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Health Care Reform: Leading Successfully Through Reform Rapids A Case Study

Tabatha Erck

University of St. Thomas, Minnesota, tabatha.erck@hotmail.com

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Health Care Reform: Leading Successfully Through Reform Rapids

A Case Study

A DISSERTATION SUBMITTED TO THE FACULTY OF THE SCHOOL OF EDUCATION
OF THE UNIVERSITY OF ST. THOMAS
MINNEAPOLIS, MINNESOTA

By
Tabatha Erck

IN PARTIAL FULFILLMENT OF REQUIREMENTS
FOR THE DEGREE OF DOCTOR OF EDUCATION

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LEADING SUCCESSFULLY THROUGH REFORM RAPIDS

UNIVERSITY OF ST. THOMAS, MINNESOTA

Health Care Reform: Leading Successfully Through Reform Rapids

We certify that we have read this dissertation and approved it as adequate in scope and quality. We have found that it is complete and satisfactory in all respects, and that any and all revisions required by the final examining committee have been made.

Dissertation Committee

Karen L. Westberg, Ph.D., Committee Chair
Thomas L. Fish, Ed.D., Committee Member
Sarah J. Noonan, Ed.D., Committee Member

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Final Approval Date
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by

Tabatha Erck
Dedication

This study is dedicated to the participants of this project. Thank you for taking time from your very busy schedules to share your stories and contribute to this important research. I also appreciate your openness and willingness to speak honestly and candidly. You made this research possible and your contribution will aid future health care leaders, the industry, and the applicable stakeholders.
Acknowledgements

I would like to acknowledge several important individuals who contributed to the formation, development, and completion of this study. I wish to first express my sincere gratitude to my chair, Dr. Karen Westberg, who patiently coached me, taught me to welcome constructive feedback in a positive manner, and pushed me over the finish line. I also want to thank the University of St. Thomas and my entire dissertation committee, Drs. Tom Fish and Sarah Noonan. I couldn’t have done it without you. Finally, thank you to Keva Meyer and Jenee Boyer for their assistance with the health insurance graphic.

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And finally, this entire study would not be possible without the tremendous support, love, and encouragement from my husband Jay. Throughout the course of my doctoral studies and this research our lives have taken many fun and unexpected twists and turns. I am indebted to
you for the time and space you provided me over the years to successfully complete my coursework and writing. I love you!
Abstract

This qualitative study explored the experiences of executive level leaders within the health insurance industry throughout the United States since the passing of the Patient Protection and Affordable Care Act (PPACA) approximately a decade ago. Fifteen leaders, including five Chief Executive Officers, five Chief Financial Officers, and five Chief Medical Officers, including three women, participated in this study. Most of the participants in this study were highly educated Caucasian males, and more than half worked for a non-profit health plan. The study addressed five primary themes: (1) health care reform, (2) education and lifelong learning, (3) leadership, (4) quality, and (5) the role of the customer. The primary modes of analysis applied through the study involved the use of Northouse’s (2019) adaptive leadership theory, Lincoln’s (1989) discourse, myth, ritual, taxonomy, Kramer & Enomoto’s (2007) ethical leadership theory, Bridges & Bridges’ (2016) transition model, and Bolman and Deal’s (2017) reframing organizations theory. The study sought to address these research questions: What knowledge, skills, and dispositions have health care leaders been using during these changes? How do clinical, administrative, and financial executives describe their leadership experience? How do current leadership practices compare to the literature? What types of decisions are health care leaders making?

Health care is a complex industry and continues to be a frequent topic of discussion and a point of contention throughout the United States. Cost, quality, and a lack of overall satisfaction remain the driving forces behind the overall frustration (An et al., 2013; Ungar & O'Donnell, 2015). The Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Acts passed in March 2010 served as a catalyst for change designed to address these concerns by expanding health insurance coverage to an additional 32 million individuals and tax credits for individuals, families, and small businesses to ensure the insurance was affordable. It also focused on shifting the health care delivery system from treatment and disease management to prevention and reduce costs and efficiency while improving quality and satisfaction. The New York Times stated it was “the most expansive social legislation enacted in decades” (Levey, 2010, September 9, p. 1). According to CNN it was a centerpiece of the 2012 presidential election campaign (Cohen, 2012, June 29).
In response to health care reform, the findings in this study indicate that Chief Executive, Financial, and Medical Officers have transformed their organizations through new visions and strategies. They shared information, built trust, and aligned their organizations. The leaders have started to see results and their key performance indicators demonstrated reductions in costs, improved outcomes in targeted areas, and improvements in the consumer’s experience.

The future is uncertain, and it is clear new that models evolved from these major changes which led to new ways to deliver health care, new and different players in the industry, new rules, and new roles and responsibilities. This is just the beginning of a major change which is expected to continue for at least the next five to ten years. Recommendations include health industry leaders need to: (1) develop and implement strategies for sustainable changes, confirm roles, responsibilities, and accountabilities are clear, and share key milestones and provide updates quickly and often, (2) seek alignment and agreement regarding the new organizational goals and measurements as well as how they are going to report their results, (3) engage employees and collaborate with stakeholders, (4) partner with educational institutions and those who provide care to their members throughout their communities, (5) develop and implement succession plans, (6) a bigger culture shift must occur before we will see higher outcomes, lower costs, and improved consumer satisfaction, (7) ensure that Chief Medical Officer have a reporting line to the Board of Directors and attend the Board of Directors meetings, and (8) have the Chief Executive Officer, Chief Financial Officer, and Chief Medical Officer provide their staff with a leadership compass, so the next generation of leaders can be effective at guiding their organization successfully through the complex health insurance rapids.

*Keywords: Health Insurance Leadership, Adaptive Leadership, Executive Leadership, Health Care Reform, Change Management, Lifelong Learner*
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CHAPTER 1
INTRODUCTION

Health care is a complex industry and continues to be a frequent topic of discussion and a point of contention throughout the United States. Cost, quality, and a lack of overall satisfaction have been the driving forces behind the overall frustration (An et al., 2013; Ungar & O'Donnell, 2015). In the last three presidential elections 2008, 2012, and 2016, the candidates’ campaigns included health care reform as part of their election platform.

According to the Centers for Medicare and Medicaid, health care spending is projected to grow 1.3 percent faster than Gross Domestic Product (GDP) from 2015 to 2025. As a result, the health share of GDP is expected to rise from 17.5 percent in 2014 to 20.1 percent by 2025. Health expenditures continued to grow steadily leading to the country spending $3.4 trillion on health care in 2016, a number that is projected to grow to $5.5 trillion by 2025 causing the United States to continue to lead as the most expensive health care program in the World (Commonwealth Fund, 2010). These increases are a result of inflation in the cost of medical services, products, and an aging population (Keehan et al., 2017). With significant funds being spent, there also continues to be disparities in access to services, and the U.S. ranked last behind most industrialized countries on health care measures including health outcomes, quality, and efficiency (Commonwealth Fund, 2010). Cost is one of the key driving forces behind the focus on health care reform.

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) (PPACA, P.L. 111-148) into law and served as a catalyst for change (Wang, 2014). The bill passed both Houses of Congress without a single Republican vote and 34 House
Democrats voting against the measure. The health law expanded health insurance coverage to an additional 32 million individuals and tax credits for individuals, families, and small businesses to ensure the insurance was affordable. The *New York Times* stated it was “the most expansive social legislation enacted in decades” (Levey, 2010, September 9).

The PPACA is over 2,500 pages long, highly complex, very confusing to those implementing it and the consumers impacted by it, and it also has a wide-range of support and criticism (Lee, 2011). The PPACA is not one single health care bill that became law but is composed of two laws: Patient Protection and Affordable Care Act (ACA) (Pub. L. No. 111-148, 124 STAT. 119) and Health Care and Education Reconciliation Act of 2010 (HCERA) (Pub. L. No. 111-152, 124 Stat. 1029) (University of Minnesota, 2018).

There were many goals and objectives within the laws but the three most significant include (a) Medicaid eligibility expansion, individual mandate requiring all U.S. Citizens to purchase and maintain qualified health care coverage or pay a penalty; (b) establishment of a government or non-profit health care exchange designed to provide eligible consumers a web-based marketplace to purchase qualified health insurance; and (c) prohibition of the ability for insurance companies to discriminate against preexisting conditions (Kaiser, 2013).

The new health laws also aimed to improve the quality and efficiency of U.S. medical care services, especially for those enrolled in Medicare and Medicaid (Rawal, 2016). To achieve these improvements, payment for services were linked to better quality outcomes. The Federal government also invested in programs designed to improve quality and delivery of care as well as fund research designed to develop and implement new approaches to treatment and care delivery. Research dollars were invested into new patient care models. Finally, in 2010 funds
were used to establish an Independent Payment Advisory Board (IPAB), a 15 fifteen-member taskforce responsible for achieving specified savings in Medicare without affecting coverage or quality (Rawal, 2016). On February 9, 2018, the United States Congress voted to repeal the IPAB as a part of the Bipartisan Budget Act of 2018 by a vote of 71–28 in the US Senate and by a vote of 240–186 in US House of Representatives. On the same day, President Trump signed the budget bill into law repealing the IPAB (Norris, 2018).

Beyond funding research and improving quality, the bill also focused on prevention of chronic disease and improving public health (Rawal, 2016). An extensive set of initiatives were dedicated to health promotion and disease prevention. The PPACA provided coverage under Medicare, without requiring a copayment or deductible, for an annual wellness visit and prevention services. In addition, funds were allocated to research public health systems and services (Rawal, 2016).

The PPACA addressed areas of concern that included improving the health care workforce (Buerhaus & Retchin, 2013). It included language funding innovations in health care workforce training, recruitment, and retention. To achieve these goals, the PPACA established a new workforce commission. The new committee, called the National Health Care Workforce Commission, must include fifteen members with most of the commission being non-providers and at least one consumer and one individual representing labor unions. The overall goal of the Commission was to provide comprehensive, unbiased information to Congress and the Administration about how to align Federal health care workforce resources with national needs. It was intended that Congress use this information to provide funding and resources to programs. The initial appointments were to occur no later than September 30, 2010 (Buerhaus & Retchin,
2013). However, as of September 2018, Congress had not provided the necessary funding for the Commission to be convened.

The post implementation analysis of PPACA showed it had achieved some of its goals. It increased the number of individuals with health care coverage, all individuals with coverage had access to 10 essential health benefits; individuals could not be denied coverage due to a preexisting health condition; it removed lifetime and annual coverage limits; and children could stay on their parents’ health insurance plans up to age 26 (Barr, 2016). At the same time, however, millions lost their company-sponsored health care plans; many businesses found it more cost-effective to pay the penalty and let their employees purchase insurance plans on the exchanges; insurance companies had to cancel many of their plans because their policies did not cover the PPACA’s 10 essential benefits; millions of people continued to pay the tax rather than purchase coverage; and health care costs continued to increase (Barr, 2016).

As for reducing costs, health insurance premiums were projected to increase by up to 4 percent for 2019 health care plans sold on the exchange (Kodjak, 2018). Overall, health insurance premiums were projected to increase by less than 4 percent nationwide. A few states such as Kentucky and Connecticut expected increases of 12 percent, but other states such as Tennessee and New Hampshire were anticipating reductions in their health care premiums in 2019 (Kodjak, 2018).

In response to the lack of support for both the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act, in November 2016 the United States elected a new President (Fisher, 2016; Oberlander, 2017). This is not the first-time health care was used as an election platform. In 1932, Franklin D. Roosevelt introduced the need for the government
to have an active role in “American life” (Fisher, 2016). It occurred again in 1948, with Truman running with a goal to move national health care forward. In 1960, John F. Kennedy made a commitment to pass a bill providing health care for senior citizens (Jacobs & Skocpol, 2015). In 1992, Bill Clinton ran on a platform focused on taking immediate action to reduce health care costs. In 2001, George W. Bush ran with a promise to update Medicare by including prescription drug coverage in it. In 2008, Barack Obama became President of the United States and proposed a plan to reform the health insurance industry (Collins, Nicholson, Rustgi, & Davis, 2008).

Donald Trump, a Republican, ran on a health care repeal and replace platform. In March 2016, as a candidate, Donald Trump issued his 7-point plan which included a desire to (a) repeal the PPACA, (b) eliminate the individual mandate, (c) allow people to shop for health insurance across state lines, (d) continue to use Health Savings Accounts (HSA), (e) equalize tax treatment in obtaining insurance, (f) increase transparency in health care pricing, (g) include Medicaid block-grants, and (h) import drugs from other countries (Fidler, 2017). In January 2017, the President told The New York Times that Republicans would have the PPACA repealed "probably sometime next week."

As of September 2018, a new court fight over the PPACA began in Texas led by a group of Republican state attorneys general. So far, Congress has been unable to successfully pass a new health care bill, but this does not mean the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act repeal effort has ended (Hirsch et al., 2017).
Purpose of the Study and Research Questions

Health care executive leaders’ roles are complex and include developing and implementing strategies designed to address complex health care issues including reducing costs; providing affordable coverage to the uninsured and the large aging population; and addressing health care disparities and ongoing patient safety issues. The purpose of this qualitative study was to describe and understand how health care executive leaders in the areas of clinical, administrative, and financial practice experienced and lead their organizations since the passing of the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Acts almost a decade ago provide dates from 2010 to 2018.

Research Questions

I adopted the following three research questions: What knowledge, skills, and dispositions did health care leaders use during the last decade since the passing of the PPACA? How do clinical, administrative, and financial executives describe their leadership experience during the adoption and implementation of the Patient Protection and Affordable Care Act (PPACA)? What types of decisions did health care leaders make to manage change?

Significance of the Study

This study may contribute to the underdeveloped area of research related to leadership, specifically regarding the health care industry. Because quantitative research is the dominant model used in health care studies (Macur, 2013), my study focuses on the human element. Only a few studies used a mixed-methods approach, combining quantitative and qualitative approaches (Strang, 2005). Due to the complexity of the health care industry, using a qualitative
approach provides data concerning the experiences of health care leaders participating in the study (Adcock, 2001; Macur, 2013; Mays & Pope, 1995; Wegscheider, 2008).

This research may prove important to all current health care leaders, including those contemplating a leadership position in the future as well as higher education institutions offering graduate and professional degrees focused on the health care industry. This approach also provided deeper insight into the health care leadership environment during times of significant change by identifying the internal and external factors contributing to or impeding health care leadership’s ability to succeed and, then, by exploring the participants’ views regarding the findings in greater depth. Additionally, this study yielded valuable results and made a step forward because of the in-depth description of the experiences of healthcare leaders using qualitative approaches.
Researcher’s Journey

I have been a leader in the health care industry for over 25 years. I have been a leader within a few different insurance companies, a couple of hospitals, a few medical clinicals, in a pharmaceutical company, a couple of different specialty health focused organizations, and have been on 4 different Board of Directors within the health care industry. I studied this topic because I want to gain a clearer understanding why the health insurance industry doesn’t take a leadership role and innovate their industry instead of waiting until the government forces change upon them through legal means. Clearly, maintaining the current program and approach was not an option if the industry intended to reduce costs, improve quality, and achieve a high level of patient satisfaction.

I am also concerned about the current cost of health care and the poor health outcomes consumers are getting for the price. I wondered if the health insurance industry embraced the new advances in technology, new standards of care, and new business models. I wondered how they addressed the growing population and changing demographics. I was also interested in learning more about how chief executives effectively and efficiently meet the needs of the various stakeholders, which include the patient, community, government, employers, providers, and payers while balancing the business needs of the organization. Addressing their stakeholder’s needs cannot leave a lot of time and energy for innovation, collaboration, and quality improvement.

Next, with the ongoing uncertainty, I wondered if executive leaders had changed their leadership approach and, if so, how, why, and what was the impact. I also wondered how they approached strategic planning and ensured a clear focus for their staff with so much uncertainty.
Finally, I was concerned about my experience in the industry, as both a leader and patient, introducing biases into my study. According to Merriam and Tisdell (2016), it is difficult, if not impossible, for the researcher to separate themselves from the data. To maintain objectivity and avoid biases with my study data and analysis, I implemented an additional four steps to my process. First, I coded and reviewed my coding multiple times over a 90-day period to ensure consistency between my interpretation of the data and what my participants said. This process included listening to my recorded interviews in addition to the scribed notes. Next, I had my participants review my results. I asked them to confirm my interpretations represented their statements and beliefs. Next, I asked those who participated in my study to provide me with examples of their statements to ensure I didn’t misinterpret their statements. Finally, I reviewed my findings with a peer. By taking this approach, I confirmed my conclusions were creditable and consistent given my data.
Overview of the Chapters

In Chapter One I provide an overview of my qualitative case study. I state the problem addressed in my study, the purpose of the study, and its significance for health care insurance executives and researchers. I also present my research questions and the qualitative research design employed in my study.

In Chapter Two I present a review of research relating to my research topic. I included the top issues in the health care industry, the health care industry’s culture, role of the health care executive, individual and organizational development, and gaps in the literature. The sections after the review of literature, I describe the theories I used to analyze and interpret my data. I selected five theoretical frameworks: Northouse’s (2019) adaptive leadership theory, Lincoln’s (1989) discourse, myth, ritual, taxonomy, Kramer & Enomoto’s (2007) ethical leadership theory, Bridges & Bridges’ (2016) transition model, and Bolman and Deal’s (2017) reframing organizations theory.

In Chapter Three I present in greater detail, the methodology adopted to conduct the study. I present an overview of the target population and sample and details regarding the target population and the participants. I describe the Institutional Review Board process and explain participant recruitment selection, data collection and analysis, and the reliability and validity of my study. In this chapter I also discuss my role as a researcher and ethical considerations. I move next to the findings of my study, organized into five theme: (1) health care reform, (2) education and lifelong learning, (3) leadership, (4) quality, and (5) the role of the customer.
In Chapter Four I present the findings from 15 interviews completed in 2018 with five Chief Executive Officers, five Chief Financial Officers, and five Chief Medical Officers working within five different health plans located within the five regions within the United States.

In Chapter Five I discuss and reflect on the results of my study. I include a summary of each of the five main themes: (a) health care reform, (b) education and lifelong learning, (c) leadership, (d) quality, and (e) the role of the consumer; the results in relation to the literature compared to earlier research studies; and discuss areas of agreement and disagreement between the literature and my study. I also outline limitations of my study, additional comments and reflections, implications and recommendations for future research, and a closing reflection.

In Chapter Six I present recommendations for Chief Executive, Financial, and Medical Officers in the health insurance industry as outcomes from my research, recommendations for future research, my conclusions, and closing reflections.

**Definition of Terms**

**Accreditation**: The proof the organization meets regulatory requirements and standards set by a recognized accrediting external organization.

**Alignment**: Linking of organizational goals with the employees' personal goals. Requires common understanding of purposes and goals of the organization, and consistency between every objective and plan right down to the incentive offers.

**Chief Executive Officer (CEO)**: The highest-ranking person in a company or other institution, ultimately responsible for making managerial decisions.
Chief Financial Officer (CFO): The senior executive responsible for managing the financial actions of a company. The CFO's duties include tracking cash flow and financial planning as well as analyzing the company's financial strengths and weaknesses and proposing corrective actions.

Chief Medical Officer (CMO): The senior level, licensed physician, who has shifted their practice to oversee clinical operations. Rather than directly care for patients at the bedside, they act as liaisons between doctors and health care executives.

Culture: A system of shared understandings, values, and norms, and to implement change, requires leadership support (DiMaggio, 1994; Zimmerman, Sloane, Cohen & Barrick, 2014).

Democrat: A member of the Democratic political party or someone who believes in equality for all people and ruling by the majority.

Disease: A disorder of structure or function in a human, animal, or plant, especially one that produces specific signs or symptoms or that affects a specific location and is not simply a direct result of physical injury.

Health Disparities: Are differences in health care outcomes between different groups of people within the population and are also called health inequalities (Braveman, 2006; CDC, 2013; Gollust et al., 2018).

Health Care Reform: A new health policy or major changes that affect health care delivery and/or health care insurance industry.
**Health Insurance Plan**: A type of insurance coverage that covers the cost of an insured individual's medical and surgical expenses.

**Leadership**: A process whereby a person influences a group of individuals to achieve a common goal (Northouse, 2019).

**NCQA**: National Committee for Quality Assurance (NCQA) is an independent 501(c)(3) nonprofit organization in the U.S. that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.

**Outcome**: Something that follows as a result or consequence.

**Patient Safety**: It is the prevention of errors and adverse effects to patients associated with health care. While health care has become more effective it has also become more complex, with greater use of new technologies, medicines and treatments.

**PPACA**: Patient Protection and Affordable Care Act, enacted on March 23, 2010, is not one single health care bill that became law but is composed of two laws the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act. The PPACA issued new rules and guidelines on the offering, administration, and acceptance of healthcare coverage in the United States (University of Minnesota, 2018).

**Quality of Care**: The extent to which health care services provided to individuals and patient populations improve desired health outcomes. To achieve this, healthcare must be safe, effective, timely, efficient, equitable, and patient-centered.
**Reimbursement Model**: Refers to a statistical or administrative methodology that attributes a patient population to a provider for the purposes of calculating health care costs/savings or quality of care scores for that population.

**Republican**: Is defined as a person who is part of the Republican political party or identifies with a system of government where the citizens can choose those who represent them.

**Stakeholder**: A person, group, or organization that has interest or concern in an organization.

**Succession Planning**: A process for identifying and developing new leaders who can replace old leaders when they leave, retire, or die.

**Health Care Transparency**: Information made available to the public, in a reliable, and understandable manner, regarding the health care system’s quality, efficiency and consumer experience with care, which includes price and quality data, to influence the behavior of patients, providers, payers, and others to achieve better outcomes (quality and cost of care).

**Triple Aim**: An approach to optimizing health system performance which includes three dimensions; reduce costs, improve outcomes, and improve patient satisfaction.

**Wellness**: An active process of becoming aware of and making choices toward a healthy and fulfilling life.
CHAPTER 2

REVIEW OF LITERATURE

Introduction

In the previous chapter, I presented the top issues in health care, which include reducing costs, reimbursement models, improving quality, health disparities, the role of the consumer, expectations from leadership, and transitioning from disease to a wellness model. After introducing the top issues in the health care industry, I describe the health care industry’s culture, the role of the health care executive, individual and organizational development, and the gaps in the literature.

In this chapter, I review the literature, identify the gaps in the literature, and describe the theories I used to analyze and interpret my data. I selected five theoretical frameworks: Northouse’s (2019) adaptive leadership theory, Lincoln’s (1989) discourse, myth, ritual, taxonomy, Kramer & Enomoto’s (2007) ethical leadership theory, Bridges & Bridges’ (2016) transition model, and Bolman and Deal’s (2017) reframing organizations theory.

The health care industry experienced decades of reform but nothing like the magnitude of the Patient Protection and Affordable Care Act (PPACA) (Connors & Gostin, 2010; Silvers, 2013; Schmitt, 2012). Unfortunately, many of the previous reforms failed (Isouard, 2010; Porter & Teisberg, 2006). After the passing of the PPACA, several scholars identified leadership as the top priority for tackling the new challenges and moving the industry successfully through unfamiliar, uncharted waters (Fibuch, 2010; Hartley & Benington, 2010; Isouard, 2010; McAlearney, 2009; Monheit, 2010; Rogers, 2012; Slavkin, 2010).
Health Care Industry Top Issues

Many issues affected the passing of the Patient Protection and Affordable Care Act (PPACA). The first and largest was cost: health care expenditures were $256 billion in the 1980s, nearly $2.6 trillion in 2010, $3.8 trillion in 2013, and are expected to reach $4.5 trillion in 2019 (Lorenzoni, Belloni & Sassi, 2014). According to Johnson (2012), approximately 60% of personal bankruptcies in the U.S. have been due to expensive medical bills, and the U.S. health care program is a "ticking time bomb" for the federal budget (p. 1). Even though the U.S. spends a significant amount of money for health care, many citizens are uninsured; disparities in access to services exist; and the U.S. ranks last behind most industrialized countries on many health care measures, including health outcomes, quality, efficiency, and patient safety (Commonwealth Fund, 2010, p. 1).

The large number of uninsured citizens is a major issue within the health care industry. In 2013, there were just over 315 million people living in the U.S. Over 41 million or 16.3% were uninsured and over 60 million low income Americans obtained their coverage through Medicaid (Kaiser, 2013). Since the beginning of 2014 with the onset of the individual mandate requiring all U.S. citizens to purchase and maintain qualified health care coverage or pay a penalty, the uninsured rate dropped 2.2 percentage points to 13.4% in the second quarter of 2014 (Levy, 2014). While the number of uninsured was reduced a year after the launch of PPACA, about 32 million Americans continue to be uninsured (Sanger-Katz, 2014).

The U.S. also has an aging population. According to the Administration on Aging, 12.9% of the U.S. population, about one in every eight, is 65 years of age or older (Aging, 2014). By 2030, there will be about 72.1 million over the age of 65, more than twice their number in 2000.
This is a critical factor in health care because in 2011 Medicare spent 28%, or about $170 billion, on patients’ last six months of life (Kaiser, 2013).

Health care quality differs among racial and ethnic minority groups and the poor. According to the Agency for Health Care Research and Quality (AHRQ), disparities in quality of care are common and include (a) adults age 65 and over received worse care than adults ages 18-44 on 39% of the quality measures; (b) Blacks received worse care than Whites on 41% of the quality measures; (c) Hispanics received worse care than non-Hispanic Whites on 39% of measures; (d) Asians and American Indians and Alaska Natives received worse care than Whites on nearly 30% of the quality measures; and (e) poor people received worse care than high-income people on 47% of the measures (AHRQ, 2014). Racial and ethnic minority groups and the poor are also less likely to have health insurance, and language barriers may be a factor in their quality of care. The Triple Aim, a term used to refer to the pursuit of improving patient satisfaction, improving health care outcomes while reducing the cost of health care, is one way the health care industry measures quality of care and outcomes (Obucina et al., 2018). The Centers for Medicare and Medicaid uses seven key measurements to confirm quality. They include mortality, safety of care, hospital readmissions, patient experience, effectiveness of care, timeliness of care, and efficient use of medical imaging.

Beyond concerns regarding cost, an aging population, and the delivery of care disparities, the health care industry is also facing concerns regarding patient safety and quality. According to the Patient Safety Movement Foundation, The Joint Commission Center for Transforming Health Care, and other subject matter experts, 10 top patient safety areas were identified as critical in 2014. The list included (a) health care-associated infections; (b) surgical complications; (c) handoff communications (information between clinicians clearly stating what
a patient needs for his or her treatment); (d) ensuring the patient is accurately diagnosed; (e) medical errors; (f) failure to implement a culture of safety; (g) lack of interoperability (lack of the ability of different information technology systems and software applications to communicate, exchange data accurately, effectively, consistently, and to use the information that has been exchanged); (h) patients’ falls (and other geriatric considerations); (i) inadequate treatment choices; and (j) alarm fatigue (a health care provider no longer hears the constant noise of alarms or overwhelmed by the sounds and turn alarms down or off).

In his thematic analysis of the literature, Weberg (2012) stated health care is rapidly changing, inherently complex, and heavily regulated. The problems in health care are not limited to complexity and regulation; they also include soaring costs and poor-quality outcomes. Weberg (2012) stated, “Poor quality, outrageous costs, and nursing shortages are symptoms of deeper underlying inefficiencies in the system. Yet, even when innovations come along to improve efficiency, they are not always implemented” (p. 268). Brennan and Mello (2009) echoed these statements when they stated, “An even more important reason for reform at this time may be cost control. Every analysis of comparative health system available revealed that the United States spends far more on health care than any other country” (p. 1814).

In contrast, Roebuck, Liberman, Gemmill-Toyama and Brennan (2011) conducted a study to examine the costs of health care and found improved medication adherence is associated with greatly reduced total health care use and costs. Their study used claims data extracted from integrated pharmacy and medical care from the CVS Caremark, which included consumers who had continuous health insurance coverage sponsored by one of nine US employers from January 1, 2005, through June 30, 2008. For every therapeutic class of drug used to treat each chronic condition, they calculated a patient’s medication possession ratio for each of the three yearly
observations as the number of days during the year when the patient had medication, divided by the number of days in the year. The researchers concluded that it is going to require more than just improving quality to reduce costs; it will require a focus around improving patient compliance. Patient compliance is defined as the degree to which a patient correctly and consistently follows medical orders (Smith & Pearlman, 2018). To reduce costs, it will take a combination of both quality and patient compliance.

Researchers found reductions in health care costs when the patient is compliant. The researchers, Roebuck, Liberman, Gemmill-Toyama & Brennan (2011), determined males constituted a somewhat higher proportion of the individuals with congestive heart failure (55 percent) and diabetes (53 percent) than females, whereas the proportions of those with dyslipidemia (50 percent) and hypertension (51 percent) were similar regardless of the patient’s gender. They also found congestive heart failure patients tended to be older (average is 77 years) than patients with the other three conditions (averages are 65–68 years). Regarding cost implications, the researchers found patient adherence reduced average annual medical spending by $8,881 in congestive heart failure, $4,337 in hypertension, $4,413 in diabetes, and $1,860 in dyslipidemia (Roebuck, Liberman, Gemmill-Toyama & Brennan, 2011).

Some researchers believe administrative costs and waste significantly impact health care costs. Milstein and Darling (2010) stated “administrative activities utilize approximately 43 minutes a day per physician on average or nearly three weeks per year, which translates into approximately $31 billion per year nationwide” (p. 34). In 2017, that number increased to 8.7 hours per week or more than double what it was just seven years earlier (16.6% of working hours) on administration (Woolhandler & Himmelstein, 2014). According to another group of researchers, one third of health care spending is due to administrative activities (Sahni,
They went on to say that approximately $600 billion is spent on wasteful clinical goods and services, fraud and abuse, and administrative activities. The federal government could save these funds if they addressed those issues. Others have found a relationship between costs and reimbursement models, quality, health disparities, and wellness (Braveman, 2006; Dowling, 2012; Ginsburg, 2013; Millar, 2013; Terry, Hussain & Nelson, 2010). There are many ways to reduce health care costs that include but are not limited to quality and patient compliance.

**Reducing costs.** The literature suggests that health care costs in the U.S. are the highest in the world, and trends have been running in the wrong direction with the U.S. spending more than other industrialized nations with no documented improvement in health outcomes (Hood & Weinberger, 2012; Oberlander, 2012; Milstein & Darling, 2010). A Kaiser (2014) study found a decrease in costs due to a reduction in the use of medical care. The study also reported that 19% of the population had serious financial problems due to medical bills, 13% had depleted all or most of their savings, and 7% were unable to pay for necessities, such as food or housing. Reports in the literature have indicated that the industry has been looking at new reimbursement models, working to improve quality, addressing health care disparities, and transitioning from disease management to wellness to reduce costs (Hamel et al., 2016).

**Reimbursement models.** In a survey study of 670 hospital and health system chief executive officers, Waldman, Smith, and Hood (2005) found that these individuals were concerned most frequently about reimbursement amounts and the financial stability of the organization. In addition to reimbursement and financing, they documented that one-third of their respondents complained about the lack of national health policies and inherent contradictions in the current system. These contradictions include mandated programs that are
insufficiently funded and expectations to provide care to the uninsured without recognizing uncompensated care can lead bankruptcy. Another study documented that hospitals continue to face rapidly declining revenues and rising labor costs, and the statistics from the Medicare Payment Advisory Commission (MedPAC) suggest hospitals’ margins have decreased between −5% and −7% since 2007 and reached −5.4% in 2012 (Chang, Tseng, & Shapiro, 2015).

Numerous studies have concluded that payment reform has been one of the significant changes driving transformation within the health care industry (Courtemanche, Marton, Ukert, Yelowitz, & Zapata, 2018; Ginsburg, 2013; Kaplan & Terrell, 2014). The studies stated that a shift in reimbursement from a volume-based approach, in which a provider is paid based on the number of services, to a value-based model, in which the clinician is paid based on the quality of the service, is being implemented in some areas in the U.S. but not in all areas and not by all providers (Cunningham, 2014; Landon, 2014; Rudmik, Wranik, & Rudisill-Michaelsen, 2014; Schmitt, 2012; Wexler, Hefner, Welker, & McAlearney, 2014; Wilensky, 2014). Instead of payments based on volume of services, the provider receives compensation for more efficient and effective care delivery, which is perceived as providing high quality at a lower cost.

Improving quality. In addition to new reimbursement models, the industry has been focusing on improving health care outcomes, improving performance, and advancing professional development (Block, 2018; Millar, 2013; Terry, Hussain, & Nelson, 2010). Quality in health care is “doing the right things for the right people at the right time and doing them right first time and every time” (Dodwad, 2013, p. 1). Quality includes structures, processes, and outcomes (Kapoor, 2011). Structures consist of buildings and people; processes comprise of clinical and administrative interactions; and outcomes include a measured change in the patient’s health care status.
According to Tengs and Graham’s (1996) research, the U.S. spends approximately $21 billion on life-saving services, preventing approximately 56,700 deaths annually. If those same dollars were used on the most cost-effective clinical interventions instead, an additional 60,200 premature deaths could have been avoided (Melzer & Chung, 2014).

Quality outcome measurements should include reports of underuse, overuse, and misuse of health care services (Chassin & Galvin, 1998). There are over 2,100 quality measurements in the 2014 U.S. Department of Health and Human Services National Quality Measures Clearinghouse, and more than 250 in the 2012 Agency for Health care Research and Quality National Health Care Quality and Disparities Report (Meltzer & Chung, 2014). Even though the U.S. has made significant advancements in health care, more opportunities for improvement regarding quality outcome measurements exist (Kapoor, 2011).

**Health disparities.** While some studies looked at costs, reimbursement, and quality, others have looked at health disparities. Health disparities, also called health inequalities, are differences in health care outcomes between different groups of people within the population (Braveman, 2006; CDC, 2018; Gollust et al., 2018). According to Nelson’s research (2002) there are significant variations in the rates of medical procedures by race, income, and age, indicating that racial, and ethnic minorities in the U.S. are less likely to receive even routine medical procedures and experience lower quality health services. According to the literature, since Nelson’s research was completed and published over 16 years ago, little has changed, and the U.S. continues to struggle providing adequate coverage and quality of care to all its citizens (Braveman, 2006; Gallagos, 2007). In a recent study that focused on racial and ethnic disparities in prevalence and care of patients with type 2 diabetes, the researchers found clinical trials did not involve a proportionate number of minorities in their clinical trials for diabetes drugs. This
was surprising because diabetes affects minorities at a disproportionate rate (Rodríguez & Campbell, 2017).

The impact health care disparities have on the U.S. health care system is more important now due to the significant number of new enrollees with access to health care insurance through the PPACA (Clancy, Uchendu, & Jones, 2014). New enrollees have been obtaining coverage through the newly formed health care exchanges and Medicaid expansion, and these enrollees have been younger, low-income, and members of racial and ethnic minority groups (Clancy, Uchendu, & Jones, 2014). These new insurance customers require more resources, support, and cost more than the current health care membership.

*Transition from disease management to wellness.* Numerous studies point to the benefits of a wellness-based health care program (Majette, 2011; Matthews, 2010; Nenn & Vaisberg, 2009). The studies have indicated that about half of Americans live with at least one chronic condition, such as diabetes, heart, and lung ailments. Chronic disease accounts for more than 75% of the nation’s medical costs. Many of these conditions occur due to unhealthy lifestyle choices which include obesity (Schansberg, 2014). A shift from disease management to wellness and healthy lifestyles will transition the industry from focusing on treating sick patients to developing and implementing wellness and healthy lifestyle choices as a model for disease prevention (Dowling, 2012; Majette, 2011).

*Health Care Industry Culture*

Culture is a system of shared understandings, values, and norms (Bolman & Deal, 2017). It is also well-documented that culture changes over time (Inglehart, Basanez, & Moreno, 1998; Welzel & Inglehart, 2013). The health care industry struggled to change its culture because it is
plagued with disempowerment, desire for the status quo, and an overall fear of change (Brazier, 2005; Terry, Hussian, & Nelson, 2010).

Health care reform forced the health care industry to change its culture, and this change was a core element in successfully implementing health care reform (Acar & Acar, 2014; Sorensen, Paull, Magann, & Davis, 2013). Changing a culture is difficult when an industry is plagued with bureaucracies and hierarchies, different types of leaders, a dated leadership model, and different stakeholders with conflicting priorities (Terry, Hussian, & Nelson, 2010). Changing culture successfully requires a strategic plan with an inspirational vision and transparent values with clear, achievable performance measures (Borins, 2001; Papke, 2013; Rubino, Esparza & Chassiakos, 2014). Health care executive leaders need to continue to disrupt long-standing culture and workflows if they want continued success.

**Bureaucracy and hierarchies.** Many studies have presented the health care industry as large bureaucratic system with hierarchies, silos, and an environment that cultivates mistrust (Brazier, 2005; Scott & Ferry, 2010; Seror, 2010). These studies have also stated that bureaucracy is associated with a corporate culture and that hierarchically structured organizations maintain power and decision-making at the top of the organization. Whereas bureaucratic systems have been viewed as stable, stability can be counterproductive if they are unable to change, which could lead to their demise (Osborne, 1993). Employees within these types of models become cogs in a machine who do just as they are told, and this kind of employee engagement results in a lack of critical or creative thinking and a lack of interaction with leadership which makes it harder to trust decisions and creates missed opportunities.
Other studies have concluded that health care needs to transition from the traditional hierarchical model of leadership, in which investments and decisions are made by a selected few at the top, to a model in which investments and development of leaders occur throughout the organization (Coltart et al., 2012; Hartley & Benington, 2010; Scott & Ferry, 2010). An essential area of development for the industry is an integrated leadership model bringing the administration and clinical leadership together (Scott & Ferry, 2010).

**Administration and clinical leadership.** One reason health care is so complex is because there are two pillars of leadership: the administrative (business) pillar and the clinical pillar (Aderholdt & Lockridge, 2011; Hartley & Benington, 2010; Scott & Ferry, 2010). Administration traditionally includes insurance companies, operations, human resources, marketing and communications, finance, compliance, regulatory, and information technology (Hartley & Benington, 2010). Whereas the clinical category tends to include physicians, nurses, patient care delivery, laboratory and radiology services, emergency rooms, urgent care facilities, and pharmacy facilities.

In a study surveying 11 current and former medical directors, Markuns, Fraser & Orlander (2010) found almost all considered themselves often unprepared as leaders in the early phases of their careers as medical directors. In addition to being unprepared, the survey respondents found they were unable to achieve the necessary system improvements focused on improving quality of care, which was one of the driving factors in their desire to be a medical director.

Henochowicz and Hetherington (2006) conducted a literature review in which they stated that clinical leaders’ training teaches them to be autonomous intellectuals who are self-reliant
and distrustful of anything unscientific. While clinical leaders are trained professionals, they have not received education and training in the field of management and need to learn how to be leaders within an organization (Henochowicz & Hetherington, 2006; Parker, 2013). Parker (2013) stated that leadership can come from any location within the organization, but not every employee can exhibit leadership qualities and become a leader.

Kaplan and Terrell (2014) would agree based on their previous research that physicians have historically been inadequate as c-suite leaders because they did not have the skills to take on the responsibility and accountability. In more recent years, physicians have been acquiring the necessary leadership skills through formal leadership/management education and on-the-job training and coaching. Other researchers have found clinical leadership training to be a relatively recent development, and the medical community needs leadership education and development to help clinicians successfully undertake their leadership roles (Parker, 2013; Trastek, Hamilton & Niles, 2014). Doctors, transitioning into leadership positions, need new skills to lead that use a collaborative, team approach (Henochowicz & Hetherington, 2006). Ongoing professional development is critical for clinical leaders to learn how to become leaders within an organization (Parker, 2013).

Administrative leaders seldom share the same education, experiences, and organizational perspective as their clinical leader peers (Waldman, Smith & Hood, 2005). A review of literature completed by Henochowicz and Hetherington (2006) found administrative leaders must manage clinical professionals who view them as outsiders and must work harder to gain their respect. The clinical leaders see their administrative peers as being only concerned about the organization’s financial performance (Sorensen, Paull, Magann, & Davis, 2013). Empowerment of frontline staff has been an emerging concept, and according to the Robert Wood Johnson
project, *Transforming Care at the Bedside*, this empowerment could lead to better clinical outcomes and assist in developing future leaders (Scott & Ferry, 2010). The level of empowerment varies based upon the culture of the health care insurance company.

**Multiple stakeholders.** Many studies have discussed that health care has many stakeholders with competing interests and varying agendas (Herzlinger, 2006; Trastek, Hamilton & Niles, 2014; VanVactor, 2012). Some of the key stakeholders include the Federal and State Governments which involve agencies like Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (DHS), Department of Commerce, Department of Insurance, Health Department, legislators, professional associations including but not limited to the American Medical Association (AMA), American Nurses Association (ANA), American Hospital Association (AHA), regulators which include Food and Drug Administration (FDA), National Council of Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), employers, consumers, and family members (Herzlinger, 2006; Trastek, Hamilton & Niles, 2014).

Diverse stakeholders come with different interests that frequently conflict (Trastek, Hamilton & Niles, 2014). According to Trastek, Hamilton, and Niles (2014) an examination of these conflicting interests provided an opportunity to reorganize a currently unsustainable health care system. With so many diverse stakeholders, leaders struggle to identify who is the primary stakeholder.

**The consumer.** Whereas Trastek, Hamilton, and Niles (2014) believe the consumer, the patient, is the primary stakeholder, other researchers have stated that some current practices do not seemingly support this belief. The current health care delivery model is an authority-based
system in which the doctor or clinician most often does not engage the patient in the process (Gambrill, 1999; Thorgaard, 2014). Since the 1980s, concerted ethical and political effort has focused on the placing patients at the forefront and has focused more on evidence-based medicine versus the current authority-based approach (Gambrill, 1999; Thorgaard, 2014). Studies have found the health care industry beginning to develop and implement a patient-centered care model with collaborative decision-making between health care providers and patients (Fontenot, 2011; Ginsburg, 2013; Parker, 2013; Saunders & Smith, 2013).

According to Parker (2013), implementing a consumer-directed care model requires that health care providers transition from the current paternalistic model of care to one focused more on a consultation style. This approach becomes patient centered when the doctor spends more time with the patient focusing on educating the patient regarding their treatment options, seeking additional information regarding concerns with diet and lifestyle, and engaging the patient in the decision-making process. Other researchers have asserted that patient engagement has been discussed for decades although health care organizations have not modified their processes to make it happen (Dowling, 2012; Krause & Saver, 2013).

In contrast, other studies have determined that the industry could improve the process of care, quality, outcomes, cost reductions, and promote wellness (Dowling, 2012; Saunders & Smith, 2013). Health care leaders need to develop strategies that go beyond engaging staff and achieving corporate goals to including patients more fully (Schansberg, 2014). Another study showed that publishing the health insurance industry’s performance led to improved performance and higher quality standards, as well as more consumers being enrolled in higher-quality plans (Jamieson, Machado-Pereira, Carlton, & Repasky, 2018). Schansberg (2014) reported that the
industry will continue to fail if health care does not have an engaged patient. Leadership is vital if the industry intends to engage the consumer in the process.

**Leadership.** Leadership is a process whereby a person influences an individual or a group of individuals to achieve a common goal (Northouse, 2019). Others define it as someone who directs others towards a shared goal which requires the ability to influence, manage, and respond to change (Al-Sawai, 2013; Vielmetter & Sell, 2014). According to VanVactor (2012), it is “both a science and an art” (p. 555). Leadership goes beyond making decisions and giving direction and includes creating a culture and inspiring excellence which is challenging (Fibuch, 2010; Giltinane, 2013).

In their thematic analysis of literature, Hartley, Martin and Benington (2008) concluded that leadership is a process, occurs with more than one person, and focuses around goals. They also found conflict within the literature about whether management and leadership are dissimilar or essentially the same. Most of the research literature has stated that leadership focuses on establishing the vision and direction of the organization whereas management performs the day to day activities designed to achieve the vision. Authors have also noted the distinction between formal and informal leadership. Formal leadership is leadership authority based on one’s role, and informal is leaders influencing others without being in a position of authority (Hartley, Martin & Benington, 2008).

Other studies have found leadership to be the top priority and have concluded that leadership must tackle the new challenges outlined within health care reform (Fibuch, 2010; Hartley, Martin & Benington, 2008; Isouard, 2010; McAlearney, 2009; Monheit, 2010; Slavkin, 2010). The 2000 NHS Plan argued for more attention on health care leadership development
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(Hartley, Martin & Benington, 2008). This included implementing innovative models and successfully navigating health care reform while maintaining financial solvency (Isouard, 2010; Rivlin, 2013; Weberg, 2012). Following past or current practices will not achieve the necessary change to be successful in the future (VanVactor, 2012), which raises the question, what is the new role of the health care executive?

**Role of the Health Care Executive**

With rapid changes within the industry, health care is demanding strong leadership, and leaders are under pressure to perform (McAlearney, 2009; Rubino, Esparza & Chassiakos, 2014; Sorensen, Paull, Magann & Davis, 2013). In a 2011 health care chief executive officer study, one third of the executives reported a lack of clarity and concerns regarding national health policies as their top anxieties (Waldman, Smith & Hood, 2005). Others have reported that doing nothing while the organization obtains clarity is not a good option, and leadership is critical for survival (Fibuch, 2010; Weberg, 2012). Developing a culture focused on continuous improvement, best practices, evidence-based protocols, shared decision making, and transparency are on the health care chief executive officer top strategies list if health care is going to reduce costs and increase quality (Gabow, Haloverson & Kaplan, 2012; Weberg, 2012).

Three of the top leaders within health care organizations include the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and the Chief Medical Officer (CMO) (Buchbinder & Shanks, 2016; Longest, Rakich & Darr, 2008; Miller & Batchelder, 2010). The CEO reports to the Board of Directors, is the chief administrator, and is responsible for leading the entire organization. This includes establishing the vision and strategy. The CFO is responsible for the financial management and reports to the CEO. The CMO is a licensed physician who acts as liaison between doctors and health care executives, ensures patients
receive the highest quality treatment, and is responsible for the hiring, evaluating, and training new physicians and doesn’t always report to the CEO or attend board meeting (Buchbinder & Shanks, 2016). Figure 1 is a graphic I designed from the results of my review of literature that depicts the complexity of the health insurance executive leader’s role after the passing of the PPACA. It begins with a juggling act, defined as a situation in which someone is trying to do two or more things at once and that they are finding it difficult to do those things properly, in which the health insurance executive must meet the needs and concerns of their various stakeholders. At the same time, the health insurance executive is attempting to achieve balance between delivering the Triple Aim, defined as cost, quality, and satisfaction, and meeting the financial performance expectations of the Medical Loss Ratio. The Medical Loss Ratio is a financial measurement used to encourage health plans to provide value to enrollees by using at least 80% of the premiums they receive to pay claims and fund activities that improve quality of care (Kirchhoff & Mulvey, 2012).
**Vision.** Organizations must be clear regarding their purpose (Osborne, 1993). It is “about doing the right things, not doing things right” (Osborne, 1993, p. 3). The primary role of the chief executive officer is to establish the future direction of the organization (Higgs, 2009; Waldman, Smith & Hood, 2005; Weberg, 2012). Organizational visions traditionally have emerged through collaboration and input from stakeholders at all levels throughout the organization (Porter-O’Grady & Malloch, 2003; Weir, 2017). A vision provides staff with purpose, meaning, clear roles, goals, and direction for the organization (Fenech, 2013; Giltinan, 2013; Hogan & Kaiser, 2005; Schimpff, 2012; White-Smith & White, 2009).
A health care vision needs to be simple, clear, and initiated from the top levels of leadership (Berry, 2007; Best et al., 2012; Brazier, 2005; Keown et al., 2014; Schimpff, 2012; Terry, Hussain & Nelson, 2010). A vision provides employees with the ability to make and influence decisions, ensuring proper alignment with the organization’s goals, objectives, and direction (Brazier, 2005). Other researchers found that a successful leader communicates the organizational purpose and plans, organizes, obtains necessary resources, and coordinates activities with a clearly defined strategy (Hogan & Kaiser, 2005; Osborne, 1993).

**Strategy.** A strategy translates a vision into clear direction and includes actions that lead to tangible, reportable results (Bolman & Deal, 2003; Osborne, 1993; Porter & Lee, 2013; Slavkin, 2010). It also identifies the organization’s core purpose and focus (Bolman & Deal, 2003; Osborne, 1993). Strategic planning, with representation throughout the organization, provides leaders with the ability to build trust, flatten hierarchies, and build strategic thinking (Fitzpatrick, 1995; Lytle, 1996; Slavkin, 2010). A strategic plan is an organization’s “road map” providing direction regarding their future direction and guides leadership in avoiding hazards (Bolman & Deal, 2003; Hartley & Benington, 2010).

**Alignment.** Alignment throughout the organization provides clarity, high level of participation and cooperation, commitment to excellence, and ensures the strategy is successfully completed (Bolman & Deal, 2003; Fenech, 2013; Papke, 2013; West et al., 2003). Leadership is needed to provide clarity which is associated with clear team objectives, high levels of participation, and commitment to excellence (Bolman & Deal, 2003; Fenech, 2013; Papke, 2013; West et al., 2003). Contingency theorists claim that proper alignment of an organization with their goals and objectives results in success (Powell, 1992). According to O'Reilly et al. (2010) leadership effectiveness is most visible when an organization changes its strategy and alignment.
across hierarchical levels to enhance the successful implementation of a strategic initiative (O’Reilly et al., 2010).

**Diversity.** A corporate diversity assessment involves comparing the talent pool and leadership with the customer population to ensure they mirror one another (Bahouth, Blum, & Simone, 2012). As health care continues to implement multidisciplinary clinical teams, diversification of the team must be part of the process (Fitzgerald & Davison, 2008; Nickitas, 2011; Rubino, Esparza & Chassiakos, 2014; Vielmetter & Sell, 2014). A functionally diverse team includes people with a variety of experiences and background to increase views, opinions, creativity, and innovation.

Even though women account for most of the workforce in health care (74%), they are underrepresented in executive leadership (Fontenot, 2011; Hauser, 2014). Hauser (2014) reported that women account for 24% of health care senior leaders, 18% of hospital chief executive officers, and 14% of individuals on health care board of directors. Compensation is also significantly lower for women than their male counterparts. Barriers for women to enter the executive suite include a male-dominated culture, lack of resources to advise and endorse women for such positions, glass ceilings, and lack of flexibility regarding work-life balance (Fontenot, 2011; Hauser, 2014). With the transformation of health care, there are more opportunities for women to move into the executive level but, based on the research (Hayden et al., 2018), it requires a comprehensive development program.

**Individual and Organizational Development**

Health care organizations have been increasing their focus on leadership development (Groves, 2007). A study completed by Robertson, Gerhardt, Nelson, and Jablons in 2015 found
workforce development as one of the top health care chief executive officers’ largest concerns regarding the future of health care. Other studies documented that two-thirds of the U.S. health systems have or are in the process of developing an education leadership program, and 88% of those with a program reported that their program was part of their strategic goals (Rubino, Esparza, & Chassiakos, 2014).

In a qualitative study focused on the effectiveness of a physician leadership development program, Smith (2014) studied 10 physicians. She concentrated on physicians because their education traditionally focuses primarily on patient care. The new health care reform required physician leaders to develop and implement quality and safety measurements. Smith found the two-year physician leadership program provided participants with an increased awareness of the organization’s complexity, increased their self-awareness, and increased their ability to question both their behavior and assumptions when considering new perspectives. The participants indicated that they wanted ongoing training on emotional intelligence.

Until recently, leadership development has focused primarily on formal training and education programs (Hartley & Benington, 2010). While formal education is still important, according to the research, more attention needs to be paid to informal training focused on developing leadership skills and abilities if individuals want to successfully implement their strategic plans and business goals (Dowling, 2012; Ramirez, West, & Costell, 2013). Areas of opportunity for development include, but aren’t limited to, the use of and integration of technology in both decision making, communication and sharing information, finance, quality of care, partnership support, community engagement, strong governance, and policy regulation (Ramirez, West, & Costell, 2013).
Other research completed by the National Center for Health Care Leadership (2008) concluded that leadership will fail without reforming education and professional development, improving leadership across all management levels and across disciplines, including administrative and clinical. Other researchers stated that organizational leaders must also identify talents of high potential employees, develop and implement a coaching and mentoring program, and utilize on-the-job training to develop leadership and critical thinking skills and abilities (Groves, 2007). Currently, these types of programs are extremely limited.

Leadership is a skill and therefore something someone can learn (Slavkin, 2010). Different approaches to developing leaders include formal education, seminars, on-the-job training, coaching and mentoring, and succession planning. Unfortunately, according to the literature, health care leadership development varies; there is little evidence available indicating return on investment; and there is no guarantee of funding in the future (McAlearney, 2009).

Leadership development programs are effective at developing organizational leaders and retaining employees (Sonnino, 2013).

**Formal and informal education and development.** Formal education includes programs in which participants earn a degree or certificate as well as programs that include corporate executive leadership development (ELD) and seminars (Sonnino, 2013; Ramirez, West & Costell, 2013). Activities within corporate-based programs are designed to develop participants’ skills with a focus on giving feedback, coaching, establishing performance goals, providing leadership experience, and providing opportunities for employees to be seen in leadership roles including but not limited to company events (Fibuch & Van Way, 2012; Ramirez, West, & Costell, 2013).
Clinical formal education programs and degrees traditionally have not included curriculum on leadership education and training (Coltart et al., 2012). A 2008 survey completed by the National Health Care Leadership Index found physicians, nurses, and administrators believed leadership development was crucial to achieving excellence (McGill & Yessis, 2013). Without adequate training, physicians and other clinicians continue to struggle to successfully fulfill key leadership and governance requirements. The PPACA outlines these requirements, and these leaders will be held accountable for meeting these requirements (Cherry, Davis, & Thorndyke, 2009; Coltart et al., 2012).

Informal education includes on-the-job training, coaching, and mentoring (Ramirez, West, & Costell, 2013; Sonnino, 2013). According to the literature, many organizations have failed to integrate management staff in the leadership development, on-the-job training, and succession planning process (Groves, 2007). According to a study completed in 2014, poor planning and a lack of succession plans in leadership, specifically the Chief Executive Officer role, is projected to cost $112 billion (Favaro, Karlsson, & Neilson, 2018).

On-the-job training. On-the-job training, also called workplace learning, includes work-based learning, work-related learning, informal learning, fellowships, and non-formal learning (Berings, Doornbos, & Simons, 2006; Fullan, 2002; Garman & Tyler, 2007). This type of training and learning is effective and essential in developing professional skills and abilities. Leadership arises from experience and postponing the development of these types of skills and abilities makes no sense (Parker, 2013). On-the-job training provides the future leader with an environment to develop leadership competencies (Fullan, 2002; Garman & Tyler, 2007).
Coaching and Mentoring. Coaching and mentoring are one of the most effective techniques for developing health care leadership core competencies (Henochowicz & Hetherington, 2006). These types of programs develop relationships and connections with senior management and have been shown to be essential for managerial career success (Groves, 2007; Ramirez, West, & Costell, 2013; Sonnino, 2013). This underutilized approach of development in health care should occur at all career stages and with employees, trainees, and patients (Henochowicz & Hetherington, 2006). The success of coaching and mentoring programs is dependent on the quality of the relationship between the participants, proactively identifying possible personality conflicts, and matching participants based on common interests and level of commitment (Groves, 2007).

Succession planning. Health care quality is an outcome of the organization’s leadership success or failure (Bahouth, Blum, & Simone, 2012). A recent health care survey by Smith (2014) found 74% of chief executive officers are planning to retire in the next 10 years. Another study reported that 43% of chief financial officers and 60% of chief nursing officers expect to change jobs in the next 5 years and fewer than one in four hospitals has built a talent pipeline (Bahouth, Blum, & Simone, 2012).

In a 2004 study by the American College of Health Care Executives, only 21% of 722 hospitals reported routine succession planning (Garman & Tyler, 2007). Health care can plan for success by identifying and developing talent for all levels within the organization. This development of employees should be an essential part of any strategic plan (Bahouth, Blum, & Simone, 2012; Fibuch & Van Way, 2012). Organizations without succession plans need to hire from outside of the company, which is usually more expensive than internally promoting personnel. For example, Bahouth, Blum, & Simone (2012) reported a 65% higher medium
income for external hires than those internally promoted. Authors have suggested that well-developed succession plans are essential for high-achieving organizations and this must go beyond the chief executive officer (Bahouth, Blum, & Simone, 2012; Fibuch & Van Way, 2012). To be successful, succession planning must have strong support from the CEO and senior executive team and be part of the leadership responsibilities and job expectations (Groves, 2007).

**Gaps in the Literature**

While several gaps exist in the literature, three were particularly relevant when I examined how health care leaders are experiencing and managing the changes associated with the ongoing challenges regarding health care reform. First, a significant amount of the leadership literature has focused on superhuman, heroic individuals and future leadership research should consider a wider range of leadership characteristics (Beycioglu, 2014). Second, the literature has assumed a one best approach to leadership (Day & Harrison, 2007). Exploring the variety of styles used by individual leaders can add complexity and depth to the discussion of health care leadership. Third, very few studies in health care leadership have employed qualitative research methodologies.

**Heroic Individuals**

A considerable amount of literature on leadership has focused on superhuman, heroic individuals (Harris et al., 2013; Hartley & Benington, 2010; Kamm, 2001; Sinclair & Lips-Wiersma, 2008). Literature is needed that explores beyond this limiting approach and needs to consider a wider range of influences that includes characteristics, challenges, capabilities, and consequences of successful and unsuccessful leaders. Finally, heroic leadership implies that others in the organization do not have the ability to be leaders or drive change, and their contributions to the success of the organization are not recognized (Beycioglu, 2014).
Debunking the “One Best” Approach

While there is not an agreement within the literature regarding which leadership theory is best, many books advocate for their one best approach to leadership (Giltinane, 2013; Hartley & Benington, 2010; Trastek, Hamilton, & Niles, 2014). A significant amount of literature ignores indirect and direct leadership, differences between leadership and management, and the power and influence of opinion leaders (Hartley & Benington, 2010). Researchers need to conduct studies focused on leaders trained and coached with a variety of leadership styles who utilize the styles as tools deployed at different times based on the situation. Implementing a broader research perspective may assist in identifying a different and potentially better leadership approach.

Qualitative Research Methodologies

Qualitative research methodology is uncommon in the health care industry (Al-Busaidi, 2008; Lingard, 2016). Quantitative research has been the dominant approach used for decades because most scientific journals would not publish qualitative research (Ioannidis, 2016; Turato, 2005). Scientific journals are now starting to publish qualitative research, and yet many still do not see the credibility behind it. The health care industry could benefit from qualitative research because it provides richer and more in-depth understanding of a patient’s life (Al-Busaidi, 2008; Ioannidis, 2016; Lingard, 2016; Turato, 2005).

Theoretical Perspective

This dissertation study used the principal components of five theoretical frameworks: Northouse’s (2019) adaptive leadership theory, Lincoln’s (1989) discourse, myth, ritual, taxonomy, Kramer & Enomoto’s (2007) ethical leadership theory, Bridges & Bridges’ (2016)
transition model, and Bolman and Deal’s (2017) reframing organizations theory. These theoretical frameworks were selected after completing a critical literature review and an overview of each is provided below, including references to others who have utilized these theories in their studies.

**Adaptive Leadership**

Northouse (2019) presented a conceptual model for leadership. He defined leadership as both a trait and a process. Traits included things like self-confidence, sociability, and integrity and are “innate qualities and characteristics possessed” by the leader (Northouse, 2019, p.19). As a process, leadership is based the leader’s behaviors and are skills and abilities that are obtained through education and experience. According to Northouse (2019), the goal of the leader is to achieve a common goal by influencing others. He went on and said that leadership is a “relationship between people in a social situation” (Northouse, 2019, p. 19) and stated there are many leadership approaches which include trait, skills, behavioral, situational, path-goal, leader-member exchange, transformational, authentic, servant, adaptive leadership. For my research study, I analyzed and interpreted my research findings based on Northouse (2019) theory of adaptive leadership.

Northouse (2019) described adaptive leadership as “the practice of mobilizing people to tackle tough challenges and thrive” (p. 258). Adaptive leaders help others do the work by mobilizing, motivating, organizing, orienting, and focusing their attention on what is important. According to Northouse (2019) adaptive leadership is must effective when an organization has problems that are not clearly defined are not, easy to identify, and do not have a clear solution.
According to Northouse (2019) there are six adaptive leadership behaviors which he labels as (1) Get on the Balcony, (2) Identify Adaptive Challenges, (3) Regulate Distress, (4) Maintain Disciplined Attention, (5) Give the Work Back to the People, and (6) Protect Leadership Voices from Below. When an adaptive leader gets on the balcony, they spend time understanding the big picture from all aspects of the situation. This approach enables the leader to “identify value and power, conflicts among people, ways they may be avoiding work, and other dysfunctional reactions to change” (Northouse, 2019, pp. 262-263).

In addition to getting onto the balcony, leaders must analyze and identify the challenges their organization is facing (Northouse, 2019). Failures occur when leaders incorrectly diagnosis the challenges and when leaders do not provide adequate or appropriate modifications to the environment or situation. After their analysis is completed, according to Northouse (2019), if the problem is a technical issue the leader can fix it with their knowledge and authority to resolve the issue. If the problems involve changes that impact beliefs, attitudes, and values, the leader must take an adaptive approach.

According to Northouse (2019), the third behavior of an adaptive leader is regulating distress. When leaders regulate distress, they have their team recognize the need for change while not overwhelming their team. The leader creates a safe environment enabling conversations to occur regarding the challenges they are facing and concerns their staff may have regarding their situation. The leader also provides direction, protection, orientation, conflict management, and productive norms. Finally, leaders regulate their own personal distress and maintain it in a productive range throughout the process.
The next behavior of an adaptive leader is maintaining disciplined attention (Northouse, 2019). When a leader maintains disciplined attention, it means the leader encourages their staff to focus their attention on the difficult, demanding, and challenging work they need to do to implement the necessary changes to drive the overall effectiveness of the organization. The leader also provides a safe space for their team to work through their differences, encouraging the team to talk about their conflicts, concerns, and issues. By taking this approach, the leader ensures the organization and the employees stay focused.

According to Northouse (2019), the fifth behavior of an adaptive leader is giving the work back to the people. When a leader gives the work back to the people, it means leaders provide their staff with direction, security, confidence, and empowers them to solve problems on their own. The leader does not enable their staff to become dependent on the leader. Instead, the staff learn how to address their issues, solve their problems, and move the organization forward while addressing their challenges.

The last behavior is protecting leadership voices from below. Leaders who protect leadership voices from below, listen to their staff and consider the ideas from everyone on their team including those who may be at the fringe, marginalized, or even considered deviant. By listening to these staff members, the leader gives equal power to all staff members and disrupts what Northouse (2019) calls “the normal way of doing things” (p. 270).

In the next section I present the next theoretical framework Lincoln’s (1989) discourse, myth, ritual, and taxonomy.
Lincoln’s Discourse, Myth, Ritual, and Taxonomy

Lincoln’s (1989) theory shows how myth, ritual, and classification hold human societies together and how, in times of crisis, they can be used to take a society apart and reconstruct it. I am not the first researcher to analyze health care leadership through Lincoln’s (1989) theories of discourse, myth, ritual, and taxonomy (Conroy, 2010; Vishlenkova, 2016). Lincoln’s (1989) theories impact the establishment of taxonomic structures through classifications within a culture. Lincoln examined how these roles and ideas impact and influence the construction of a society or culture. Lincoln (1989) defined discourse as a collective mind that thinks similarly which, in turn, provides members with the ability to make sense of themselves and of the world around them. They have a shared reality in which they can take part in molding the world in accordance with their perceived needs and communication. These things identify the group and establish the boundaries separating cultures.

When applied to the health care setting, written documentation such as compliance manuals, code of conduct, electronic health records with embedded clinical standards, value statements, job descriptions, as well as spoken communication are part of this discourse (Durrenberger & Erem, 1997; Smith & Stewart, 2011; Tonuma & Winbolt, 2000). Also, part of the discourse is what is not voiced, for example, dissatisfaction, errors within a process, processes not followed, and mistakes made by senior leaders. This type of discourse establishes culture and defines what is right and wrong.

Myth. Lincoln (1989) also discussed the concept of myth as a component of leadership. Myth is distinct from fable, legend, and pure history. It is instead composed of folk stories or a selected group of stories that possess credibility and authority and establish the culture. In health care, these stories determine and maintain the goals and purposes of health care. These stories
also emphasize the critical components of their culture and, when effective, ensure stability. For example, organizations like the National Institute on Health and the American Medical Association state clinical research is vital to provide safe and effective care, which leads most consumers to believe what a doctor does is backed by solid science. Yet, only a fraction of what a doctor does is based on solid evidence. Some researchers believe the rest is based frequently on no evidence, weak evidence, poor research, or on subjective judgment (Epstein, 2017; Tunis, Stryer, & Clancy 2003).

**Rituals.** Supporting the myths are the rituals of a society (Lincoln, 1989). These are the specific acts that provide ongoing support for the myth, which includes acts, words, and documents. Lincoln argued that rituals can be powerful constructs for maintaining a society. In a time of crisis, myths are used against the society, organization, and culture to take it apart and reconstruct it (Lincoln, 1989). Rituals establish organizational hierarchy and modes of operations. Discourse, ritual, and myth define and maintain the cultural identity of the organization and industry. In the health care industry, examples of rituals include the patient scheduling process, intake process once the patient arrives to his or her visit, gowned of the patient, the history and medical exam process, billing and claims process, filling a prescription, and purchasing health insurance. Perhaps new rituals could help reconstruct the industry and redefine the culture.

**Classification.** The next category of social constructs presented by Lincoln (1989) is classification. Classifications derive from a current set of facts or truths and attempt to predict future facts or truths. Classification involves organizing the physical world, organization, or industry into discrete taxonomic systems (Lincoln, 1989). Classification operates as a means of organizing concrete knowledge and as a product of social construction. While classification is
carefully constructed, there is an inherent risk with current or future events labeled as anomalies. When classified as an anomaly, these events challenge the classification and their existence upon the whole system.

The PPACA constructed a new classification within the health care industry and it disrupted to the current rituals. For example, providers are paid based on the quality of their care and service versus solely on the volume of services. The medical loss ratio is another example of a changed ritual. Insurance companies now have standards regarding the percent of premiums they must spend on claims and expenses that improve health care quality.

Figure 2 below is a graphic I designed from the results of my research that depicts the current and future U.S. health care industry revenue taxonomy in which volume is the primary driver in the current model. In the future state, volume and value-based models consisting of high-levels of cost, quality, and satisfaction measurements will generate revenue.

![Figure 2. US Health Care Industry Revenue Taxonomy](image)

As depicted in the figure above, health care providers need to generate high-levels of quality and satisfaction with large numbers of patients while driving down the costs to successfully generate
LEADING SUCCESSFULLY THROUGH REFORM RAPIDS

revenue (Carlson, Sullivan, Garrison, Neumann, & Veenstra, 2010; Ginsburg, 2013; Kaplan & Terrell, 2014; Shortell, Wu, Lewis, Colla, & Fisher, 2014). The PPACA changed the way in which the health insurance industry operates, how it is evaluated, and its financial performance. The transition is to a revenue model based on lowering costs, increasing quality, and increasing satisfaction measurements. This new model will develop new myths, rituals, and classifications within the health insurance industry. The next section is an analysis of ethical leadership theory.

Ethical Leadership Theory

Ethical leadership is a form of leadership in which an individual demonstrates conduct for the common good that is acceptable and appropriate (Kramer & Enomoto, 2007). In an ethical leadership study, Levine and Boaks (2012), assessed the relationship between leadership and ethics. First, they questioned if there was a conceptual link between leadership and ethics. Next, they used an ethical lens to evaluate “good leadership.” The researchers focused on how particular values and character determine ethical leadership, and on how power and ethics should go together with the goal of determining if leadership is a virtue. Levine and Boaks (2012) also found in their research various authors who tied leadership and ethics together. The researchers also found a connection between leadership and ethics as well very high expectations that they believe few leaders will meet. They concluded that the different theoretical lenses they examined presented a way to connect leadership and ethics and gave reasons to support the claim that ethics and leadership must go together.

Ethics defined. Kramer and Enomoto (2007) defined ethics as “the search for a rational understanding of the principles of human conduct” (p. 3). Being an ethical leader is not as simple as doing what is right and avoiding what is wrong. It is messier and more complex than that as most leadership is complex and requires nuanced thinking. To assist leadership in
evaluating ethical dilemmas, Kramer and Enomoto presented the theory and application of the DIRR (description, interpretation, rehearsal, and rediscernment) method in their book, *Leading Through the Quagmire: Ethical Foundations, Critical Methods, and Practical Applications for School Leadership*. An ethical dilemma is one in which there is more than one equally viable choice which leads to a positive result.

**Ethical tensions.** Kramer and Enomoto discussed four sources of ethical tension: virtue, desire-based, good society, and duties-based ethics. Virtue ethics considers the characteristics and qualities of a person; desire-based ethics, also called utilitarian ethics, considers the outcome for oneself; good society ethics considers what is in the best interest of those outside oneself and could extend to humanity; and finally, there is duties-based ethics which includes consideration of regulations, laws, religion, and government.

Doing what is in the best interest of the patient, when the result leads to a better outcome than the alternative, would be applying good society ethics. Deciding which would result in a higher bonus check for oneself would be applying ends-based ethics. One of the reasons why health care is so complex is that there are many stakeholders with competing interests and varying agendas that result in tensions between ends and means, and not all issues can be addressed at the same time and with equitable resources (Herzlinger, 2006; Trastek, Hamilton & Niles, 2014; VanVactor, 2012). Also, health care providers take an oath which can come into conflict with laws, corporate standards, research results, and religious beliefs and values when assessing ethical dilemmas. Having a tool like the DIRR could provide health care leaders with a process to systemically contemplate their ethical dilemmas.
Transition Model

Bridges and Bridges (2016) stated that change is situational, occurs in three phases, and people gradually accept the details of the new situation and the associated changes. There are different ways in which a leader can assist their staff through the transition process. This includes assessing how ready the company and staff are for change and having a solid communication strategy that includes messaging focused on before, during, and after the change. A leader should also identify the gains and losses, sell the problem, frequently talk about the transition, and acknowledge their employee’s feelings as being normal throughout the process. The process should also include a way to respectfully acknowledge and mark the end of the current situation and the official beginning of the new beginnings (Bridges & Bridges, 2016). Once the organization transitions to the new beginning, the leader should ensure quick successes, symbolize the new identity, and celebrate successes.

When dealing with nonstop change, a leader must have an overall design separating each of the changes as different elements (Bridges & Bridges, 2016). The design should include leadership announcements before, during, and after each of the different elements. Having a clear vision and the ability to articulate what it means to each member on the team is critical for success. Organizations that experience successful transitions have plans in place that include policies, roles, culture, leadership, structure, resources, and histories (Bridges & Bridges, 2016). Having a plan that includes these elements would help health care leaders develop and implement strategies and transition plans to successfully navigate their staff and stakeholders through health care reform.
Reframing Organizations

Bolman and Deal’s (2017) theory on reframing organizations focuses on transformation and change of both an organization and leadership. Transformation and change were outcomes of the complex, overwhelming changes the chief executive officers were facing since the passing of the Patient Protection and Affordable Care Act (PPACA) almost a decade ago.

Bolman and Deal’s (2017) theory provides a leader with the ability to review the same situation through at least four unique ways including leadership, change, and ethics. It also provides leaders with how to design the structure of their organization to fit the organization’s strategies, tasks, and context. Next, it shows how to achieve effectiveness through people, the political framework, the struggles for resources and power, and the implications of symbols and culture. Finally, their theory describes how leaders can improve leadership through a focus on change and ethics. Bolman and Deal’s (2017) theory is a relevant lens to analyze the findings of my study.

According to Bolman and Deal (2017), having the right structure ensures that employees are aligned, effective, and positive in their roles. This is achieved by developing the staff through coaching, training programs, promotions, and removal of ineffective or hostile employees. To have an effective structure requires the organization to achieve six assumptions. The six assumptions include having an established strategy with goals and objectives, being effective and efficient, utilizing coordination and collaboration, having staff that focus on the organization versus personal agendas, align with the current organizational situation and resources, and the organization utilizes problem solving and restructuring to address their issues.
When resources are scarce and when the organization has conflicting or different options, politics is used to make decisions both within and outside or an organization (Bolman & Deal, 2017). Internal and external organizations include different people and groups with diverse interests, values, beliefs, information, and views. Unfortunately, these individuals and groups utilize bargaining and negotiation to influence outcomes that align with their interests.

Power is a key resource within an organization and is used to make things happen (Bolman & Deal, 2017). Power can come from the position someone holds within the organization, for example, with their title. They also can gain power by having the ability to block something using expertise and information, reputation, and access to the decision makers as well as the ability to communicate their position clearly using beliefs, values, and their ability to influence. According to Bolman and Deal (2017), goals, policies, and structure develop because of ongoing negotiation. In large organizations, the dominant power is often controlled by senior management. Those who have power win. Power doesn’t guarantee the outcome will be fair or a wise business decision.

An organization’s culture is expressed through its symbols (Bolman & Deal, 2017), whereas an organization’s vision, values, and myths instill a deeper purpose. An organization’s vision, values, and myths also bring an organization together, establish the direction for the organization, and provide clarity to staff and stakeholders. Their vision, values, and myths frequently overlap with one another and determine the organization’s ethics (Bolman & Deal, 2017). Finally, when an organization works together as a team with clear alignment, they become a high performing team.
Bolman and Deal (2017) believe leaders within an organization have four frames through which they can assess an organization. They include structural, human resource, political, and symbolic. The four frames should also be used when assessing barriers to change and managing conflict. An effective leader analyzes each leadership activity through the four frames and selects which one or ones are likely to be the most helpful given the situation. According to Bolman and Deal (2017), effective leaders utilize multiple frames.

Summary

I selected the principal components of five theoretical frameworks: Northouse’s (2019) adaptive leadership theory, Lincoln’s (1989) discourse, myth, ritual, taxonomy, Kramer & Enomoto’s (2007) ethical leadership theory, Bridges & Bridges’ (2016) transition model, and Bolman and Deal’s (2017) reframing organizations theory to guide the structure and analysis of my research. I believe these theories contribute to meaningful reflection on the experiences of Chief Executive Officers, Chief Financial Officers, and Chief Medical Officers throughout the complex health insurance industry since the passing of the Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act in March 2010. They help us understand how health care executive leaders in the areas of clinical, administrative, and financial experienced and led their organizations during this period of ongoing uncertainty. They also assist in analyzing the findings of the study which address the research questions for this study: What knowledge, skills, and dispositions are they using during these changes? How do the clinical, administrative, and financial executives describe their leadership experience? How do current leadership practices compare to the literature? What types of decisions are health care leaders making?
CHAPTER 3

METHODS AND PROCEDURES

Introduction

In the previous chapter, I reviewed the literature, identified the gaps in the literature, and described the theories I used to analyze and interpret my data. I selected five theoretical frameworks: Northouse’s (2019) adaptive leadership theory, Lincoln’s (1989) discourse, myth, ritual, taxonomy, Kramer & Enomoto’s (2007) ethical leadership theory, Bridges’ (2016) transition model, and Bolman and Deal’s (2017) reframing organizations theory.

In this chapter, I explain the methods and measures used in this study to determine the research design, select the participants, collect interview data, analyze findings, and address potential limitations. The purpose of this qualitative study was to describe and understand how health care executive leaders in the areas of clinical, administrative, and financial are experiencing and leading their organizations in a complex industry since the passing of the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Acts.

Qualitative Methodology

Selecting a qualitative approach allowed me to gather descriptive data and to incorporate the experiences of the people with whom I dialoged into my study (Bogdan & Biklen, 2007). This included discovering what they believed the issues were, how they were facing them, how they interacted with others, and how health care reform impacted their ability to perform their job functions. A qualitative research approach also provided me with the opportunity to gather thick, rich data not achievable through a traditional quantitative study approach.
For my study, I was interested in interpreting participants’ experiences and the meaning they attributed to their experiences (Merriam & Tisdell, 2016). As a researcher, this was important because it enabled me to achieve an understanding of what was happening versus attempting to predict what may happen in the future. I also wanted to reach beyond the traditional study that focused on the what, where, and when. I was interested in exploring the why and how behind the participants’ behaviors and the reasons that governed their behavior. I wanted to understand what their professional lives were like prior to the passing of health care reform. I wanted to hear their story and understand where they are today and ask them to look back and reflect on the last decade of change they have faced. And, I wanted to know what was different today, and what their professional world was like in their specific situations (Merriam & Tisdell, 2016).

Case Study

After reviewing the six approaches to qualitative research which includes phenomenology, ethnography, grounded theory, narrative inquiry, basic qualitative study, and a case study approach (Creswell, & Poth, 2018), I selected a case study qualitative approach because it enabled me to explore real-life situations that included multiple participants over a period of time through detailed and in-depth data collection (Creswell & Poth, 2018; Merriam & Tisdell, 2016). It also provided me with the ability to collect data using observations, interviews, and audio recordings. I selected one broad issue and multiple people to illustrate the issue from several research locations and environments. I purposefully selected multiple cases to obtain different perspectives on the issues. Because I had multiple people participate in my study, I collected and analyzed data using a multicase approach, which enabled me to explore, study, and compare their interpretations of their situations. I also selected interviews as the primary vehicle
for conducting this study. Finally, I selected a case study approach because it enabled me to explore how health care executive leaders in the areas of clinical, administrative, and financial are experiencing and leading their organizations during ongoing uncertainty and to draw upon multiple sources of information to provide an in-depth picture of the case.

**Recruitment and Selection of Participants**

Prior to recruiting participants, I received approval from the University of St. Thomas Institutional Review Board to conduct the study. The participants recruited in my study included current, future, and recently retired health care executive leaders within the health insurance industry. I found this part of the process to be time consuming. If the organizations I contacted did not immediately respond, I made phone calls to move the process forward. The process was more efficient once I made direct contact with those who agreed to be participants in my study.

To be eligible to participate in my study the participants had to be, at the time of the interview, formal health care leaders as defined by their titles of Chief Executive Officer, Chief Financial Officer, and Chief Medical Officer, and working in either a for-profit or non-profit organization. I wanted to find three Chief Executive Officers, three Chief Financial Officers, and three Chief Medical Officers from four different health insurance companies located throughout the United States.

I recruited participants by sending written letters to the National Center for Health Care Leadership, Health Care Leadership Council, Women in Health Care Business Leadership, Congress on Health Care Leadership, and the American College of Health Care Executives for recommendations. I also utilized my professional contact and networking list. Initially, I sent written letters and reached out through email to each of the leaders in my contact and networking
list. In my communication, both written and electronic, I introduced myself, my dissertation topic, and questioned if they would be willing to be interviewed for my study. Each email I sent included an attachment of my participation consent form. Only a couple individuals responded immediately. I sent a follow-up email to those who did not respond, and in some cases, I placed a call to confirm their interest and to schedule interviews.

Once I secured my participants, I requested all participants in my study to consent to participate in interviews. See Appendix A for a copy of my consent form. Each participant received a copy of my approved consent form to complete and return. I sent two emails to the participants – an original invite and one reminder a few days later. I also made sure I did not force anyone to participate and provided prospective participants with the option to say, “No, thank you.”

The participants worked at different health insurance companies located within the West, East, South, and North regions of the United States. The Western area included Alaska, Washington, Oregon, California, Colorado, Nevada, Hawaii, Idaho, Utah, Guam, and Arizona. The Eastern region included states of Maine, New Hampshire, Massachusetts, Rhode Island, District of Columbia, Pennsylvania, Connecticut, New York, New Jersey, Delaware, Maryland, Virginia, Vermont, and North Carolina. The Southern region included Florida, Puerto Rico, Virgin Islands, Georgia, South Carolina, West Virginia, Alabama, Kentucky, Mississippi, Tennessee, Arkansas, Louisiana, Oklahoma, New Mexico, and Texas. Finally, the Northern region included Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Montana, Wyoming, North Dakota, Ohio, South Dakota, and Wisconsin. Individuals from each region, not every state, were represented in the study.
My initial plan was to interview 12 participants that included one Chief Executive Officer, one Chief Financial Officer, and one Chief Medical Officer from each of four different insurance companies representing the four different regions of the United States. The plan was to interview individuals in person, over the phone, or via Skype. I added three more individuals: one Chief Executive Officer, one Chief Financial Officer, and one Chief Executive Officer for two reasons. The first reason for this occurred as a result of my discussions with the health care executives located within the Northern region. They asked about my study, what I was studying and why, what I hoped to gain, and how I structured my study specifically regarding what states were included within each region. The leaders I interviewed within the northern region encouraged me to break the Northern region into two regions. They explained while the administration of health care can be national or even large regional health plans, the care provided to patients and the approach, they believed, would be different in the Midwest than it is in the Northern regions. The leaders within the northern region felt strongly I should break the Northern region into two regions. The Northern region would include Michigan, Minnesota, Montana, Wyoming, North Dakota, and Wisconsin and the Midwestern region would include Illinois, Iowa, Kansas, Missouri, South Dakota, Nebraska, Ohio, and Indiana. They thought I would have a gap in my study if I didn’t include at least one health plan from the Midwest.

The second reason I interviewed more individuals was to ensure I would have “saturated” data. Saturated data occurs when hearing the same responses to my interview questions or when observing the same behaviors from my study participants (Merriam & Tisdell, 2016). Because this was a qualitative study, I didn’t wait until the end of my study to analyze my data. Instead, I analyzed data throughout my study. I wasn’t confident that I was achieving saturation, so I added one more Chief Executive, Financial, and Medical Officer from a health plan located
within the Midwest region. During my last set of interviews, I received many of the same responses as I had from my earlier participants.

**Description of Participants and Their Work Environments**

The 15 participants in my case study included five Chief Executive Officers, five Chief Financial Officers, and five Chief Medical Officers within one of five different health plans located throughout the five regions of the United States. One group of leaders were from an organization in the Western region of the United States, one in the Eastern region, one in the Southern region, one in the Northern region, and one in the Midwest. One group, the Northern region, unintentionally became a group interview versus the individual interview approach I took with all other regions. This happened because of the language I used in my email to explain to the administrative assistant what I was trying to coordinate, schedule, and achieve, and she misunderstood my intent. Thus, I interviewed the CEO, CFO, and CMO from one organization together in a single session. After this situation, I spoke over the phone with all other participants and those with whom I coordinated to schedule the individual interviews to ensure this didn’t happen again. Pseudonyms were used for the names of all participants in the study. The following are facts about all 15 participants:

- 80% of the participants were males and 20% of the participants were females
- 70% were Caucasian
- 60% of the organizations were non-profits and 40% were for-profits
- 100% had a baccalaureate degree, 30% had a doctorate degree, and all but one participant had an advanced degree.
**Chief Executive Officers.** A total of five Chief Executive Officers participated in the study. Some demographics about these participants include:

- 100% were males
- 100% were Caucasian
- One had a Doctorate degree
- One had a Law degree
- 100% have advanced degrees

Additional information about this group is shown in Table 1.

**Table 1**

*CEO Participants' Gender, Education, Region, and Profit Status*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Education</th>
<th>Region</th>
<th>For or Non-Profit</th>
</tr>
</thead>
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<td>PhD</td>
<td>Southern</td>
<td>For-Profit</td>
</tr>
<tr>
<td>Michael</td>
<td>Male</td>
<td>MBA</td>
<td>Western</td>
<td>Non-Profit</td>
</tr>
<tr>
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<tr>
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<td>MPH in Progress</td>
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</tbody>
</table>
Chief Financial Officers. Five Chief Financial Officers (CFOs) participated in the study. Some key facts about these participants include:

- 80% were males and 20% were females
- 60% were Caucasian
- 50% had a master’s in business administration degree
- All but one had an advanced degree.

More specific information about this group is listed in Table 2.

Table 2

*CFO Participants’ Gender, Education, Region, and Profit Status*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Education</th>
<th>Region</th>
<th>For or Non-Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jay</td>
<td>Male</td>
<td>MBA</td>
<td>Southern</td>
<td>For-Profit</td>
</tr>
<tr>
<td>Bob</td>
<td>Male</td>
<td>MBA</td>
<td>Western</td>
<td>Non-Profit</td>
</tr>
<tr>
<td>Richard</td>
<td>Male</td>
<td>MAS</td>
<td>Midwest</td>
<td>For-Profit</td>
</tr>
<tr>
<td>Tony</td>
<td>Male</td>
<td>MBA</td>
<td>Eastern</td>
<td>Non-Profit</td>
</tr>
<tr>
<td>Amy</td>
<td>Female</td>
<td>BBA</td>
<td>Northern</td>
<td>Non-Profit</td>
</tr>
</tbody>
</table>
Chief Medical Officers. Five Chief Medical Officers participated in the study. Some key facts about these participants include:

- 60% were males and 40% were females
- 60% were Caucasian
- 100% had at least a Doctorate degree
- 100% were Medical Doctors.

Additional information about the Chief Medical Officers is shown in Table 3.

Table 3

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Education</th>
<th>Region</th>
<th>For or Non-Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patrick</td>
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<td>Doctorate</td>
<td>Southern</td>
<td>For-Profit</td>
</tr>
<tr>
<td>Karen</td>
<td>Female</td>
<td>Doctorate</td>
<td>Western</td>
<td>Non-Profit</td>
</tr>
<tr>
<td>Cindy</td>
<td>Female</td>
<td>Doctorate</td>
<td>Midwest</td>
<td>For-Profit</td>
</tr>
<tr>
<td>Ray</td>
<td>Male</td>
<td>Doctorate</td>
<td>Eastern</td>
<td>Non-Profit</td>
</tr>
<tr>
<td>Mark</td>
<td>Male</td>
<td>Doctorate</td>
<td>Northern</td>
<td>Non-Profit</td>
</tr>
</tbody>
</table>

Participants’ Health Insurance Plans. The health plans whose executive leaders participated in this study include both for-profit and non-profit companies throughout the United States. The health insurance products these organizations offer included Commercial, Medicare, and Medicaid. Commercial products include products for consumers who receive their health plan coverage through their employer and for those who purchase directly from the health plan. They are traditionally individuals under 65 years of age and can include families. Medicare members include those who are 65 and older or disabled and are currently enrolled in Medicare.
Parts A and B and have elected to enroll in a Medicare Advantage health plan. Medicaid members include individuals with low income, families and children, pregnant women, the elderly, and people with disabilities.

The five organizations represented within this study included start-ups, small, medium, and large health plans. A start-up is a health insurance company in an organization that has been in business for less than five years. Small health plans have less than 25,000 members, medium have between 25,000 to 1 million members, and large have over a million members. Health plans refer to individuals as “members and covered lives”. For my study, I had one start-up with revenues over $50,000,000, one small health plan with revenues over $200,000,000, two medium health plans with revenues between $2,000,000,000 and $5,000,000,000, and one large, national health plan with revenues over $50,000,000,000.

The membership within these organizations varies based on their location as either a local, regional, or national health plan. Local includes members within a county or series of counties, regional includes one state or multiple states, and a national health plan has membership throughout the United States. Most national health plans have over one million members, and the top five have over 160 million members combined.

Finally, three of the organizations from which I interviewed participants were solely health plans. That means they offer health insurance products and services, the physicians who are providing care to the health plan members are not employees, and the hospitals are separate corporations. Two of the health plans from which I interviewed individuals were Integrated Delivery Systems (IDS). IDS are organizations that combine hospitals, physicians, medical clinics, universities, and health insurance companies into one organization. Integrated Delivery
Systems may not be obvious because the organizations within it do not always have the same name. Traditionally, the physicians who work in an Integrated Delivery System are employees of the organization, and the hospital and other health care services are one organization with a centralized mission, vision, and values.

**Data Collection**

The research questions guiding the study were: What knowledge, skills, and dispositions are they using during these changes? How do the clinical, administrative, and financial executives describe their leadership experience? How do current leadership practices compare to the literature? What types of decisions are health care leaders making? Interview questions were formulated around these research questions.

My interview questions began as broad as possible, what Creswell (1998) calls the grand tour question (central question) and, as I moved through them, they narrowed. My questions also evolved as I collected and analyzed my first series of interviews, especially my follow-up questions. By taking this approach, I was able to use open-ended, semi-structured questions focusing on the “how” and “why” of the impact of ongoing health care reform and the impact to executive leadership. The interview guide I used is included in Appendix B.

I conducted interviews with participants during Winter and Spring, 2018, almost a decade after the passing of the PPACA. I sent all participants, per their request, the questions I was going to ask them during each of their interviews. I used a digital recording device to record the interviews which lasted between 45 to over 90 minutes. All interviews were completed over the phone. I obtained a confidentiality agreement prior to submitting my interview digital recordings of my interviews for transcription. I used a professional transcription service offered through Rev.com. My digital records were uploaded into a password protected secure website offered
through Rev.com. To ensure I didn’t forget any key details, I made notes within 30 minutes of each interview regarding my thoughts, feelings, and any follow-up questions I might have for a participant.

I collected data by interviewing those who volunteered to participate in my study. In addition to conducting the 15 interviews, I requested additional records to support interview content or facts that were important to the research questions. The records I requested included facts and figures regarding their organization. The records included details regarding the size of their organization measured by revenue and membership, organizational charts, overview of each organization, mission, vision, and values, links to their websites, and an overview of their products and services.

Data Analyses

Data analysis makes meaning out of the data (Merriam & Tisdell, 2016). The data I collected enabled me to tell the story of health care clinical, administrative, and financial executive leaders prior to the passing of health care reform and the current environment that included ongoing uncertainty and frustration. This approach enabled me to gather insight into what leadership skills and abilities the participants believed will be necessary to be successful in the next five to ten years. I started my data analysis process by reading and rereading all my transcripts, notes, and memos. My goal was to take my raw data and turn it into findings.

Coding

Coding is the process of taking text data or pictures, segmenting sentences (or paragraphs) or images into categories, and labeling these categories with a term, often a term based on the actual language of the participant (Bogdan & Biklen, 2007).
I started my data analysis process by reading and rereading all my transcripts, notes, and memos. My goal was to take my raw data and turn it into findings. To achieve this goal, my data analysis documented patterns, important categories, dimensions, and interrelationships. Multiple times, I read all the transcripts to obtain a general sense of the information and to reflect on its overall meaning. I also listened to the audio recordings multiple times to ensure I didn’t miss any inflections that provided additional meaning. I documented inflections within my coding process.

I also utilized peer debriefing and obtained feedback from an experienced researcher with a doctoral degree in education. The impartial peer examined some my transcripts, general methodology, and findings. This process helped me become more aware of my own views regarding the data. I received and incorporated this feedback.

**Major Themes and Categories.** After I read all the data multiple times, I coded it utilizing both Microsoft Word and Excel. I used a color-coding approach to document which words, sentences, and paragraphs were associated with an identified code. I identified major themes and categories by using inductive analysis. Inductive analysis is an approach in which the researcher allows theory to emerge from the bottom up versus searching out data to prove or disprove a hypothesis (Bogdan & Biklen, 2007). I continued to recode until I had arrived at my final codes. The major themes or categories that emerged from this process were (a) health care reform; (b) education and lifelong learning; (c) leadership; (d) quality; and (e) the role of the member.

**Subcategories.** After I identified my major themes, I reviewed, coded, and refined the subcategories. By identifying subcategory codes, I found it easier to make interpretations and
meaning out of my data. This approach provided a better understanding of the experiences of the health care executives who participated in my study. My major themes and subcategories are as follows:

**Major theme: Health Care Reform**

Subcategories:

1. Uncertainty
2. Major Change
3. Government and public policy
4. Data and technology

**Major theme: Education and lifelong learning**

Subcategories:

1. Advanced degrees
2. Lifelong learning
3. Certificate programs
4. Share the knowledge
5. Credible

**Major theme: Leadership**

Subcategories:

1. Collaboration
2. Leadership style
3. Trust
4. Transparency
5. Succession planning
6. Culture
7. Strategy  
8. Alignment  
9. Disparities  
10. Leadership development  

Major theme: Quality  

Subcategories:  
1. Measurement  
2. Accreditation  
3. Opportunity for Improvement  

Major theme: The Role of the consumer  

Subcategories:  
1. Contact and engagement  
2. Disenrollment  
3. Medicare star rating  

My goal when completing the data analyses was to use a variety of processes and procedures to enable me to transform the qualitative data I collected into some form of explanation, understanding, and interpretation of the people and situations within my study.  

**Role of the Researcher**  

In this study, my role as the researcher was to provide meaning of the experiences of my participants. The participants were consulted to ensure credibility of the descriptions I gleaned from their interviews and information they shared with me. I sent the participants copies of their transcribed interviews and draft copy of my dissertation for their review. I asked each participant to review my documents and confirm I accurately represented their voice. Not one
participant sent back any changes. While I implemented many tools and techniques, I recognize that some biases and limitations likely exist in the study.

My experiences, beliefs, and values undoubtedly influenced the research I completed. It began with the choice of my research topic and my methodology, which likely had some influence on my interpretation of findings. To reduce my biases, while incorporating my experiences, beliefs, and values, I addressed this by writing memos and observer comments as well as maintaining a journal throughout the process to surface my own experiences and reactions.

Summary

In this study, I used a case study qualitative research approach because it allowed me to learn about participants’ real-life experiences. It also allowed me to access the study participants’ thoughts and feelings. I was able to gather descriptive data and incorporate the experiences of the people who participated in my study. It provided me with an understanding of what was happening versus attempting to predict what may happen in the future, to reach beyond the traditional study focused on the what, where, and when, and to explore the why, how, and reasons behind the participants’ behaviors.

To be a participant in this study, the participants had to be, at the time of their interviews, formal health care leaders as defined by their titles of Chief Executive Officer, Chief Financial Officer, and Chief Medical Officer. I initially recruited four Chief Executive Officers, four Chief Financial Officers, and four Chief Medical Officers from four different health insurance companies located throughout the United States and added one more to each category. I used pseudonyms to protect my participants’ identity.
Most of the participants in this study were highly educated Caucasian males, and more than half worked for a non-profit health plan. This isn’t surprising since most executive leaders throughout the United States are Caucasian males. All the Chief Executive Officers were Caucasian males. Whereas, the Chief Financial Officers included one female and two were non-Caucasian, and the Chief Medical Officers included two females and two who were non-Caucasian.

The final step in my methods and measures process was to code the interview transcripts. To complete this process, I took my raw data and turned it into findings. I identified patterns, important categories, dimensions, and interrelationships. Multiple times, I read all the transcripts and listened to the audio recordings to ensure I didn’t miss any inflections that provided additional meaning. This led to the five themes: (a) health care reform; (b) education and lifelong learning; (c) leadership; (d) quality; and (e) the role of the member. After I identified my major themes, I reviewed, coded, and refined the subcategories.
CHAPTER 4

FINDINGS

Introduction

In the previous chapter, I explained the methods and measures used in this study to determine the research design, select the participants, collect interview data, analyze findings, and address potential limitations. The purpose of this qualitative study was to describe and understand how health care executive leaders in the areas of clinical, administrative, and financial are experiencing and leading their organizations in a complex industry since the passing of the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Acts.

This chapter discusses the findings from 15 interviews completed in 2018 with five Chief Executive Officers, five Chief Financial Officers, and five Chief Medical Officers working within five different health plans located within the five regions within the United States. The purpose of this study was to understand how health care executive leaders in clinical, administrative, and financial areas are experiencing and leading their organizations during ongoing uncertainty. It examined what knowledge, skills, and dispositions these leaders use during these changes. It explored how clinical, administrative, and financial executives described their approach to leadership and what is needed to be successful leaders in the future. Finally, it analyzed what types of decisions these leaders are making.
The major themes or categories that emerged from this process were (a) health care reform; (b) education and lifelong learning; (c) leadership; (d) quality; and (e) the role of the member. The five themes and subcategories within each theme are described below.

**Health Care Reform**

Health care reform is the first theme that emerged from the data. At the beginning of the interviews, one of the first questions I focused on was the impact of the Patient Protection and Affordable Care Act (PPACA) on the industry, their organization, and their ability to lead. During the conversations with the participants all but two of the participants acknowledged that the health plan industry has experienced decades of reform but nothing to the magnitude of the Patient Protection and Affordable Care Act (PPACA). The last time the industry went through this much change occurred in July 1965 when Medicare was signed into law. Medicare was passed because people over 65 found it virtually impossible to get private health insurance coverage which is the same issue the PPACA was attempting to address for those under the age of 65. Issues related to uncertainty, change, government policy, and technology in the current era of health care reform was at the forefront of the interviews.

**Uncertainty**

Participants in this study believed the current environment has an enormous amount of uncertainty which is impacting their ability to strategize and provide their stakeholders with any level of assurance and confidence. Nick, a Chief Executive Officer, stated “Certainly change is at the tops of our minds and figuring out how to navigate great uncertainty, … as leaders, it's huge.” Scott said, “So what I've tried to do is just be very clear to the Board and our key stakeholders and make sure everyone is on the same page with that potential uncertainty.” He went on to say, “Our focus hasn’t changed. We are here to provide care for people and I want us
to be more behind the scenes, ensuring that we have a long-term and sustainable model, so that we can be here, like I said, another 100 years.” Richard said “Things are uncertain. Right now, it is about anticipating the what if’s, and having contingency plans.” Based on those who were interviewed for this study, this uncertainty has made planning for the future a complicated matter for health care providers, payers, pharmaceutical, government agencies, new entrants, and employers.

Mergers and acquisitions are also driving a substantial amount of uncertainty. Scott, Chief Executive Officer, discussed the impact these changes are having on the industry and changing landscape. He said, “As an insurer, we are not just acquiring smaller health plans. We are not merging in ways we have in the past. This is leading to more vertical integration within the industry.” Two Chief Executive Officers, Michael and Brian, shared examples of mergers between health insurance plans and hospitals and large medical systems. Nick, Michael, and Dr. Mark questioned if a standalone, local or regional health plan will be a thing of the past. Dr. Mark, a Chief Medical Officer, stated the uncertainty has an even greater impact for “regional and community-based plans” that are only a health plan and not part of a medical group, hospital, or a University. Jay, a Chief Financial Officer, stated “It's all about anticipating the what if's, and having and developing contingency plans to the extent that the environment continues to be uncertain.” He said they do a lot of “contingency planning” and how this is a “big part of” what he and his peers do daily.

Uncertainty caused stress within these organizations. Scott, CEO of a Midwestern health plan, shared a story in which just a couple of years after the passing of the PPACA his annual employee survey had one of the highest scores in the category of stress and confusion their organization had seen in over 20 years. He said, “As leaders, we were stressed but we had no
idea how it was impacting our staff until we saw our employee survey results.” He went on to say, “even though we were very busy, we decided to hold more staff meetings with the goal of providing our staff with an opportunity to share how they were feeling and talk about their areas of concern.” Tony, CFO of an Eastern health plan, said: “We have to be candid about where the uncertainties lie and be transparent about them.” He went on and said, “we must have ongoing conversations with our team or the stress and uncertainty will continue to increase our employee turnover.”

Dr. Cindy, Chief Medical Officer, and Dave, Chief Executive Officer, believed there are opportunities that lie beneath the uncertainty. Dr. Cindy stated, “There’s tremendous opportunity right now for those who are willing to push the envelope and drive change.” Brian stated there continues to be a demand for healthcare services because of the aging population, increasing prevalence of chronic disease, and the desire for a higher quality of life. These all lead to growth within the industry. Bob, the Chief Financial Officer, believed there is an opportunity for “out of the box thinker-types” and “entrepreneurs.” He said that if you continue to perform business as usual “you will die”, meaning the organization will cease to exist in its present form. Dr. Cindy, a Chief Medical Officer, stated “There’s tremendous opportunity.” She stated that if you want to grow your business, improve patient satisfaction while delivering high-quality, and patient-centered care, the organization that can “deliver value-creating solutions” will succeed in this new health care environment. The environment is uncertain and impacted health care leaders’ ability to strategize and provide their stakeholders with any level of assurance and confidence.

**Major Change**

In addition to uncertainty, the participants agreed the affordable care act changed the face of health insurance in the United States. It is transforming the industry and its impacts have been
vast and wide. Jay, a Chief Financial Officer, explained that the changes have been impacting their entire business model—changes in the marketplace, their products, their structure; and a redefinition of their value proposition. Jay said, “Something had to change” because consumers, employees, and government agencies could not afford the high premiums for health insurance. He went on to say that it is challenging to lead right now due to the large number of changes, and that leaders in the health insurance industry “don't know what other changes are coming.” Dr. Cindy, a Chief Medical Officer, said “My big focus right now is change management.” According to Scott, Chief Executive Officer, it is “rapid change, its everywhere... it's painful.” All participants acknowledged the tremendous amount of change occurring in the industry right now from a variety of fronts.

Some of the changes resulting from health care reform were described as positive. For example, the previously uninsured now have coverage, have access to care, and are part of a health insurance plan. The coverage expansion included expanding Medicaid, adding new members, and adding the development and implementation of the health care exchanges which added a substantial number of new individuals and small employer groups as members in health plans and the millions of young adults who are now able to stay on their parent’s health plan. Michael, a Chief Executive Officer, said “The most significant impact it [health care reform] had on the industry would have to be the Medicaid expansion.”

In addition, participants in my study described areas of opportunity for ongoing improvement. Dr. Cindy shared how they now have medical doctors on their Board of Directors in response to health care reform. While these providers have impressive clinical backgrounds, they do not have any experience as leaders working within an insurance company. She questioned their ability to effectively drive change when they are not knowledgeable about the
organization or industry. Yet, as board members, they are responsible for establishing policies for corporate management, oversight, and making decisions on major company issues. She said, “I believe it would benefit the organization if the Chief Medical Officer attended or has dotted line [reporting responsibility] to the Board of Directors.”

Mergers and acquisitions have not only been driving uncertainty, they are a key reason for some of the major changes that the health insurance industry has been experiencing today, and mergers and acquisitions will continue to provide challenges in the future. Participants in my study talked about mergers and acquisitions that occurred in the last decade since the passing of the PPACA. Michael and Nick, Chief Executive Officers, shared details regarding how the national health plans are now purchasing clinics, and one even acquired a bank. Michael and Nick referenced the previous merger negotiations between Anthem and Cigna. During my interviews with Nick, Bob, and Jay they analyzed the merger between Aetna and pharmacy chain CVS. Bob, Amy, and Dr. Mark referenced the fact that UnitedHealth Group has been acquiring doctor groups and ambulatory-care providers for years. Dr. Mark, Dr. Cindy, and Nick questioned how the smaller health plans will be able to compete when these health plans have most of the market and the ability to negotiate substantial savings.

Participants indicated different views about how people respond to changes in the health care industry. Scott and Dr. Ray said the industry is starting to embrace the major changes and move forward with implementation of health care reform. Scott also stated he was surprised there were still leaders in the industry who believe the federal government is going to repeal and replace the PPACA. Dr. Ray, a Chief Medical Officer, said “There's a lot of people in the industry who would just as soon keep their heads in the sand and not change.”
There also appeared to be a lack of confidence, however, in the longevity of the changes being implemented. Dr. Ray and Scott specifically discussed this topic. For example, Dr. Ray said, “There's a lot of people that just say, well, they'll just keep rolling them back and change will really never happen.” Scott, Chief Executive Officer, was one of the leaders who was excited about the changes and indicated it would give their organization an advantage. He said, “We will go in and grab market share, which we have, because others were, perhaps, too cautious or didn't quite figure out the right formula.” Successful health plans are those that can stabilize administrative costs, lower medical costs, and deliver high customer satisfaction that meets the needs of a local market.

The ability to change, adapt, and evolve during these major changes was important. Those who participated in my study felt that organizations that embraced these changes and responded to them effectively, efficiently, and appropriately obtained a competitive advantage and should do better than their competition in the future.

**Government and Public Policy**

The government, both Federal and State, plays a significant role in the health insurance industry. It includes but isn’t limited to the rules and laws that guide expectations and how the industry is expected to perform. The Patient Protection and Affordable Care Act (PPACA) established a new relationship between the government, employers, and individuals for ensuring that all Americans have access to affordable and good-quality health insurance.

Most private insurance is regulated at the state level. In 2014, state and federally administered health-insurance marketplaces were established, as required within the PPACA, to provide additional access to private insurance coverage with income-based premium subsidies.
for low- and middle-income people. Health insurance leaders saw the government play a different role after the passing of health care reform. Dr. Mark said, “ACA in some ways launched the government as a key driver of change in the market place, whether it's value-based contracting, innovative pilots, different coverage[s], and purchasing models”. He went on to say, “The governments been driving a lot of…those changes…because perhaps larger payers and certainly smaller payers weren't doing some of what we perhaps could have been doing.” The role of the federal government in health care continues to evolve and change since the passing of the PPACA. All the participants in this study questioned what the government’s role will be in the next three to five years.

The federal government is a payer, a regulator of the health insurance industry, and the largest payer and regulator in the United States. It reshaped, through innovation and disruption, the country’s health insurance market. Historically, the government has used public policy to drive change. Not everyone who participated in the study thought the government made the right decisions when they drafted and passed the PPACA. Tony said, “I think you need either a government program or more of a completely private sector one. Going in the middle with compromises just doesn't work.” The passing of the PPACA was proof of the federal government’s power to disrupt and influence change within an industry. Dave explained,

I think, get ready for disruption. That is the thing we're seeing today, politically and in other venues. It is all about disruption. The ones who can either disrupt and improve the system, or who are adaptable enough to go with and ride the wave of disruption will be the winners. Those who stay with the same old way of doing things will be left behind.
It was clear from the participants if a health plan wants to succeed going forward, it must recognize the need for change, embrace change, and lead the transformation which includes developing and implementing tactical plans and holding their staff accountable to help drive the change.

It is through its regulator role that the federal government establishes minimal health care standards. Effective regulatory requirements protect consumers from harmful clinical outcomes and the health insurance industry. This was illustrated by Dr. Mark who said, “[The] government starts questioning whether health plans are really adding enough value in the model” and Dr. Ray who stated, “The government tends to get really aggressive when they believe we [the health insurance industry] are not providing value.” Health insurance leaders acknowledged the industry is focusing on improving outcomes. The areas of focus include clinical care pathways, which are outcome measurements, payment reform, and reducing costs by managing chronic conditions to avoid more expensive care, such as visits to the emergency room. For example, Dave, CEO of a Southern health plan said,

I believe in my heart of hearts we must focus on outcomes. I personally believe we will obtain better outcomes if we collaborate and work with people who are diverse, not just diverse in ethnicity, but diverse in gender, diverse in thinking, and diverse in geography.

Richard had a slightly different view. He said his organization is focusing on lowering costs, improving patient experience, while improving outcomes. If we want to succeed going forward, we must be successful at all three measurements.

The government also sponsors research, demonstrations, and education and training programs for health care professionals. This broad scope strengthens its role as a purchaser,
health care provider, and regulator. Going forward, the health insurance industry needs to be a participant in the change process, or they will be a victim of the process. Dr. Cindy put it this way,

The reason it is important we [the health insurance industry] have a seat at the table is so we get a chance to get involved in policy. You get an opportunity to say, ‘Wait a minute, that's not the best thing’ or, ‘How are we looking at this and [can we] work together to determine how we can positively impact this outcome?

Until now, there hasn’t been a better time for health insurance companies to partner with others in the industry and the federal government to pilot new payment models, care models, and new ways of delivering care.

One of the reasons why the government has so much influence on the insurance industry is the percentage of membership and revenue the insurance industry receives from the government. For example, Tony, a Chief Financial Officer said, “Why do we act surprised when the government intervenes, we already know this is a government-run program effectively, [and] most people get subsidies.” Michael, Chief Executive Officer, discussed how most regulators do not understand how health care works, how it is funded, and how their decisions impact success or failure. He believed that government regulators just don’t understand the differences unique to the health care industry. The health insurance industry is in a unique position to be a leader in changing health care in the United States. Success will be measured in their ability to manage health costs while improving patient safety and outcomes. Achieving these goals requires having meaningful data, information, facts, and figures in a timely manner, which leads to another area in which reform is occurring, the use of data and technology.
**Data and Technology**

The health care industry hasn’t developed, invested in, and leveraged technology like other industries. The industry is in a difficult position because it is ill prepared to leverage the digital revolution. Bob explained that they were behind the times compared to his previous experiences outside of the health insurance industry. Jay admitted that their technology tools are primitive. They were not the only ones who felt this way. Dave also said, “I think we're behind other industries, and so maybe we'll see larger movements.” The health care industry doesn’t believe they are the only ones who are behind in the use of technology and leveraging data. According to Dr. Mark, “Federal and State governments are smartly recognizing they have data and are using it in a way that they [didn’t use] 10, 15 years ago.”

Some of the changes in technology include big data, the cloud, telemedicine, portal technology, wireless technology, wearable technology, payer and provider analytics, artificial intelligence, key performance indicators, and leadership dashboards. By collecting data on their users, forward thinking insurance companies have the capability to customize their service and experience for each member, which increases customer loyalty, differentiates their products and services in the marketplace while also reducing costs. Dr. Karen talked about how important it is to have high quality data and the knowledge and ability to leverage it. Dave and Tony shared how companies are moving their infrastructure to the cloud which allows them to update and streamline their infrastructure and enable them to hire resources throughout the world. Dr. Cindy said if you want to be a senior leader in health insurance, “You really need to know how to look at data.” She went on to say, “You really need to learn how to be able to read reports, how to do pivot tables, and you need to be able to read information like financial reports.” Being able to
mine the health plan data, provides the leader with the ability to tell a story about what happened and why, to predict future performance, and to make better decisions.

In the health insurance industry, data analytics is more than just running a business and generating a profit. The industry uses data to improve health care outcomes. According to Dr. Cindy, data can determine what needs to be updated based on the latest research, and how to “standardize workflows to improve accuracy and clinical outcomes.” The health plan data provides them with the ability to identify and implement initiatives designed to improve both the cost and quality of care. The data also enable them to develop and implement new approaches which include bundled payments, quality measures, shared savings, and pay-for-performance initiatives.

Despite the participants’ recognition that technology needs to be used more widely, Michael, Nick, Amy, and Dr. Mark shared hesitations they and others have regarding implementing and leveraging technology as quickly as is done in other industries. Michael and Nick talked about the delay in moving forward with new technology and with using big data was due to the passing and implementation of Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) law, and the costs associated with these programs. HIPAA and the HITECH law addresses the privacy and security concerns associated with the electronic transmission and use of health information. Michael said, “HIPAA is playing a major factor in why we haven’t moved forward aggressively with technology and what the industry calls “big data.” The system is full of resilience and full of imperfections, so we are moving forward cautiously.” Michael went on to explain that they are starting to identify and install new technology with the goal of mining their
data which will enable them to understand the results of their decisions, implement a timely course correction, and make better business decisions in the future.

Amy and Dr. Mark focused on data security. Amy said, “Data security is one of our top priorities.” She went on and said, “we made a lot of investment in our technology and have implemented new training programs.” Dr. Mark agreed with Amy’s views, but he was not as confident as Amy. He talked about the role of their employees. He said, “Data security is no longer fixed by having anti-virus software. Today, it takes just one email with an attachment sent to an employee and boom now have malware on your computer, server, and throughout our system.”

The other reason for not moving forward implementing new technology is the cost. For example, Amy stated, “It is difficult investing in new technology due to the costs associated with it.” She shared details regarding the rules and medical loss ratio rule that limits the amount they can spend annually on administrative costs. Amy explained that the medical loss ratio law is a financial measurement used to encourage health plans to provide value to enrollees by using at least 80% of the premiums they receive to pay claims and fund activities that improve quality of care. Technology is expensive. The health insurance industry needs to invest in their data management tools while meeting requirements like the medical loss ratio rules and protect patient information from data breaches.

**Education and Lifelong Learning**

To be a leader in the health care industry, education is a must, which emerged as a second theme. The participants in this study were highly educated. All had a baccalaureate degree, 30% had a doctorate degree, and all but one had an advanced degree. Health insurance leaders who
participated in my study stated it is unlikely a leader who achieves their levels, Chief Executive, Financial, or Medical Officer, would not have at least a bachelor’s degree and would most likely have a master’s degree. Dr. Ray said, “If I was giving advice to future leaders, I would tell them they better have an advanced degree. This industry requires it and I would strongly suggest an MBA.” Michael felt the same way as Dr. Ray. He said leaders could move up through the ranks without an advanced degree but will struggling obtain a leadership outside of that health care organization. Finally, Jay said, “There are roles within the industry that requires an MBA or a MD but it seems like the industry now expects everyone [in executive leadership] to have an advanced degree.” He went on and said, “If you want to be a CEO or CFO, I would suggest an MBA.”

Requirements for senior-level positions in healthcare organizations are demanding, and some require specific degrees or licenses. This includes an insurance license if the employee sells health insurance, and all the organizations represented by the participants require their Chief Medical Officer to have either a Medical Doctor (M.D.) or a Doctor of Osteopathic Medicine (D.O.) degree. All the participants in the study had at least a bachelor’s degree and all but one had an advanced degree. All the participants also continued to enroll in additional educational programs as well as strongly encourage those who want to be an Officer in the future to obtain an advanced degree. Dr. Karen, a Chief Medical Officer at a Western health plan, explained that she participated in a two-year fellowship with the California Healthcare Foundation Leadership Program. Although recognizing the need to additional training, some participants have had difficulty determining which degree they should pursue. Dr. Cindy shared, “I was really torn between the MPH and an MBA.” And, Dr. Mark said,
As I talked to my advisors about ... [furthering my education] they said ‘[Dr. Mark], you need to get a degree.’ Because [they] believed that was really important, I pondered the choice of getting an MPH versus MBA. I chose the MBA route. At that time, there were only four MBA programs in the country that had a structured healthcare management curriculum. Those were Wharton, Duke, Kellogg, and to a much smaller extent, Stanford. At that time, Harvard did not have a healthcare MBA program. I ended up... where I could be a general medicine fellow and do the healthcare MBA program, so that's what I did.

To successfully lead their organizations, participants believed that ongoing education is required. Education has provided these leaders with skills, strong general business acumen, and the tools and abilities to lead large, complex organizations.

**Lifelong Learners**

A degree program is not the only education these leaders have acquired. It was clear from their interviews, they are lifelong learners. They continue to obtain knowledge, expand their skills and abilities, and network with their peers. One way they achieve this is by attending annual health care conferences and seminars which enable them to hear more about new research, meet vendors and suppliers, and learn from others. By attending conferences, these leaders obtain new technology, skills, and tools to enable them to continue building their abilities to effectively lead their organizations. Nick said, “As you know, “Leadership is a journey and not a destination.” I am always focusing on improving my leadership skills.” He went on and said, “I am constantly attending conferences, reading books, listening to podcasts, and journaling. I also use 360 feedback to identify areas that I need to improve.” Of those who participated in my study, the Chief Clinical Officers are the only leaders required to have
additional training, certificates, and complete their annual continuing educational courses. Despite no requirement for additional education, all leaders in my study continue to obtain new knowledge, skills, and abilities.

**Certificate Programs**

Health insurance leaders who participated in my study attended certificate programs and week-long learning modules designed to build their knowledge. For example, Dr. Cindy did a certified physician executive program through the Association for Physician Leadership, and Dave has completed programs such as the abbreviated programs at Duke and the Center for Leadership, a four-week program for non-MBAs to learn the business aspect of healthcare. The health care industry has offered a variety of curriculum coursework. Dave talked about programs at Cornell, Harvard, Stanford as well as programs available online. He went on and said, these courses are general in nature as well as based specifically on an area of interest and leaders’ roles, such as the finance and risk management. He then talked about health care specific programs and courses offered through America’s Health Insurance Plans (AHIP) trade association.

Many of the educational training programs the participants attended were not health-care specific. There are benefits of obtaining an education and training outside of the industry. For example, Dr. Ray enrolled in a cohort-based MBA program that he thought was helpful because he was learning from the other people in the group representing different industries. Dr. Ray wasn’t the only one. Jay, Bob, Richard, Tony, Dr. Patrick, Dr. Cindy, Dr. Karen, and Dave also attended learning programs offered outside of the health-care industry. Dave talked about programs at Cornell, Harvard, Stanford as well as programs available online. Bob, Richard, and Tony talked about how they believe these programs enabled them to think differently and learn
new skills and abilities that are currently limited in the industry. Jay stated, “I appreciate having leaders on my team who have a background and experience outside of the [health insurance] industry.” Drs. Patrick, Cindy, and Karen talked about how they must maintain their medical license and they appreciate attending programs that expand their knowledge and skills. They said that certificate programs are great because they take a shorter time to complete, are less expensive than a degree program, and provide new tools needed to succeed.

Share the Knowledge

Sharing knowledge is a tool used by leadership within health plans to develop the staff throughout their organization. Some utilize training classes, while others coach and mentor their staff. For example, Amy put together a training program for all leaders in her organization to give them training on “finance 101” from the health plan perspective. She wanted to show them the connection between what they do and how it influences the finances of the organization for better decision making. Dave said, “Sharing knowledge is more important now than ever before.” He explained it was more important now than ever due to the large number of staff hired in the past five years with the majority having no experience in the health insurance industry. Nick and Bob talked about the importance of coaching and developing their team and how it increased the productivity of their staff. Dr. Cindy felt sharing her knowledge and experiences has been one of the most effective ways to increase their staff’s performance, skills, and abilities.

Health plan leaders also feel it is important to develop their leadership teams. They believe by sharing knowledge and developing their leadership’s skills and abilities, projects are completed on schedule and on budget; they can attract and retain top talent; and they work more efficiently and effectively. Bob explained that he provided education at the executive leadership
level to help the leadership understand how the financial system worked. Amy talked about how developing leadership within their organization has increased innovation and collaboration. She also shared how she has personally learned by coaching and mentoring her staff. For example, Amy shared a story about a time in which she mentored an operations manager. During that year, she learned a lot about the detailed challenges and successes of operations within her health plan. She commented about how she wouldn’t have learned what she did if she hadn’t participated in the mentoring program. Based on the responses from the participants in this study, sharing knowledge builds the confidence of future leaders, it fosters an environment in which people feel free to take initiative, and it sparks innovative ideas.

**Credible**

The participants’ background, additional education, and credentials made health care leaders credible with their health plan peers. For example, Dr. Cindy shared how additional education besides being a medical doctor has helped her in her role when she transitioned from a doctor practicing in a clinic to a health plan leader. She stated, “I find when you have these other credentials, it gives you a better seat at the table.” Brian, Chief Executive Officer, put it this way, “I'm still learning, we all are, but it's [additional training] been very helpful.” The Chief Clinical Officers shared their desire to be involved throughout their organizations in more than just a clinical leadership capacity. They also shared how they felt they needed additional education about the business aspects of the health plan. Drs. Cindy and Mark stated that prior to obtaining their Master’s in Business Administration (MBA), they said they were not as involved in the strategic planning aspect of the business. They also mentioned how these degrees increased their self-confidence. Dr. Patrick shared how important business degrees are for Chief Clinical Officers. He said, “To be successful in the future, Chief Medical Officers will need to
understand the business and clinical aspects of health care.” Education and lifelong learning came through as an important aspect for these participants to be successful.

**Leadership**

Leadership was the third theme that emerged. The participants in this study talked about collaboration; their leadership styles, trust, transparency, succession planning; how to establish a productive culture, and leadership development. All participants were leaders who recognized the need to provide effective direction to their organizations. The Chief Executive Officers shared how they are trying to refocus their attention on the bigger issues and future for the organization while giving their staff space to do the day-to-day tactical activities. They were struggling because so much is unknown and poorly defined. Scott said, “It’s easy to get caught up with all that uncertainty. So, the first thing I try to do is just make sure I set the right expectations, I am candid about where those uncertainties lie, and transparent with my staff so they can successfully perform the day-to-day tasks.” Michael, Scott, and Nick were also concerned because if they get it wrong, they could be out of business. Brian said his job as the leader is to “create an environment that influences people to be engaged at the highest level, that they understand their role on this team, and how their role impacts the purpose and the goals.”

Leadership during times of major change and uncertainty has been difficult. Uncertainty has driven fear, and health insurance leaders have been spending more of their time communicating with their employees and stakeholders, managing their emotions, and focusing on what they can control.

**Collaboration**

Because of the increasing challenges of being leaders in the health-care industry, health insurance leaders who participated in my study recognized and acknowledged that collaboration
is an important leadership skill and focus. Nick believed his organization was able to obtain better outcomes due to collaboration, and he shared how decisions made in isolation generally do not lead to the best decisions. According to Michael, “Internal collaboration, we can't function without it.” He went on to say,

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We've got a sales department, and an underwriting department, and an enrollment department, and a billing department, and a benefit configuration department. And if we want to install a new case, all of those [departments] have to work together in a business process. So, all the massively cross-functional business processes that we have in health care really demand very skilled collaboration.
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Dave reinforced the importance of collaboration when he said, “We can't do it alone.” He went on to say, “If we do it together, we can do more,” and “That's kind of why we're here.” Another reason collaboration is important is because those within the industry need to purchase services from one another even though they are competitors. For example, Dave said,

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As a managed care company, I need to not just buy provider services from my own affiliated brands, but I have to buy from all others. Other managed care companies need to buy from me. We all sort of need to get comfortable that we are going to have business transactions with each other.
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Regardless of their roles (Chief Executive, Medical or Financial Officer of the organization), as leaders in the health care insurance industry, collaboration has been a necessary skill for all of them. For example, Dave, Chief Executive Officer, explained that he needed to determine the needs in his organization and find bright people who could address the need. Dr. Mark, Chief Medical Officer, talked about how important his role was as the clinical leader of
the health plan and how he and his team must collaborate with the medical community. He said, “When we work with our provider partners and we're looking at high level metrics and financials and different measurements, we jointly problem solve about what might interventions look like.” Amy, Chief Financial Officer, said, “I partner really closely with the clinical team and my team partners around initiatives and cost management.” She went on to say how much she has learned about the other aspects of the business when she collaborated with their stakeholders.

Although each participant talked about how he or she needed to collaborate with others, some discussed situations in which they have faced an unwillingness or inability to collaborate. Dave said, “While we are making significant strides, there continues to be lack of trust between the health insurance industry and health care providers.” Nick, Bob, Brian, and Dr. Karen who were in the industry in the 1980s reflected on the launch and implementation of capitation, which means being paid a flat fee no matter how many services are performed, and how it negatively impacted many hospitals and health care providers throughout the United States. Some of those who were practicing at the time are now leading hospitals and large care systems.

Dr. Karen questioned if the medical providers’ and hospitals’ previous experience could be the reason for some of the lack of trust. She said, “You have to find people who are willing to be a little wacky and be early adopters. I have found more barriers than I have found collaborators.” Previously, health care providers had to rely on reports and data from the health insurance companies and government agencies. Dr. Mark, Chief Medical Officer, said, “It's getting harder to collaborate, of course, because providers are developing data capabilities.” Today, many of the healthcare providers in the United States have developed and implemented data capabilities that enable them to produce their own reports versus relying solely on the insurance companies and government agencies. Previously, healthcare providers relied on health
plans to obtain access to reporting tools that enabled them to review and analyze their data. Healthcare providers now have access to comprehensive reporting tools, which is why collaboration between the health plan and healthcare provider is more important than ever before. Collaboration is an important leadership skill and focus for health insurance executive leaders.

**Leadership Style**

As an authority figure, leadership is key to success. Understanding a leader’s leadership style is vital and provides an understanding of their strengths and weaknesses and what needs to change to be a more effective leader. All participants were asked to describe their leadership styles. The participants portrayed their leadership style as being a combination of many styles. For example, Michael, Chief Executive Officer, said, “I am somewhat of a player and a coach leadership style, where I like to participate in doing, while also mentoring and offering advice and counsel people.” He went on to say, “My team is too big and diverse for me to use one leadership style if I want to be effective.” Dave felt he was a more effective leader because he had more than one leadership style. Nick believes he has a dominant style and he leverages his different styles when playing different roles when motivating and leading his staff. Dr. Cindy referenced a situation in which she inspired her team, using stories, to achieve a goal. She found it made her a more credible leader with her team. Brian and Nick referenced how they play the role of coach to assist their staff in improving their performance and solving problems. Utilizing different working styles and skills are needed to be an effective leader when faced with different situations and when working with each staff member.

The participants also shared how they work together with their teams and the approaches they use to develop their people into future leaders. A strategy for developing employees,
especially future leaders, is one of the most important things a health insurance leader does to positively impact the organization’s culture of your organization. Good health insurance leaders obtain feedback and ideas from employees through the organization while providing their staff an opportunity to collaborate with one another and to take risks. Amy, the Chief Financial Officer said, “I value working across the organization and value my teams working across the organization. I have a teacher learner mentality.” She went on to say, “I am teaching my team how to be flexible, to move back and forth, and to be strategic from a future perspective as you move up the ladder.” Dr. Mark, the Chief Medical Officer within the same organization said, he likes to have open discussion and said, “I like open debate. I think it's critically important to ask tough questions and talk about them in a very open way, even when they're uncomfortable.” He went on to say, “As a leader, I make sure the goal is clear and I empower my people to do their job and to apply their skills and to achieve and succeed.” Jay, Chief Financial Officer within a Southern health plan, also referenced empowerment. He said, “I'm fairly consultative in nature. I would say that I empower my team. I give direction. Let them run with what they do best.” Tony, Chief Financial Officer of the Eastern region, said,

> What I try to do from a management perspective is take things up and make sure they're simple and understandable throughout the organization. To me, what's extremely important, is making sure that everyone that reports to me not only is thinking in that way, but also in terms of kind of their goals and the things I want them focused on. I try to keep it simple.

He explained that he likes to “connect with people on a personal level…. [and] try to be respectful of people's time and their lives.” He made it clear, that this doesn’t mean going easy on his staff. Instead, it is about being consistent with the amount of pressure he applies while
maintaining a professional approach. He described his experiences being yelled at by his leaders, how he didn’t appreciate that leadership style, and how he takes a different leadership approach. Leadership style is the way in which leaders provide direction, implement plans, and motivate their staff. There are many approaches to leadership, and leaders use more than one approach at a time with different employees. Next, I explain how discussions about trust emerged as an important skill for effective health care leaders.

Trust

Trust has an impact on a leader’s ability to be effective and is critical for succeeding. When a leader’s team trusts them, it increases their staff’s commitment, creates more open honest conversation, and increases creativity and productivity. For example, Nick, Chief Executive Officer, shared his recent experience presenting the updated vision and strategic plan to his direct reports. The feedback he received affirmed, in his mind, that he is a trusted leader because his employees appeared comfortable with changes he was championing and were embracing the new vision and plan. He did not believe that would have happened if his team didn’t trust him. The interviews made it clear that trust and, how it encourages employees to give their best effort, is powerful.

Participants expressed a great deal of passion when sharing their views regarding the power of trust. Dr. Cindy said about being a doctor,

People trust you because of those two letters behind your name. They trust you on site, and you have to really earn that trust. Even though they don't ask you to earn it, you have to earn it, and that means knowing your stuff and doing the right thing by people.
Michael, Jay, Bob, and Dr. Mark talked about trust as a two-way street. They questioned how a leader can expect his or her people to trust them if they don’t trust their people. This appeared to be even more important in their role as an executive within a very large organization. Michael, Executive Officer, shared how it was physically impossible to know everything going on within his organization and how he must trust his people. If he didn’t, activities would take too long to complete, he would be burned out, and in a few key situations their organization would have missed a great opportunity.

Like collaboration, trust doesn’t just happen and there is reluctance by some in the industry to trust others. For example, Dr. Cindy explained, “Everybody is so reluctant. Everybody is holding everything tight to their vest.” She went on to say, “I'm like, ‘I don't want to know how much money you make. I just want us to come together’… I just couldn't get them to do it. I couldn't get them to trust me.” She was referring to her current situation. Trust can be built if you listen, but it takes time and patience. Scott, Chief Executive Officer, described how he attempts to get beyond reluctance and start building trust. He said that he starts by being consistent, listens to his team, gathers their feedback, and presents the best way to achieve the goal. He obtains buy-in from his team and believes success encourages his team to trust him in the future. Besides trust, the participants shared examples and stories about the need and power of transparency.

**Transparency**

Consumers, providers, the government, and regulators are challenging the health insurance industry to implement more transparency. A basic definition of transparency is publicly sharing health care costs and outcome results. Nick, Chief Executive Officer, illustrated this when he said,
I try to be very transparent with the numbers, the options. I've kind of made a career at [Midwest Health Plan] putting together these one-pagers for all these folk so they can make decisions at the top of the company. Here's our problem. Here's the impact from a financial. Here are our options. Here are the pros and cons of these options. Here's our recommendation. Here's why.

He also explained that it is essential to communicate with everyone, everywhere.

Not everyone who was interviewed, however, believed transparency occurs, and Jay, Dr. Ray, and Dr. Cindy were frustrated by the lack of it. Jay said, “While I believe the industry is more transparent than ever, we have a long way to go.” Dr. Ray shared a story about his experience as a provider in a clinic prior to joining a health plan. He was shocked to see how much data the health insurance industry had and can’t wait for the day in which the industry shares more of it with their network provides. Dr. Cindy, Chief Clinical Officer, stated that because things move so quickly, change does not always get addressed and communication is sometimes missing, which means transparency has been lacking. Dave, Michael, Jay, and Brian talked about the difficulty of being transparent with consumers because they tend to not understand how health insurance works and may make decisions that could harm them or cost them more money because they are uninformed. Dave, Michael, and Brian shared stories about their experiences educating the consumers on their Board of Directors and the Consumer Advisory Board. Dave said, “Many of us have been in the industry for years and we speak our own language.” He went on and said, “I have to remember to stop and explain what we mean by certain terms like outcomes and HCPC codes.” Jay had a different perspective regarding consumers. He said, “We feel, to be successful, our consumers must understand how health care works. Therefore, we have added consumer education programs to our strategic plan. They are
also part of our member satisfaction calculations.” If the information isn’t clear to the consumer, it is difficult to be transparent. Education is an important element for being transparent and is necessary when working with health plan consumers.

**Succession Planning**

There is high employee turnover, specifically executive leadership, within the health-care industry, which led to questions about succession plans. The small and medium-sized health plans generally did not have formal succession plans. For example, Michael, Chief Executive Officer of a Western health plan, said they do not have formal succession plans. Bob, Chief Financial Officer, explained it this way, “I think when you look at small to a mid-size health plan from a succession standpoint, the person we hire is going to need knowledge and skills beyond their job time.” He went on to say, “They [the person they hire into a Chief role within a small to mid-sized health plan] really need to have a complete understanding of operations, and how everything interconnects, especially within a small organization.” He did express concerns about not having a succession plan for key positions. His concern focused on the high level of knowledge a new executive leader needs regarding all aspects of a small and medium sized health plan, and without this knowledge he doesn’t think they will be successful.

Executive leaders at the larger health plans explained that they have formal succession plans for their leadership roles. For example, Jay, Chief Financial Officer, explained that they use a 9-Box succession planning model at his company. He explained that the 9-Box model is method of evaluating current talent and identifying potential leaders. It is a grid in which an employee’s performance and potential are placed within one of nine boxes. The boxes range from not meeting performance and having limited potential to mastered current role and ready for a new challenge. In contrast to that, Brian stated that his organization has succession plans.
He also shared how he is amazed at how some of the largest organizations in the United States do not have succession plans and when a key leader leaves, they use the lack of an identified, prepared successor as an excuse for why they did not achieve their quarterly financial targets.

**Culture**

Becoming an executive leader in a health plan organization provides opportunities to shape culture of their organizations. Culture is expressed and seen in the ways in which an organization and staff get things done as well as how people interact, make decisions, and influence others. Executive leaders in health plans work to establish a productive and specific culture. Those who participated in my study talked about culture. For example, Nick explained how he used his leadership position to represent the organization in various forums, some more ceremonial, but also as the voice in formal public and media settings. As a leader Nick is “…[t]he guardian of the culture, someone responsible for developing a vibrant culture and a team of employees with the resources, tools, abilities to be successful.” Nick went on to explain that he worked hard at creating a culture with lots of the “right energy”, and by that he meant creating an environment that allows people to enjoy what they do.

In addition to recognizing that they need to work on developing culture, health insurance executive leaders are focusing on transforming their current culture. Their goal is to shift their current corporate culture so that it aligns behaviors, organizational structures, and processes with new strategy. Dr. Cindy said, “if we are going to change our culture, it needs to start with a focus around continuous improvement.” Brian explained that he is starting with quality improvement, building a strong team, and making sure the staff understand the strategy.
To be effective, continuous improvement must go beyond one leader with the title of quality improvement and include more than just quality improvement projects. Brian, Chief Executive Officer, said, “To be effective we need to define meaningful indicators, we need to build them into our performance management system, and we need to engage every employee in the process.” He explained how he and his leadership team are encouraging employees to identify every idea, suggestion, and area of concern because the improvements do not have to be significant to be meaningful.

Participants expressed that the importance of a strong team is a crucial aspect of culture change. In fact, health insurance executive leaders felt a strong team culture is more important now than ever before. A strong culture enabled their organization to remain effective and efficient in the rapidly changing health care environment. Scott, Chief Executive Officer, discussed how satisfied employees are more creative and how this results in lower costs, provides better member service, and provides greater productivity.

The participants of this study also discussed ethical tensions between leadership, the success of the organization, and the oath a medical doctor takes. Drs. Cindy and Ray shared stories in which they both previously worked for two different organizations that made them choose between implementing and supporting a business initiative or their medical oath. These situations led these Chief Medical Officers to leave their organizations. They felt the organizational culture of those two organizations put pressure on the medical doctor to choose between the two options. Since these situations, when interviewing to be part of different organization, Drs. Cindy and Ray now use their experiences in these former situations in the form of questions to assess a health insurance company’s culture.
Determining a strategy for improvement is interrelated with the establishment of trust. Nick, Chief Executive Officer, shared how their leadership team is seeking to drive cultural change throughout their organization. He said, “For us to be successful we must present a clear vision and a work environment that reflects our core values. This requires a new hiring process, staff development, performance reviews, [and] leadership leading by example.” He believes taking this approach will foster closer working relationships, increase collaboration, continue to build trust among employees, and make them a better organization today and into the future. Michael shared a story regarding his first few weeks on the job as the Chief Executive Officer. He explained how he implemented a monthly all-staff meeting in which he asked for feedback, ideas, and open discussion. He said, “Trust is difficult to achieve and easy to lose.” Health insurance companies that wanted to drive change started by building trust. Building trust was the first step leaders implemented in order to change and grow their company’s culture.

The responsibility for establishing and growing the company’s culture does not exist just with the Chief Executive Officer. Ten participants shared stories and experiences about how they develop their culture and how they recognize that this was not just their responsibility. For example, Dr. Cindy, Chief Clinical Officer, explained that her job entailed being a “jack of all trades”, although she preferred to focus on certain things and her big focus has been on change management and culture in addition to her technical work. She also said that future employees need to understand the culture of the company for which they will be working. Study participants explained that culture can be seen in the ways in which their organizations and their staff get things done as well as the way people interact, make decisions, and influence others.
Strategy

Every participant discussed the process they have used to update and build a strategic plan. Nine participants shared stories regarding the shift in direction they took in response to the changes occurring because of health care reform. For example, Nick said, “I think strategic clarity is a premium quality but also a challenge in this environment.” He explained that they worked on a strategic plan for the next 3-5 years of his organization, and said, “We know that we obviously aren't in a position to be a five million lives health plan, but we need to get bigger and figure out how to grow while still being [Northern Health Plan.] [Our previous CEO] used to say, "The marketplace doesn't need another Blue Cross." We offer something different and we hope it's making a difference.” Eleven of the participants shared examples of how they are reviewing and updating their strategic plans every quarter now versus annually in response to the major changes and uncertainty within the industry.

Strategic planning is a skill and takes a lot of time and patience. Dr. Ray explained that they have had executives in the c-suite whose focus is solely on strategy. He questioned this though when he stated, “We had a Chief Strategy Officer, and we've had a lot of discussion about whether...we still need a Chief Strategy Officer.” He went on to say, “I think this function should be part of everyone’s job.” Some leaders talked about strategy as something that requires time and patience. For example, Brian said, “You have to be very patient about how you create your strategies, and you also have to be very patient in terms of that achievement.” He went on to explain,

The first two years were worse than the third year, but without patience we might have pulled the plug after that third year. What happened in year four is that we made all the
money back that we had lost, plus some, and then now we're in year five and we're doing well again, so patience is critical.

Scott and Richard were not sure why their strategy was working but did not appear to be worried about it. Scott, Chief Executive Officer, shared how he felt there is a combination of both skill and luck in successfully implementing their strategic plan. He explained that they were able to achieve goals and hit earnings targets despite their lack of investment in processes and system. The majority of those interviewed are using strategic planning to drive change throughout their organizations. To successfully navigate these turbulent waters, health care leaders believe a good compass and a sound strategic plan are needed if they want to stay afloat.

Alignment

When interviewees were asked about the changes in health care because of reform, they shared stories and examples about transformation occurring and the need to make sure everything in their organization was aligned. They focused on what needs to be done to ensure their team and staff were ready to transition for the future. For example, Nick, Chief Executive Officer of a Northern health plan, said, “You have to project confidence and clarity, both internally and externally about the organization’s future.” He also described how important alignment is and the approach his organization takes to achieve it. He ensures all employees understand what makes their organization different, the direction they are heading, and how they can contribute to the success of the organization. To be an effective health insurance executive, leaders need to do more than just focus on what needs to be done. Leaders also need to make sure their staff is clear on expectations and the direction they are going as an organization. To ensure alignment, Bob, Chief Financial Officer, shared an example in which he starts by confirming that everyone is on the same page. He said he reiterates, “Here’s what we discussed.
Here's the timeline, and here's what is expected to be delivered.” As a health insurance executive being on the same page is important for many reasons. Brian, Chief Executive Officer, described why alignment is so important for an integrated delivery system. He said, “We need to work together, to be aligned because we're all in this together versus float on your own.” Dr. Cindy talked about how she sets high standards, communicates expectations, and hold their people accountable. Taking this approach, she finds, ensures that she and her team are aligned. Scott said, “Alignment begins with my leadership team. When all my leaders work together to accomplish a common purpose, we are aligned. We debate the issues, proactively support each other, we are focused on what is most important, and are committed to learning and improving.”

Alignment doesn’t just apply to the internal stakeholders. To achieve the goals within the PPACA, health insurance companies worked together with the clinical delivery providers, hospitals, pharmaceuticals, and health care systems. Dave said, “Incentives [defined as how and what a health insurance company and health care provider are paid] are aligned better than they ever have been among consumers, providers, and managed care companies. They're not perfect, they're not there yet, but they're better than they used to be.” Alignment, working together for a common purpose, is more important than ever due to the current health care insurance environment. Health care insurance organizations struggled with the changes in their external environment which lead to ongoing change within their organizations. Making sure everything has been aligned and everyone is working towards the same goal has been critical for their success.

Leadership Development

The health care industry has transitioned from a cottage industry to big business and now the industry is finding itself in a difficult position because it didn’t develop the necessary skills
and competencies in people for reinventing the current healthcare delivery model. The participants in my study agreed that leadership development must be a priority going forward. For example, Dr. Ray believed that basic leadership skills will continue but said it will be important that future leaders understand populations and understand how to look at data. He also believed future leaders need to understand “big data or machine learning.” One area he added was “being to some extent a good negotiator.” In addition to those areas, Jay expressed that he believed future leaders need the “ability to influence” and “relationship building, and trust, and influence.” He explained that they need to network within and outside of the organization and industry. Participants shared stories regarding how their previous training did not prepare them for the changes they are currently facing. For example, Dave said, “If we want to stay ahead of our competition, we need to identify and develop high-potential talent from within our organization.” He went on and said, “When I first became a leader, I would simply analyze the situation, decide what needed to be changed, and move forward. Leadership today is a lot more complicated.” They also shared examples of situations in which they had the data, but they did not have the tools, skills, and abilities to mine the data to identify areas of opportunity to improve health care outcomes and lower costs. Scott talked about how it is business critical that health care insurance leaders develop and empower their teams. He is concerned that if they don’t, those organizations will continue to see high staff turnover, high employee absenteeism, and disengaged employees which leads to low productivity and higher costs.

They did not all describe, however, the same areas in which skills are necessary for leaders to have in the next five to ten years. Some of the leaders who participated in my study discussed the need for technical skills in finance and strategic abilities. While others thought regulatory and collaboration were the key areas of focus for future leaders. For example, Dave,
Tony, and Dr. Cindy shared examples of skills they felt future leaders need to develop to be successful. Tony said that they placed more focus on the activities that provide long-term value to the health care delivery system. He went on to say, “I think we will see a need for the technical skills in finance.” The leadership within the Northern health plan all agreed the focus should be on “learning how to be flexible and to be strategic.” Dr. Cindy focused on other skills, saying she believed leaders in the next five to ten years must understand the “regulatory environment and public policy” if they want to successfully lead their organizations. Dave, Chief Executive Officer, stated that the “ability to lead during times of uncertainty and disruption is critical.” His advice for future leaders included learning how to collaborate and how to make connections with the community by serving on local boards and becoming involved. He also said future leaders must make the mission of the company a part of the community mission. He said, “You're really part of the fabric of where you live.” The responses from the participants in my study indicated several areas, which included technical skills in finance, strategic abilities, regulatory, collaboration, and leadership, as one in which the health plan leadership needs future development, knowledge, and additional skills.

Quality

Health insurance leaders who participated in my study provided examples of the activities they have implemented related to the quality of healthcare services now and activities for the future. For example, Dr. Ray said, “We [are] doing a lot around quality improvement…it's about quality, making sure the quality of care is the highest and trying to get people to create systems to provide the highest quality care.” He also discussed quality in relationship to innovation when he talked about how a focus on quality leads to innovation, and those organizations who innovate and improve quality will be more successful than those who do not. Drs. Patrick, Karen, Cindy,
Ray, and Mark shared different examples of future activities they will be doing to improve quality within their organizations and in the medical community that provides care to their members. Dr. Mark told me about a quality program they are designing with the Centers for Medicare and Medicaid services that has a focus on outcomes within behavioral health. Drs. Karen and Patrick are in the planning phase of a program designed to improve quality and outcomes within rural communities. Dr. Cindy is working on a program designed to reduce health care disparities.

Quality was clearly a key area of focus for health plans represented by those who participated in this study. For example, Dr. Cindy stated, “I would be shocked if you found a health plan not focusing on quality.” Participants in my study shared stories regarding the need to drive down the cost while improving health care outcomes. Dr. Ray said, “High-quality, patient-centered care is not possible unless both health plans and the patient care community work together on improving quality and efficiency of care.” Quality has been and will continue to be an area of focus for health insurance companies and the health care industry.

Measurement

Identifying and measuring health care outcomes is important because it informs health insurance organizations about the care their members receive. In sharing stories about how measurements have an impact on the financial aspects, clinical outcomes, and patient satisfaction, Dave cited the quote he attributed to W. Edward Deming, “What gets measured gets done”. A few of the other participants shared stories regarding what happened when they implemented new measurements and how these new measurements identified underuse, overuse, and misuse of health care services. For example, Michael talked about how they developed and implemented a new outcome measurement for pediatric laboratory tests. When they
implemented their new measurement, they discovered laboratory tests being completed on children that were not medically necessary. As a result, they educated their network providers and continue to audit for medical necessity when those laboratory services were performed on children. Tony, Chief Financial Officer of a health plan located in the Eastern region, shared how his organization is “trying to really achieve the Triple Aim, which means you want high quality products, high quality services, combined with lower costs, combined with a good member experience.” He went on to add, “[A]nd the last piece [of measurement] is just managing our administrative costs, and making sure it's in line and appropriate, especially given relative to our competitors and how we perform historically.”

Tony was not the only leader who talked about the Triple Aim. Dr. Karen, a Chief Medical Officer of a Western health plan, agreed it is about delivering on “the Triple Aim.” She explained that the Triple Aim is technically one Aim with three measurements of success. It is the pursuit of improving the patient experience, improving the patient’s health, while reducing the cost of health care. Quality measurements improve patient safety, measure and improve how care is delivered and the health outcomes, and help consumers make informed choices about their care, while reducing costs associated with overuse and misuse of health care services.

**Accreditation**

Accreditation became even more important after the passing of the PPACA because it validated a health care organization’s commitment to quality and accountability. For the health care insurance industry, it is a formal process in which an organization is officially recognized for meeting or exceeding a standard. Accreditation in this industry is also not new. Dr. Mark specifically referenced “NCQA accreditation” as he shared a story about a conversation he and other Chief Clinical Officers had at the American Health Insurance Plan (AHIP) conference a
few years ago, and other participants in my study agreed that NCQA is the brass standard for all health plans. Dr. Mark explained that his role in the organization included being “the voice articulating the clinical strategy and clinical vision of the organization, and that includes the goals in terms of improving health, improving quality, improving the experience for members who are receiving care as patients.” He was very proud that they “have high quality scores.” Dr. Cindy, another Chief Medical Officer, agreed and said, “Quality is making sure that we're within the regulatory requirements and meeting accreditation standards.” She talked about the importance of both NCQA and Utilization Review Accreditation Commission (URAC) accreditation.

Health insurance companies who achieve accreditation distinguish themselves from others. It is proof the organization meets regulatory requirements and standards set by a recognized accrediting external organization. Dr. Cindy said, “It is the difference between saying something is true and having the ability to prove it.” She went on and said, “Most employers, customers, and government agencies want to see the proof.”

Not everyone interviewed believed the process is perfect, and Dave and Dr. Karen believe the accreditation process still needs attention. Dave stated that he believed the current quality assessment process is at the level it should be but acknowledged room for improvement. He said, “I think we have some rudimentary measures that make a lot of sense. I don't think we're done evolving those [measurements].” He went on and said, “I think we could probably all sit at a table and agree on what good indicators of high-quality services and care are.” Dr. Karen also talked about the need to develop quality measurements and added her belief about the “need to add quality of life to our quality measurements.”
The Role of the Consumer

When you read the Patient Protection and Affordable Care Act (PPACA), there are multiple references throughout the bill regarding the consumer. It included items like affordable care for all; protecting consumers’ choice of doctors; allowing children to stay on their parents coverage until age 26; ending lifetime limits; ending pre-existing condition exclusions; the medical loss ratio designed to ensure the majority of the dollars collected in premiums are used to pay for health care costs and not administration; no-cost preventive care; and protecting the patient’s rights. Participants told stories about how health plans have had very low member satisfaction prior to the passing of the PPACA. Nick said, “What we found is our member’s dissatisfaction was a result of not understanding how their [health] plan works.” He went on and said, “We made consumer education a priority and we are starting to see an increase in our member satisfaction.” Dave saw member satisfaction differently. He said, “I believe our low satisfaction was a result of higher premiums and more out-of-pocket costs.” Dave’s organization reduced their premiums two years in a row and they saw an increase in their overall member satisfaction survey results. Health insurance leaders who participated in my study acknowledged their focus on improving the members’ experiences. Individuals from the health plans in the Southern, Western, Eastern, and Northern regions referenced programs and communications they are developing and implementing to educate their members about their health care benefits, about how to collaborate with health care providers to ensure the patient’s care is being coordinated among doctors and other healthcare providers, and how to make sure they provide high quality customer service.

Participants discussed that one of their top priorities is achieving a positive member experience today and in the future. They shared specific initiatives they implemented to achieve
this. For example, when Tony talked about providing good value to their members, he said, “What we look at is the net promoter score, which measures our member experience.” He explained a net promoter score measures the willingness of customers to recommend a company's products or services to others. Dr. Karen, Chief Medical Officer, explained her commitment to members this way, “I am responsible for making sure they [the members] have the best healthcare that they can, and by golly that is what I'm going to do.” Dr. Karen went on to say, “We have added members to our Board of Directors, we developed and implemented a member Advisory Board, and we use members in our Medicare Advantage plan to help explain our program to new Medicare members.” She talked about the positive impact these changes have had throughout their organization. For example, she shared a story in which a consumer on their member Advisory Board told about her experience with their health insurance call center and the consumer’s frustration with her inability to obtain the information she needed to decide about a health care procedure. Dr. Karen shared the feedback with the health plan’s call center leadership team and they updated their protocols to ensure a positive experience in the future. The call center’s leadership team called the member to thank her for her honest candid feedback, shared the changes they made, and asked if she had any other recommendations. Dr. Karen said that wouldn’t have happened if we didn’t implement the member Advisory Board. She said contact and engagement with our members is what is going to make sure a better organization in the future.

Contact and Engagement

Dr. Mark and Nick explained that having direct, regular contact with their members is part of their culture and an expectation. Dr. Mark said they are “member touching and member facing.” He went on to say, “We have hundreds of employees who are licensed clinicians,
nurses, social workers, and we [our employees] interact with members directly to help them manage and coordinate their care.” He explained that their entire team is focused on “improving the experience for members.” Nick, Chief Executive Officer, also talked about striving for improved consumer satisfaction when he said, “Whenever I'm faced with any issue, I'm thinking about it not in terms of the issue at hand but how it connects to longer range implications for our members, for the organization, and for the community.” He went on to say, “[F]or me, it's what motivates and energizes my leadership and that's our mission in connecting and improving our members’ lives.”

**Member and Customer Disenrollment**

Health insurance organizations lose money when members disenroll from their health plan. In addition to the cost when a member leaves a health plan, there is a cost to obtain a new member. Various government agencies are sharing the performance of health plans with the public to enable consumers to make informed decisions regarding the health plan they purchase in the future. Because of member disenrollment, health plans have been making member satisfaction a key focus. Tony expressed frustration as he told me a story about how they have been tracking their individual exchange membership plan and shared how “one of the problems with the subsidy is that it leverages premium differentials to a huge degree, which leads to a lot of member turnover.” Turnover drives up the cost of health care, making their products not as competitive, which puts them out of business.

**Medicare Star Ratings**

The other reason member satisfaction is important, if they are a Medicare Advantage plan, is the Medicare Star ratings. According to Medicare, the star rating was designed to provide overall rating of the plan’s quality and performance for the types of services each plan
offers. There are five areas in which a health plan is measured. They include (a) staying healthy, which focuses on screening tests and vaccines, (b) managing chronic (long-term) conditions, (c) member experience, (d) member complaints, and (e) member turnover.

According to Tony, “[Their] Star ratings are one of our key quality measurements for our Medicare Advantage members.” Dr. Mark said, “Medicare Star ratings are very important because Medicare Advantage is probably the second biggest line of business here at [Northern Health Plan]. A low Medicare Star rating can impact a health plan in a variety of ways, including a competitive disadvantage and damage to their reputation. Many Medicare members select their supplement health plan based on feedback from friends and family. A negative score could reduce their number of members, revenue, and ability to negotiate better pricing that enables them to offer their Medicare members an affordable rate.

**Power of the Consumer**

The consumer was a driving force behind health care reform in the PPACA. The consumer’s issues included an inability to obtain health care coverage much less obtain affordable coverage; annual double-digit premium increases; preexisting conditions used as barriers to obtain health insurance and denied payment for care; poor quality of care; patient safe concerns; a focus on treating illness versus keeping the consumer healthy; and fragmented, poorly coordinated care. The consumers are key stakeholders, and they continue to play a critical role in the decision-making process. By passing health care reform, the consumer has been identified as a powerful force in accelerating change. Participants in my study shared examples of how they worked to engage, involve, and partner with consumers. The health plans want informed consumers who can and will choose higher value products and services. Scott, Brian, Nick, Dr. Karen, and Dr. Cindy shared examples how they partnered with members in
their health plan and prospective members to implement tools with a goal of improving health care compliance and getting the consumer to take individual responsibility for their health. These included programs and communications designed to identify and change behaviors and lifestyle choices which significantly impacted the cost, quality, and health care outcomes. The federal government believes that by providing consumers with data regarding the cost, benefits, and quality of care, the consumer will be motivated to select health plans that provide the best value.

**Summary**

Several findings emerged from the 15 interviews I completed in 2018 with five Chief Executive Officers, five Chief Financial Officers, and five Chief Medical Officers working within five different health plans located throughout the United States. The findings led to the identification of five themes which were: (a) health care reform; (b) education and lifelong learning; (c) leadership; (d) quality; and (e) the role of the member. Most of the participants in my study expressed some level of frustration, acknowledged how difficult it is to be a health care leader today based on the significant level of uncertainty, and shared the importance of their roles.

The health plan industry has experienced decades of reform but nothing of the magnitude of the Patient Protection and Affordable Care Act (PPACA). This major change altered roles and responsibilities, increased uncertainty, and identified the importance of the ability to adapt and change. Uncertainty made it difficult for executive leaders, who participated in this study, to strategize and provide their stakeholders with any level of assurance and confidence. It transformed the industry with vast and wide impacts. Not everyone in the industry has embraced
the change. Some of the participants talked about how not everyone in the industry embraced the major change and moved forward with implementation of health care reform. They believed some of the delay to implement was a result of some government leaders, led by President Trump, who are pursuing legal actions to repeal and replace the PPACA.

Mergers and acquisitions lead to a substantial amount of uncertainty. Participants shared specific examples of the impact these changes have on the industry and how they change the landscape. Dave, Scott, Jay, Bob, Dr. Cindy, and Richard believed there is opportunity in this new health insurance environment and questioned if organizations will survive if they don’t merge with larger health plans. They viewed the ability to change, adapt, and evolve during this period as being critically important. Organizations that embraced these changes and responded to them effectively, efficiently, and appropriately appear now to have a competitive advantage and increased their likelihood of survival.

Roles and responsibilities also changed because of the Patient Protection and Affordable Care Act (PPACA). Health care reform established new relationships between the government, employers, and individuals. The goal was to ensure that all Americans have access to affordable and good-quality health insurance. It reshaped, through innovation and disruption, the country’s health insurance market. The passing of the PPACA was proof of the Federal government’s power to disrupt and influence change within an industry. According to those who participated in this study, if a health plan wants to succeed going forward, it must recognize the need for change, embrace change, and lead the transformation. This includes developing and implementing tactical plans and holding their staff accountable to help drive the change.
To drive successful change and innovation, leaders in this study believed the use of data was critical. Quality data enabled them to make decisions based on fact rather than intuition or observation alone. The health care industry hasn’t developed, invested in, and leveraged technology like other industries. Participants in my study stated that the industry is in a difficult position because it has not been prepared to leverage the digital revolution. They also did not believe they were the only ones who have been behind in the use of technology and leveraging data. They said the Federal and State governments recognize the need for improved use of data.

The participants discussed that the changes needed in technology include using big data, the cloud, telemedicine, portal technology, wireless technology, wearable technology, payer and provider analytics, artificial intelligence, key performance indicators, and leadership dashboards. By collecting data on their users, forward thinking insurance companies have the capability to customize their service and experience for each member, increase customer loyalty, and differentiate their products and services while reducing costs. Being able to mine health plan data helps leaders tell a story about what happened and why, predict future performance, and make better decisions. Participants also expressed frustration with either their inability, their staff’s inability, or their organization’s inability to generate the data necessary to drive change, grow their business, and address ongoing care issues. Leaders recognize that using data can improve health care outcomes.

Cost and data security have led to delays in the implementation of new technology. The industry is starting to identify and install new technology with the goal of understanding the results of their decisions, implementing timely course corrections, and making better business decisions in the future. Participants raised questions and concerns about how long new technology would continue to protect patient information from data breaches and when costly
updates would be needed to maintain these new standards. Participants stated that data security was one of their organization’s top concerns.

To be a leader in the health care industry, education is a must, which emerged as a second theme. The participants in this study were highly educated. All had a baccalaureate degree, 30% had a doctorate degree, and all but one participant had an advanced degree. The CMOs had medical degrees. All the participants stated it is unlikely that a leader who achieves their levels, Chief Executive, Financial, or Medical Officer, would not have at least a bachelor’s degree and would most likely have at least a master’s degree. The participants believed in lifelong learning, obtaining additional educational certificates, sharing their knowledge with their staff and leadership teams, and they believed additional education and knowledge provided them with creditability. Education and lifelong learning came through as an important aspect for these participants to be successful. The participants strongly encourage those who want to be an Officer in the health insurance industry in the future to obtain an advanced degree.

Leadership was the third theme that emerged. The participants in this study talked about collaboration, leadership styles, trust, transparency, succession planning, culture, strategic planning, alignment, health care disparities, and the importance of leadership development. All participants recognized the need to provide effective direction to their organizations since the passing of the PPACA and how this major change and uncertainty made it difficult to lead. Uncertainty drove fear and to address that fear, health insurance leaders spent time communicating, managing their emotions, and focusing on what they could control. Participants in my study discussed how they focused their time and attention on transforming their current culture with the goal of shifting their current corporate behaviors, organizational structures, and processes with the new strategy and culture.
Regardless of their roles (Chief Executive, Medical or Financial Officer of the organization), collaboration and leveraging different leadership styles were important leadership skills during these times of major change. Participants discussed the importance and impact that trust had on their ability to be effective leaders. They expressed that when their teams trusted them, staff commitment increased, more open, honest communication between staff and leadership occurred, and creativity and productivity increased. They also shared how important staff and leadership development was and how it must be an ongoing key area of focus.

The participants in my study talked positively about areas that have improved since the passing of the PPACA and negatively about other areas that have not improved. Health insurance leaders who participated in my study expressed some level of frustration with regards to transparency, succession planning, outcomes, and the lack of effort on addressing disparities in health care. The chief executives who participated in this study do not all agree that transparency has occurred, and some were frustrated because of their inability to be transparent and partner with the consumer. Some of this inability to engage with the consumer was due to the consumer having a general lack of knowledge about the industry. Michael, Nick, Bob, Amy, and Dr. Mark also expressed concerns about no succession plans in most of the organizations. As for disparities in health care, the concerns were two-fold. The first was their inability to get the necessary data to drive change. The second concern was that addressing disparities in care is expensive. Several participants admitted that they did not have a specific plan for how and when they will address concerns about disparities of care.

Quality was the fourth theme. Nine participants specifically talked about the need to drive down costs while improving health care outcomes. They felt it was unattainable unless both health plans and the patient care community work together to improve quality and
efficiency of care. Whereas, all the health plan leaders who participated in my study acknowledged their focus on improving quality, obtaining accreditations, and/or using the Triple Aim to align their organization to deliver high-quality outcomes, lower costs, and provide consumer satisfaction. Leaders also acknowledged the critical need for improvements in data reporting and analyses and for an ongoing focus on improving quality measurement tools.

The fifth theme that emerged was the role of the consumer. The consumer plays a critical role in the decision-making processes within the health care industry. By passing health care reform, consumers identified themselves as a powerful force in accelerating change. All the participants had a goal to improve their member’s experience today and into the future. The participants of health plans in the Southern, Western, Eastern, and Northern regions referenced how they educate their members about their health care benefits, how they collaborate with health care providers to ensure the patient’s care is being coordinated among doctors and other healthcare providers, and how they make sure their organization provides high quality customer service at every touch point with the consumer. Improving the consumer’s experience results in decreased costs by reducing the number of members who disenroll. Improving the members’ experiences impacts the company’s ability to grow its business because high rankings, such as the Medicare Star Ratings, increases their number of enrollments.

In the next chapter I present the conclusions, discuss the results, and present my recommendations.
CHAPTER 5

DISCUSSIONS, LIMITATIONS, COMMENTS, AND REFLECTIONS

Introduction

In the prior chapter, I summarized the findings from 15 interviews completed in 2018 with five Chief Executive Officers, five Chief Financial Officers, and five Chief Medical Officers working within five different health plans located within the five regions within the United States.

In this chapter, I discuss the results of my study and include a summary of each of the five main themes: (a) health care reform, (b) education and lifelong learning, (c) leadership, (d) quality, and (e) the role of the consumer, the results in relation to the literature compared them to earlier research studies, and discussed areas of agreement and disagreement between the literature and my study, limitation of my study, additional comments and reflections, implications and recommendations for future research, and a closing reflection.

The purpose of this case study was to explore the experiences of Chief Executive Officers, Chief Financial Officers, and Chief Medical Officers in the complex health insurance industry since the passing of the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Acts in 2010. I wanted to understand how health care executive leaders in the areas of clinical, administrative, and financial experienced and led their organizations during this period of ongoing uncertainty. The questions guiding the study were: What knowledge, skills, and dispositions are they using during these changes? How do the clinical, administrative, and financial executives describe their leadership experience? How do
current leadership practices compare to the literature? What types of decisions are health care leaders making?

Discussion of the Results

This study surfaced strategies, tactics, and leadership approaches of Chief Executive Officers, Chief Financial Officers, and Chief Medical Officers leveraged to navigate change in response to the passing of the PPACA. This study yielded five main themes: (a) health care reform, (b) education and lifelong learning, (c) leadership, (d) quality, and (e) the role of the consumer. Below is a summary of each theme.

Health Care Reform

Health care has been and will continue to be a frequent topic of discussion and a point of contention throughout the United States. Cost, quality, and a lack of overall satisfaction remain the driving forces behind the overall frustration (An et al., 2013; Ungar, L, & O'Donnell, 2015). In the last three presidential elections, the candidates elected included health care reform as part of their election platform. The Chief Executive, Finance, and Medical Officers are designing and implementing innovative models to navigate the current and future health care reform rapids with the goal of also maintaining financial solvency.

Education and Lifelong Learning

To be a leader in the health care industry, education is a must. The participants in this study were highly educated. All had a baccalaureate degree, 30% had a doctorate degree, and all but one participant had an advanced degree. These leaders also have continued to obtain additional knowledge, skills, and abilities by attending annual health care conferences, seminars, certificate programs, week-long learning modules, and networking with their peers. Education
provided these leaders with skills, strong general business acumen, and the tools to lead large, complex organizations. These executive leaders also shared their knowledge throughout their organizations to develop and increase their staffs’ performance, skills, and abilities. It is unlikely a leader who achieves the level of Chief Executive, Financial, or Medical Officer in the health insurance industry would have anything less than a bachelor’s degree and most likely would have a master’s degree.

**Leadership**

The participants in this study believed collaboration, leadership styles, trust, transparency, succession planning, culture, and leadership development were key leadership areas that significantly affected a health insurance industry executive leader’s success. All participants recognized the importance of providing their staffs with the new vision which ensured alignment throughout the organization. More than half of those interviewed have been refocusing their attention on the bigger issues and the future of the organization, while empowering their staffs to manage and take responsibility for the day-to-day tactical activities. They have been struggling with the unknown and are concerned about getting it right, making leadership at these times very difficult. According to those I interviewed, uncertainty drove fear and, to address that fear, health insurance leaders spent time communicating, managing their emotions, and focusing on what they could control. More than half of the participants also focused their time and attention on transforming their current culture with the goal of shifting their current corporate behaviors, organizational structures, and processes with the new strategy and culture. This does not leave a lot of time to complete many of the other key activities that need to be completed.
Quality

All participants identified and implemented efforts to improve the quality of healthcare services now and in the future. The participants believed a relationship between innovation and quality exists. Those organizations that innovated and improved quality were more successful than those that did not. More than half of individuals who participated in the study believed their focus on quality led to reduced costs and improved health care outcomes. Success occurred when both the health plan and the patient care community worked together on improving quality and efficiency of care. All the Chief Medical Officers who participated in the study acknowledged that their primary focus going forward will continue to be on improving quality within their organization and within the medical communities that provide care to their members.

The Role of the Consumer

The consumer, a key stakeholder, has been a driving force behind health care reform, and consumers will continue to play a critical role in the future. By passing health care reform, consumers identified themselves as powerful forces in accelerating change. More than half of those interviewed acknowledged their belief that health plans overall have very low customer satisfaction scores. This has led to the development and implementation of initiatives designed to improve the members’ experience. Participants from four of the five health plans described programs they have implemented to educate their members about their health care benefits, to collaborate with health care providers to ensure patients’ care is being coordinated among doctors and other healthcare providers, and to make the health insurance company provide high quality customer service.

External focuses have also driven consumer engagement. The government implemented a plan for public sharing of the results of assessments, like the Medicare Star Rating system,
designed to provide overall ratings of the health plans’ quality and performance. Health insurance companies know Medicare members select their health plans based on feedback from friends and family. Therefore, positive scores have a direct impact on a health plan’s membership, revenue, and ability to grow its business. This will also be an ongoing area of focus for the health insurance companies and industry.

**Discussion of the Results in Relation to the Literature**

How do these findings align with the literature described in Chapter Two and other pertinent research? Reflected here is a discussion of the themes through the lenses of Northouse’s (2019) adaptive leadership theory, Lincoln’s (1989) discourse, myth, ritual, taxonomy, Kramer & Enomoto’s (2007) ethical leadership theory, Bridges & Bridges’ (2016) transition theory, and Bolman and Deal’s (2017) reframing organizations theory. This discussion revisits these theories through the journey of Chief Executive Officers, Chief Financial Officers, and Chief Medical Officers who participated in my study since the passing of the Patient Protection and Affordable Care Act (PPACA) in March 2010.

**Adaptive Leadership**

Northouse’s (2019) definition of leadership, a process whereby a person influences an individual or group of individuals to achieve a common goal, and the fact that there are many leadership approaches, helped me better understand the participants’ reality. I applied his theory of adaptive leadership to interpret Chief Executive, Financial, and Medical Officer’s perceptions during change related to their environment since the passing of the Patient Protection and Affordable Care Act (PPACA). Northouse (2019) presented a conceptual model for leadership. He defined leadership as both a trait and a process. Traits included things like self-confidence, sociability, and integrity and are “innate qualities and characteristics possessed” by the leader.
As a process, leadership is based on the leader’s behaviors and are skills and abilities that are obtained through education and experience. According to Northouse (2019), the goal of the leader is to achieve a common goal by influencing others. He said that leadership is a “relationship between people in a social situation” (Northouse, 2019, p. 19). He also lists the various leadership approaches which include trait, skills, behavioral, situational, path-goal, leader-member exchange, transformational, authentic, servant, and adaptive leadership.

Northouse (2019) described adaptive leadership as “the practice of mobilizing people to tackle tough challenges and thrive” (p. 258). Adaptive leaders help others do the work by mobilizing, motivating, organizing, orienting, and focusing their attention on what is important. According to Northouse (2019) adaptive leadership is most effective when an organization has problems that are not clearly defined, not easy to identify, and do not have a clear solution. Adaptive leadership is difficult to implement, and there is resistance because staff’s priorities, beliefs, roles, and values may have to change.

Participants in my study shared how their focus was on motivating their staff to achieve more than what they had been expected to produce in the past. Participants reported their focus on improving their staff’s performance to function at their fullest potential. For example, Dr. Cindy leveraged sharing information, knowledge, and experiences as one way to effectively motivate her staff and increase their performance, skills, and abilities. To achieve these goals, they communicated frequently with staff, shared the new vision, established goals, held staff accountable, and conveyed confidence throughout the process. For example, Nick, Chief Executive Officer, shared his recent experience presenting the updated vision and strategic plan to his direct reports. The feedback he received affirmed, in his mind, that he is a trusted leader.
because his employees appeared comfortable with changes he was championing and were embracing the new vision and plan. Scott said, “Once standards were defined and communicated, it is my job to hold people accountable to meet and hopefully exceeding them on a regular basis.” Tony shared how his organization developed and implemented new recognition and reward programs. They now celebrate Employee Appreciation Day, provide managers with the ability to give a spot bonus to those employees, and a formal peer-to-peer recognition program. Previously, they only had a “Years of Service” award. He found these programs raised employee morale, retained key employees, increased productivity, and reduced employee stress, absenteeism, and turnover.

There are six adaptive leadership behaviors which Northouse (2019) labeled as (1) Get on the Balcony, (2) Identify Adaptive Challenges, (3) Regulate Distress, (4) Maintain Disciplined Attention, (5) Give the Work Back to the People, and (6) Protect Leadership Voices from Below (Northouse, 2019). When an adaptive leader gets on the balcony, they spend time understanding the big picture from all aspects of the situation. This approach enables the leader to “identify value and power, conflicts among people, ways they may be avoiding work, and other dysfunctional reactions to change” (Northouse, 2019, pp. 262-263).

In addition to getting onto the balcony, leaders must analyze and provide an example of each of the challenges their organization is facing (Northouse, 2019). Failures occur when leaders incorrectly diagnosis the challenges and when leaders do not provide adequate or appropriate modifications to the environment or situation. After their analysis is completed, according to Northouse (2019), if the problem is a technical issue the leader can fix it with their knowledge and authority to resolve the issue. If the problems involve changes that impact beliefs, attitudes, and values, the leader must take an adaptive approach.
According to Northouse (2019), the third behavior of an adaptive leader is regulating distress. When a leader regulates distress, they have their team recognize the need for change while not overwhelming their team. The leader creates a safe environment enabling conversations to occur regarding the challenges they are facing and concerns their staff may have regarding their situation. The leader also provides direction, protection, orientation, conflict management, and productive norms. Finally, the leader regulates their own personal distress and maintains it in a productive range throughout the process.

Health care reform increased stress, turnover, and was overwhelming for many staff members in the health insurance organizations who participated in my study. Scott, CEO of a Midwestern health plan, shared a story in which just a couple of years after the passing of the PPACA his annual employee survey had one of the highest scores in the category of stress and confusion their organization had seen in over 20 years. He said, “As leaders, we were stressed but we had no idea how it was impacting our staff until we saw our employee survey results.” He went on to say, “even though we were very busy, we decided to hold more staff meetings with the goal of providing our staff with an opportunity to share how they were feeling and talk about their areas of concern.” Tony, CFO of an Eastern health plan said, “we have to be candidate about where the uncertainties lie and be transparent about them.” He said, “We must have ongoing conversations with our team or the stress, and uncertainty will continue to increase our employee turnover.”

The next behavior of an adaptive leader is maintaining disciplined attention (Northouse, 2019). When a leader maintains disciplined attention, it means the leader encourages their staff to focus their attention on the difficult, demanding, and challenging work they need to do to implement the necessary changes to drive the overall effectiveness of the organization. The
leader also provides a safe space for their team to work through their differences encouraging the team to talk about their conflicts, concerns, and issues. By taking this approach, the leader ensures the organization and the employees stay focused.

Dr. Mark shared his leadership philosophy during health care reform. He said, “getting things done helps us focus.” He went on to say that sometimes he would tell his team, “don’t worry about what you’re hearing about regarding health care reform, let’s get this stuff done.” Dr. Mark did not believe their health plan was the only health plan navigating health care reform and it was their job as leaders to reduce turmoil and confusion. Brian, CEO of a Eastern health plan, felt the only way their organization was going to get anything done was by focusing and providing their staff with the tools they need to get the work done.

According to Northouse (2019), the fifth behavior of an adaptive leader is giving the work back to the people. When a leader gives the work back to the people, it means the leader provides their staff with direction, security, confidence, and empowers them to solve problems on their own. The leader does not enable their staff to become dependent on the leader. Instead, the staff learn how to address their issues, solve their problems, and move the organization forward while addressing their challenges.

The last behavior is protecting leadership voices from below. Leaders who protect leadership voices from below, listen to their staff and consider the ideas from everyone on their team including those who may be at the fringe, marginalized, or even considered deviant. By listening to these staff members, the leader gives equal power to all staff members and disrupts what Northouse (2019) calls “the normal way of doing things” (p. 270).
The Chief Executive, Financial, and Medical Officers who participated in this study described that they went through a significant change in response to the passing of health care reform legislation. For example, Jay, a Chief Financial Officer, explained that the changes have been impacting their entire business model—changes in the marketplace, their products, their structure; and a redefinition of their value proposition. Jay said, “Something had to change” because consumers, employees, and government agencies could not afford the high premiums for health insurance. He went on to say that it is challenging to lead right now due to the large number of changes, and leaders in the health insurance industry “don't know what other changes are coming.” They shared how these major changes transformed the way they led their organization. For example, Dr. Cindy, a Chief Medical Officer, said “My big focus right now is change management.” According to Scott, Chief Executive Officer, it is “rapid change, its everywhere... it's painful.” All participants acknowledged the tremendous amount of change occurring in the industry right now which is coming from a variety of fronts.

Adaptive leaders also empower and nurture their staff (Northouse, 2019). They raise awareness and lead their teams to go beyond their own interests and focus on helping others. For example, Jay, Chief Financial Officer within a Southern health plan, said, “I'm fairly consultative in nature. I would say that I empower my team. I give direction. Let them run with what they do best.” Health insurance leaders utilized adaptive leadership to set clear goals, high expectations, and encourage staff. They also provided support and recognition, got people to look beyond their self-interest, and inspired their staff to reach for the impossible.

In times of change, adaptive leaders become strong role models, create a vision, establish clear organizational values, build trust, and collaborate with others (Northouse, 2019). For example, Nick, Chief Executive Officer of a Northern health plan, said, “You have to project
confidence and clarity, both internally and externally about the organization’s future.” He also shared about how important alignment is and the approach his organization takes to achieve it. He ensures all employees understand what makes the organization different, the direction they are heading, and how they can contribute to their success. To ensure there is alignment, Bob, Chief Financial Officer, shared an example in which he starts by confirming that everyone is on the same page. He said he recaps meetings by saying, “Here’s what we discussed. Here's the timeline, and here's what is expected to be delivered.”

Drawing on Northouse (2019) and looking at the findings in Chapter Four, I can conclude that Chief Executive, Financial, and Medical Officers use adaptive leadership behaviors to navigate change. They created a vision and connected with people to build relationships and utilized the six adaptive leadership behaviors when leading their organization there these significant changes. By taking this approach, they ensured they are aligned with each other and moving in the same direction. In the following sections, I will further apply Northouse’s (2019) leadership theory by unpacking the role of strong role models, vision, organization values, building trust, and collaboration.

**Strong role models.** According to Northouse (2019), leaders serve as an example of the values, attitudes, and behaviors they want their followers to adopt. Chief Executive, Financial, and Medical Officers shared the importance of the work they are doing to drive a cultural change throughout their organization. Success requires a clear vision and a work environment that reflects their core values. This has led to new hiring processes, staff development programs, and leading by example. This approach fosters closer working relationships, increases collaboration, builds trust among employees, and makes them a better organization today and into the future. This view was illustrated by Nick who felt his organization was able to obtain better outcomes
due to collaboration and shared how, in his opinion, decisions made in isolation generally do not result in the best decisions.

With the rapid change within the industry, health care is demanding strong leadership, and leaders are under pressure to perform (McAlearney, 2009; Rubino, Esparza & Chassiakos, 2014; Sorensen, Paull, Magann, & Davis, 2013). In a 2011 health care chief executive officer study, one third of the respondents stated a lack of clarity and concerns regarding national health policies were their top anxieties (Waldman, Smith, & Hood, 2005). Most of the Chief Executive, Finance, and Medical Officers within my study expressed the need to make sure there is alignment throughout their organization. For example, Brian, Chief Executive Officer, described why alignment is so important for an integrated delivery system. He said, “We need to work together, to be aligned because we're all in this together versus float on your own.” The health care officers who participated in this study shared how they focus their time and energy specifically on those activities that drive their organizations forward. A few discussed what they did to ensure their team and staff were ready to transition for the future.

Doing nothing while an organization obtains clarity is not a good option, and leadership is critical for survival. Developing a culture focused on continuous improvement, best practices, evidence-based protocols, shared decision making, and transparency are on the health care chief executive officers’ list of top strategies if health care is going to reduce costs and increase quality (Gabow, Haloverson & Kaplan, 2012; Weberg, 2012). This was illustrated Dr. Ray, for example, when said, “We [are] doing a lot around quality improvement…it's about quality, making sure the quality of care is the highest and trying to get people to create systems to provide the highest quality care.” He also discussed quality in relationship to innovation when he talked about how a focus on quality leads to innovation and those organizations who innovate
and improve quality will be more successful than those who do not. Drs. Patrick, Karen, Cindy, Ray, and Mark shared examples of future activities they will be doing to improve quality within their organizations and the medical community that provides care to their members.

Vision. Adaptive leaders have a clear vision (Northouse, 2019). Their vision is simple, realistic, and creates energy. Organizational visions traditionally emerge through collaboration and input from stakeholders at all levels throughout the organization (Porter-O’Grady & Malloch, 2003). The vision enables an organization to be clear regarding its purpose and provides staff with meaning, clear roles, goals, and direction for the organization (Fenech, 2013; Giltinane, 2013; Hogan & Kaiser, 2005; Osborne, 1993; Schimpff, 2012; White-Smith & White, 2009). It is “about doing the right things, not doing things right” (Osborne, 1993, p. 3). According to the Officers within my study, they felt they were the voice of the vision of the organization. For example, Nick, Chief Executive Officer, shared the importance of the work their leadership team is doing to drive a cultural change throughout their organization. He said, “For us to be successful we must present a clear vision and a work environment that reflects our core values. They also felt the vision must be clear and their work environment must reflect their core values. To verify the participants in my study had a vision statement, I had all participants in the study send copies of their vision statement and half also sent me copies of their employee and community newsletters that include their vision statement. A vision provides employees with the ability to make and influence decisions, ensuring proper alignment with the organization’s goals, objectives, and direction (Brazier, 2005). Other studies have found that a successful leader communicates the organizational purpose and plans, organizes, obtains resources, and coordinates activities with a clearly defined strategy (Hogan & Kaiser, 2005; Osborne, 1993).
According to the literature, the primary role of the Chief Executive Officer is to establish the future direction of the organization (Higgs, 2009; Waldman, Smith & Hood, 2011; Weberg, 2012). It’s not surprising that the Chief Executive Officers within the study shared how developing and implementing a new vision was essential to their overall success. A health care vision needs to be simple, clear, and initiated from the top levels of leadership (Berry, 2007; Best, et al., 2012; Brazier, 2005; Keown, et al., 2014; Schimpff, 2012; Terry, Hussain & Nelson, 2010). The Chief Executive Officers in this study shared their vision with their staff and by taking this approach, the Chief Executive Officers increased trust and affirmed alignment.

**Organizational values.** Northouse (2019) states leaders must have a “strong set of internal values and ideals, and they are effective at motivating followers to act in ways that support the greater good rather than their own self-interests” (Northhouse 2019, p.169). The participants in this study shared the importance of their organizational values and how they impact their overall success. Scott, CEO in the Midwest region said, “For our organization to be successful, we must present a clear vision and a work environment that reflects our core values.” Scott shared examples of how his organization incorporates their corporate values in their hiring process, staff development, and performance reviews. By taking this approach, Scott stated they developed closer working relationships, increased collaboration, continued to build trust among employees, and improved their organization in the present and for the future.

Not everyone interviewed agreed about the existence of positive corporate values in their organization. Dr. Karen, CMO in the Western region said, “The challenge is, we don't have a culture that values family, neighbors, social connections. Just “love thy neighbor” seems to have gone by the wayside. Yet, that is the most powerful three words that will heal people.” Dr. Cindy analyzed values through the lens of a personal versus corporate view. She shared a story
about how her organization completed a cultural competency program and how she was amazed at the results. She said,

The things that came out and what I learned about the people who were sitting next to me was shocking. Some of the values and the opinions that people held are very, very strong, and they bring that stuff to work. I am not sure how an organization can change their staff’s values to match the corporate values. Those personal values impact how they treat our members, one another, and they become hidden agendas when negotiating for resources. It has a direct impact on their ability to listen.

While corporate values support the vision, shape the culture, and are the organization’s identity, the personal values cannot be ignored and can impact the leader’s ability to drive change and overall success of the organization. It is critical that an organization has clearly defined core values and incorporates them in the hiring, review, and promotion process.

**Build trust.** Northouse (2019) stated that leaders create trust by being clear and consistent. When a leader creates trust, there is a sense of honor, reliability, and authenticity. The participants in the study shared how difficult it is to obtain buy-in and achieving alignment when there is a lack of trust. More than half of the participants in the study discussed the ongoing general lack of trust between the health insurance industry and health care providers which included doctors, clinics, and hospitals.

Trust is important during times of uncertainty (Northouse, 2019). Ten out of the fifteen interviewees spoke about the importance and impact trust has on their ability to be effective leaders and critical during times of change. Jay, CFO in the Southern region said, “With everything going on right now, I am focusing on relationship building, and trust, and influencing
others are my areas of focus.” He went on and said, “Right now we are focused on the tactical and technical day-to-day activities, and it is easy to forget to build those relationships that are very important, especially with the significant change we have been facing.” He talked about the importance of building trust and how it leads to an increase in commitment from his staff, more open honest conversation, and increased creativity and productivity.

The interviews revealed the power of trust and how it encourages employees to give their best effort. Other participants talked about trust as a two-way street and how they were not sure how a leader can expect their people to trust them if they don’t trust their people. Based on what participants shared, trust is as important as an executive is within a large health insurance organization.

**Collaboration.** Great leaders are successful at bringing people together to achieve a common goal (Northouse, 2019). Teamwork and collaboration are highly valued by adaptive leaders. For example, Nick felt his organization was able to obtain better outcomes due to collaboration, and he shared how decisions made in isolation generally do not result in the best decisions. According to Michael, “Internal collaboration…we can't function without it.” Organizational visions traditionally emerge through collaboration and input from stakeholders at all levels throughout the organization (Porter-O’Grady & Malloch, 2003).

In his thematic analysis of literature, Weberg (2012) found health care is rapidly changing, inherently complex, and heavily regulated. The problems in health care are not limited to complexity and regulation but include soaring costs and poor-quality outcomes. Weberg (2012) stated, “Poor quality, outrageous costs, and nursing shortages are symptoms of deeper underlying inefficiencies in the system. Yet, even when innovations come along to
improve efficiency, they are not always implemented” (p. 268). Clearly, innovation alone will not address the problems in the health care industry.

The health insurance industry has diverse stakeholders with separate goals and objectives that frequently conflict with each other (Trastek, Hamilton, & Niles, 2014). The participants of this study affirmed they have a large list of stakeholders with competing interests making it challenging to collaborate. However, they described efforts for fostering collaboration. For example, Scott said, “So what I've tried to do is just be very clear to the Board and our key stakeholders and make sure everyone is on the same page with that potential uncertainty.” He went on to say, “Our focus hasn’t changed. We are here to provide care for people and I want us to be more behind the scenes, ensuring that we have a long term and sustainable model, so that we can be here, like I said, another 100 years.” Collaboration doesn’t just happen, it requires a commitment by the organization, a strategy, time to build trust, and ongoing communication for it to work.

The participants within this study recognized that collaboration is an important leadership skill and necessary if they want to continue to reduce costs, improve outcomes while improving the consumers’ experience also known as the Triple Aim. For example, Tony was not the only leader who talked about the Triple Aim. Dr. Karen, a Chief Medical Officer of a Western health plan, agreed it is about delivering on “the Triple Aim.” These changes will not occur nor be sustainable without ongoing collaboration. Many stated that collaboration has been critical and a driving focus in the success of their initiatives. Others felt that by working closer together and building relationships, they will build a better organization for the future. In the next section, I continue to analyze my research findings through the lens of Lincoln’s (1989) Discourse, Myth, Ritual, and Taxonomy theories.
Lincoln’s Discourse, Myth, Ritual, and Taxonomy

Lincoln (1989) defines discourse as a group of individuals who think similarly, which provides members with the ability to make sense of themselves and of the world around them. They have a shared reality in which they can take part in molding the world in accordance with their perceived needs and communication. Activities, documents, and rules identify the group and establish the boundaries separating cultures. These include all methods of communication.

When applied to the health care setting, written documentation, such as compliance manuals, code of conduct, electronic health records with embedded clinical standards, value statements, job descriptions, and spoken communication are part of this discourse (Durrenberger & Erem, 1997; Smith & Stewart, 2011; Tonuma & Winbolt, 2000). Also, part of the discourse is what is not voiced, for example, dissatisfaction, errors within a process, processes not followed, and mistakes made by senior leaders. Discourse establishes culture and defines what is right and wrong.

Health care is currently a $1.7 trillion industry that is heavily regulated. The health insurance industry is plagued with bureaucracies and hierarchies, different types of leaders, a dated leadership model, and different stakeholders with conflicting priorities (Terry, Hussain, & Nelson, 2010). This leads to disempowerment, desire for the status quo, and an overall fear of change (Brazier, 2005; Terry, Hussain, & Nelson, 2010). According to participants in this study uncertainty has driven fear, and some in the industry are unwilling to change. For example, Scott said, “It’s easy to get caught up with all that uncertainty. So, the first thing I try to do is just make sure I set the right expectations, I am candid about where those uncertainties lie, and transparent with my staff so they can successfully perform the day-to-day tasks.” Michael, Scott, and Nick were also concerned because if they get it wrong, they could be out of business. Brian
said his job as the leader is to “create an environment that influences people to be engaged at the highest level, that they understand their role on this team, and how their role impacts the purpose and the goals.”

**Myth.** Lincoln (1989) also uses the concept of myth. Myth is distinct from fable, legend, and pure history. Myth is instead composed of folk stories or a selected group of stories that possess credibility and authority and establish the culture. In health care, these stories determine and maintain the goals and purposes of health care. One example of a myth in health care is that health care is a system. According to Merriam-Webster’s dictionary (2018), a system is defined as “something that regularly interacts, things that are connected with one another to form a complex whole, a set of principles or procedures in which something is done, or an organized approach or method.” To be a system, health care would need to develop an approach in which a procedure or method is implemented and coordinated in a consistent, logical order. The participants in the study believe being a system should be a vision for the industry. They felt this would reduce false expectations, confusion, and frustration from stakeholders, including consumers.

The participants in this study shared stories of how in the 1980s the health insurance industry implemented capitation, a payment system for services provided to a specific list of members who are enrolled in the health plan that pays physicians a set amount if a person receives care or not. The participants believed this is one of the reasons why the medical community is often unwilling to collaborate with the health insurance industry. The participants also believed the substantial amount of misinformation about the PPACA led to inaccurate stories and confusion about the goals and outcomes of this law. Some of the participants in this
study also questioned the impact of partisan politics and poor public education and communication.

Study participants were surprised there are leaders in the health insurance industry who still believe the PPACA will be repealed and replaced. For example, Scott stated he was surprised there were still leaders in the industry who believe the federal government is going to repeal and replace the PPACA. Dr. Ray, a Chief Medical Officer, said “There's a lot of people in the industry who would just as soon keep their heads in the sand and not change.” They leverage this to maintain their current goals and purpose. The leaders who believe the PPACA is going to be repealed and replaced are using this to ensure stability and creditability within the organization and with their stakeholders. Staff and stakeholders follow these opposing leaders because they may reference it as a goal of the President of the United States; they are also educated which provides them with creditability; and they hold a position of authority. These elements would be illustrations of what Lincoln (1989) labels as myth.

**Rituals.** Supporting the myths are the rituals of a society (Lincoln, 1989). These are the specific acts that provide ongoing support for the myth, which includes acts, words, and documents. Lincoln argues that rituals can be powerful constructs for defining and maintaining a society. According to the Chief Executive, Financial, and Medical Officers in this study, rituals include the roles and responsibilities of the executive leaders. For example, the executives are responsible for building the vision while their lower level staff attend to the day-to-day activities. The participants spoke about the Patient Protection and Affordable Care Act (PPACA) that guided expectations and how it defined the new expectations for the industry.
All of the participants also talked about the power of their culture and organizational values. Culture is defined as shared values and a means for motivating and influencing an employee’s behavior (Wiener & Vardi, 1990). The executive leaders within this study felt strongly it was their role to drive a cultural change throughout their organization. For example, Nick said he was “the guardian of the culture, someone responsible for developing a vibrant culture and a team of employees with the resources, tools, abilities to be successful.” Nick went on to explain that he worked hard at creating a culture with lots of the “right energy”, and by that he meant creating an environment that allows people to enjoy what they do. Although participants all discussed the importance of establishing the culture of their organizations, the five different health insurance organizations represented had different organizational cultures. The participants shared specific details regarding their corporate values, beliefs, attitudes, customs, and behaviors.

**Classification.** Classification is the next category of social constructs presented by Lincoln (1989). Classifications derive from a current set of facts or truths and attempt to predict future facts or truths. Classification involves organizing the physical world, organization, or industry into discrete taxonomic systems (Lincoln, 1989). Classification operates as a means of organizing concrete knowledge and as a product of social construction. While classification is carefully constructed, there is an inherent risk with current or future events labeled as anomalies. When classified as an anomaly, these events challenge the classification and their existence upon the whole system. The PPACA is an example of classification within the health care industry because of its disruption to the current rituals. The PPACA changed the way in which the health insurance industry operates, how it is evaluated, and its financial performance.
Based on the participants in my study, prior to passing the PPACA, the United States health care industry received revenue based on the number of patients and procedures. The higher number of patients and procedures led to higher revenue. One of the desired outcomes of the PPACA was to have compensation based on reducing costs while improving quality and satisfaction. Therefore, a high number of procedures will not lead to higher revenue.

**United States Health Care Industry Revenue Taxonomy**

![Revenue Taxonomy Diagram](image)

*Figure 2. US Health Care Industry Revenue Taxonomy*

The transition is to a revenue model based on lowers costs, increasing quality, and increasing satisfaction measurements. This new model will develop new myths, rituals, and classifications within the health insurance industry. In the next section, I will analyze my research findings through the lens of Kramer and Enomoto’s (2007) Ethical Leadership theory.

**Kramer and Enomoto’s Ethical Leadership Theory**

Kramer and Enomoto (2007) define ethics as “the search for a rational understanding of the principles of human conduct” (p. 3). Being an ethical leader is not as simple as doing what is right and avoiding what is wrong. It is messier and more complex than that as most leadership is
complex and requires nuanced thinking. To assist leadership in evaluating ethical dilemmas, Kramer and Enomoto present the theory and application of the DIRR (description, interpretation, rehearsal, and rediscernment) method in their book. An ethical dilemma is one in which there is more than one equally viable choice which leads to a positive result. The participants throughout my study shared details regarding the major changes they are experiencing and the enormous amount of uncertainty plaguing the health insurance industry. These beliefs are attributed to the fact there is not one simple answer.

**Ethical tensions.** Karmer and Enomoto (2007) described four sources of ethical tension: virtual, ends-based, good society, and duties-based ethics. Virtual ethics considers the characteristics and qualities of a person; ends-based ethics, also called utilitarian ethics, considers the outcome for oneself; good society ethics considers what is in the best interest of those outside oneself and could extend to humanity; and duties-based ethics considers regulations, laws, religion, and government. Doing what is in the best interest of the member, when the result leads to a better outcome than the alternative, would be applying good society ethics. Deciding which would result in a higher bonus check for oneself would be applying ends-based ethics.

One of the reasons why the health insurance industry is so complex is that there are many stakeholders with competing interests and varying agendas. This leads to tensions between ends and means and equity in time and resources (Herzlinger, 2006; Trastek, Hamilton & Niles, 2014; VanVactor, 2012). Also, health care providers take an oath that can come into conflict with laws, corporate standards, research results, and religious beliefs and values when assessing ethical dilemmas. Drs. Cindy and Ray, Chief Medical Officers interviewed for this study, described ethical dilemmas in which they previously worked for an organization that made them
choose between implementing and supporting a business initiative or their medical oath. These Chief Medical Officers no longer work for those organizations because of this dilemma.

The Chief Executive, Financial, and Medical Officers within this study did not voice the issues they are facing as ethical issues. Instead, they believed they are business strategy challenges or opportunities. A few times during the interviews, the conflict between high-quality care and reducing costs was discussed. They discussed three issues related to this conflict. The first issue is how and who decides what is considered high-quality. The second issue is the belief that most of the medical community, those who provide care to the health insurance members, embrace providing high-quality, patient-centered care. The participants within this study were frustrated because that isn’t the case with many medical providers. The third issue is the role and responsibility of the consumer for personal health. About half of Americans live with at least one chronic condition, such as diabetes, heart, and lung ailments (Schansberg, 2014). Chronic disease accounts for more than 75% of the nation’s medical costs. Many of these conditions occur due to unhealthy lifestyle choices, which include obesity. These issues contribute to the tension regarding high quality care and lower health care costs.

The United States also has an aging population which has an impact on health care costs. According to the Administration on Aging, 12.9% of the United States population, about one in every eight, is 65 years of age or older (Aging, 2014). By 2030, there will be about 72.1 million over the age of 65, more than twice their number in 2000. The health insurance industry also knows that in 2011 Medicare spent 28% of its total cost, or about $170 billion, on patients’ last six months of life (Kaiser, 2013). The government and consumers want the health insurance industry to reduce the costs of health care, and the leaders within my study are concerned about the ethical tensions that occur when they discuss how the health insurance industry could reduce
health care costs. The ethical tensions include who should make the decision regarding end of life care, should there be rationing of care in futile treatments, and how much should be paid to provide end-of-life care. The participants in my study want direction and guidelines from the federal government before implementing any program or process that are considered political and high risk. In the next section, I analyze my research findings through the lens of Bridges and Bridge’s (2016) Transition Model.

**Transition Model**

According to Bridges and Bridges (2016), change is situational. Leaders tend to focus on the change and not the traditions, which are not the same things. Change is conditional or circumstantial whereas transitions are psychological. The participants of this study all agreed the affordable care act changed the face of health insurance in the United States. It transformed the industry and its impact was vast and wide. The changes have impacted the entire health care business model, changed the marketplace, introduced new products, led to mergers and acquisitions that changed the structures, and led health insurance organizations to redefine their value proposition. These leaders believed they were successfully leading their organizations and focused not on the change but on assisting their team through the change transition. The difference between change and transition is subtle but important. Change is something that happens to people, can happen even if they don't agree with it, and happens very quickly. Transition is internal, occurs in people's minds as they go through change, and occurs more slowly.

There are different ways in which a leader can assist their staff through the transition process (Bridges & Bridges, 2016). This includes assessing how ready the company and staff are for change and having a solid communication strategy that includes messaging focused on
before, during, and after the change. A leader should also identify the gains and losses, sell the problem, frequently talk about the transition, and acknowledge their feelings as being normal throughout the process. For example, Nick, Chief Executive Officer of a Northern health plan, said, “You have to project confidence and clarity, both internally and externally, about the organization’s future.” He also shared about how important alignment is and the approach his organization takes to achieve it. He ensures all employees understand what makes the organization different, the direction they are heading, and how they can contribute to their success. Bridges and Bridges (2016) state that the process should include a way to respectfully acknowledge and mark the end of the current situation and the official beginning of the new beginnings. Once the organization transitions to the new beginning, the leader should ensure quick successes, symbolize the new identity, and celebrate successes. For example, Michael shared a story regarding his first few weeks on the job as the Chief Executive Officer. He shared how he implemented a monthly all staff meeting in which he asked for feedback, ideas, and open discussion. He felt this was very important to mark the officially beginning of the new organization, culture, and kick-off the process of building trust.

When dealing with nonstop change, a leader must have an overall design separating each of the changes as different elements (Bridges & Bridges, 2016). According to the executive leaders who participated in the study, there has been rapid change in everything they do and from multiple directions. All participants expressed that there is a tremendous amount of change occurring in the industry after the passing of the Patient Protection and Affordable Care Act (PPACA). They focused a lot of energy around developing a new strategy, communicating their new vision and articulated what it meant to their staff, and collaborating with stakeholders throughout the industry. They felt this was critical for success. Organizations are more apt to be
successful if they have a transition plan in place that includes policies, roles, culture, leadership, structure, resources, and histories (Bridges & Bridges, 2016). Having a plan that includes these elements helps health care leaders develop and implement strategies and transition plans to successfully navigate their staff and stakeholders through health care reform.

Studies focused on leadership, health care, and ongoing change in response to health care reform have been published more frequently in recent years. However, there is a general lack of theory used in analyzing this research (Gabel, 2012; Garman & Lemak, 2011; Henochowicz & Hetherington, 2006; Parker, 2013). Therefore, there seems to be an opportunity to explore alternative frameworks specifically regarding the health care insurance industry that could result in new theory. In the next section, I also analyze my research findings through the lens of Bolman and Deal’s (2017) Reframing Organizations theory.

Reframing Organizations

After completing my interviews with the fifteen health care officers and reviewing my research question, purpose, and findings, I considered another theory as a framework for understanding my analyses. The additional theory was Bolman and Deal’s (2017) theory on reframing organizations. I selected Bolman and Deal’s (2017) reframing organizations theory because it focused on transformation and change of both an organization and leadership. Transformation and change were outcomes of the complex, overwhelming changes the chief executive officers were facing since the passing of the Patient Protection and Affordable Care Act (PPACA) almost a decade ago.

Bolman and Deal’s (2017) theory provides a leader with the ability to review the same situation through at least four frames for understanding organizational change. It also provides
leaders with a frame for how to design the structure of their organization to fit the organization’s strategies, tasks, and context. Next, it provides a frame for how to achieve organizational effectiveness through people, a frame for better understanding the political framework and the struggles for resources and power, and a frame for examining the implications of symbols and culture. Finally, their theory describes how leaders can improve leadership through a focus on change and ethics. Bolman and Deal’s (2017) theory is a relevant lens to analyze the findings of my study.

According to Bolman and Deal (2017), having the right structure increases the likelihood that employees are aligned, effective, and positive in their roles. This is achieved by developing the staff through coaching, training programs, promotions, and removal of ineffective or hostile employees. Participants in the study talked about how they are developing their people. For example, Nick and Bob talked about the importance of coaching and developing their team and how it increased the productivity of their staff. Dr. Cindy felt sharing her knowledge and experiences has been one of the most effective ways to increase their staff’s performance, skills, and abilities. Having an effective structure requires the organization to achieve six assumptions. They include having an established strategy with goals and objectives, being effective and efficient, utilizing coordination and collaboration, having staff that focus on the organization versus personal agendas, aligning with the current organizational situation and resources, and the utilizing problem solving and restructuring to address their issues. The importance of strategy emerged as one of the key areas in my study for successfully responding to change in the health care industry. For example, Nick said, “I think strategic clarity is a premium quality but also a challenge in this environment.” To have an effective strategy requires time and resources. Brian
said, “You have to be very patient about how you create your strategies, and you also have to be
very patient in terms of that achievement.”

According to Bolman and Deal (2017) when resources are scarce and when the
organization has conflicting or different options, politics is used to make decisions both within
and outside an organization. Internal and external organizations include different people and
groups with diverse interests, values, beliefs, information, and views. These individuals and
groups utilize bargaining and negotiation to influence outcomes that align with their interests.

Power is a key resource with an organization and is used to make things happen (Bolman
& Deal, 2017). Power can come, for example, from the position someone holds within the
organization. Individuals also can gain power through their expertise and information,
reputation, access to the decision makers, ability to communicate their position clearly using
beliefs and values, ability to influence through charisma, energy, and political intelligence; or
ability to block something from occurring. According to Bolman and Deal (2017), goals,
policies, and structure develop because of ongoing negotiation. In large organizations, the
dominant power is often controlled by senior management. Those who have power win. Power
doesn’t guarantee the outcome will be fair or a wise business decision.

Power was a discussed in my study. For example, Tony talked about how the passing of
the PPACA was proof of the federal government’s power to disrupt and influence change within
an industry. Dave explained,

Get ready for disruption. That is the thing we're seeing today, politically and in other
venues. It is all about disruption. The ones who can either disrupt and improve the
system, or who are adaptable enough to go with and ride the wave of disruption will be the winners. Those who stay with the same old way of doing things will be left behind.

If a health plan wants to succeed going forward, leaders must recognize the need for change, embrace change, and lead the transformation which includes developing and implementing tactical plans and holding their staff accountable to help drive the change. Understanding the role of power and political influence is important and health insurance leaders need to leverage it going forward to drive change within their organizations, with the government, and with their stakeholders.

An organization’s culture is expressed through its symbols (Bolman & Deal, 2017). Whereas an organization’s vision, values, and myths instill a deeper purpose, an organization’s vision, values, and myths also bring an organization together, establishes the direction they are going, and provide clarity to their staff and stakeholders. Their vision, values, and myths frequently overlap with one another and determine the organization’s ethics (Bolman & Deal, 2017). When an organization works together as a team with clear alignment, they become a high performing team. It is the role of the executive leader, with a title that symbols responsibility, power, and control, to establish and maintain the corporate culture.

Executive leaders in health plans work to establish a productive and specific culture. Nick used his leadership position to represent the organization in various forms, some more ceremonial, but also as the voice in formal public and media settings. For example, Nick talked about his role as a leader and “the guardian of the culture, someone responsible for developing a vibrant culture and a team of employees with the resources, tools, abilities to be successful”.

As stated earlier, Bolman and Deal (2017) suggest there are four frames that can be used to assess an organization. The four frames could also be used when assessing barriers to change and for managing conflict. According to Bolman and Deal (2017), effective leaders utilize multiple frames, but determine which one or two is most helpful in focusing on changes in an organization at a particular time. Bolman and Deal’s theory about organizational change is useful in understanding how the leaders interviewed for the study have approached their roles. Transformation and change were outcomes of the complex, overwhelming changes the chief executive officers were facing since the passing of the Patient Protection and Affordable Care Act (PPACA) almost a decade ago.
Limitations of the Study

Limitations are potential weaknesses usually out of the researchers’ control (Simon & Goes, 2013). The limitations in qualitative research could include researcher bias, a small sample size, limited sample demographic, sampling procedures, and data collection procedures (Johnson, 1997). Researcher bias is defined as a researcher finding what they want to find due to selective observation, selective recording of information, and allowing one’s personal views to affect how the research is conducted and the results are analyzed.

To support the internal and external validity of my study, I implemented the following to address these limitations:

1. Implemented reflexivity by writing memos and documenting my feelings throughout the process.
2. Searched for examples that disconfirmed my expectations of what I am studying.
3. Interviewed leaders in the five areas of the United States. This includes the West, East, North, Midwest, and South.
4. Implemented “member checking” and shared my interpretations with the participants.
5. Spent a significant amount of time with each of my participants so I could understand the relationships among participants in the same organization and why they occurred.
6. Utilized peer debriefing in which I worked together with one of my colleagues. I had the debriefer review my transcripts, methodology, and final report. I received and incorporated this feedback.

This study had several potential limitations. First, I invited, selected, and interviewed the five Chief Executive Officers, five Chief Financial Officers, and five Chief Medical Officers
working within five different health insurance companies located throughout the United States who volunteered for the study. Due to the amount of time I have worked in the health care industry, over 25 years, all but one of the participants in the study are people I know or have met in the industry. Those who left the industry were not invited to participate in the study, so their views were excluded. Participants who chose to interview for this study, may have been motivated by wanting to share their positive results since the passing of Patient Protection and Affordable Care Act (PPACA). To ensure these participants shared all the details and didn’t assume I knew what they meant by their responses, I asked them throughout the interview process to pretend as if I had no knowledge, background, and experience in the industry and with anyone who participated in the study.

Second, the study was conducted with participants in five locations within five regions. The health plan organizations that participated may not have had members or business within all the States they represented in their region.

Third, all interviews were done over the phone. The results may have been different if they were completed face-to-face and over the phone. Some of the things I might have missed included an ability to respond to visual cues and potential loss of contextual data being unable to observe their work environment during the interviews.
Additional Comments and Reflections

When reflecting on the study, I realize there were things that I didn’t know before completing the research; some findings were known and reinforced; other findings were affirmed and led to recommendations; and other topics were not discussed at all. The study validated my belief that the current health care model is an illness-based model. Drs. Karen and Cindy, Chief Medical Officers, talked about it being an illness-based model as an ongoing issue. They said the industry spends something like 90% of our health care resources on care related to a disease, which is reactive versus proactive. These officers questioned if the industry focused on health and wellness versus illness, could the industry significantly reduce costs, improve outcomes, and address some of the other related concerns including, but not limited to, health care provider shortages.

The study also affirmed the ongoing collaboration challenges between the health insurance and the clinical provider industries. While it has gotten better, according to those interviewed in my study, this issue continues. Finally, articles and recruiters in the industry continue to acknowledge the large number of c-suite leaders who have left the industry for other opportunities and due to retirement. Those who participated in my study confirmed there have been many c-suite leaders who have left their positions, and they were expecting more to leave in the next few years. This is a concern for the industry.

There were also things I didn’t realize prior to completing this study. I didn’t realize how much transition had occurred and how quickly some practices had been successfully implemented. Health insurance leaders are using new strategies to drive change throughout their organizations while utilizing a variety of leadership approaches to successfully implement these
changes. Finally, the participants in the study are very aware of the changes they have faced and are expecting to face in the future.

Finally, there were topics that surprisingly were not discussed or minimally mentioned during my interviews. These included the disparities, medical loss ratio, social determinants of health, and single payer insurance. Because most of the non-profit health insurance companies already spend 80-85% of their revenue on quality and cost of care, this topic may not have been important to those organizations, and 40% of the organizations I interviewed were non-profit. I wonder if it would have been a theme if I had only interviewed for-profits.

According to the National Institute on Health, “Health status disparities refer to the variation in rates of disease occurrence and disabilities between socioeconomic and/or geographically defined population groups.” Disparities in health care was one of the most talked and written about topics in the industry. Yet only two of those interviewed in my study talked about disparities. When asked about how frequently disparities in care occurs Dr. Cindy said, “Oh, all the time. All the time.” She went on to say, “That's always foremost in my mind, making sure the access is equitable, the level of care is equitable.” Dr. Cindy also talked about the education and coaching she provides to patients and members. She said, “[I] tell them [her staff] all the time…ask a lot of questions…ask until you understand. No question is a dumb question.” She continued and said, “I talk about it a lot. I've always talked about it a lot.” Dr. Ray, Chief Medical Officer at an Eastern health plan said, “[We] have disparities in the care [patients receive] and different people are receiving different care.” He went on to say how amazed he has been about the fact that many people do not realize how common this issue has been within the health care industry. He explained that he is hopeful that once health care leaders can review their own clinical data, they will be shocked at what they find regarding
health care disparities within their own clinic, hospital, and health care delivery system. By disparities, he was referring to how people of color and lower income experience differences and difficulties in accessing care, receiving poorer quality care, and having worse health outcomes.

Social determinants of health, according to the World Health Organization (2018), are conditions in which people are born, grow, live, work, and age that impact the distribution of money, power, and resources. Social determinants of health were the most frequent topics presented at the top three largest health insurance and healthcare conferences in 2018. This has been a relatively new topic in health care but referenced in over 5,000 articles in the first six months of 2018. Although those who participated in my study didn’t discuss social determinants of health, Drs. Karen and Cindy, Chief Medical Officers, acknowledged the need to address disparities in health care.

I was also surprised that I didn’t hear any individual in my study acknowledge the single payer system concept. A single payer system is a national health insurance program in which all United States residents would be covered for all medically necessary services, including doctor, hospital, preventive, long-term care, mental health, reproductive health care, dental, vision, prescription drug, and medical supply costs (PNHP, 2018). For the last several years it has received ongoing attention and discussion at both the state and federal level. Legislation related to this has been introduced in 26 states at one time or another, and it was a key theme during both Bill and Hillary Clinton’s campaigns. Also, Hillary Clinton, as first lady, published a book on the topic.
In the next chapter I present recommendations for Chief Executive, Financial, and Medical Officers in the health insurance industry as outcomes from my research, recommendations for future research, my conclusions, and closing reflections.
CHAPTER 6

RECOMMENDATIONS, CONCLUSIONS, AND CLOSING REFLECTIONS

Introduction

In the previous chapter, I discuss the results of my study and included a summary of each of the five main themes: (a) health care reform, (b) education and lifelong learning, (c) leadership, (d) quality, and (e) the role of the consumer, the results in relation to the literature compared them to earlier research studies, and discussed areas of agreement and disagreement between the literature and my study, limitation of my study, additional comments and reflections, implications and recommendations for future research, and a closing reflection.

In this chapter, I present recommendations for Chief Executive, Financial, and Medical Officers in the health insurance industry as outcomes from my research, recommendations for future research, my conclusions, and closing reflections.

Recommendations for Future Practice

I have recommendations for Chief Executive, Financial, and Medical Officers in the health insurance industry as outcomes from my research. First, health industry leaders need to develop and implement strategies for sustainable changes. This includes making sure staff know where the organization is going and why they are transforming. Make sure the “What’s in it for us?” is clear at all levels throughout the organization. Confirm roles, responsibilities, and accountabilities are clear. Share key milestones and provide updates quickly and often. Once they have shared this information with their staff, survey the staff to confirm they understand the vision, values, the direction the organization is going, and confirm the staff knows how their job impacts the success of the organization. If the organization already does an annual all employee
survey, due to the ongoing uncertainty and major changes they are experiencing, administer the survey at least twice a year. Then, use the results to improve the organization’s communication strategy.

Next, the executive leadership team needs to confirm they, as a leadership team, are in alignment and agreement regarding the new organizational goals and measurements as well as how they are going to report their results. Alignment brings purpose, strategies, and goals together and makes an organization’s aspirations more credible, achievable, and provides the organization with a competitive advantage.

Third, the organization needs to engage employees and collaborate with stakeholders. This engagement and collaboration need to occur throughout the transformation journey. This includes sharing updates, results, and being more transparent, for example, with a monthly report card with their staff and key stakeholders that includes key performance indicators. This should include regular all staff meetings and, if face-to-face meetings are not possible, utilize emails, voicemails, and videos to ensure everyone receives updates regularly and timely. For those external to the organization, consider using town hall meetings or key stakeholder face-to-face meetings, and/or develop a digital strategy that could include a dedicated YouTube page with videos and other key updates.

Next, the officers within the organization need to partner with educational institutions and those who provide care to their members throughout their communities. For the educational institutions, their goal should be to ensure the students who are the future staff of the health insurance industry have the knowledge, skills, and abilities to succeed. As for those who provide care to their members, their goals should be to focus on wellness and the health of their
populations, increase community engagement in an entirely new manner, eliminate disparities, and address social determinants of health. The health insurance companies’ clinical partners should receive higher reimbursement for delivering high-quality, patient-centered care and receive lower amounts for not delivering outcomes and low patient satisfaction.

Next, health industry leaders need to develop and implement succession plans. Succession plans are a great way to identify employees who have the current skills, or potential, that can help them move up in an organization, or into other key positions. A leadership succession plan prepares the organization when a leader position becomes available. In addition, the process of succession planning can help identify other areas of performance where employees may be weak and where training could help to manage and improve performance outcomes. Sharing and implementing succession plans can also help improve employee retention.

Next, there is a bigger culture shift that needs to occur before we will see higher outcomes, lower costs, and improved consumer satisfaction. Many of the executive leaders in the health insurance industry today appear to use traditional business approaches, such as improving marketing programs, updating products, enhancing phone and online customer service systems, and adding a few new technology enhancements. Unfortunately, these are not the same consumers and environment of decades ago. If the industry wants to avoid costly regulatory mandates in the future, these leaders need a culture of collaboration, transparency, education, and trust.

Finally, I recommend the Chief Medical Officer have a reporting line and attend the Board of Director’s meetings. I also recommend their Board of Directors add a consumer to the
board, and they establish a consumer advisory council to get their members more engaged and part of the process for strategy to implementation. I believe by taking these approaches, the organizations will increase their focus on clinical outcomes and collaboration with their external patient care stakeholders and their consumers.

**Recommendations for Further Research**

I recommend interviewing the members of the organizations who participated in this study two years from now, which would be the ten-year mark since the passing of the PPACA. I suggest interviewing them if they are still in the same roles within the same organization or if they have left their roles or the industry. The focus would be obtaining an update based on the findings from these interviews, explore what else has changed, determine if they are still in business, and learn how they are succeeding and struggling. I would also ask if they would have done anything differently based on what they know now and if they are leading their organizations differently than they did during this study. If they left their previous role, the organization, or the industry, I would want to explore why and gather any advice they would have for leaders in the industry.

I would also recommend interviewing the leaders of companies who are no longer in business, who are in the process of going out of business and who left the health insurance industry. Interviewing these individuals may provide a different perspective regarding how leaders experienced and led their organization during health care reform. We could learn a lot from their experiences. They might have a leadership compass that could help guide future leaders and those currently navigating health care reform.
Finally, this study also did not include other leaders within the organization. This includes the Chief Compliance Officer, Chief Operations Officer, and General Council. The study also did not include any lower level leaders within the organization, for example, the directors, managers, and supervisors. All these leaders play an important role within the organization. A study focused on how they are experiencing health care reform and what leadership skills and abilities they are utilizing would contribute to a fuller understanding of the challenges health insurance leadership are facing since the passing of the PPACA.

Conclusion

The goal of this study was to understand how health care executive leaders in clinical, administrative, and financial areas are experiencing and leading their organizations in a complex industry during ongoing uncertainty, focusing on what knowledge, skills, and dispositions are they using during these changes, how do the clinical, administrative, and financial executives describe their leadership experience, how does the literature compare to current practice, and the types of decisions leaders are making. The Chief Executive, Financial, and Medical Officers first and foremost are transforming their organizations by leading them through the changes in response to health care reform. To successfully lead their organizations, they developed and implemented a new vision and strategy and are leading by example. They are sharing these changes with their team to continue to build trust by aligning their staff throughout the organization. By leading by example and using multiple leadership styles, they are changing their culture. They are weaving their values throughout their organization by including their values in their hiring process, annual self-assessments, and staff evaluation processes.

Externally, they influenced public policy at the local and national level. They are also getting involved in their local communities to educate and build trust. The consumer is now part
of their organization as a member of their advisory communities, reviewing materials prior to
distribution, and assisting in the development of new products and services. Both internally and
externally, they are collaborating and using data and technology to increase transparency,
improve disparities, improve quality of care, reduce costs, and improve the consumer’s
experience.

The leaders are starting to see results that lead them to believe they are on the right track.
Their key performance indicators are showing they are successfully reducing costs, beginning to
improve outcomes in targeted areas while improving the consumer’s experience. This is just the
beginning of a large change expected to continue for at least the next five to seven years.

**Closing Reflections**

Leaders continue to face challenges since the passing of the Patient Protection and
Affordable Care Act and Health Care and Education Reconciliation Act in March 2010. In the
past decade, it has been difficult and demanding to be an executive leader in the health care
industry. As a new era emerges, health insurance leaders will be required to continue to manage
increased levels of risk, uncertainty, and rapid change. Successful chief executives will be those
who recognize both opportunities and when to shift priorities.

The future is uncertain, and it is clear the new models that evolve from these major
changes will result in new ways to deliver health care, new and different players in the industry,
new rules, and new roles and responsibilities. Health insurance organizations that are poorly
positioned to take advantage of these new opportunities, run the risk of being left behind.
Effective health insurance organizations will be those that can provide value measured by their
ability to reduce costs, improve health care outcomes while delivering a high level of consumer
satisfaction. Health insurance organizational leaders need to understand shifting priorities and position themselves strategically, so they can navigate the changes and provide their staff with a leadership compass, so the next generation of leaders can be effective at guiding their organization successfully through the rapids.
References


Markuns, J. F., Fraser, B., & Orlander, J. D. (2010). The path to physician leadership in community health centers: Implications for training. Family Medicine, 42(6), 403.


Appendix A

Interview Consent Form

Health Care Reform: Leading Successfully Through Reform Rapids

IRBNet Tracking Number: 771124-1

You are invited to participate in a research study about how health care executive leaders in the areas of clinical, administrative, and financial are experiencing and leading their organizations during ongoing uncertainty. You were selected as a possible participant because you are in the industry, are either a Chief Executive Officer, Chief Financial Officer, or a Chief Medical Officer, and work for a health insurance payer. You are eligible to participate in this study because you are a health care executive. The following information is provided in order to help you make an informed decision whether or not you would like to participate in an interview for the study. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Tabatha Erck a Doctorate Candidate at the University of St. Thomas in Minneapolis, MN. This study was approved by the Institutional Review Board at the University of St. Thomas.

Background Information

The purpose of this study is to understand how health care executive leaders in the clinical, administrative, and financial areas are experiencing and leading their organizations during ongoing uncertainty. The information is important to all current health care leadership, those contemplating a leadership position in the future, and institutions of higher education offering graduate and professional degrees focused on the health care industry.

Procedures

If you agree to participate in this study, I will ask you to do the following things: I will request you to complete a participant consent form. You will be asked to be interviewed in person at your office, over the phone, in a private setting, and through the use of Skype. The interview will include 5-7 general questions and may last approximately 1½ to 2 hours. Based on the response from other participants, I may want to follow-up with to obtain additional questions. During the interviews, I will audio record the interview. The information will be kept confidential and maintained on a password protected IPad dedicated solely to this
study and kept in a locked cabinet and on the University of St. Thomas OneDrive. The data will be destroyed 12 months after successfully defending the dissertation. If I use a transcriptionist, I will obtain privacy and confidentiality documents from that person.

**Risks and Benefits of Being in the Study**

The study has minimal risks. To minimize risks for the participants, I will use pseudonyms for all participants. Also, to reduce the risk of a participant becoming uncomfortable, emotionally upset, or vulnerable, I am providing participants with the option to skip any questions or topic they find upsetting or uncomfortable. Finally, I am providing each participant with the opportunity to review the transcript of his or her interview and clarify any statements.

There are no tangible benefits to you for participating.

**Incentives**

*There are no costs to you or payments made for participating in this study.*

**Privacy**

Your privacy will be protected when participating in this study. The information will be kept confidential and maintained on a password protected IPad dedicated solely to this study and kept in a locked cabinet and on the University of St. Thomas OneDrive. The data will be destroyed 12 months after successfully defending the dissertation. If I use a transcriptionist, I will obtain privacy and confidentiality documents.

**Confidentiality**

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include recordings, transcripts, master lists of information, and computer records, which will be kept on a password protected IPad dedicated solely to this study and kept in a locked cabinet and on the University of St. Thomas OneDrive. The data will be destroyed 12 months after successfully defending the dissertation. If I use a transcriptionist, I will obtain privacy and confidentiality documents from that person. All signed consent forms will be kept for a minimum of three years upon completion of the study. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

**Voluntary Nature of the Study**

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with any health care-related individual, employer, agency, institution or the University of St. Thomas. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected about you will not be used
in the study. You can withdraw by contacting Tabatha Erck at erck1770@stthomas.edu or Dr. Karen Westberg, my advisor, at klwestberg@stthomas.edu. You are also free to skip any questions I may ask.

Contacts and Questions

My name is Tabatha Erck. You may ask any questions you have now and any time during or after the research procedures. If you have questions later, you may contact me at 952-688-2322 or erck1770@stthomas.edu or Karen Westberg, PhD, my advisor and a University of St. Thomas Professor at 651-962-4985 or klwestberg@stthomas.edu. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or muen0526@stthomas.edu with any questions or concerns.

Statement of Consent

I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give permission to be audio recorded during this study.

You will be given a copy of this form to keep for your records.

__________________________  __________________
Signature of Study Participant  Date

_______________________________________________  __________________
Print Name of Study Participant  Date

__________________________  __________________
Signature of Researcher  Date
Appendix B

Interview Questions

Chief Executive Officer (CEO):

1. What does the CEO do? How is it different from the CFO and CMO?

2. How long have you been in this role? What did you do prior to becoming the CEO?
   
   Describe your educational background (e.g. degrees, certificates, conferences).

3. Describe your leadership style.

4. As the CEO, what leadership qualities do you draw upon? Is it any different prior to the passing of the PPACA, today, and what about 5-10 years from now?

5. Impact of change on your sense of effectiveness and confidence as a leader? Is it any different prior to the passing of the PPACA, today, and what about 5-10 years from now?

6. How do you look at the political and strategic environment? Any difference prior to the passing of the PPACA, today, and what do you think you might say 5-10 years from now?

7. As CEO, describe if and how your engagement with the staff has changed in response to the uncertainty and ongoing change health care reform?

Chief Financial Officer (CFO):

1. What does the CFO do? How is it different from the CEO and CMO?

2. How long have you been in this role? What did you do prior to becoming the CFO?
   
   Describe your educational background (e.g. degrees, certificates, conferences).

3. Describe your leadership style.

4. As the CFO, what leadership qualities do you draw upon? Is it any different prior to the passing of the PPACA, today, and what about 5-10 years from now?
5. Impact of change on your sense of effectiveness and confidence as a leader? Is it any different prior to the passing of the PPACA, today, and what about 5-10 years from now?

6. Describe the standards and regulatory requirements that apply to the CFO? Are they the same as the CEO and CMO?

**Chief Medical Officer (CMO):**

1. What does the CMO do? How is it different from the CEO and CFO?

2. How long have you been in this role? What did you do prior to becoming the CMO?
   
   Describe your educational background (e.g. degrees, certificates, conferences).

3. Describe your leadership style.

4. As the CMO, what leadership qualities do you draw upon? Is it any different prior to the passing of the PPACA, today, and what about 5-10 years from now?

5. Impact of change on your sense of effectiveness and confidence as a leader? Is it any different prior to the passing of the PPACA, today, and what about 5-10 years from now?

6. Describe the standards, regulatory requirements and/or others that apply to a CMO? Are they the same as the CEO and CFO?