To gain access to participants, I sent an email to the vice president of human resources. In this email, I explained my study and the data collection process. I requested access to healthcare leaders within the organization who implemented patient satisfaction strategies. Once I received approval for access to healthcare leaders from the vice present of human resources, I documented permission with letters of cooperation. The letter of cooperation included steps for participant selection, interviews, data collection, the member checking process, and voluntary and confidential practices of the study. After obtaining consent to collect data, I identified leaders who successfully used strategies to improve patient satisfaction.

Upon receipt of the signed letter of cooperation and participant contact information, I established working relationships with research participants. I contacted them using email invitations to participate in my study and continued our relationship through the interview process.

Research Method and Design

In this subsection, I discuss the qualitative research method and why I selected this method for my study. I then describe the qualitative research design, and reasons why the case study design was the most appropriate design for my study.

Research Method

There are three research methods for the study. The three research methods are qualitative, quantitative, and mixed methods (Yin, 2018). I employed the qualitative approach to explore strategies healthcare leaders used to improve patient satisfaction by gathering information from participants and interpreting findings. Researchers use the qualitative method to present information related to the study through interviews and data collection (Hewitt & Pham, 2018). The qualitative approach involves understanding perceptions through interviews and data collection (Cypress, 2017; Vass et al., 2017). The qualitative method was most appropriate for this study as I conducted interviews and data collection related to strategies used by healthcare leaders.

The quantitative approach requires close-end questions and involves testing hypotheses (Barnham, 2015; Saldaña, 2015). Hypothesis testing and analysis of variable relationships or differences was not a requirement to address the purpose of this study. The quantitative method involves measurable and quantifiable data (McCusker & Gunaydin, 2015). For this study, measurable and quantifiable data were not relevant; therefore, the quantitative approach was not appropriate for this study.

Mixed methods research includes both qualitative and quantitative data (Tillman et al., 2011). Researchers use the quantitative method to measure data and describe

aspects of a phenomenon (Morse, 2016). The mixed methods design was not appropriate for this study because I did not collect and analyze quantitative data.

Research Design

Researchers use one of four research designs to develop their research. The four research designs considered for this qualitative study were: (a) ethnography, (b) phenomenology, and (c) case study. After considering the four qualitative study designs, I selected a single case study research design.

Researchers use the ethnography design to focus on a cultural group and its values, behaviors, beliefs, and language through participant observation and documentation in natural settings (Anderson et al., 2014; Walliman, 2017). Researchers use the ethnography design to study participants and understand their culture (Garson, 2017). I selected a single case study research design after considering the three qualitative study designs. The ethnography design was not appropriate for this study as this study does not involve exploring a cultural group in a natural environment.

Researchers use the phenomenological design to highlight an event or phenomenon in terms of bringing together experiences, assumptions, and perceptions based on spoken or written accounts of personal experiences related through participant observations, interviews, and discussions (Anderson et al., 2014). Researchers who use the phenomenological design research experiences of participants in real life settings Lien et al., 2014). The phenomenological design was not appropriate for this study because this study is not about an individual participant's personal experiences with the phenomenon.

Case study researchers seek to conduct empirical explorations of phenomena within a real-world context bounded by time (Yin, 2018). Researchers who use the case study design seek to explore intricate research issues through a broad scope (Harrison et al., 2017). The case study design was most appropriate for this study because I explored a phenomenon within a real-life context. The case study design allowed me to gain insight into best practices to improve patient satisfaction in healthcare organizations.

Using extensive data collection techniques, I analyzed data from interviews, archival documentation, and CMS data from the hospital compare website. To achieve data saturation, the researcher must exhaust all available data (Fusch & Ness, 2015). I continued to interview healthcare leaders until no further information appeared, and I identified all themes and achieved data saturation. I conducted a rigorous study by gathering enough data through semi-structured interviews via member-checking, archival document reviews, and qualitative data obtained from the CMS hospital compare website to ensure data saturation.

Population and Sampling

The target population for this study was healthcare leaders (vice presidents and directors). The population is the information source from which the sample emerges (van Rijnsoever, 2017). For this study, each participant held a director or vice president position within a healthcare organization that used successful strategies to improve patient satisfaction.

The sample aligns with the purpose of the study and reflects the specific phenomenon that occurs with the target population. In qualitative research, sample sizes

tend to be smaller and include data-rich results based on interview questions (Vasileiou et al., 2018). The proposed sample size of this study was five healthcare leaders.

Using purposeful sampling, I selected participants who met criteria for participating in the study. Researchers use purposeful sampling to research quality data that relates to the phenomenon (Palinkas et al., 2015). Purposeful sampling helps in terms of identifying participants for information rich cases (Etikan et al., 2016). As purposeful sampling subjects, participants provided rich and unique data. Purposeful sampling was appropriate for this study because with the information rich data that purposeful sampling identifies, an in-depth understanding of the research.

Participants successfully implemented strategies to improve patient satisfaction as members of the senior leadership team. Participants had awareness of patient satisfaction scores, as reported in the CGCAHPS and HCAHPS. Focusing on participants that met criteria aided with relevant research. I collected data using interviews, archival documentation, and the CMS hospital compare website. In conducting interviews and reviewing archival documents from the healthcare organization, I ensured there was no new data, and no new themes emerged from collected data after reaching data saturation. I conducted interviews and member checking through virtual conference meetings. Meetings offered ample time for me to conduct thorough interviews. I requested archival documentation for review from participants during interviews. I reviewed the CMS hospital compare website to obtain the healthcare organizations CMS star ratings, which is comprised of 64 hospital quality measures categorized into 7 specific groupings: patient experience, mortality, safety of care, readmission, timeliness of care, effective

care, and use of medical imaging (CMS, n.d.). I reviewed the hospital compare website to get insight of the healthcare organization's overall patient satisfaction results.

Ethical Research

As the researcher, I am responsible for obtaining and presenting accurate information. To ensure credible research, participants received and signed informed consent forms that included the purpose and nature of the study, participant privacy and confidentiality, voluntary participation, and right to withdraw. Each participant reviewed and acknowledged consent (see Appendix) before participating in interviews. The informed consent form included the nature and purpose of the study, participant criteria, voluntary participation, confidentiality guidelines, and the role of participants.

For this study, if participants wished to withdraw from the study, they could do so by contacting me by email or telephone expressing the desire to withdraw from the study without explanation. In research, participants have the right to withdraw from the study at any time by requesting removal of data (Kaye et al., 2015). There were no consequences if participants chose to withdraw from the study at any time. There were no incentives for participating in the study.

I kept all collected data on a password-protected external flash drive used for the exclusive purpose of conducting this study and stored in a safe for a minimum of 5 years to protect confidentiality of participants and healthcare organization. After 5 years, I will discard data on the flash drive by deleting it to protect confidentiality. Walden University's Institutional Review Board (IRB) approval number for this study is 04-02-

21-0551963. To ensure ethical protection, each participant received a unique numeric identifier from P1 to P5, and the healthcare organization remained confidential.

Data Collection Instruments

As the primary data collection instrument of this qualitative single case study, I conducted semistructured interviews and reviewed archived organizational documents to discover underlying themes. As the data collection instrument, the researcher must collect rich data and draw meaningful insight (Moon, 2015; Xu & Storr, 2012). The quality of the data collected relies on the data collection instrument, the researcher's ability to objectify and measure phenomena (Sutton & Austin, 2015; Xu & Storr, 2012). As the primary data collection instrument, I collected quality data objectively.

I collected data through semistructured one-on-one virtual conference interviews that included open-ended questions using an interview protocol (see Appendix) to guide the discussion. I followed the interview protocol to ensure interviews remained on track. In addition to conducting semistructured interviews, I asked participants to share organizational documents relevant to improving patient satisfaction. Archival documentation review is a process of collecting data from preexisting records (Pacho, 2015). The archival documentation review included reports, survey results, workflow, and process improvements that may highlight specific strategies used by healthcare leaders.

To improve the reliability and validity of the study, I used the interview protocol, which included the interview questions and member checking processes to ensure accurate data collection that validates each participant's interview. Member checking

allows the participant to review, comment, and approve the interpretations of the discussions, increasing the accountability and credibility of the research (Birt et al., 2016; Naidu & Prose, 2018). I summarized my interpretation of each interview response into a Microsoft Word document. I shared the synthesis of the interviews and member checking with each participant to ensure an accurate understanding of the interview responses.

Data Collection Technique

The data collection techniques that I used in this study included the data collected during the virtual semistructured interviews lead with open-ended questions, archived documents from the healthcare organization, and data collected from the CMS hospital database. Methodological triangulation in my study included three data collection techniques: virtual semistructured interviews, archival document review, and data from the CMS hospital compare website.

Semistructured Interviews

I collected data for the study by conducting semistructured video conferencing interviews using WebEx, one participant at a time, that included open-ended questions using an interview protocol (see Appendix) to guide the conversation. I emailed and introduced myself to the participants with an invitation to take part in my research study (see Appendix). Each interview that I conducted was audio recorded with the participant's consent as disclosed in the informed consent form (see Appendix). Using an interview protocol aids with the transparency and accuracy of the research to reduce bias (Galdas, 2017; Heydon & Powell, 2018; Wright et al., 2018). I created the interview questions to ensure the alignment of the purpose statement, the problem statement, and

the research question. I created the interview protocol to ensure that the conversations in the interviews remain on track and consistent with the research question. During the interviews, I kept a notepad to document nonverbal behavior, expressions, and other nuances not captured by the audio receiver. I audio recorded the participant interviews using WebEx video conferencing and one device for backup for technical difficulties. The backup device that I used was an iPhone 6s.

Upon reviewing the details of the study with the healthcare organization's leadership and receiving the signed Letter of Cooperation in agreement to allow the participation of five healthcare leaders, I sought to obtain archival documentation from the healthcare leaders. The archival documentation included patient satisfaction survey scores, leaders' notes, reports, standard operation procedures, reporting methods, training plans, and other documents related to improving patient satisfaction. The semistructured interviews include beginning each interview with the informed consent form outlining the participants' confidentiality, rights, and my contact information to reduce bias and address any questions or concerns from the participants.

Upon completing of the interview questions (see Appendix), I scheduled the 60-minute virtual conference member checking interview and confirmed the contact information for the participants. I ended the interview process and thanked the participants for their time. I again provided my contact information for follow-up questions and any concerns that the participants may have. I thanked each participant for their time. I turned off the audio recorder and concluded the interview. During the scheduled virtual conference member checking interviews (see Appendix), the following

steps took place: I turned on the audio recording device and noted the date and time of the interview. I began the 60-minute member checking virtual conference interview and ensured that the participants did not have any questions or concerns before starting the interview. I explained to the participants that the focus of the member checking interview was to confirm my interpretation of the interview responses and address any modifications to my variations of the interview.

The data collection technique, semistructured interviews, has disadvantages and advantages. A disadvantage of semistructured interviews includes the participants may feel discomfort with the interviewer and provide vague answers, maximizing the interviewer's influence in the research. Another disadvantage of semistructured interviews is timing; the participant's schedule is not conducive for the interviewer, potentially affecting the number of qualified participants for the study (McIntosh & Morse, 2015). The researcher’s responsibility is to conduct unbiased research, which includes fair ethical treatment and may also include flexibility with participants to meet the needs of the research study.

An advantage of semistructured interviews includes the use of video conferences for the interviews. Video conference interviews offer flexibility and established control of the interview (Heath et al., 2018). Through video conference interviews, the interviewer can capture both verbal and nonverbal cues from the participants during the interview to help the interviewer identify any moments of discomfort or excitement during the interview.

Archival Documentation Review

I analyzed and reviewed archived documents from the healthcare organization's planning and implementation of best practices to improve patient satisfaction for data collection. Archival documentation review entails considering historical, present, and future data (Moore et al., 2016). The process of archived documentation review includes perusing the leaders' notes, patient satisfaction scores, and other material related to the improvement of patient satisfaction within the healthcare organization. An advantage of using archival documents includes understanding the healthcare organizations' business practices as related to patient satisfaction. Data analysis of the archival documents could produce the analysis of the data with one or more documents (Moore et al., 2016). A disadvantage of data collection of archival material is that some documents may be confidential. Another disadvantage of using archived documents includes lost, destroyed, or damaged documents (Patil & Karandikar, 2016). The request for archived documents may prove to be a challenge for the researcher if the healthcare leaders do not keep the records, resulting in further research to enhance the reliability of the data collection instrument.

CMS Hospital Compare Website

The review of the CMS hospital compare website served as a data collection technique that provided a global insight into CMS ratings of the healthcare organization and the patient perspective of the healthcare organization and the clinical care teams. CMS created the hospital compare website as a tool to provide consumers with insight into how well healthcare clinicians provide care to patients and the overall performance

of healthcare organizations by comparing each to other healthcare organizations and clinicians. The hospital compare website is a consumer-based website that provides prospective patients with data collected from 6 publicly reported quality domains (1) HCAHPS and CAHPS patient experience surveys, (2) readmission rates and deaths, (3) timely and efficient care, (4) complications, (5) use of medical imaging, and (6) payment and value of care for individual healthcare organizations through a quality rating system (CMS, n.d.). The rating system provides consumers with quality-of-care measures and data to help consumers make an informed decision about physicians, health plan coverage, and the overall healthcare organizations.

The advantages of reviewing the hospital compare website include an overall view of the healthcare organizations rating with CMS and the use of the star system to rate the organization and the patient's perception of the healthcare organization. The disadvantage of reviewing the hospital compare website includes the in-depth data related to medical imaging and death. The inclusion of multiple quality domains into the overall star rating does not benefit the patient (Hu et al., 2017). Another disadvantage includes the inability to confirm if a patient decided to see a physician based on the hospital compare website. Consumers may choose a healthcare organization or physician based on recommendations from other physicians, family, or friends, making it impossible to determine if consumers use the hospital compare site (Blake & Clarke, 2019). The data used to score and rate healthcare organizations and clinicians may not entirely reflect the patient's perception of care and improved patient satisfaction.

Member Checking

Member checking entails a follow-up interview with participants to ensure the interpretation of the interview responses is correct. Participants confirm the validity of the interview during member checking (Caretta & Pérez, 2019). Through member checking, participants review and identify any gaps or inconsistencies in the data (Yang et al., 2018). Member checking provides further opportunities to build accountable, trustworthy relationships with the participants and obtain more insight from leaders that might enhance the research (Caretta, 2016; Harvey, 2015; Iivari, 2018). Through member checking, the interview participants play an active role in the study and establishing trustworthy relationships will help ensure that the interpretations are accurate. I conducted virtual follow-up interviews with each participant to ensure the prompt completion of member checking (see Appendix).

Data Organization Technique

I began drafting my interpretations in a Microsoft Word document, which I saved and imported into NVivo and a flash drive for backup. I discussed my interpretations of the interview responses with the participants for member checking. Upon the healthcare leaders' approval of my elucidations, I progressed to data coding and NVivo. NVivo will allow me to manage the collected data. NVivo is a qualitative software program used to facilitate and simplify data analysis (Røddesnes et al., 2019). I saved and scanned all physical documents as Adobe Acrobat files for importing into NVivo. To ensure the data accuracy and confidentiality, I created coded folders for each interviewee to protect each participant's confidentiality. I scanned the consent form into each participant's folder. I

interpreted the interview using Microsoft Word, then added the interpretations to each participant's coded folder. I kept track of raw data by cataloging and labeling the data by participants. I documented my understanding of the interviews and saved the audio recordings to the participant's folder. I used a reflective journal for recording my notes of the interview to reference any physical observations in the interview with each participant. The reflective journal will reflect the interview details, handwritten with the date, time, location of the interview, and the participant's number identifier to safeguard each participant's identity.

I transferred and securely stored all hard copies of the documents collected on a password-protected flash drive. I secured the flash drive in my personal safe for a minimum of 5 years from the interview date to protect the identities of the participants and the healthcare organization. After 5 years, I will destroy all documents and materials associated with the study as per the Walden University IRB requirements.

Data Analysis

I used methodological triangulation by conducting multiple interviews and reviewing additional documentation and data to align with the data analysis process. The use of triangulation in case studies ensures the reliability of the study and increases understanding of the phenomenon (Farmer et al., 2006). The four types of triangulations are: (a) methodological triangulation, (b) investigator triangulation, (c) theory triangulation, and (d) data triangulation (Bruning et al., 2018). Methodological triangulation includes using multiple types of collected data, including interviews and review of archived documents (Bruning et al., 2018). I used three data sources to ensure

data saturation, virtual interviews, archival document review, and the CMS hospital compare website. I followed Yin's (2018) five-step process for data analysis. The five steps are: (a) compiling the data related to the research question, (b) disassembling the data to determine data techniques, (c) reassembling or organizing the data, (d) interpreting the data, and (e) concluding the data.

Yin's Five-Step Data Analysis

Compiling

The compiling phase includes reviewing the field notes, recordings, and other data sources (Yin, 2018). The first step of the five-step process was collecting and compiling data from the semistructured interviews and documentation review, reflecting the patient satisfaction data from the most recent 5 years (2017-2021) provided by the healthcare leaders. I reviewed the documents provided older than 5 years, as the documents provided additional historical data. I analyzed the interview data obtained from the semistructured interviews, and I looked for repetitious terms and keywords, universal themes, and unfamiliar vocabulary. I broke down the data collected into specific details to determine how the data may answer the original research question. With the collection of detailed data, I began to organize the data into relevant elements to the study and started interpreting the collected data into the research. I referred to the literature review to correlate the emergent themes with the conceptual framework.

Disassembling

The disassembling phase may result in the reduction of data (Yin, 2018). During this phase, I looked for patterns of common themes while analyzing the audio recordings

of the interviews and the journal notes collected during the interviews. I coded the words into categories seeking emerging theme identification.

NVivo allowed me to find patterns in the data collected upon completion of inputting the data into the program to conduct the coding process. The emerging themes identified during the disassembling phase provided meaning and value to the case study. After coding, I analyzed the data and included any additional codes and themes to the current list of articles.

Reassembling

During the reassembling step, I reassembled the data and categorized the data into a broader theme. I grouped the data to identify any conflicts or similarities in the data to find emerging themes. When making decisions during this step, comparisons should continue with other patterns or themes (Yin, 2018). Utilizing NVivo to arrange and sort data aided with organizing the data into specific themes.

Interpreting

After reassembling the data to find any related patterns and themes, I completed data interpretation. I interpreted the data using the central research question. Interpreting data includes complete, accurate, fair, and credible research (Yin, 2018). Interpreting data should be broad regarding terms of the relationships and global findings in the data (Castleberry & Nolen, 2018). I interpreted the data while keeping my focus on the themes of the study.

Concluding

The last step of Yin's five-step data analysis, concluding, entails presenting the study results. The interpreted data becomes the findings of the study (Castleberry & Nolen, 2018). The conclusion of a study provides suggestions for future research (Yin, 2018). I concluded the investigation by confirming my findings while eliminating bias, achieving data saturation, and accurately reporting the research study.

The software that I used for identifying emerging themes includes cross-referencing the data using NVivo. I created a matrix for each interview and use + and – to scale the statements by the respondents into distinct categories to gain an insight into the participant's role, views, and expectations of patient satisfaction. I focused on the key themes by interpreting, reviewing, and coding all the interviews using NVivo to identify the themes related to the research question.

I used the NVivo software program to aid with data collection. NVivo aided with identifying key themes from my transcribed data. NVivo is consistent with a complex and in-depth analysis of data (Castleberry & Nolen, 2018). The NVivo software allows the researchers to identify themes of codes (Castleberry & Nolen, 2018). I used NVivo to ensure the accuracy and efficiency of the data collected. I focused on an iterative process of reflecting on my thoughts about the themes, data, and information in the literature review.

I compared the themes from the study to the literature and the theory of caring. Upon comparing the themes, I then classified and coded the themes into categories that aligned with my research question. The key themes found and correlation to literature

helped me to better understand the successful strategies used to improve patient satisfaction in healthcare.

Reliability and Validity

Reliability and validity ensure that the researcher conducts verification of all study perspectives with rigor to reduce any subjectivity to the research. In qualitative research, the rigor of research is a necessary component to reach the reliability and validity of the study (Cypress, 2017). Reliability and validity imply trustworthiness in the study. Four concepts help the researcher to reach reliability and validity to ensure the rigor and trustworthiness of the research. The concepts include transferability, dependability, credibility, and confirmability. To accomplish the reliability and validity of this study, I conducted member checking and methodological triangulation.

Reliability

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Validity

I employed methodical triangulation to ensure the validity of the research using the interview and reviewing the healthcare system reports related to patient satisfaction. Validity in qualitative research depends on the purpose of the study and the methods used to address the threats to the validity of the study (FitzPatrick, 2019). The viewpoint of validity has some classifications, such as authenticity, trustworthiness, and quality assessment; establishing trust is the ultimate interpretation (FitzPatrick, 2019). Through the open dialogue with the healthcare leaders, the documents shared reflected authenticity and quality through the processes used to improve patient satisfaction.

I provided a rich, thick description of the data collected, including the interviews and archived documents, to enhance the transferability of this study. Transferability in research allows other researchers to determine if the findings of a study are valid or beneficial to the new research (Connelly, 2016). The researcher is responsible for providing detailed data of the research process to contribute to future research by other researchers who can transfer the results to their setting to ensure transferability (Korstjen & Moser, 2018). Through interviews, archived documents, and review of the hospital compare database, other researchers may find the data helpful in establishing processes to improve patient satisfaction in other healthcare organizations.

To ensure the confirmability of the study, I kept detailed notes, a reflective journal, and audio transcription of the interviews conducted documenting the research journey. Confirmability is the record-keeping of all data sources, sampling, and implementation of procedures (El Hussein et al., 2016). To reach confirmability in

research, other researchers' interpretation of the data confirms the data as accurate, verifiable data, and not as false or exaggerated (Korstjen & Moser, 2018). In a qualitative research study, researchers use confirmability to prove the researcher's unbiased perspective but that of the study participants (Korstjen & Moser, 2018). Through the recordings, reflective notes, and the reflective journal, I documented the details of the participants conversation and expressions making note of any positive or negative tones or responses.

As the researcher, I collected data until no new themes or data emerged. Data saturation in research confirms the thoroughness of the data collected (Carnevale, 2016). Data saturation occurs when all aspects of the research phenomena reach the maximum level of data collection, and any additional data will not contribute to the research (Carnevale, 2016). To support data saturation of my findings, I collected and analyzed data through interviews and member checking, followed by a review of documents.

Transition and Summary

In Section 2, I discussed my role as the researcher, I selected participants who successfully implemented patient satisfaction strategies and established relationships with them, I eliminated personal bias by using an interview protocol to ensure each participant received equal treatment before, during, and after the interview. I used methodological triangulation by conducting multiple interviews and my data collection instruments included reviewing archival documents and the hospital compare database while using Yin's (2018) five-step process to align with the data analysis process. I described and discussed the qualitative research method and designs and the methods that I selected for

the study. I discussed the application and meaning of ethical research. Lastly to ensure the trustworthiness of my study, I examined the reliability and validity of the qualitative research using member checking and methodological triangulation.

In Section 3, I include a detailed description of the presentation of the findings, application to professional practice, and social change. The implication for social change includes investigating healthcare leaders' practices to improve patient satisfaction in healthcare. Healthcare leaders can use the findings from this study to improve patient satisfaction and the financial performance of healthcare organizations. The results of this single case study may create an awareness of the need to establish effective strategies to improve patient satisfaction in all healthcare organizations. I close Section 3 with my recommendations for action for further research and my reflections of the study.

Section 3: Application to Professional Practice and Implications for Change

Introduction

This qualitative single case study involved exploring strategies healthcare leaders used to improve patient satisfaction. I conducted semistructured interviews with five healthcare leaders who successfully improved patient satisfaction within an organization in metropolitan Detroit, MI. Qualitative data analysis included interview transcripts and member checking. Upon checking primary sources, I reviewed secondary data sources, including patient satisfaction scores, policies, procedures, and accountability tools. I also reviewed the CMS hospital compare website to explore real-time patient perceptions of the healthcare organization.

In this section, I present findings of this study which include four major themes that indicated strategies healthcare leaders use to improve patient satisfaction. The four themes were (a) caring for patients through communication, (b) patient-centered care, (c) compliance through CMS patient satisfaction processes, and (d) leadership. I also considered applications to professional practice and the impact that patient satisfaction has on social change. I discuss my recommendations for further research, reflect on the doctoral study process, and conclude the study.

Presentation of the Findings

This section includes information regarding emerging themes from interviews. To conduct interviews, I used an interview protocol to explore the overarching research question: What strategies do healthcare leaders use to improve patient satisfaction? The population consisted of five healthcare leaders who have improved patient satisfaction

within their organization through training and education. The healthcare organization is in metropolitan Detroit, MI, and currently employs over 30,000 employees. To ensure the privacy of participants, I assigned each participant with an alphanumeric code (P1, P2, P3, P4, and P5) for identification. Mayeroff's theory of caring was the conceptual framework for this study. After analyzing collected data through interviews, I identified four themes: (a) caring for patients through communication, (b) patient-centered care, (c) compliance through CMS patient satisfaction processes, and (d) leadership. I discuss each theme in the following subsections.

Theme 1: Caring for Patients Through Communication

Establishing communication plans for staff and physicians to adhere to when caring for patients helps achieve patient confidence in the care team and organization. When communication with patients is purposeful, their anxiety levels tend to decline, improving their health and symptoms (P. Leonard, 2017). Providing patients with time frames in terms of when physicians are in the room, delays in care, or next steps helps improve communication between physicians and patients. To improve patient satisfaction, healthcare leaders implement workflows to enhance communication for patients from the time they enter the facility to when they leave. In some cases, clinician's follow-up with patients to ensure comprehension of any prescribed medication or the next steps for their next office visit.

Effectively communicating with patients plays a crucial role in ensuring that they feel satisfied and willing to follow their care requirements. Healthcare leaders implement training courses for employees and physicians to ensure that patients always receive

effective communication. Healthcare workers may improve patient satisfaction through effective communication, as it is related to the patients' perception of the care received.

All participants mentioned the implementation of training courses that outline communication with patients. Each participant provided examples of how effectively communicating with patients about wait times, care, balances, and overall outcomes improved their perception of their care and the healthcare organization. P1 said, "patients will tell us if they had a positive experience or a negative experience or an experience in the middle." When asked about patient experiences and outcomes since implementing training, P1 said, "constantly reminding them and educating them and really keeping it in the forefront." P2 said, "there are some things that we can do that will impact that entire experience." P2 also said, "once you break it down that simple, your staff realize, I'm talking to this patient at this moment, and I'm going to own it." P3 shared, "we meet all of the new employees every time they come in, and we're able to share the expectations of courtesy and respect and communication." P4 explained, "It's really about the reconnection and the trust that we have now with these patients that we see over and over again. Or patients that call us and know that they are going to get the assistance and the care that they need when they call our team." P5 explained, "We start the conversation once we validate and check the patient in, we will just start having a conversation with the patient, just being transparent with the patient. We always explain our why, what we are doing." Care provided to individual patients includes communication (Newnham et al., 2017). Participants spoke positively about communicating with every patient, what is

happening, why it is happening, and listening to patients concerns improves their outlook and perception of the healthcare organization.

Through the review of the participants' archival documents, the processes that the leaders created included, communicating with patients' information related to their appointment at the time of checking in for the appointment, such as delays, changes, or confirmations of upcoming appointments. Leaders are responsible for ensuring that employees provide proper communication to every patient using an observation scorecard. The observation scorecard includes a list of tasks that employees must complete with patients during registration. Another expectation set in the process guidelines that I reviewed in the archival document ensured proper transition of patients from one area of the facility to the next while informing patients of expectations during each step of the office visit. Documents included leadership observations to ensure that employees adequately communicate to patients. Leadership observations help create standardized processes, accountability, and ensures that employees meet expectations of healthcare leaders.

Archival documents shared by P1 included a standard operating procedure that included workflows and expectations for employees. This document included expectations of leaders to ensure that employees adhered to expectations of the standard operating procedure, greeting every patient, communicating any changes or delays, and thanking every patient for visiting. Through the standard operating procedure, leaders created a strong communication structure between the staff and set a clear expectation of the overall goal to improve patient satisfaction.

In reviewing the CMS hospital compare website, patients expressed mixed feelings about communication within the healthcare organization. Some patients felt that communication from the clinical team was sufficient and prompt, while other patients thought that communication was poor and inefficient. Upon review of the CMS hospital compare website, the results, as captured from the patient's perspective reflected that the communication between the employees and the patients were satisfactory to the patient, leaving the patient feeling cared for and appreciated. The best practices, standards for communicating with patients, used within the departments that receive positive patient feedback may prove to be beneficial to other clinics or hospital areas throughout the healthcare organization thereby creating a standard process for communicating and caring for patients.

In 2020, the healthcare organization experienced a decrease in overall patient perceptions of healthcare provider communication. Patients provided feedback regarding providers' communication in terms of their health ability to listen to patients carefully. Patients expressed concerns about timely communication of physicians and clinical teams as well as answering questions and providing feedback and physicians' awareness of patients' medical history and willingness to listen to concerns and overall needs.

Theme 2: Patient-Centered Care

As patient care has shifted to patient-centered care, many healthcare organizations changed their cultures to improve patient satisfaction. Healthcare leaders who implement a patient-centered care culture, create an environment that includes patients in their care decisions by ensuring that clinicians communicate with patients about their care, and

provide through education about care decisions. Healthcare organizations that practice patient-centered care tend to have improved patient outcomes, improved job satisfaction, and increased safety and quality care (Kuipers et al., 2019). Creating an environment where patients are partners with the healthcare team builds an environment of trust and respect.

All participants shared the healthcare organization's goals and the changes the healthcare leaders implemented to focus on patient-centered care. Some participants mentioned that there were new processes implemented within the organization to meet patients' expectations, such as leader rounding in the hospital and clinics to ensure patients feel heard and appreciated, creating a warm and inviting atmosphere by ensuring that the appearance of the hospital and clinics are warm and welcoming to everyone who enters the healthcare organization, and creating committees to ensure standard appearances and practices within the healthcare organization. Healthcare leaders' willingness to make continuous improvements to improve patient satisfaction reflects a culture of caring. P1 stated, "I want to understand what this great thing was that the registration person did and see if we can spread that across other areas so other patients can feel the same experience that the one patient felt." Patient satisfaction should start when the patient enters the parking lot or calls the healthcare organization to schedule an appointment. P2 said, "the patients were able to get the appointment time for the day that they wanted. They didn't spend a lot of time waiting for us to respond if they called us. I want to know; did that impact their satisfaction with our experience? I'm trying to understand just overall how these improvements impact our patient's satisfaction through

panel optimization." P3 expressed, "there are multiple strategies that we use to improve satisfaction, and the reason there are multiple strategies is that satisfaction goes across every aspect of our company." P4 shared, "we are working on the workflows across the organization that will impact patient satisfaction, because so often patients are scheduled for appointments many different ways, and there's never a discussion about if the patients are going to be impacted financially." P5 stated, "we have lean daily management where we will have all leaders round on the units, using plan, do, check, act around patient satisfaction." This healthcare organization holds each department accountable for patient satisfaction, starting with leaders who lead by example by setting standards for patient satisfaction.

In the review of the archival documents shared by P5, healthcare leaders created a governance council. The council includes leaders and employees who developed healthcare practice decisions focusing on safe and compassionate care and exceptional patient experiences. The council requires a 1-year commitment and consists of a chairperson, cochair person, and members. The council includes five focus areas: practice excellence, professional development, quality and safety, retention and recognition, and business operations. Council participants are expected to provide input and make decisions, as well as communicate the needs of individual employee teams and outcomes of decisions made by the council to employee teams in order to ensure that goals are achieved.

The governance council advocates for improved patient outcomes and employee engagement through shared decision-making; through the council, members review and

seek opportunities to improve patient care within the healthcare organization through discussions of clinical and administrative experiences affecting patients. Through the governance council, patient experiences are discussed and reviewed to improve outcomes and create an environment of patient-centered care through process improvements and accountability.

In reviewing the CMS hospital compare website, patients' satisfaction with the healthcare organization decreased based on the results of the CGCAHPS and HCAHPS. According to participants, in 2019, the results of the CGCAHPS and HCAHPS reflects patients were more satisfied with physicians' overall quality of communication and care as well as accessing appointments when needed. In 2020, the healthcare organization converted office visits to virtual visits. This added to patients' concerns regarding access to quality care. Many patients expressed discontent with virtual visits or lack of access to the Internet. Patients' inability to see physicians led to frustrations and negative feedback regarding lack of communication.

Theme 3: Compliance through CMS Patient Satisfaction Processes

The CMS makes many recommendations related to patients' type of health services, insurance payments and reimbursements for services rendered, and improving patient satisfaction. Through CMS recommendations, healthcare organizations must meet quality standards. Patient perception and feedback help determine ratings and reimbursement rates of healthcare organizations involving safety and quality of the healthcare organization and care received. The CMS uses multiple measures to rate hospitals and reviews them monthly as well as annually. Data collected by the CMS is

provided to patients to assist in making sound decisions about quality and safety of healthcare providers delivering care.

Through the HCAHPS and CGCAHPS, patients can provide feedback regarding care received while in the hospital or visiting a clinic for office visits. Patients can further offer feedback on care received and individual providers and physicians within healthcare organizations through the CMS hospital compare website. The CMS launched the Hospital Compare website to inform patients about healthcare organizations and physicians through feedback and reviews to empower them to make conscious decisions about patient care while encouraging competition between U.S. hospitals (Dor et al., 2015). The CMS rates healthcare organizations using a star rating system that involves patient satisfaction. Star ratings vary from one to five stars, with five stars being the best. The CMS created this rating system to provide patients with guides to hospital quality (Papageorge et al., 2020). Patient feedback is shared via the CMS hospital compare website to provide consumers with personal reviews from current patients. Through these websites and assessments, healthcare organizations can increase sustainability through patient recommendations and perceptions.

Participants in this study reflected upon CMS patient satisfaction processes and how their healthcare organization implemented strategies to improve patient satisfaction. Improved patient satisfaction within healthcare organizations positively impacts patients' health outcomes and increases the likelihood of patients recommending them (Simsekler et al., 2021). When asked, the participants spoke about the HCAHPS and the CGCAHPS and how each team reviews the patient experience, P1 said, "We keep it out there right in

the middle of everyone so that they can see how we're doing and be very transparent." P2 said, "there are some things that we can do that will impact that entire experience." P2 said, "patients will forgive the small details of the visit when provided with an experience focused on the individual patients." P3 shared, "likelihood to recommend is a target that we monitor; it's a metric that we utilize. CMS also monitors likelihood to recommend." P3 said healthcare leaders use audit tools such as leadership rounding to ensure that teams follow initiatives and ensure accountability for everyone. P4 shared, "I think that when you don't measure quality in a way that has a direct impact on both patients and colleagues in this instance, you leave a lot of opportunity on the table." P5 stated, "coming from the HCAHPS scores; it is kind of important to see where we can grow. You can see we have these metrics and targets, and we can see how we align with our competitors, and we can see how we rank nationally." Participants expressed the importance of the HCAHPS and CGCAHPS, reviewing patient comments, and sharing data with their teams to ensure everyone is involved with the patient experience. Engagement with teams influences improved patient outcomes and perceptions (Bombard et al., 2018). Through engaged teams, leaders can reflect on improvements and meeting CMS patient satisfaction processes.

In reviewing the CMS Hospital Compare website, the overall satisfaction of the healthcare organization in which the healthcare leaders interviewed are employed received an overall Medicare and patient rating of 3 out of 5 stars. The performance across multiple areas of quality, including timely and effective care, complications and death, unplanned hospital visits, psychiatric unit services, and payment and value of care

are key indicators used to determine Medicare ratings. The patient rating measures the patients' experience during a visit to a healthcare organization (Medicare.gov, n.d.). The ratings help patients make conscious decisions about their care on healthcare organizations and the clinicians employed within the healthcare organization.

In reviewing archival documents, P1 shared a department Service Level Agreement (SLA). The SLA includes the scope of service, including delivering quality customer service through greetings and structured interactions with patients, setting expectations of wait times for care, professional appearance of employees, and clinical cleanliness. The SLA provides details of the expectations of the employees and leaders to ensure that every patient receives a quality experience when arriving at the healthcare organization. An SLA is an accountability tool, created with the outcome in mind. The SLA outlines the intended goals and the methods used to reach the goals (Jahani et al., 2021). Establishing expectations and protocols to guide patient satisfaction improvement may be a useful tool for healthcare leaders creating strategies to improve patient satisfaction.

Theme 4: Leadership

Healthcare leaders play an integral role in ensuring that patient's perception of the healthcare organization, the employees, and the physicians is a continuous positive experience and patient-centered at every visit. These leaders adapt to an ever-changing environment with high expectations of quality, safety, high-performing teams, and patient satisfaction. Through those changes, healthcare leaders must effect change amongst the team to implement new processes. Patient satisfaction will vary from one patient to

another; however, there are key processes that leaders can implement that will improve the patient experience and engage the team. Leaders who are transparent and build trust with their teams and provide an open line of communication with the teams have a greater opportunity to affect change within the healthcare organizations. Leading by example and communicating with employees the changes needed to impact patient satisfaction can ensure that every patient receives personable care. The relationships built between the leader and the team help promote and enrich patient experiences (Wanser & Luckel, 2021). Leaders who support their teams by communicating and including employees in creating processes and providing input on change initiatives have a significant opportunity to improve patient satisfaction while engaging the team for innovative ideas that may create future healthcare leaders.

When asked about leadership, the participants offered their input on how leadership within the healthcare organization implements processes and supports their teams. P1 shared, "when implementing a new patient satisfaction initiative, regardless of what role you held in our department, we all participated. I think that was immensely powerful when it came to our team. We were not holding one person to this expectation." P2 described how they process and support their leadership team:

> I'm working with their leaders, and I'm helping them plan a way to make them feel empowered. I'm meeting with my leaders, and we're having this great way of picking apart the experience, talking about their roles and how they are changing to this new experience strategy, and having them focus on each team member.

P3 shared, “Leader rounding is very evidence-based. No matter what role you hold, the expectation is that you too will be rounding on patients. So, every leader expects to round on patients and provide feedback.” P4 reflected on why the team supports patient satisfaction and the rewards the teams receive. P4 shared:

> They do it for the reward, the emotional reward really because when they can connect those patients, it is just unbelievable. I hear the stories, and I feel so proud. It really is heart work. It is heart work, and it’s rewarding.

P5 shared, how the executive leadership team provides input and engages the team to improve patient satisfaction:

> I think transparency and knowing our why and just sticking to that. We have a bigger goal, which we call “True North” and it’s all based around customer service or care experience. Having a leadership team that values its team members and evokes creative input and ideas of team members creates a healthcare organization that focuses on the entire patient and empowers them to do what is best for the patient.

Each participant expressed different ways the leadership teams receive support and the processes implemented; however, each participant expressed the importance of communicating and the value for one another and the patients. Healthcare leaders recognize that patient satisfaction is the foundation of healthcare leadership (Wolf, 2017). Improving patient satisfaction stands as a call to action for healthcare leaders to determine best practices for ensuring patient satisfaction at every visit. Through these interviews, healthcare leaders expressed the importance of including the team in

decisions of change and implementation, being transparent, and providing an open line of communication to enrich the patient experience. Through their leadership, each leader provided insight into how patients reacted to the improvements made to meet and exceed the patient's expectations.

Through the review of archival documents shared by the leaders, improving patients' perception of the healthcare organization reflects leadership teams that considered patient's input and improved patient satisfaction consistently through surveys, meetings, discussions, and patient panel discussions. The measurement of patient experiences is an effective tool for implementing quality service and improving strategic goals for every healthcare organization (Al-Abri & Al-Balushi, 2014). The healthcare leaders use various measures to create an environment focused on improving patient satisfaction; through those measures and data collection, employees are accountable for meeting the goals established by healthcare leaders.

To align with the leadership, in reviewing the archival documents from P1 and P5, the leaders share supporting data with the teams to reflect the progress of patient satisfaction and improvements. When leaders can review and educate clinicians using metrics and key performance indicators to make or improve healthcare decisions, and then train and educate all healthcare employees about the aspects of respectful and dignified care, fundamental and patient-centered care occurs (Feo & Kitson, 2016). Through the data and reporting metrics, the leaders can show the teams how creating strong processes, such as communicating and focusing on patient-centered care, can improve the patient's perception of the healthcare organization.

In reviewing the hospital compare database, there is certainly room for improvement from the patient's perception; the healthcare organization reflects an average rating scale of 1-5. Patient satisfaction ratings are indicators on a global level of physicians and healthcare organizations' quality, efficacy, and feasibility of patient care and services (Boquiren et al., 2015). The healthcare organization plans to review the results of the patient feedback and the CMS star rating results and implement process improvements beginning with the administrative areas within the healthcare organization then follow up with the clinical areas after that, to not overwhelm the clinical teams while managing through the Covid-19 pandemic. Improvements include fast and efficient appointment scheduling, communication about updates, changes, and follow-up. Through the improvements discussed with the healthcare leaders, these improvements will provide patients with a sense of care and concern from the healthcare organization, improving patient satisfaction within the healthcare organization.

Applications to Professional Practice

The results of this study may prove valuable to healthcare leaders. Healthcare leaders may find the strategies referenced in this study helpful within a healthcare organization. Improving patient satisfaction is a continuous goal of healthcare organizations around the world. The findings of this study include four themes: (a) caring for patients through communication, (b) patient-centered care, (c) compliance through CMS patient satisfaction processes and, (d) leadership.

This study provides healthcare leaders with the strategies used to improve patient satisfaction within one healthcare organization. Through these strategies, healthcare

leaders can seek opportunities to improve the quality of care and perception that patients receive by implementing a patient-centered care culture. Healthcare leaders that seek to enact excellence make patient perception a priority (Al-Abri & Al-Balushi, 2014). Educating employees and physicians with the proper training and tools to provide every patient with a level of care that exceeds the patient's expectations. The education begins with workflows, policies and processes, shadowing, patient rounding, and accountability measures.

The target audience for this study included healthcare leaders who are responsible for improving patient satisfaction. The results of this study may contribute to key research related to patient satisfaction. The role of the healthcare leaders is crucial in establishing quality patient satisfaction, measures should be created to ensure improved patient satisfaction within the healthcare organization (Asif et al., 2019b). The challenges the guidelines of the PPACA enforced related to patient satisfaction, reimbursements, and improved delivery models, encouraged leaders to implement strategies to improve patient satisfaction and balance cost (Pascual, 2021). When leaders implement and empower employees, the strategies implemented imply patient-centered care and patient inclusion in the healthcare experience (Pascual, 2021). Healthcare leaders can apply the strategies identified in this study to existing research conducted by healthcare leaders who seek improvements to patient satisfaction and inclusion of patients in the visit while positively impacting the community.

Implications for Social Change

The findings within this study may have positive implications for one broadly related area of social change. The area of change includes transforming care experiences in patient care and well-being through communication and education, thereby improving patient satisfaction. Through communication and education within the healthcare organization, patients within the community may see improved health outcomes.

Patient engagement within the community plays a critical factor in social change for healthcare organizations. Through communication and education, healthcare leaders should seek opportunities to provide the community with resources through donations, classes, activities, and testing sites. These resources can enhance patient care, quality of care, and the perception of care within the healthcare organization. Shifting the focus of care to the patient's overall well-being improves the outcomes for quality patient care.

Healthcare leaders can use the results of this study to positively impact the patient's perception of care within the healthcare organization through implementing processes that enhance patient care. A leader's ability to influence change and motivate others to achieve a higher level of achievement is extensive in a thriving workplace with the transformational leadership style (Schwartz et al., 2011). Healthcare leaders are increasingly seeking opportunities to improve patient care, patient satisfaction, and the financial outcome of the healthcare organization to maintain sustainability (Jacko et al., 2021). With improved patient satisfaction through communication and education, healthcare organizations may improve revenue through value-based care, all while

applying strategies to improve overall patient care and the well-being of patients within the community.

Recommendations for Action

The recommendations for the actions described in this section are for consideration of healthcare leaders seeking to improve patient satisfaction. Healthcare leaders may distribute these actions through professional associations and forums for healthcare leaders. The study findings included four themes: (a) caring for patients through communication, (b) patient-centered care, (c) compliance through CMS patient satisfaction processes and, (d) leadership.

The first recommendation for practice is to care for patients through communication. Healthcare leaders should create an environment built on communication amongst staff and employees and patients and their family members, ensuring that everyone involved in patient care understands the expectations of the patient's outcome. Creating an accountability tool helps ensure that the staff and employees can follow each communication process step. Providing training to staff and employees centered around the individual patient stimulates patient-centered care and patient satisfaction (Fatima et al., 2018). Empowering staff and employees with education and goals, enriches the organization’s culture, thereby improving the patient experience and patient satisfaction.

The second recommendation is patient-centered care. This theme includes implementing training to understand the needs of patients. Healthcare leaders should educate and provide staff and employees with the tools needed to create a patient-centered care model within the healthcare organization. Patient-centered care requires a

culture shift from the regular idea of patient care to patients in partnerships with their care (Alabdaly et al., 2021). Healthcare leaders should develop best practices for ensuring that patients are included in health decisions and understand those decisions. Leaders should establish workflows and processes that ensure that employees and physicians have an open dialogue with patients by explaining expectations and time frames. These processes should include accountability measures and goals to meet organizational and patient needs. Patient satisfaction ratings are global indicators of physicians' and healthcare organizations' quality and efficacy of patient care and services (Boquiren et al., 2015). This shift in the culture towards a patient-centered care model can provide patients and their families with reassurance that they are cared for and heard as a patient.

The third recommendation, compliance through CMS patient satisfaction processes; through the guidance of CMS payments for care received include patient care and the patient experience, insurance payers initiate and approve these payments. Through the HCAHPS and CGCAHPS surveys, patients can rate their care based on the experiences, respect, and care within a healthcare organization. Through these surveys, healthcare leaders should initiate a culture shift within the healthcare organization to improve patient satisfaction and perception. In addition to the HCAHPS and CGCAHPS, CMS uses hospital quality measures to determine and adjust hospital payments using the VBP. The VBP promotes improved clinical outcomes and patient experiences while improving care and reducing costs (CMS, n.d.). Patient-centered care has become the foundation for healthcare organizations to keep viability in an ever-changing world.

The fourth recommendation is leadership; Healthcare leaders should be part of the overall goal to improve patient satisfaction through patient visits and hospital or clinic rounding to ensure that the patient feels cared for and acknowledged. The top-down approach offers patients the ability to voice their concerns to leaders in real-time and address any problems at the time of the visit. Support from top leaders (e.g., chief executive officers) for implementation of change initiatives play a key role in overcoming objection or protest to organization goals (Birken et al., 2015). Healthcare leaders should include employees and physicians in patient feedback. Sharing the feedback and reviews from the patient perspective, both the good and the bad, with the staff and employees, creates an environment of compassion and care from the patient's perspective. Sharing feedback will allow the teams to learn from their mistakes or the mistakes of others while improving patient satisfaction. Engagement with patients further creates a patient-centered culture that employees and physicians can reflect on. Making improvements for the entire healthcare organization will require input from everyone, including physicians. Higher patient satisfaction because of the physicians' behavior results in better health outcomes for patients (Simsekler et al., 2021), and the overall outcome for the healthcare organization. Through employee and staff buy-in, shifting the focus to patient experience to enhance each patient's care experience and improve patient satisfaction within the organization may affect the patient's perception of care.

Recommendations for Further Research

This qualitative single case study aimed to explore the strategies that healthcare leaders used to improve patient satisfaction. This study had three limitations. The first

limitation of the research was the potential biases of the healthcare leaders during the interviews based on a limitation of the amount of information the leaders shared. The second limitation was, I conducted the research on a single healthcare organization, limiting the strategies to other healthcare leaders. The third limitation was the focus of the study was specific to the strategies used to improve patient satisfaction, duplication and testing of the strategies may occur in other demographic and geographical locations with a methodological design.

In conducting the research for this study, I discovered three recommendations for more research. The first recommendation was due to the limitation of using one healthcare organization to conduct the research; other healthcare leaders within a similar size and demographic healthcare organization may have other strategies that prove successful. The second recommendation is the sample size of this study; I interviewed 5 healthcare leaders for this study; I would recommend a larger sample size to interview other healthcare leader's perspectives and recommendations to improve patient satisfaction. My last and final recommendation is for future researchers to conduct a multi-case study to compare strategies and best practices while developing a multi-faceted approach that healthcare leaders use in any healthcare organization.

Reflections

In my reflections of this study, the DBA Doctoral Study process challenged me to my fullest potential. This study was a spiritually guided test that taught me the importance of never giving up; if I fall, I get back up and keep going, and things happen the way they are supposed to happen. When I started this journey, there was limited data

about patient satisfaction. Over the last several years, an abundance of data has surfaced to support this much needed tool in healthcare. Having worked in healthcare for many years, I had the opportunity to see the improvements implemented within my healthcare organization and how the patient-focused improvements affected patient's health outcomes while improving employee engagement and the financial outcome of the healthcare organization.

Patient care is vital in every healthcare organization; it is our primary purpose for being in healthcare. Through this study, I learned that patients interpret their care from when the patient enters the healthcare facility to when the patient leaves the healthcare facility. Further, the patient's interpretation of the healthcare organization may substantially affect the patient's care and the entire healthcare organization. My bias has shifted from focusing only on the clinical aspect of healthcare to the whole healthcare organization. After conducting this study and getting insight from healthcare leaders from different areas of a healthcare organization, I have gained a greater appreciation for the work and the data put into this subject matter; I understand why this research is critical for healthcare.

Conclusion

The purpose of this qualitative single case study was to explore the strategies that healthcare leaders use to improve patient satisfaction. The single case study design is the study of the complexity of one case and understanding the importance of that case (Harrison et al., 2017). By completing semistructured interviews with healthcare leaders of a single healthcare organization, this study may assist healthcare leaders in improving

patient satisfaction, the quality of care, and the financial outlook of their healthcare organization. Building a patient-centered care environment is the primary focus of quality improvements to reduce patient errors and provide adequate care (Kadom & Nagy, 2014). Through the interviews and review of the archival documents that the healthcare leaders shared, the leaders expressed emphases on the importance of improving patient satisfaction and the strategies used to ensure that every patient receives quality service and care. In reviewing the CMS hospital compare database, there is still room for improvement to meet and exceed patient expectation, it appears through continued process improvements, the healthcare leaders will achieve quality patient satisfaction improvements.

I recorded the interviews, coded the interviews, analyzed the data retrieved from coding, archival documents, and the CMS hospital compare website to determine the common themes. Four themes emerged from the analysis: (a) caring for patients through communication, (b) patient-centered care, (c) compliance through CMS patient satisfaction processes and, (d) leadership. The findings suggested that communication, empathy, education, training, and implied leadership are effective measures to improve patient satisfaction. Healthcare leaders can review and implement these processes to improve patient satisfaction outcomes within their healthcare organization. Through patient education, engaged leaders, physicians, and staff, healthcare leaders can invoke social change in the surrounding communities, improving outcomes for patients, the community, and the entire healthcare organization.

The findings of this study were relevant to healthcare business practices in identifying possible measures and strategies for improving patient satisfaction. With the everchanging healthcare regulations, I recommend continuous research for best practices to improve patient satisfaction. The recommended strategies may aid healthcare leaders with improving patient satisfaction within their healthcare organization; improving patient satisfaction may improve patient health outcomes and increase profits for the healthcare organization.

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Appendix: Interview Protocol

As communicated in the consent form that I sent you, I am a Doctor of Business Administration-Leadership Student at Walden University, conducting my doctoral study in partial fulfillment of the requirements for the degree. The purpose of this interview is to explore the strategies healthcare leaders use to improve patient satisfaction. The results of this study may contribute to effective business practices by serving as a business model for healthcare leaders to achieve sustainable patient satisfaction solutions within healthcare organizations.

During the virtual interview, I will take notes and audio record the conversations to accurately capture the discussion. Your responses are and will remain confidential. Once I transfer the recorded audio to a Microsoft Word document, I will schedule time with each participant to review my interpretations for accuracy; this step is member checking.

The following steps will take place during the interview:

- I will turn on the audio recording device and note the date and time of the interview.
- I will ask the participants if there are any questions or concerns before starting the interview.
- I will ask each participant the following interview questions:
    1. What strategies did you use to improve patient satisfaction?
    2. What strategy did you find worked best to improve patient satisfaction?
    3. How did you measure the success of the strategies used?
    4. What were the key barriers to implementing the strategies for improving patient satisfaction?
    5. How did your organization address the critical barriers to improving patient satisfaction?
    6. How did patients respond to your strategies to improve patient satisfaction?
    7. What else would you like to share that you did not address regarding the strategies used to improve patient satisfaction?
- I will ask each participant to share any relevant documentation, such as policies, procedures, and workflows of the strategies used.

- I will end the interview process.
- I will schedule the 60-minute member checking interview and confirm the contact information of the participants.
- I will provide my contact information for follow-up questions or any concerns that the participants may have.
- I will thank each participant for their time.
- I will turn off the audio recorder and conclude the virtual interview.

During the member checking interview, the following steps will take place:

- I will turn on the audio recording device and note the date and time of the interview.
- I will begin the 60-minute virtual member checking interview and ensure that each participant does not have any questions or concerns before starting the interview.
- I will explain to the participants that the focus of the member checking interview is to confirm my documentation of the interview responses and address any concerns of my documentation of the interview.
- I will provide each participant with my documentation of the individual interview responses.
- I will note any revisions and ask for clarification if needed to ensure the proper changes to the documentation.
- I will thank the participants for their time.
- I will turn off the voice recorder and conclude the member checking interview.