2016

Developing Strategies of Organizational Sustainability for Solo and Small Business Medical Practices

Gerald Lloyd Anderson
Walden University

Walden University

College of Management and Technology

This is to certify that the doctoral study by

Gerald Anderson

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

Review Committee
Dr. Craig Martin, Committee Chairperson, Doctor of Business Administration Faculty

Dr. Edward Paluch, Committee Member, Doctor of Business Administration Faculty

Dr. Lynn Szostek, University Reviewer, Doctor of Business Administration Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2016

Abstract

Strategies to Promote Organizational Sustainability of Solo and Small Business Medical Practices

by

Gerald L. Anderson

MGA, University of Maryland University College, 1987

BS, University of Maryland University College, 1992

BA University of Maryland University College, 1983

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

Walden University

June 2016

Abstract

Recent trends point toward a decline in solo and small business medical practices, yet, the need and demand still exists for this model of health care. The purpose of this case study was to explore effective approaches to help physicians in solo practice and small medical group primary care practitioners (PCPs) retain their small business medical practices. The study included purposive sampling and face-to-face interviews: 11 physicians, predominately primary care practitioners, in the Baltimore-Washington metropolitan region, were interviewed until data saturation was reached. A component of systems theory (strategic thinking) and the dynamic capabilities concept were used to frame the study. Audio recordings were transcribed and analyzed to identify themes regarding effective competitive approaches to help small medical group physicians retain their practices. Four major themes emerged: need for flexibility and adaptability, need for higher levels of business acumen, need to fully embrace automation, and a focus on pursuing financial stability before pursuing growth and expansion of the medical practice. Results may benefit society by preserving and strengthening a source of patient-centered, effective, affordable health care for communities served by small business medical practices. Implications for social change include presenting methods to enhance stability and organizational sustainability of small business medical practices.

Strategies to Promote Organizational Sustainability of Solo and Small Business Medical Practices

by

Gerald L. Anderson

MGA, University of Maryland University College, 1987

BS, University of Maryland University College, 1992

BA University of Maryland University College, 1983

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

Walden University

June 2016

Table of Contents

List of Tables

List of Figures

Section 1: Foundation of the Study

As in other types of small businesses, physicians in solo and small group primary care medical practices face challenges from changing business environment conditions and the need for timely responses to those changing conditions (Martin, Weaver, Currie, Finn, & McDonald, 2012). Small businesses, historically acknowledged as critical to the U.S. economy, represent 99% of U.S. businesses and account for nearly 50% of all jobs in the country (Labedz & Berry, 2012). Nonemployee status physicians are small businesspeople with community-based financial and social influences (Tideman, Arts, & Zandee, 2013).

Over the last 20 years, entities responsible for payment of health care costs in the United States became increasingly sensitive to the need for cost containment, and where possible cost reduction (Martin, Hartman, Whittle, & Catlin, 2014). Martin et al. (2014) revealed that the federal and state governments bore responsibility for paying 44% of annual health care costs within the United States; private employers and individual households, usually through third-party insurance companies, shouldered 49% of the costs. Since the mid-1990s, third-party payers, whether government or private insurers, aggressively sought ways to reduce expenditures, generally resulting in diminishing income levels for health care practitioners, and particularly solo practitioners and small group primary care medical practices (Laugesen, Wada, & Chen, 2012; Hariharan, 2014).

Background of the Problem

Over a 20-year period, solo practitioners and small group primary care medical practices faced diminishing levels of market share, and associated reductions in income streams, because of implementation of viable alternatives to the historical fee-for-service payment arrangements that physicians enjoyed for decades (Wilensky, 2014). Additional pressures presented by steadily increased use of nurse practitioners (NPs) with expanded provision-of-care privileges for the NPs into areas traditionally restricted to physicians, further eroded the amount of market share and income sources available, particularly to solo practice and small business medical practice primary care physicians (Liu, Finkelstein, & Poghosyan, 2014; Tseng, 2013). The combination of competitive pressure, cost containment initiatives, and lack of guidance for physicians on business-oriented methods to cope with those factors since the mid-1990s may have been factors contributing to the trend of decreasing numbers of solo practitioners (Angood & Shannon, 2014). Physician leaders of small medical group primary care practices often lack knowledge of optimal strategies for practice viability and competitiveness in a changing marketplace (MacCarrick, 2014; Snell, Eagle, & Van Aerde, 2014).

In 1996, solo practitioners represented 40.7% of total health care providers in the United States; by 2005, the percentage declined to 32.5% (Kirchhoff, 2013). Peikes and Dale (2015) highlighted a significant drop in the number of solo practice family medicine physicians between 2008 and 2013, as well as a concurrent reduction in the number of physician-owned medical practices between 2012 and 2014. Meanwhile, an imbalance developed between availability of primary care provider physicians (Matthews, Seguin,

Chowdhury, & Card, 2012) and the increasing patient demand for services (Tsai, Eliasziw, & Chen, 2012), with an expectation for future worsening of the current imbalance (Petterson, Liaw, Tran, & Bazemore, 2015). Solo and small group primary care medical practice physicians must develop methods that work toward reestablishing the balance (Bradbury, 2015), in ways that help to competitively (Brunt & Bowblis, 2014) and ethically ensure (Gunning & Sickles, 2013) continued viability of their small business medical practices.

Problem Statement

Continuing a 20-year trend, the number of solo practice or small medical group practice primary care physicians (PCPs) in the United States is declining (Peterson, Baxley, Jaen, & Phillips, 2015), and in the current competitive health care delivery marketplace is under pressure to consolidate (Liaw, Jetty, Petterson, Peterson, & Bazemore, 2016), with no outlook for change (Paul, 2014; Tseng, 2013). In 2013, only 11% of PCPs were solo practitioners, a noticeable decline from 16% in 2008 (Peikes & Dale, 2015). Peikes and Dale (2015) further showed that the percentage of physicians owning practices declined from 49% in 2012 to 35% in 2014. The general business problem is that the number of solo practice and small medical group practice PCPs are diminishing. The specific business problem is that many physicians in solo practice and small medical group PCPs are unaware of effective methods for retaining small business medical practices.

Purpose Statement

The purpose of my qualitative, explanatory collective case study was to explore effective competitive approaches designed to help physicians in solo practice and small medical group PCPs retain their small business medical practices. I investigated tactics for organizational sustainability of the practices. Using purposive sampling, I interviewed a set of predominately primary care practice physicians in the Baltimore-Washington metropolitan region, until achievement of data saturation. Purposive sampling (Bristowe, Selman, & Murtagh, 2015; Dayna, 2013) of physicians facing significant changes allows for detailed information until reaching data saturation (Lockyer, Wycliffe-Jones, Raman, Sandhu, & Fidler, 2011).

A better understanding of study participants' perceptions of medical practice business management behavior patterns may reveal how the patterns impact current and future conditions. Participants chose to share new ideas geared toward enhancing organizational sustainability, tailored for each participant's separate small medical group practice. The positive social implication is primary care physicians maintaining medical-practice stability with effective methods for retaining small business medical practices.

Nature of the Study

I used a qualitative approach for my study to explore effective competitive approaches designed to help physicians in solo practice and small medical group PCPs retain their small business medical practices. A qualitative approach was pertinent for this study because the approach allowed for small-size samples with purposeful selection (Morse J., 1999), and allowed generalization, after achieving saturation (Fairweather &

Rinne, 2012). Qualitative approaches provide opportunities to draw concrete, practical recommendations that can be implemented by clinicians (Morse J., 2015). Qualitative research presents a path for understanding phenomena from the insider viewpoint of the individual or subject under analysis, often using less specific methodologies than more structured methods found in quantitative research (Marais, 2012). Quantitative approaches and mixed methods with prominent quantitative elements entail experimental or quasi-experimental strategies and data collection using psychometrically based collection tools, with pre-and post-testing, time-intensive requirements (Frels & Onwuegbuzie, 2013). A quantitative approach was not appropriate for my study because the topic, requiring less structure than a quantitative approach, allowed for capturing of nuances. Using the qualitative approach revealed greater understanding of the nuances associated with primary care practice transformation (Bitton et al., 2012). Solo practice physicians, along with some other groups of professionals who exhibit a strong affinity for autonomy, often responded positively to qualitative approaches (Lin, 2014; Saba et al., 2012).

I used a case study method to explore effective competitive approaches designed to help physicians in solo practice and small medical group PCPs retain their small business medical practices. The case study method is appropriate when the researcher conducts an examination of the dynamics that surround radical change (Chreim, Williams, & Coller, 2012). The environment of a rapidly shifting health care marketplace in which physicians operate their medical practices was an example of dynamic, radical change. Case study methods were particularly useful with studies in health services

research, enabling targeted focus on individual phenomenon in real life contexts (Yin, 1999). Although phenomenological research can address human experience phenomena (Yin, 2014), an explanatory case study method more closely matched the complex change factors examined within my study. Case study methodology is adaptable to the type of available sources and procedures in business environments and often results in developing new models or modifying existing organizational structures (Zivkovic, 2012). Ethnographic research usually centers on predictable behavior patterns in anthropologic cultural settings (Wong & Wu, 2012). Narrative research methods are frequently used to pursue understanding of world relationships through individual life experiences (Volkman & Parrott, 2012). Both narrative and ethnographic research methods seemed inappropriate for exploring effective competitive approaches designed to help physicians in solo practice and small medical group PCPs retain their small business medical practices.

Research Question

The central research question guiding this study aligned with the specific business problem: What competitive approaches help physicians in solo practice and small medical group PCPs retain their small business medical practices?

Interview Questions

1. From a strategic thinking perspective, to retain their small business medical practices, what 5-year and 10-year goals should PCPs set for the practice?

2. From your strategic thinking perspective, what behavior patterns and personal characteristics are necessary for physicians to retain their small business medical practices and achieve the 5-year and 10-year goals you identified?
3. Strategically thinking, how and when would you measure whether or not you achieve each of the goals you identified to help retain small business medical practices?
4. From a strategically adaptive perspective how would you go about achieving the identified goals to help retain small business medical practices?
5. From a strategically adaptive perspective, what past medical practice business behaviors might prevent you from achieving the stated goals associated with retaining small business medical practices?
6. Strategically thinking, what current medical practice business policies and procedures are useful in helping you continue toward the stated goals associated with retaining small business medical practices?
7. From a strategically adaptive perspective, how do innovations and new ideas and medical practices, such as accountable care organizations or patient-centered medical homes affect goals associated with retaining small business medical practices?
8. Strategically thinking, how do factors like the country's economic state, technology advances, changing demographics, government policies affect goals associated with retaining small business medical practices? Specifically, address each factor.

9. From a strategically adaptive perspective, how do a different set of factors such as competitive rivalry, increased patient sophistication, and bargaining power, increased use of physician-extender providers, and potential barriers to entry of new competitive markets affect goals associated with retaining small business medical practices? Specifically, address each factor.
10. Considering the factors in the prior two questions, how would you strategically adapt and adjust the goals and measures you identified earlier in the interview, in a way that adequately responds to all the factors that can affect efforts associated with retaining small business medical practices?

Conceptual Framework

I used a component of systems theory (strategic thinking), and the dynamic capabilities concept to examine competitive approaches that help physicians in solo practice and small medical group PCPs retain their small business medical practices. The systems theory concept, specifically the strategic thinking outgrowth component, emphasizes a concurrent willingness to modify business practices, in ways suitable to changing conditions. Strategic thinking aligns with systems theory, for which von Bertalanffy is considered the seminal thinker (von Bertalanffy, 1950, 1968). Lazlo (2012) contended that von Bertalanffy made notable contributions to modern versions of systems theory. Strategic thinking concepts (Kunc, 2012) emerged with Porter's five forces model, allowing an examination of how: (a) barriers to market entry, (b) product substitutes, (c) supplier bargaining power, (d) customer bargaining power, and (e) competitive rivalry, could affect a business (Porter, 2008). The five forces model

component of strategic thinking provides an effective mode for examining competitive approaches that help physicians in solo practice and small medical group PCPs retain their small business medical practices.

The dynamic capabilities concept originated in 1994 as a new paradigm from Teece and Pisano, who advocated gaining and holding competitive advantages by maintaining an awareness of change in the business environment in which the company operates. Teece and Pisano recommended strategic adaptations to the changes through organizational reconfiguration and altering functional competencies in response to changing environments. Critical aspects of strategy require determining which course of action to follow and how to implement the selected course of action (Checkland, 2012). Even more important is the need for dynamic strategic thinking and planning, rather than static thinking (Markides, 2012; Nolsoe-Grunbaum & Stenger, 2013; Zuckerman, 2014). The dynamic capabilities concept was a supplemental framework for examining competitive approaches that help physicians in solo practice and small medical group PCPs retain their small business medical practices.

Operational Definitions

Accountable care organizations (ACOs): Health care organizations composed of health care providers working together, to deliver patient care. An ACO can include primary care providers, specialty providers, and hospitals. The distinguishing characteristic of an ACO is that it has accepted collective accountability for the costs associated with delivering quality care to a specific population of patients (Shortell, et al., 2014).

Adaptive leaders: Leaders who are technically adept, while at the same time able to adapt to new conditions without established protocols, processes, or clear-cut answers, while navigating their organizations toward desired goals (Peterson & Rutledge, 2014).

Changing health care environment: Takes into account the revolutionary transformations brought on by the Patient Protection and Affordable Care Act in 2010. Scarcer resources, a more educated patient population with near-instant access to information, uncertain economic conditions, and the fast pace of global change further exacerbates changes within the health care environment (Zuckerman, 2014).

Evidence-based medicine (EBM): Uses evidence obtained from current, structured, and well-designed scientific research in which physicians integrate their expertise with research evidence to design the best course of care for patients. Decision-making and policy-setting rely on scientific evidence, rather than opinions and traditions (Smith & Rennie, 2014).

Patient-centered care: Care given is responsive and mindful of individual patient values, needs, and preferences. Patient values should guide clinical decisions about care delivery. Patient-centered care requires patient engagement in all possible aspects of care delivery (Berry, Beckham, Dettman, & Mead, 2014).

Physician-centered care: A health care delivery structure designed to maximize efficiency by physicians and to make full use of their time (Huang, Zhu, & Wu, 2012).

Primary care provider (PCP): A health care provider who addresses common medical problems encountered by patients while simultaneously acting as a gatekeeper managing access to specialty care when needed. A PCP can be a physician, usually

within the specialties of family practice, pediatrics, internal medicine, or obstetrics/gynecology. Nurse practitioners (NPs) and physician assistants (PAs) are increasingly used as key contacts, often serving as a PCP for patients (Tseng, 2013).

Small and medium-size enterprises (SMEs): Understood globally as a segment of the business community of organizations with fewer than 500 employees (Khatri, Wilson, & Dalmat, 2013).

Strategic leadership: Combines visionary understanding of operational management techniques with a philosophical thought process that enables leaders to embed the leadership ideas throughout company operations. A strategic leader has mastery of routine operational supervision while concurrently maintaining a long-term strategic outlook (Malewska & Sajdak, 2014).

Third-party payer, or payor: Refers to a company or institution that delivers reimbursement for health care services rendered to patients by designated health care providers (Downey, Zun, Burke, & Jefferson, 2014).

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions are hypothetical presuppositions researchers make based on rational choice theory (Martin & Parmar, 2012). Decision-making and formation of results may be driven by assumptions of the studied population as rational actors, or assumptions about a pragmatic need to structure organizational processes. Martin and Parmar (2012) explained that explicit revelations about the researcher's role, role of the studied

population, and the surrounding environment bolstered credibility for all parties involved and increase the likelihood of acceptance and validity of study results.

My primary assumption for the study was that the physician population surveyed would provide honest responses and feedback for the interview questions. A second assumption was that the surveyed physicians provided a representative sample of physicians in the geographic area. A third assumption was that the interview questions were appropriate and would elicit useful feedback to benefit physicians in solo practice and small medical group PCPs and answer the research question.

Limitations

Study limitations are systemic biases about research design, methodology, or constraints that do not afford the researcher sufficient ability to manage or control interactions, leading to unexpected effects on the results of the study (Firmin, Bouchard, Flexman, & Anderson, 2014). One limitation emanated from the geographic boundaries associated with the urban region of the country selected for study. Another limitation, inherent with case study methodology, involved a potential for lack of generalizability. Extrapolation of study findings to the general population of physicians may be difficult.

Delimitations

Study delimitations are also systemic biases, used for the purpose of affording the researcher some degree of control by demarcating and limiting the study's parameters (Firmin, Bouchard, Flexman, & Anderson, 2014). I restricted the type of physician interviewed to solo practice, small medical group practice physicians, and employed

physicians classified as primary care practitioners. As a result, I was more likely to receive feedback that was directly relevant to my research question.

Significance of the Study

Insight generated from responses to the interview questions may add value to small business solo and small medical group practice physician owners. The participant-derived perspectives revealed competitive approaches that may help physicians in solo practice and small medical group PCPs retain their small business medical practices. Characteristics and fundamental operational concepts commonly ascribed to small businesses are similar to characteristics found in solo and small medical group practices (Surdez, Aguilar, Sandoval, & Lamoyi, 2012). One fundamental concept is that strategies are constructed to allow a firm to adjust its resources to properly address existing environmental conditions (Marek, 2014).

Marek (2014) revealed a second fundamental concept focused on strategy development designed for long-term implementation to achieve company goals. When leaders perform organizational self-assessments, a resulting situational awareness (internal and external) allows for identification of performance gaps and recognition of potential program enhancement opportunities (Trousdale, 2015). Operating in an increasingly competitive marketplace driven by technologic, political policy, and research changes requires physicians to exhibit many behaviors that are like service providers in other businesses or vocations.

Contribution to Business Practice

This study was of value to business because the findings provided strategic value analysis that may aid physicians in solo practice and small medical group PCPs retain their small business medical practices. The interview questions offered a structure for a modified strategic assessment tool that revealed useful competitive approaches. No business entity can afford to neglect strategic value analysis, especially within the health care delivery services arena, regardless of the field of endeavor or size of the business entity. Using systems theory (especially the strategic thinking element) in this study, paired with the dynamic capabilities concept I investigated study participants' perspectives regarding opportunities to apply effective business practices with evaluation methods, strategic adaptation to changes, and courses of action for holding competitive advantage within a changing health care environment. Care delivery to meet treatment needs within the United States health care system does not always include integrated, affordable models (Qazi, 2012). Competitive, cost-effective health care delivery includes innovative organizational and systematic business models, tailored to the unique needs of specific patient populations and the providers who serve those populations (Weeks, 2012).

Austin (2013) identified three characteristics that small business owners need for effective strategic thinking: (a) willingness to create a new mindset, (b) ability to transform ideas in sustained actions, and (c) being at ease, in an environment of shifting contexts. The value of strategic thinking and planning cannot be understated in business climates where decreasing resources require short and long-term points of view, and

adaptability (Zuckerman, 2014). Understanding and effectively addressing third-party payer concerns and meeting patient expectations do much to move a practitioner from survival tactics to sustainability strategies (Jakielo, 2011). An awareness of systems dynamics helps small business owners, including physicians, to understand how to measure strategy performance, how to determine potential difficulties for strategy implementation, and which mitigation strategies allow for increased performance levels that ultimately achieve strategic goals (Kunc, 2012).

Making fundamental transformative changes that involve health care professionals can be difficult because of human inclinations to fight change and retain that which is familiar, despite availability of better alternatives. Gravitating away from a desire to regenerate former comfort zone modes of operation, and instead, embracing roles to help reinvent health care delivery models along with the accompanying financial and business model ramifications, may move practitioners toward enhancing practice stability (Howell, 2010). Developing transformational mindsets helps physicians enhance their practice models and establish critical productive working relationships with third-party health insurance payers (Saxton, Pawlson, & Finkelstein, 2013). Physicians, along with many other types of professionals, who embrace strategic change as beneficial, rather than a threat to the professional identify, enhance income production opportunities (Schilling, Werr, Gand, & Sardas, 2012).

Implications for Social Change

Enhancing and stabilizing the solo and small medical practice primary care-focused practices, benefits society by preserving and strengthening a source of patient-

centered, effective, affordable health care delivery for the communities served by the small business medical practices. The interview questions contributed to positive social change by revealing opportunities and competitive methods that enhance the stability of small business medical practices. Political and academic leaders readily acknowledge the importance of small businesses and the positive impact, socially and economically, that small business has upon the country. Establishment and sustainment of small businesses is a major factor in job opportunity generation and economic development for the communities in which the businesses operate.

A Review of the Professional and Academic Literature

The purpose of my qualitative, explanatory collective case study was to explore effective competitive approaches designed to help physicians in solo practice and small medical group PCPs retain their small business medical practices. I investigated tactics for organizational sustainability of the practices. In the exhaustive literature review that follows, I highlight peer-reviewed research and provide a historical context, current status, and future projections about the role that the solo practice physician or small medical group practice has in the health care services delivery arena of the United States.

The studies included in the literature review gave support to, or demonstrated application of, one or both conceptual frameworks, the strategic thinking aspect of systems theory and the dynamic capabilities concept. Each of the subtopics within this review of literature offer an expanded discussion of ideas and situations that emanate from either (or both) conceptual frameworks, and particularly how the subtopic can negatively impact viability of solo and small medical group primary care practices.

Segmenting the literature review about physician practice business models into three distinct categories (historic, current, and future) provided a more expansive awareness of issues surrounding the current status of the solo and small medical group practitioners, and helped in developing strategic business models for coping.

In this study, I addressed a gap within the existing literature. The literature on this topic, while helpful with isolated sets of limited innovative recommendations, lacked a cohesive synthesis of previous, current, and future environments in a way that established a clear, decisive path for achieving stability of solo and small medical group primary care practices in a rapidly changing health care environment. I attempted to address a portion of the gap by including discussion of the previous, current, and future environments, elaboration of the subtopics, and explanation of the organizational self-assessment-focused interview questions. Physicians in the solo or small group practice configurations face significant challenges while pursuing financial viability and competitiveness in the health care services delivery marketplace (Paul, 2014). Physicians need help developing current business-focused processes and knowledge sets, to establish paths toward organizational sustainability (Martin, Weaver, Currie, Finn, & McDonald, 2012). Analysis of the literature revealed a rationale appropriate for a qualitative case study to address the 20-year steep decline in the number of family medicine physicians, and other specialties, practicing as solo and small medical group practitioners, and the associated loss in market share and income (Peikes et al., 2015).

I organized the literature review by topic and used multiple sources to find relevant historical and current research for this study. Sources included a heavy reliance

on academic databases, and a less frequent use of books, and Federal websites. The research databases included ABI/INFORM, Emerald Management, MEDLINE, SAGE Premier, Health and Medical Complete, PubMed, Business Source Complete, and PsycARTICLES. Search terms used to query the databases included solo physician, small medical group practice, competition in health care, health care delivery, physician autonomy, and physician competition.

The literature review included 249 sources, of which 207 were from peer-reviewed journals, six were from peer-reviewed-comparable government reports, eight were from seminal articles and books, five were from relevant book sources, and 23 were from relevant non-peer-reviewed journal articles (or peer-reviewed journal articles older than 5 years), with greater than 87% of the sources less than 5 years old from the date of my anticipated graduation in 2016. Of the sources greater than 5 years old, eight of the articles or books were seminal works. I begin the literature review with a discussion of the two conceptual frameworks used for the study.

Conceptual Framework

I used two separate but related conceptual frameworks as the basis for this doctoral study; both frameworks lent support to examining competitive approaches that help physicians in solo practice and small medical group PCPs retain their small business medical practices. The systems theory concept (specifically, the strategic thinking outgrowth component) with a concurrent willingness to modify business practices, in ways suitable to changing conditions in the health care marketplace, and the dynamic capabilities concept both influenced the research direction taken within this doctoral

study. Strategic thinking aligns with systems theory, for which von Bertalanffy is considered the seminal thinker (von Bertalanffy, 1950, 1968), with notable contributions to modern versions of systems theory (Lazlo, 2012). Strategic thinking concepts (Kunc, 2012) emerged with Porters five forces model that allowed evaluation of how barriers to market entry, product substitutes, supplier bargaining power, customer bargaining power, and competitive rivalry could affect a business (Porter, 2008).

The dynamic capabilities concept, originating in 1994 as a new paradigm from Teece and Pisano, is used to explain gaining and holding competitive advantage by maintaining an awareness of change in the business environment in which the company operates, as well as strategic adaptations to the changes. Teece and Pisano (1994) recommended organizational reconfiguration and altering functional competencies in response to changing environments. Critical aspects of strategy require determining which course of action to follow and how to implement the selected course of action (Checkland, 2012). Even more important is the need for dynamic strategic thinking and planning, rather than static thinking (Markides, 2012; Nolsoe-Grunbaum & Stenger, 2013; Zuckerman, 2014).

Physician leaders of small medical group practices often lack knowledge of optimal strategies to maximize practice viability and competitiveness. The purpose of my qualitative case study was to explore optimal strategies for organizational sustainability, designed for physician leaders of solo and small medical group practices. The two-pronged conceptual framework upon which I based my research focus was strategic thinking (Porter, 2008) originating with systems theory (von Bertalanffy, 1950), and

dynamic capabilities (Teece & Pisano, 1994) closely associated with innovative performance and profitability sustainment (Nolsoe-Grunbaum & Stenger, 2013), which required require short and long-term points of view, and adaptability (Zuckerman, 2014).

Checkland (2012) suggested approaching a complex problem by using Descartes's philosophy of breaking the problem into multiple parts, analyzing each part's function and interaction with other parts, and problem-solving one part at a time. Using systems thinking for an organization is appropriate when viewing the organization as a complex entity with many moving parts. Applying systems thinking includes focusing on processes, relationships, and interconnections, rather than structures, components, and separation (Lazlo, 2012). Lazlo (2012) further suggested that evolutionary systems thinking surpassed systems thinking by concentrating not only on the current big-picture view of the organization, but on the big moving picture that showed how the system had changed and how changes might continue in the future.

Stacey (2011) concluded that systems-based thinking encouraged synthesis of positive and negative feedback loops that revealed points of leverage and led to changes that produced effects benefitting the organization. Systems-based thinking produces permanent solutions by providing simultaneous problem resolution for numerous problem root causes, increased return on investment, and growth in employment and stock value (Willis et al., 2014), while encouraging deep learning and critical thinking (Albert & Grzeda, 2014). Systems-based thinking also enhances the organization members' ability to conceptualize the organization's emergent properties, to understand why and how the member's smaller organization is a part of a larger organization

(Checkland, 2012). Understanding the emergent properties concept makes it easier for an organization member to see the big picture and tends to increase worker involvement and productivity. However, Gilson et al. (2014) pointed out that in primary health care delivery environments, sometimes staff-level workers failed to take ownership for change initiative results and subsequently became impediments to achieving desired outcomes.

Systems-based thinking benefits an organization in numerous ways, particularly the organizational learning aspect, which includes capacities and processes within the organization to maintain and improve worker performance by using lessons learned from both positive and negative experiences. Caldwell (2012) viewed the organizational learning aspect of systems thinking quite differently by challenging the concept's validity because of undefined social practices of learning, and the perception that the concept does not disperse power, autonomy, or knowledge within the workplace. Caldwell's negative view of organizational learning is not widely held.

Strategic management research portrays leadership inertia as deadly (Albert, Kreutzer, & Lechner, 2015), because it allows an environmental deterioration within organizations, which can be corrected only with a drastic transformation. Albert et al. (2015) suggested that organizations must continually adapt to environmental conditions while pursuing opportunities that enhance product or service delivery productivity. Health care delivery service organizations fare well when adopting the use of systems that integrate social and technical knowledge capabilities (Suarin, Rooke, & Koskela, 2013), positioning the organization to eliminate waste of resources by consistent alignment with customer and supplier needs. All components of the health care delivery

system, from major medical centers to individual physician practices, can flourish if the component understands the principles of retail competition. Most important, though, is a willingness to respond appropriately and to fully implement the retail competition principles because sustainability of the system component depends upon the competition principles (Grube, Cohen, & Clarin, 2014). Rather than trying to simplify conflicts within an organizational setting, reviewing and simplifying the desired objective may produce better results. In health care services delivery settings of all sizes, using a systems integration approach has advantages over an individual-oriented approach (Meli, Khalil, & Tari, 2014).

Having sets of dynamic capabilities enables companies to gain competitive advantage and hold that advantage (Teece & Pisano, 1994), and may require organizational reconfiguration and altering functional competencies in response to changing environments. A need for the degree of change requiring reorganization or restructuring involves an array of complex dynamics (Chreim et al., 2012). Achieving successful restructuring can require an unusual confluence of factors that influence powerful stakeholders to coalesce around an agreed-upon change outcome. Chreim et al. (2012) stressed that success of an initiative is predicated on change leaders taking appropriate actions that address critical stakeholder interests, in a satisfactory manner. Leaders who achieve successful change initiatives understand the history, values, and interests of the affected stakeholder groups, and encourage shared decision-making (Renz, Conrad, & Watts, 2013).

Segmenting the literature review about physician practice business models into

three distinct categories (historic, current, and future) provided a more expansive awareness of issues surrounding the current status of the solo and small medical group practitioners, and helped in developing strategic business models for coping. The existing literature, while helpful with isolated sets of limited innovative recommendations, lacked a cohesive synthesis of previous, current, and future environments in a way that establishes a clear, decisive path for achieving stability of solo and small medical group primary care practices.

Studies during the historic segment from the 1800s to 2000 addressed the nearly unlimited autonomy given to physicians and the unquestioned fee-for-service custom in which physicians set the level of payments for the medical care service provided to the patient. The advent of third-party payers (insurance companies, Federal Medicare, and Medicaid programs) and the growing popularity of managed care plans began during the 1960s, grew during the 1970s, and during the 1980's began shifting the balance of economic power from the physician community toward the third-party payer groups.

By the late 1990s, selective contracting by managed care companies was one of the factors that completed the shift of financial control to the third-party payers and placed many physicians accustomed to unchallenged autonomy, into a reluctant, resistant posture of financially subordinate dependency. The literature within the current concepts segment, between 2001 and 2010, included discussion about survival tactics that included mass migrations into group practices, sales of solo practices to hospital systems, and employment arrangements between individual physicians and hospital systems. The future-focused literature, from 2008 to the present, included an examination of innovative

practice arrangements and inferences to the need for new worldviews and skill sets.

Historical Perspectives: 1800s to 2002

The process of strategically examining competitive approaches, which help physicians in solo practice and small medical group PCPs retain their small business medical practices, should begin with a review of the historical context. Checkland (2012), in support of von Bertalanffy's systems theory, advocated breaking a problem into multiple parts, analyzing each part's function and interaction with other parts, and problem-solving one part at a time. Applying the problem-solving approach was useful when viewing various perspectives (historical, current, and future) as parts to be examined, one part at a time. Caldwell (2012) highlighted how the organizational learning aspect of systems-based thinking addresses capacities and processes within the organization to maintain or improve performance by using lessons learned from historic perspectives derived from both previous positive and negative experiences.

From the country's beginning until well into the 1980s, physicians within the United States preferred solo practices (Howell, 2013), and avoided working in small group practices of two-to-seven physicians, or large group practices of seven physicians or more (Wolinsky, 1982). The early 1970s gave rise to concerns from physicians about the expansion of managed care companies and the accompanying reduction of reimbursement rates to the physicians (Libby & Thurston, 2001). Discussion about managed care become a fixation for the physician community with many hoping it was a fad that would run its course (Ginzberg & Ostrow, 1997). Managed care companies reportedly denied contracts to certain physicians, particularly solo practitioners who

served a higher proportion of uninsured patients, which encouraged a trend of solo practitioners providing less charity care than larger group practice physicians (MacKinney, Visotcky, Tarima, & Whittle, 2013). By the late 1990s, the power of selective contracting shifted the balance of economic power from the physician community to the managed care plans, placing many physician in a posture of battling for economic survival (Shmueli, Stam, Wasem, & Trottmann, 2015), while paradoxically reducing the gender-based earnings gap among physicians (Modestino, 2013).

Current Concepts: 2003 to 2012

The process of strategically examining competitive approaches that help physicians in solo practice and small medical group PCPs retain their small business medical practices, should include an awareness of the current environment. Maintaining an awareness of change in the current business environment in which the organization operates, as well as strategic adaptations to the changes, are rudimentary to the dynamic capabilities concept (Teece & Pisano, 1994). Situational awareness of current business conditions is fundamental for developing effective short and long-term, strategically adaptable points of view (Zuckerman, 2014). Albert et al. (2015) advised organizations to maintain an awareness of current conditions, continually adapt to environmental conditions, and simultaneously pursue opportunities that enhanced product or service delivery productivity.

Solo practitioners' representation within the ranks of total health care providers shrank from 40.7% in 1996, down to 32.5% in 2005 (Kirchhoff, 2013). During the same time span, group practices grew to comprise 50% of all office-based physicians (Hing &

Burt, 2007), with mounting evidence that care delivery in group practice settings increase the level of quality provided for primary care (Damiani, et al., 2013). Autonomy, a highly-prized commodity, was a prime motivator for many physicians who sought to maintain solo practices, particularly physicians among the male, minority, and older demographic groups (Lee, Fiack, & Knapp, 2013).

Despite the inherent financial constraints and clinical limitations, many physicians within those demographic groups continue to believe that solo practice offers a sociological heroic image (Saba, Villela, Chen, Hammer, & Bodenheimer, 2012), unconstrained autonomy (Lin, 2014), and limited responsibility for well-being of the national health care system (Sanford, 2013). Solo practice physicians must restructure practice philosophy away from functional independence and move toward financial trend analysis, systematic technology review, audit risk assessment, and compliance plans which establishes a survival path.

A Sustainability Focus for the Small Business Solo Practitioner

Perceptions of a lack of situational awareness and organizational sustainability mindsets has some members of the medical community discounting the ability of solo practice physicians to participate in innovative future-based models of health care delivery (Vaughan & Coustasse, 2011). Patient-centered medical home (PCMH) practices represents one of the innovations where Coustasse (2011) perceived many solo practice physicians as being unprepared for participation. The PCMH model reduces costs for patient, physician, and third-party insurance payers, particularly through the use of health information technology, coordinates care efforts and obtains better health care

outcomes for patients (Klein, Laugesen, & Liu, 2013). Alexander and Bae (2013) saw the PCMH model as improving access to care, controlling and stabilizing service utilization levels, and increasing patient satisfaction and quality of care. Of special significance to medical providers, PCMH models have better payment systems because of incentives for care coordination and nontraditional methods of care delivery (Ewing, 2013).

Hospital systems and large retail corporations such as CVS and Walmart recently began opening or acquiring retail clinics as a means to increase their health care market share through enhanced referrals and establishing a closer connection to health care consumers (Kaissi & Charland, 2013). The retail clinic's emphasis on no-appointment-needed, no-long-wait service for routine medical care draws customers away from traditional doctor offices (McKinlay & Marceau, 2012). Many solo-practice physicians attempt to differentiate themselves from retail clinics by using quality of care as a defining factor; however, differentiation drives customer decision-making only when the customer places a high value on the difference (Harvard Business School, 2005). Feedback from retail clinic customers, who are typically younger adults, supports research assessments that despite lower costs, quality of care by the retail clinic is similar to that received in physician offices and surpasses the care provided by hospital emergency departments (Kennedy D., Nordrum, Edwards, Caselli, & Berry, 2015). Emergence and growth of the retail clinic health care delivery model presents a direct competitive threat to solo and small group practice health care providers.

Among the skill sets that physicians need to implement new models of health care delivery and work proficiently within those new models are expertise in negotiation,

conflict resolution, performance improvement, financial acuity, and innovation (Ellner et al., 2015). A practitioner can transition from survival tactics to sustainability strategies if able to understand and effectively address third-party payer concerns and meet patient expectations (Jakielo, 2011). An awareness of systems dynamics helps small business owners, including physicians, to understand how to measure strategy performance, how to determine potential difficulties for strategy implementation, and which mitigation strategies allow for increased performance levels which ultimately achieve strategic goals (Kunc, 2012).

When businesses pursue strategies that align with the values of external forces with which the business must interact, the business adapts with appropriate organizational structure or operational level changes (Diaz-Foncea & Marcuello, 2012). Developing transformational mindsets may help physicians restructure their practice models and establish critical productive working relationships with third-party health insurance payers (Saxton et al., 2013). Physicians, along with many other type professionals, must embrace strategic change as beneficial, rather than a threat to their professional identity (Schilling et al., 2012).

Issues Affecting Change Paradigms

Survival of an organizational entity is contingent upon the entity's ability to convince customers and other consumers within the marketplace of the entity's legitimacy. Managerial practices and organizational structures are subject to external environmental pressures and for the purpose of survival should be adapted, when

necessary, to retain legitimacy and viability within the environment (Battilana & Casciaro, 2012).

Successful implementation of change initiatives is a never-ending requirement within most business organizations, and especially within health care organizations. Of significance are human resource functions and the effect that culture and values have on change. Equally important are business processes that do not impede effective communication and access to information that accelerates many change initiatives (Kash, Spaulding, Johnson, & Gamm, 2014).

The established paradigms for implementing changes within companies usually include linear and logical methods, driven by a formidable leader who expects to see results based on the leader's use of predictable, replicable methods which were easy to plan and control (Lawrence, 2015). This standard approach is limited in focus because change does not remain confined to a singular point-in-time occurrence that needs to be isolated and rigidly governed. Change should be seen as the constant and using a multi-dimensional approach is better to develop a balanced relationship between change and continuity (By, Armenakis, & Burnes, 2015).

Conventional wisdom and prior research point to three primary reasons for resistance to change, particularly for individuals within professional services sectors (Schilling et al., 2012). The first explanation suggests that people resist change because of emotional fears of the unknown, low tolerance for changes, or a dread of loss of control. The second explanation covers the perception or anticipation of personally-focused negative consequences via a loss of status, power, money, or security. The third

explanation involves principle-based objections, driven by perceptions that harm will come to an organization or group of people. The objection emanates from a business-focused concern rather than for self-interest. When professional service organizations undergo strategic change, specific consideration must be given to the concept of identity threat, both personal and professional image. The level of influence and perceived power afforded the affected professionals are important considerations when shaping the role and involvement in organizational or environmental strategic change.

Attempts to restructure and redesign health care delivery platforms are a part of many worldwide pursuits to achieve higher levels of efficiency and effectiveness in health care delivery (Chreim et al., 2012). Leaders who manage successful change initiatives understand the values and interests of each affected stakeholder group (Chreim et al., 2012). Success of initiatives is predicated upon change leaders taking appropriate actions that address critical stakeholder interests in a satisfactory manner which may require exercising new, different options.

Exploring New Affiliation Options

Exploring effective competitive approaches designed to help physicians in solo practice and small medical group PCPs retain their small business medical practices should include exploring new affiliation options. All components of the health care delivery system, from major medical centers to individual physician practices, can flourish if the component understands the principles of retail competition (Grube et al., 2014). A willingness to respond appropriately and fully implement the retail competition principles is important because sustainability of the system component depends upon the

competition principles. Transparency, readily available information via technology, and increasing levels of sophistication of health care consumers combined to create the new dynamic of consumer willingness to shop around for care.

Retail health care is consumer-driven, based on retail principles, and sensitive to market forces. Strategic and financial analysis by health care components must be in-depth, attuned to, and consistent with best-practice approaches used by the major retailers (Hermanson, Berkshire, Leaming, & Piland, 2013). Strategic development practices must understand risk assessment, risk analysis, and risk management processes (McNellis, Genevro, & Meyers, 2013). Component reconfiguration, where indicated, should be timely and consumer-focused, and may require evaluating other models of care delivery. In the sections that follow, discussion covers patient-centered medical homes, accountable care organizations, multi-disciplinary teams, and high performing work practices. Each of the entities represent potentially effective competitive approaches designed to help physicians in solo practice and small medical group PCPs retain their small business medical practices.

The patient-centered medical home (PCMH). The Patient Protection and Affordable Care Act of 2010 had structured incentives that encouraged innovations in delivery of primary care. One innovation was the patient-centered medical home (PCMH). Pediatricians pioneered the medical home concept, beginning in 1967, with a focus of care directed toward children with special needs. The PCMH definitional concept expanded in later years to encompass a physician-directed primary care team that

emphasized accessibility, continuity, compassion, coordinated comprehensive scope of care, and family-centered (Ullrich, MacKinney, & Mueller, 2013).

Impressions about the patient-centered medical home (PCMH) model of care evolved from skepticism about the concept to wider acceptance, as a model for enhanced primary care delivery and cost reduction (Hollingsworth, et al., 2012). Lower patient use of emergency services, better health care delivery and higher satisfaction levels from patients and staff are some of the results observed from adoption of the PCMH model (Coleman et al., 2014).

Bitton et al. (2012) recognized that new operational models for medical practices were being tested, to get physicians off the hamster wheel, a situation where physicians saw more patients by implementing shorter visits for shrinking levels of remuneration. The payment-linked PCMH was analyzed to carefully, critically determine the effects that transitioning to that model, from the old fee-for-service model, had on the primary care medical practice (Bitton, et al., 2012). A wide variety of change tactics should be used, based on the contextual factors surrounding the individual practices (Knapp, et al., 2014). Each practice requires different approaches, although ongoing medical payment reform means small practices must achieve rapid, substantial change and address the challenges of sustaining the change.

Accountable care organization (ACO). An accountable care organization (ACO) can be defined as an organization of providers that hold joint responsibility for attaining quality improvements that can be measured, with accountability for achieving reductions in the rate of health care spending growth rates (Anderson, Ayanian,

Zaslavsky, & McWilliams, 2014). An ACO can be configured as primary care medical groups, hospital-based systems, integrated delivery systems, or virtual networks of physicians. Regardless of the configuration, an ACO must have a strong emphasis on providing primary care.

The ACO concept has significant potential for cost reduction and improvement of quality of health care delivery (Epstein, et al., 2014). The cost and improvement factors attracted attention from health care policymakers and clinical leaders. Transitioning from fee-for-service payment arrangements toward payment models that hold health care providers accountable, including physicians, hospitals, and other entities within the health care delivery and services marketplace are inevitable (Fisher & Corrigan, 2014).

Berry and Beckham (2014) pointed out that ACOs must establish teamwork as an inherent cultural priority. Simultaneously, ACO leaders must acknowledge established behavioral patterns of health care providers that tend toward an autonomous, resistant nature. Cultural alignment, team-building philosophies, and resource pooling mindsets are critical for ACO mission accomplishment.

Multi-disciplinary team concepts. Multiple studies identified multidisciplinary health care delivery approaches (Aizer, et al., 2012) as the most preferable model for dealing with the complex issues surrounding treatment of prostate cancer (Prades, Remue, van Hoof, & Borras, 2015). Challenges that surround successful implementation of multidisciplinary care (MDC) model involve communication and relationship qualities among the patient, the physician provider, and other allied health professional providers. Delivery of high-quality care, unimpeded access to care, reasonable costs, as well as costs

control, are the goals of the majority of health care provider entities, ranging from major medical centers to solo practitioners (Berry & Beckham, 2014). One of the most intractable barriers to achieving stated goals is fragmentation of health care delivery systems. Integration of the health delivery system, particularly through teamwork and team-based care delivery, serves as an antidote for the results and negative outcomes of fragmentation.

High performing work practices (HPWPs). Improving quality of care delivered by health care providers is possible by using high-performance work practices; however, perceptions exist that HPWPs concepts is an underused strategy. Assessments of HPWPs implementation should use an evidence-based model for measuring adaptation of complex innovations (McAlearney, Robbins, Garman, & Song, 2013). Elements of HPWPs include teamwork, continual learning to achieve elevated skill sets and honest performance appraisal. At a micro level, HPWPs implementation focused on improving employee morale, engaging employee participation, and elevating the quality of care provided by employees. At a micro level, implementation focused on improving perceptions of quality and patient satisfaction, transforming entity culture, and enhancing entity reputation. Medical practice physician-owners work in a competitive landscape and are losing market share, financial stability, and autonomy (Vaughan & Coustasse, 2011). Many physicians, because of concerns about maintaining autonomy (Skinner, 2013), shy away from classification as businesspeople and fail to embrace business strategies to control the loss of market share and maintain competitiveness or implement improvement measures when needed (Guo & Hanriharan, 2012).

A Brief Review of Retail Health Clinics. The term disruptive innovation is used when describing better-quality technology services or products for a lower price, using different approaches that bring perceptions of added value to a new group of customers. The emergence, rapid growth, and increasing popularity of retail clinics represents a disruptive innovation in the health care delivery services marketplace (McKinlay & Marceau, 2012). Current and anticipated shortages of primary care physicians, less-than-optimal chronic disease management, and evidence of increasing health care disparities are converging factors that created a gap which retail health clinics can fill.

Mehrotra (2013) also viewed the concept of retail health clinics as a disruptive innovation. If primary care practitioners do not make decisive moves toward developing viable alternatives to retail health clinics, they risk additional loss of market share and a decline in scope of care capability (Mehrotra, 2013). As a new entrant into the health care delivery marketplace, corporate-level retail clinic owners are introducing less expensive, less expansive services to gain a foothold in the health care services delivery arena. The next step entails gradual expansion of scope, now evident with availability of treatment for chronic disease care and full-service primary care in the clinics. The final step transpires when retail health clinics represent themselves as a more attractive alternative to the traditional primary care clinician model.

Patient users of retail clinics usually cite two factors as prime motivators that draw them to retail clinics (Shrank, et al., 2014). The first attractor is the convenience of not needing an appointment to receive care and the ability to just walk in. The second attraction is the lower cost which is transparent and readily available to the patient.

Patient satisfaction levels are consistently high, and assessments of quality of care are high, too.

Individual patients who sought care at a retail clinic experienced costs savings per episode of illness that were 40% to 80% lower than costs for comparable care provided at urgent care sites, physician medical offices, or hospital emergency departments (Sussman, et al., 2013). Retail health clinics can serve as high-quality, lower-cost alternative sites for care delivery, in part, because of utilization of evidence-based, clinical practice guidelines enhanced by electronic medical records systems. Even when retail clinic sites share space within retail stores that house pharmacy operations, the total health care expense per care episode remains lower than when care occurs in other traditional settings.

Sussman et al. (2013) identified two explanations for the cost savings associated with retail clinic care delivery models. Ready availability of care from the retail health clinic may motivate patients to seek treatment for a condition earlier than if they had to wait for an appointment with a primary care physician. Seeking early treatment in the natural course of illness may cost less to treat the ailment because delays can result in higher costs and levels of effort to achieve favorable outcomes.

A second potential explanation involves the availability of retail clinics. If access to the clinic were not available, patients would have sought care at higher-cost locations such as emergency departments and urgent care centers (Fenton, Jerant, Bertakis, & Franks, 2012). Convenient access to retail clinics helps contain overall medical costs and lower the total cost of care.

Frustrations resulting from inaccessibility and limited appointments to see primary care providers led consumers of health care services (patients) to seek the more customer-friendly models of health care found in retail health clinics (Kaissi & Charland, 2013). Convenient venues, predictable waiting times, extended hours with weekend access, and lower prices that are clearly posted for acute care services are among the incentives that make retail clinics attractive to customers (Faezipour & Ferreira, 2013). Kaissi et al. (2013) saw the retail clinic health care delivery model design as customer-centric when compared to the totally physician-centric medical office model.

The patient-centric, high-quality care and convenience focus of retail health clinics offers a model for adaptation by large and small health care organizations (Kennedy & Nordrum, 2015). In an increasingly predominant per capita payment model environment, patient-centricity must drive system design, programs, and processes. Kennedy et al. (2015) projected that retail clinics will continue gaining market share because of quality care and lower costs, which threatens the viability and sustainability of some health care systems, particularly for smaller primary care medical practices.

Approximately 80% of primary care physicians perceive that retail clinics present a business threat for their medical practices (Garbutt, et al., 2013). As retail clinics expand the level of service provided to include chronic disease management, preventive care, and physical examinations, the level of business threat to primary care physicians will increase. Garbutt et al. (2013) surmised that because retail clinics offer the convenience of not requiring appointments and short wait times, customers (patients) prefer the clinic option to visiting a primary care provider office. Transparency and

stability of a price schedule that is lower than a visit to a physician office helps make the retail clinic option more attractive.

The retail clinic concept is not without detractors. Garbutt et al. (2013) acknowledged that some providers suggested that suboptimal care was given to patients, but other providers who had experienced prompt follow-up communication with retail clinic staff were more inclined to report that care given at the retail clinic met recommended clinical guidelines. Rohrer et al. (2013) identified concerns that some critics have expressed about fragmented care and continuity, however, supporting evidence for those concerns is sparse. When care provided in retail clinics was available in a metropolitan area, a trend of reduced usage of emergency rooms and acute care facilities emerged (Rohrer J., Angstman, Garrison, Pecina, & Maxson, 2013). One advantage that retail clinics provides is an additional source of care for patients who are members of disadvantaged populations. An additional advantage that retail clinics bring is that NPs/PAs are more cost-effective when they function as primary care providers in retail clinic settings.

In a different study, Rohrer, Angstman, Garrison, Maxson, and Furst (2013) suggested that the increasing popularity and number of retail medicine clinics gives rise to concerns that patient-physician relationships are weakened, and continuity of care endangered. The lower costs of retail clinic care, coupled with the high value that patients attribute to speed-of-access, are reasons for the increased use of the retail clinic model. While a minority, 42% of patients older than 50 years old use retail clinics, a majority, 53% of patients between the ages of 18 and 29 years old preferred using retail clinics.

Rohrer et al. (2013) selected two randomized groups of patients, the first comprised of 200 patients seen in retail medical clinics and the second group of 200 patients from traditional physician office visits, and found higher levels of associated continuity of care in the traditional physician office setting. Patterns of lowered health care costs developed because of decreased hospitalizations, improved chronic disease management, and better delivery of preventive services. However, Rohrer et al. (2013) were not wedded to traditional notions of continuity and suggested that if retail clinics widen the range of care provided, the clinic could become the chief source of primary care for a greater proportion of the population and reduce concerns about continuity of care.

Retail-based health care clinics appeared in the year 2000, so they are still considered a recent phenomenon in the health care delivery service arena (Williams, Kahanfa, Harrington, & Loudon, 2011). Sometimes derisively referred to as "Docs-in-a-box" by their competitors (primarily solo practitioners and small medical group practices), these clinics are on a path of steady growth. Williams et al. (2011) revealed that the clinics began appearing when one man had difficulty getting an appointment at the doctor's office for his son to have a simple test done. The man and his two business partners (one of whom was a family practice physician) instituted a set of pilot clinics in Minnesota, and from that genesis, today's plethora of clinics range from Walmart to CVS to Target and even to some supermarkets. Leaders of the CVS organization established a dominant presence in the retail clinic arena with the MinuteClinic Division.

The CVS approach. *MinuteClinic*, established in the year 2000, is the division of CVS Caremark that provides direct patient care. By establishing patient clinics within a retail store environment, the CVS MinuteClinics helped address the current, and worsening, shortage of primary care physicians. Continuing the medical industry's move away from the traditional solo physician's office-based model of care, the CVS model increased the available number of health care providers by using nurse practitioners and physician assistants for routine medical care (CVS Caremark, 2014). The corporate leaders' decision to establish the MinuteClinic division positioned CVS to exploit fully the opportunities created by passage of the Affordable Care Act (ACA). The ACA resulted in an expanded pool of insured patients, enabling those patients to receive care; CVS was ready to provide the care sought and increased its market share within the health care delivery systems arena.

Three concepts are relevant to any entity desiring a sustainable organizational future, whether it is a large corporation on a trajectory that encourages acquisition and expansion, or just a small businessperson pursuing survival in a constantly changing landscape. The concepts are a pathway creation designed to meet future generation needs, developing long-term strategic institutional mindsets that encourage building diverse networks, and thinking differently in ways that stimulate real change from status quo processes and prior operational imperatives (Senge, Smith, Kruschwitz, Schley, & Laur, 2010). The business decision by CVS Caremark to encourage innovation throughout the corporation and to establish the MinuteClinic division reflects a full understanding and

adaptation of the third concept, supporting advocates thinking differently and changing the status quo.

CVS Caremark demonstrated an effective application of strategic planning processes and resultant action plan when it created the MinuteClinic division. The plan allowed CVS to profit from an evolving health care delivery need with an innovative approach through retail health clinics by abandoning the last century's predominant corporate philosophy of flocking behavior. Through undifferentiated, cohesive competitive strategies, CVS fully embraced industry evolution philosophies which are necessary for the sustainment of large complex adaptive systems. Corporate leadership adopted a life cycle assessment that emphasized intensive interpersonal collaboration and provided management via cultural sharing instead of a rigid, formalized governance structure (CVS Caremark, 2014).

A sustainable value framework that breaks away from status-quo thinking encourages evolution into a different type of conscious awareness, resulting in new skill sets that are necessary for attaining sustainability (Macfarlane, 2014). Competitive strategies are successful only when created based on how well a company understands, adapts, and relates to the existing environment. When companies pursue strategies that align with the values of external forces with which the companies must interact, the companies adapt with appropriate organizational structure or operational level changes (Diaz-Foncea & Marcuello, 2012). The CVS Caremark *MinuteClinic* division gave CVS entry to the primary health care systems delivery domain previously dominated by solo

and small group practice physicians, and large health maintenance organization clinics (CVS Caremark, 2014).

Small Business Owner and Small Business Entities Characteristics

Political and academic leaders acknowledge the importance of small businesses and the positive impact, socially and economically, that business has upon the country. Establishment of small businesses is a major factor in job opportunity generation and economic development for the communities in which the businesses conduct operations. Similar socio-demographic and psychological characteristics exist in entrepreneurial individuals who are business owners.

Surdez et al. (2012) chronicled a list of behavioral characteristics often found in business owners. An obsession for opportunity, a need to accomplish, risk tolerance, self-confidence, creativity, and determination were characteristics observed. Additional characteristics are a strong need for control and a preference for innovation. Larger percentages of business owners within the services sectors have higher levels of knowledge-based expertise, gained from formal education and training. In addition to occupational expertise, business owners who successfully maintained their businesses had developed knowledge in administrative and financial management (Surdez et al., 2012). Creativity and a willingness to negotiate were additional cognitive skills necessary for success in entrepreneurship.

Surveys of the United States employer demographic revealed that in the year 2007, approximately 79% of recognized firms had fewer than ten employees. When expanding the number of employees to 20 or fewer, 89% of US companies fell into that

category. The label small business is often used with different connotations in diverse political, economic, and popular contexts (Cunningham, Sinclair, & Schulte, 2014). Common differentiating attributes that distinguish large businesses from small businesses include degree of manager centricity, number of employees, agents business, workforce, business structure, culture, and construct management. When compared to larger businesses, small firms have a smaller scope of operations, limited facilities and equipment, fewer operations, and fewer numbers of distinct occupational focuses.

Cunningham et al., (2014) inferred that while small high-tech companies with highly educated employees can be well-financed, smaller firms are often dwarfed by larger organizations financial capabilities. Small business structures tend toward a single geographic location with a single industry or service. Large organizations, typically, are legally structured as corporations. By contrast, approximately 95% of firms classified as sole proprietor or self-employed had less than 20 employees.

Some literature on small business research (McCullough, 2012; Surdez et al., 2012) typifies owners of small firms as perceiving the firm as an extension of their personalities and personal selves. Characteristics such as competitive natures, striving personalities, restlessness, Type-A personalities, and an entrepreneurial spirit, are often observed in small firm owners. The cultural expectations found in small firms often focus on independence, pragmatism, control, fiscal responsibility, and survival.

Marketing strategies for small and medium- sized enterprises (SMEs), regardless of discipline or occupational focuses, should adhere to certain fundamental concepts. One fundamental concept is that firms construct strategies to adjust its resources to address

existing environmental conditions (Marek, 2014). Regardless of organizational size, leaders for the firm should adopt the first fundamental concept. A second fundamental concept assumes that strategy development focuses on long-term implementation for achievement of company goals (Marek, 2014). Inherent in that concept is that the firm's leadership, particularly in SMEs, desires organizational continuity and sustainability.

The SMEs have certain marketing strategy development advantages not available to larger firms. In larger firms, multiple divisions have to compete for the strategic focus of a firm's marketing initiatives. Lower degrees of complexity among the stakeholders for SMEs allows for easier formulation of a marketing strategy. Large firms have more extensive access to media; yet, SMEs often have more familiarity with and greater knowledge of the local competitive market. Marek (2014) posited that SMEs would benefit from using the three classical marketing strategy components: (a) market segmentation, (b) marketing positioning, and (c) effective marketing mix. Emphasis should remain on building perceptions of value and quality achieved through product or service availability, reputation, level of service delivery, and pricing.

An SME has a limited geographical market and retains customer loyalty through effective relationships and credibility. Marek (2014) acknowledged using a niche strategy but saw it only as a short-term strategy. Horizontal integration strategy enables SMEs to collaborate and leverage resources with other smaller organizations, enabling an effective competition with larger companies. A vertical integration strategy is appropriate for firms with relationships within a value chain. A co-ompetition strategy (Marek, 2014) requires

cooperative interaction with many sources including competitors and serves as a long-term, value-added approach for a SME.

Based on the common characteristics of small business owners, solo practice and small medical group physicians meet the criteria for being classified as small business owners. Characteristics ascribed to small businesses are similar in nature to characteristics found in solo and small medical group practices. Operating in an increasingly competitive marketplace requires physicians to exhibit many behaviors that are like other service providers in the business arena. Unfortunately, some behaviors led to complications for physicians involving collusion and price fixing (Gunning et al., 2013).

Austin (2013) identified three characteristics that small business owners need for effective strategic thinking including willingness to create a new mindset, ability to transform ideas in sustained actions, and being at ease in an environment of shifting contexts. Strategic thinking and planning is critical in business climates where decreasing resources require short and long-term points of view, and adaptability (Zuckerman, 2014). Small business health care providers must have a strategic awareness that the answer to any question associated with health care services delivery includes the concept of reimbursement (Carpenter, 2013). No business entity can afford to neglect strategic value analysis, especially within the health care delivery services arena, regardless of the type or size of the business entity. Any business must understand that value derives from the product or service function's ability to satisfy a consumer need (Chauvet, 2013).

Awareness of and understanding competitive forces is key to SME survival. For small medical group practices, retail clinics are a potent source of competition.

Common Small-Business Competitive Practices

Military strategist, Sun Tzu, posited that there are five essential elements necessary for any battle strategy. The elements are: (1) know when to fight and when not to fight, (2) develop understandings of how to fight a superior opponent, and how best to fight an inferior opponent, (3) assure that the thirst for victory exists in every single member of the organization, (4) fully prepare yourself and wait for the adversary to reveal a lack of preparation, and (5) always have the necessary capacity for the fight (Tsu, 2009). The five elements also apply to business leaders in any field, as they face adversaries and changing conditions within the marketplace.

Organizational owners and leaders must maintain an awareness all products and all services have specific life cycles (Sychrova, 2012). Leaders must use strategically-based techniques continuously, to assess progress of the product lifecycle to improve business performance. A business, whether product or service, may have at one point held a competitive advantage, but without innovative responses marketplace changes ultimately degrade any competitive advantage gained (Langdon, 2013).

Introduced in 1994 as a conceptual framework, dynamic capabilities was used to help companies understand how to assess and address their organizational shortcomings, and create sustained competitive advantage (Teece & Pisano, 1994). Dynamic capabilities included a focus on enterprise performance in an environment of rapidly progressing technological change, assessing and revising competitive strategies and even

changing customers if warranted. In a volatile marketplace, adding an organizational mindset of innovation to company operations enhances dynamic capabilities in a way that improves performance and profitability for small and medium-size enterprises (Nolsoe-Grunbaum & Stenger, 2013).

Employing joint innovation efforts adds new perspective to creating value for a company and should include open approaches that involve customers in the process (Martinez, 2014). Consistent value creation and value maintenance of a product or service is imperative to maintain operational and organizational sustainability. Gaining and maintaining competitive advantage is possible when leaders understand the need for providing a quality product or service, being flexible, and embedding a mindset of innovation within organizational culture (Ferreira de Lara & Neves Guimaraes, 2014). For innovative mindsets to benefit a company, leaders must prioritize and balance new ideas with the requisite project management techniques needed to transform an idea into a profitable product or service (Hakkarainen & Talonen, 2014). Failing to utilize available technology can stunt the effectiveness of any competitive advantage that a company amasses, and diminishes opportunities for value creation (Robinson, 2014). Regardless of the product or service, profession or vocation, organizational leaders must engage in strategic thinking.

Strategic Thinking for Small Medical Group Practices

All components of the health care delivery system, from major medical centers to individual physician practices, can flourish if the component leaders understand the principles of retail competition. A willingness to respond appropriately and fully

implement retail competition principles is important because operational sustainability of the system component depends upon the competition principles (Grube et al., 2014). A trend toward transparency, readily available information via technology, and the increasing levels of sophistication of health care consumers - the patients –, combined to create a new dynamic, demonstrated by consumer willingness to shop around for care.

Grube et al. (2014) emphasized that retail health care is consumer-driven, based on retail principles, and sensitive to market forces. Major retailers such as CVS Health, Walmart, Walgreens, and even Target are firmly entrenched in the health care delivery marketplace and are expanding operations. Strategic and financial analysis by health care components must be in-depth, attuned to, and consistent with best-practice approaches used by the major retailers. The strategic development practices must demonstrate an understanding of risk assessment, risk analysis, and risk management processes (Wright, Paroutis, & Blettner, 2013). Component reconfiguration, where indicated, should be timely and consumer-focused.

Demographic transitions, financial pressures, changing political and social expectations have all converged, requiring that health care systems, of all sizes throughout the world, practice cost containment while improving the quality of health care services delivery. Researchers have begun working cooperatively to develop innovative responses for the challenges faced by organizations needing change (Martin, Weaver, Currie, Finn, & McDonald, 2012). In some instances, innovation alone may not lead to sustained changes.

Martin et al. (2012), focusing on both primary care-based organizational innovation and hospital-based organizational innovation, identified seven specific challenge issues that affected the degree of sustainability for organizational innovation. The challenges included shifting priorities and sparse evidence of effectiveness, contextual divergence causing difficulties with establishing cost-effectiveness, dependency on external forces outside of the immediate organizational unit, varying levels of organizational influence for the unit leaders, inability finding and establishing appropriate innovation strategies, varying levels of proactive responses to change, and overcoming environments of inertia. Martin et al. (2012) concluded that pursuing sustainable, innovative change requires continuing effort and requires the right organizational champions for change. Make change in a manner that is flexible enough to react properly to rapidly changing conditions.

As of 2013, the percentage of family physicians who operated as solo practitioners was only 11%, a noticeable drop from the 13.9% that solo practitioners represented in 1993 (Peikes et al., 2015). In rural areas of the United States, a decline in the number of primary care solo practitioners threatens the level of access to care for the population. Although declining in number, the one-physician model still constitutes a sizable proportion of the total number of primary care medical practices.

Peikes et al. (2015) offered seven pertinent questions for examination about the work of solo practitioner family physicians. The first question inquired whether solo practitioners are an endangered species. A second question asked if use of other clinicians, such as nurse practitioners and physician assistants, changes the predominance

of solo practitioners. The third question examined whether the size of the primary care practice is affected by patient and community characteristics. The fourth question sought information about whether smaller group and solo practices encounter greater difficulty with health care system reforms and payment system changes.

The fifth question dealt with examining variances based on practice size for factors such as patient outcomes, quality, cost, and access. A sixth question focused on how access to primary care might be affected by the declining numbers of solo practitioners. The final question generated discussion about whether specific policies should exist for the support of solo and small medical practice models. Peikes et al. (2015) suggested that the location and effectiveness of small practices should be the deciding factors that determined the value of preserving that particular health care services delivery model.

Although affected by subjective and objective criteria, the patient's level of perceived satisfaction is a vital determinant of health care quality ratings. The amount of time patients spent waiting to see a health care provider coupled with the amount of time spent with the provider are the two components that drive patient perceptions about satisfaction levels (Patwardhan, Davis, Murphy, & Ryan, 2012). The overarching goal of convenient care clinics (CCCs), also called retail health clinics, is providing convenient, time-saving routine health care service delivery, and at a lower cost than encountered at a physician's office.

Patwardhan et al. (2012) measured patient waiting times when visiting a CCC, compared with waiting times at a traditional primary care physician office. Patients

utilizing CCCs experienced significantly reduced waiting times to see the provider when compared to a visit in a primary care physicians' office. Patient time spent with the provider was noticeably longer at a CCC than time spent with the physician at the medical group office. Patwardhan et al. (2012) contended that increased encounter time allowed the patient to have all needs addressed, enabled increased communication quality with better health outcomes.

Expertise in negotiation, conflict resolution, performance improvement, financial acuity, and innovation are among the skill sets that physicians need to implement new models of health care delivery and work proficiently within those new models (Ellner, et al., 2015). Understanding and addressing third-party payer concerns while meeting patient expectations helps move a practitioner from survival tactics to sustainability strategies (Jakielo, 2011). An awareness of systems dynamics helps small business owners, including physicians, understand how to measure strategy performance, determine potential difficulties for strategy implementation, and decide which mitigation strategies allow for increased performance levels that achieve strategic goals (Kunc, 2012). Developing transformational mindsets helps physicians restructure their practice models (Alyahya, 2012) and establish critical productive working relationships with third-party health insurance payers (Saxton et al., 2013). Physicians, along with many other type professionals, must embrace strategic change as beneficial, rather than a threat to the professional identify (Schilling et al., 2012).

As physicians consider the nature of competitive threats within the health care delivery marketplace, there should be a mindfulness of potential threats from within the

professional discipline. Covenants-not-to-compete, provisional clauses often found in contracts, require agreement by the signing parties to not compete, particularly after the parties end a work relationship (Beauchamp, Benson, & Daniel, 2014). When an employee-physician faces such restrictions, to continue working the physician frequently has to leave the geographic area for a specified period. The physician departure can cause interrupted continuity of care to the patients for whom the physician provided care and possible physician shortages in the community.

Legally compliant behavior does not always align with social definitions of ethical behavior. Beauchamp et al. (2014) recommended that physician leaders and decision-makers consider all parties who were affected by the decision, while pursuing equitable legal and ethical outcomes. Physicians in large and small medical groups face competition from fellow physicians, as well as retail health clinic organizations.

Third-party payers, commercial and governmental, direct the largest share of reimbursements for medical services delivery to hospitals and physicians. Of the two groups, physician reimbursement receives a higher level of scrutiny (Gunning et al., 2013). On one side, patients and payers contended that physician fees are too high while on the other side physicians insisted that reimbursement levels too low. Along with efforts to exert market power, unethical behaviors of collusion emerged by some groups within the physician community and brought review with enforcement actions by the United States Department of Justice. Physicians were not allowed to engage in joint negotiations, which Gunning et al., (2013) saw as having a dampening effect on joint ventures and other collaborative initiatives. Physicians coming from solo practice of

small medical group practice environments increasingly migrate into leadership positions at larger health care organizations and should develop awareness of organizational leadership requirements and expectations.

Leadership in Health Care Entities of all Sizes

Points of interest. In competitive, challenging, and complex environments organizations with adaptive leaders are more likely to survive and thrive. Technically-adept leaders can adapt to new conditions without established protocols or processes and no clear-cut answers, and can navigate their organizations toward desired goals (Peterson et al., 2014). Distributive approaches to leadership and results-oriented approaches that mix strategic awareness and action-based decision-making is fundamental to core leadership skills (Delmatoff & Lazarus, 2014). Peterson et al., (2014) saw the need for character traits like integrity, a sense of self-awareness and other emotional intelligence-related skills, an evident sense of fairness, and a passion for personal development through lifelong learning.

A confluence of systems dynamics, evolutionary modeling, equilibrium, and self-organizing within certain industries can lead to patterns of management focus on short-term profiteering, with minimal attention to longer-term strategies (Stacey, 2011). In an organization where leaders view uncertainty as inevitable, an evolutionary complex model positions the company to experiment with various strategies and anticipate emergence of an effective strategy. In environments where risk-taking and experimentation are part of normal operating procedure diversity and creativity regularly emerge. Awareness of the dynamic factors that drive business evolution and revenue

expansion can lead to both short-term and longer-term, sustainable profitability (Jacobides, Winter, & Kassbarger, 2012).

Health care consumers have higher levels of life quality driven by degrees of sophistication and access to information not available as recently as 25 years ago. The sophistication and access factors enable consumers to be an initiating source that pushes innovative changes in current service delivery models. Innovative responses to consumer demand are fundamental when developing perceptions of better value through new service delivery methods and equips a provider with an ability to compete (D'Alvano & Hildago, 2012). Leaders that use innovation management tools position their companies, regardless of size or professional focus, to manage more complex innovation initiatives, rapidly adapt to changing circumstances, and systematically confront market fluctuations. Innovation should include a process of regular reviews so that strategies, processes, rules, procedures, and policies maintain alignment with leadership and organizational objectives (Self, Self, Matuszek, & Scharaeder, 2015).

Having the right tools available is important, just as is having a leadership team with the right mindset needed for navigating through the dynamic, ever-changing marathon in pursuit of organizational sustainability. The world is now a place where businesses, environments, societies, and economies are so interdependent, interconnected, and inseparable that all comprise a single entity (Tideman et al., 2013). Leadership decisions made without considering a complete picture of the single entity and without a change in the normal status-quo thinking will not provide an operationally sustainable path for a company.

Potential leadership hurdle. A major stumbling block to effective leadership is hubris. Petit and Bollaert (2012) described hubris as having three dimensions, each with identifiable behavioral and cognitive aspects. The first dimension of a hubristic person included an inappropriately ostentatious sense of self. The second dimension of a hubristic personality involved a mindset where the individual felt above, and better than the community of humans to which he or she belonged. The third dimension involved behaviors by an individual who felt unconstrained by existing societal norms, laws, and policies because he or she considered themselves to be at a level far above having to comply.

In health care environments, egocentricity and hubris are characteristics sometimes found in health care leaders from the organizational management sector and the clinical sector. Regardless of the area of professional expertise, if a health care leader subscribes to hubristic behavior, the result is poor patient outcomes and sub-par organizational performance. An effective way for leaders in health care to remove restraints to best practices is by eliminating hubris, avoid egocentric behavioral patterns, and stay connected to his or her true self (Petit et al., 2012). Leaders who practice an authentic leadership style demonstrate mastery of the four components of authentic leadership/followership. The four components are self-awareness, relational transparency, balanced processing, and internalized moral perspective (Hinojosa, McCauley, Seng, & Gardner, 2014). Another potential health care leadership stumbling block deals with treading too close to violating regulatory strictures because of a desire for profit-maximization, or unfamiliarity with the rules governing reimbursement.

Potential for fraud, waste, and abuse. A desire to understand health care expense reimbursement structures should include an examination of the Blue Cross and Blue Shield plans that began in the 1930s. The Blue Cross plans, strictly controlled by the hospital industry, established reimbursement arrangements that paid hospitals' billing charges at 100% of the charge, a situation very favorable to the hospital industry (Feldstein, 2012). Similarly, Blue Shield plans, tightly controlled by physician groups, established a system for full payment of physician fees. Discounting of physician fees for hospital bills was not a part of the health care services payment or reimbursement structures.

Feldstein (2012) showed that patients benefited from Blue Cross plans because of no deductibles or copayments associated with hospital stays. On the other hand, Blue Shield left patients, depending on their income levels, somewhat vulnerable to handling paying a portion of the physicians' customary fee. An environment where hospitals and physicians encountered limited competitive pressure, the potential for cost sharing patient limited demand for services, and minimal existence of third-party payers, created a degree of stasis; instances of fraud, waste, and abuse was rare. The Blue Cross and Blue Shield plans dominated the health insurance market until the entry of commercial insurance during the 1950s.

The Medicare and Medicaid programs in the mid-1960s introduced a new dynamic in the American health care marketplace. The expanded base of medical beneficiaries, coupled with an infusion of additional physician providers from medical schools and foreign medical graduates, helped establish a more competitive health

services delivery marketplace. More commercial insurers entered the health insurance market, giving health care consumers additional options that had not existed before. Feldstein (2012) highlighted how low out-of-pocket expenses for patients merged with physician-induced demand for services and created an environment that lacked any financial incentive to control use of services. Within that environment, opportunities for widespread fraud, waste, and abuse were rampant because of patient insensitivity to pricing, and hospitals and physicians taking advantage of inappropriate over-delivery of medical services for revenue-enhancing purposes.

The Medicare and Medicaid programs became notoriously vulnerable to instances of fraud, waste, and abuse. Physician self-referral arrangements, kickbacks, billing for services not provided, purposeful billing for services at higher levels than had been provided, provision of medically unnecessary care, illegal marketing, and complex billing frauds, were behaviors that became common among providers of medical services and medical equipment (Hill, Hunter, Johnson, & Coustasse, 2014). In response to the fraudulent behavior observed, the United States Congress updated the Social Security Act establishing criminal and civil penalties for false and fraudulent billing for services (United States Government Accountability Office (GAO), 2012).

A series of statutes to combat such fraudulent behavior included an anti-kickback provision, self-referrals prohibitions, a false claims act, and bans against introducing adulterated or misbranded pharmaceutical products or devices. Even though commercial insurers have long since implemented anti-fraud measures, the Centers for Medicare and Medicaid Services (CMS) is now moving aggressively to improve information

technology systems and expand programs such as the Recovery Audit Coordinator (RAC) program. The initiatives are efforts to gain greater control and reduce fraudulent activities (United States Government Accountability Office (GAO), 2014).

The need for flexibility. Exploring effective competitive approaches to help physicians in solo practice and small medical group PCPs retain their small business medical practices must include an understanding of flexibility. The word flexibility represents the concept involving an ability to make appropriate changes in response to changed environmental conditions. An inherent, explicit inference is that maintaining or increasing organizational performance and maintaining a competitive advantage requires flexibility (Dunford et al., 2013). Leaders must navigate through a myriad of definitions surrounding the term flexibility to successfully implement organizational change. A cohesive, contextual understanding and application of flexibility becomes critical when conducting significant organizational transitions (Matejun, 2014).

Dunford et al. (2013) pointed out that turbulent marketplace environments often require dismantling status quo hierarchies and removing established boundaries. Creating new relationships and alliances based on trust and mutual understanding increases opportunities to exercise flexibility. Leadership awareness of the new avenues presented by adopting flexibility leads to increased innovation capacity (Matejun, 2014). Some degree of balance between old and new models is important and requires attention by organization leaders to avoid either extreme of chaos or rigidity.

Flexibility often represents short-term, temporary actions needed for adjustment to evolving conditions. Another term, adaptability, suggests long-term, more permanent

flexible adjustment to a transformed environment (Lewis, Andriopoulos, & Smith, 2014). Operational flexibility entails small, incremental, and reversible responses to predictable changes. Structural flexibility allows for organizational realignment in response to other entities or networks (Krzakiewicz & Cyfert, 2014). Strategic flexibility gives an organization the expanded response capability needed for unexpected, significant marketplace and environmental changes that require new organizational norms, values, and responsibilities.

Transition

The purpose of my qualitative, explanatory collective case study was to explore effective competitive approaches designed to help physicians in solo practice and small medical group PCPs retain their small business medical practices. In the literature review was an overview providing a historical context, current status, and future projections about the roles available to the solo practice physician or small medical group practice.

In Section 2, I provided an overview of the proposed steps for use while conducting my doctoral study. The section also included an extended discussion justifying use of a qualitative explanatory collective case study. Conception and development of the qualitative case study had a focus of exploring effective competitive approaches available to small business solo practice or small group practice physicians. The study was designed to elicit understandings of the adaptive capabilities, strategic initiatives, and operational decisions expressed by the participants.

In Section 3, I provided discussion covering presentation of findings, application to professional practice, an identification of implications for social change,

recommendations for action and further study, reflections, and a concluding statement. My goal within this section was lessening the existing gap and lack of a cohesive synthesis of past, current, and future environments, in a way that establishes a clear, decisive path for achieving stability of solo and small medical group primary care practices in a rapidly changing health care environment. The outcome desired was a synthesis of effective competitive approaches designed to help physicians in solo practice and small medical group PCPs retain their small business medical practices.

Section 2: The Project

The purpose of my qualitative, explanatory collective case study was to explore effective competitive approaches designed to help physicians in solo practice and small medical group PCPs retain their small business medical practices. Qualitative case study research is appropriate when the researcher conducts an examination of the dynamics that surround radical change (Chreim et al., 2012), and is especially relevant for the current, rapidly shifting health care marketplace. Case study approaches were particularly useful with studies in health services research, enabling targeted focus on individual phenomenon in real life contexts (Yin, 1999). Case study methodology allowed for adaptation to available sources and procedures in business environments desirous of developing new models or modifying existing organizational structures (Zivkovic, 2012). Through the use of individual interviews and review of relevant available documents, my intent was to collect data from solo practice, and small medical group practice primary care physician owners regarding methods to protect the viability of their small business medical practices.

Purpose Statement

The purpose of my qualitative, explanatory collective case study was to explore effective competitive approaches designed to help physicians in solo practice and small medical group PCPs retain their small business medical practices. I investigated tactics for organizational sustainability of the practices. Using purposive sampling, I interviewed a set of predominately primary care practice physicians in the Baltimore-Washington metropolitan region, until achievement of data saturation. Purposive sampling (Bristowe

et al., 2015; Dayna, 2013) of physicians facing significant changes allowed for detailed information and data saturation using a sample size of 20 participants (Lockyer et al., 2011).

A better understanding of individual participants' perceptions of previous medical practice business management behavior patterns revealed how the patterns impact current and future conditions. Participants explored new ideas geared toward enhancing organizational sustainability, based on each participant's perceptions of small medical group practice. The positive social impact was to enhance medical practice stability with business-focused processes, knowledge sets, and effective methods for retaining small business medical practices.

Role of the Researcher

My role as researcher in this study was to explore effective competitive approaches designed to help physicians in solo practice and small medical group PCPs retain their small business medical practices. Impartially facilitating perspective and experience sharing by study participants is a key responsibility for researchers (Wahyuni, 2012). Maintaining impartiality and employing effective listening skills techniques to enhance accurate interpretation of what the study participants shared during the interview process are critical behaviors for qualitative researchers (Roulston & Shelton, 2015). Acting in the role of the data collection instrument, the researcher exercises reflexivity by maintaining a sense of self-aware analytic thoughtfulness (Wolgemuth et al., 2015).

Role in the Data Collection Process

My role as researcher, particularly during the data collection process, involved asking relevant questions, exhibiting good listening skills, remaining perceptive and adaptive, fully comprehending the issues under study, and avoiding biases (Yin, 2014). A critical concept that the researcher must master is encouraging participants in a manner that elicits a true sharing of experiences and perspectives around the phenomenon being researched (Wahyuni, 2012). Equally important is the need for the researcher to understand which data sets to access and analyze to produce meaningful insights (Moon, 2015).

My Role With the Topic

I am a retired health care administrator with managerial and executive leadership experience in the private health care sector, military health care community, and at Federal government health care policy-making agencies. My experiences drive my perspectives about the health care services delivery system of the United States in each of those three areas. Although retired, I maintain my membership in the American College of Healthcare Executives (ACHE), participate in annual continuing education courses, and read monthly peer-reviewed health care management periodicals. During the mid-1980s, as a vice president-level member of the executive leadership team of a private-sector small community hospital in an urban setting, I functioned with line authority over the employed physicians. A prior position as a mid-level assistant administrator at a large medical center had me in a peer-level working relationship with employed physicians.

My concurrent military reservist career required me to fulfill a multitude of diverse assignments as a Medical Services Corps officer, with frequent pulls back to extended active duty tours, especially after September 11, 2001. Those assignments provided command-level responsibilities for all assigned personnel, in environments ranging from isolated combat field hospitals to critical medical evacuation missions within trans-oceanic airborne intensive care units. Additional management assignments in peer-level positions with physicians included major medical centers that served as teaching hospitals, and later, national defense medical contingency response planning and policymaking.

I was a Medicare health maintenance organization compliance officer/auditor during the late 1980s at the then Health Care Financing Administration (HCFA), now known as the Centers for Medicare and Medicaid Services (CMS). As an evaluator of contracted health care entities of all sizes, I saw firsthand how the resources of the federal government can help and protect some of its most vulnerable citizens. I worked as a senior health policy analyst in the early 1990s with the then Agency for Health Care Policy and Research (AHCPR), now known as Agency for Healthcare Research and Quality (AHRQ). The AHRQ assignment placed me on a regulatory team responsible for federal funds that flowed to nongovernmental medical researchers. The researchers developed best practices that changed, for the better, the way primary and tertiary care is delivered in the United States and throughout the world.

During the mid-1990s, as a branch chief at the Health Resources and Services Administration (HRSA), I set policy and led recruitment efforts to help place primary

care physicians, dentists, nurses, and other health care providers in remote and medically underserved areas of the United States. The recruitment efforts increased by the use of federal funds for scholarships and student loan repayment programs. From the late 1990s until retiring in 2010, I worked at the Food and Drug Administration (FDA). As a senior management advisor working with employed physicians, I saw how federal tax dollars fund food safety programs, drug oversight and approval programs, medical-device oversight and approval programs, biologic and therapeutics oversight and approval programs, veterinary safety oversight and approval programs, and anti-bioterrorism efforts.

My Relationship with Study Participants

In the more than 35 years in health care management and executive leadership positions, my contact with physicians in many specialties was extensive. Qualitative approaches offer bridges that enable researcher-orientation and practitioner-orientation to more closely align by creating shared language and commonly-understood contexts (Guercini, 2014). Some of the physicians I interviewed are friends, acquaintances, and former co-workers. I did not have any business or familial relationships with any of the interviewees.

Researcher Role Related to Ethics

In preparation for conducting this study, in 2014, I completed the National Institutes of Health (NIH) course Protecting Human Research Participants. Conducting my qualitative, explanatory collective case study required the use of human subjects. The Belmont Report was one of several seminal efforts to rectify the damage inflicted on

unsuspecting research study participants by unethical researchers (Davidson, 2012). Guidelines established within the Belmont Report emphasized three basic ethical principles: respect for persons, beneficence, and justice (US Department of Health and Human Services, 1979). Davidson and Page (2012) pointed out that the Belmont Report attempted to address unethical research practices that occurred in the United States. Although retired, I maintain my membership in the American College of Healthcare Executives (ACHE) and am subject to the ACHE code of ethics. I participate in annual continuing education courses related to health care systems management and read monthly peer-reviewed health care management periodicals.

Bias Mitigation

While conducting the study, I recognized that achieving complete objectivity or totally eliminating bias was unrealistic (Parl, 2013). Rather than striving for an unrealistic goal, I maintained an awareness of biases developed during my career and pursued a degree of control (Roulston & Shelton, 2015). Yin (2014) articulated how researchers can control the degree of bias in a study by avoiding preconceived concepts about the topic and remaining open to alternative evidence that may be contrary to an initial premise. Takhar-Lail and Chitakunye (2015) identified reflexive introspection in qualitative research as one avenue to mitigate bias when viewing data from a personal lens. Prior knowledge and understanding of an area for study often serves as an advantage, but researchers must exercise extra care to avoid selective perception with data collection and analysis (Kooskora, 2013). My leadership experience in multiple areas of the national health care delivery system provided a broad, global understanding of the system.

However, during the study, I exercised effective listening skills, impartial facilitation, and avoidance of selective perception through reflexive introspection (Takhar-Lail & Chitakunye, 2015; Wolgemuth et al., 2015).

Rationale for Interview Protocols

Ethical research principles and protocols ensure normative standards of conduct that clearly delineate acceptable behavior patterns from unacceptable behavior patterns (Mikesell & Bromley, 2013). The principles establish parameters for researchers so that research participants receive fair treatment that balances research risks with research benefits. Protocols and principles also ensure that researchers respect the privacy implications inherent with data collection (Nunan & Di Domenico, 2013).

Participants

The purpose of my qualitative, explanatory collective case study was to explore effective competitive approaches designed to help physicians in solo practice and small medical group PCPs retain their small business medical practices. The study plan included individual interviews, in a natural setting at the medical practice sites with a set of predominately primary care physicians, including solo practice physicians and small medical group practice physicians in the Baltimore-Washington metropolitan region. I also included organizationally employed primary care physicians in the sample because many understood the challenges faced by small group physicians and offered strategic insight about overcoming the challenges. Choice of the types of physician was purposeful because the sample included individuals who were rich sources of detailed information

about the research topic, thus enabling me to best achieve the desired research objectives (Beauchamp et al., 2014; Dayna, 2013).

Purposive sampling allows for selection of participants with specific characteristics or knowledge that is relevant to the study's research questions (Bristowe et al., 2015). The diverse selection allowed for an examination that included the conceptual frameworks, strategic thinking, and dynamic capabilities. The use of interviews and relevant document review (Firmin, Bouchard, Flexman, & Anderson, 2014) allowed for triangulation of data, or the use of multiple sources to enhance data collection, confirmation, interpretation, and validity checking (Bekhet & Zauszniewski, 2012).

Specification of the types of physicians for inclusion in the sample satisfied the first point within the model of a four-point approach to qualitative sampling (Robinson O., 2014). Robinson (2014) listed the other three points that included decisions about an appropriate sample size, creation of a sample strategy, and determining the sample source. Traditionally, sample size was associated with study goal integrity, data depth, and alignment with the appropriate theory (Roy, Zvonkovic, Goldberg, Sharp, & La Rossa, 2015). However, researchers should avoid a myopic focus with misdirected concerns about small sample sizes, and should rather seek achieving results that support analytic generalizations, especially when conducting case study research (Yin, 2014).

When seeking access to the study participants, I clearly defined the problem to be studied, emphasized the potential value of the study, and used different approaches when appropriate. The group of participants were likely to be motivated if a problem relevant

to them was clearly defined and was likely to result in availability of favorable business practice and policy alternatives (Cacari-Stone, Wallerstein, & Minkler, 2014). An important aspect of gaining access to participants for the study was that the participants had favorable perceptions of the value of participating in the study (Bengry-Howell & Griffin, 2012). Also important was understanding that different approaches might be necessary when gaining access to potential participants from different cultures and professional orientations (Evangelista, Poon, & Albaum, 2012).

One strategy that helps establish an effective working relationship with study participants is for the researcher to suppress a natural tendency toward subjectivity; the researcher should refrain from preconceived ideas and allow an unbiased reality to develop (Reybold, Lammert, & Stribling, 2012). Another strategy is trust building through maintenance of introspection and self-awareness by the researcher with a focus on positive outcomes that allow for some degree of deference, where appropriate, to the study participants (Blix & Wettergren, 2014). A third strategy, important for retaining effective working relationships with study participants, is for the researcher to vigilantly monitor that the expectations of study participants match with how data collected are used (Hammersley, 2013).

Practitioners from minority groups received particular emphasis because solo practice models are more common in the community of African-American and Hispanic primary care practitioners (Liaw et al., 2016; Stange, 2016). Autonomy, a highly prized commodity, is a prime motivator for many physicians who seek to maintain solo practices, particularly physicians among the male, minority, and older demographic

groups (Lee et al., 2013). A second motivator for working with this subgroup was the historical circumstances of legislative, educational, and economic segregation targeted at physicians of color (Baker et al., 2009; deShazo et al. 2014; Washington et al., 2009).

A third motivator involved the current challenges of economic marginalization and lingering perceptions of subpar skill levels (Elder & Miller, 2006; Hausman et al. 2013) with which the group must contend. The group was very likely to benefit from an exploration of what effective competitive approaches provide assistance for physician leaders of solo practice and small medical group primary care practices to retain their small business medical practices. The targeted audience for this study was primarily solo practitioners, although results may be of interest to many population groups, group practices, hospital systems, other allied health care providers, and third-party payers, within the health care delivery services marketplace.

An anticipated outcome of the study was an opportunity for data that are of interest to a broader-based population of solo practitioners. Many physicians, particularly those who completed medical school before the beginning the 21st century, are conditioned to seek professional autonomy and independence (Norback, 2013). One byproduct of such conditioning was difficulty adjusting to rapid, drastic changes occurring in the current health care delivery marketplace.

In a study examining the effects that physicians experienced during a time of shifting roles and responsibilities and significant changes to the focus of their medical practices, researchers achieved data saturation with a sample size of 20 physicians

(Lockyer et al., 2011). The Lockyer et al. (2011) study looked at the effects from transitions deemed as critically intense learning periods, during which individuals fundamentally re-evaluated established identities and methods used in operating a medical practice. Qualitative research, particularly with purposeful sampling, helps reduce concern about sample size (Starr, 2014). Researchers should target the elements of change that emphasize "the what" (change content) and "the how" (change process), which are closely linked together (Gilbert et al., 2015).

Research Method and Design

Research Method

Of the three types of research methods, quantitative, qualitative, and mixed methods, I used a qualitative approach for this study. Primary care physicians face a multitude of challenges presented by a competitive, rapidly changing health care delivery marketplace. I explored effective competitive approaches designed to provide assistance for physician of solo practice and small medical group primary care practices to retain their small business medical practices. A qualitative approach was pertinent for this study because it allowed for small-sized samples with purposeful selection (Morse, 1999). The approach gave the ability to generalize, after achieving saturation (Fairweather & Rinne, 2012), and provided an opportunity to draw concrete, practical recommendations implementation by the clinicians (Morse, 2015).

Qualitative research matched well with pragmatist and constructivist paradigms and was useful in exposing inherent dynamic factors found in change processes (Garcia & Gluesing, 2013). Qualitative research approaches permitted incorporation of a

researcher's experience with the analysis performed, and did so in a manner which did not create dissonance between the analysis and the researcher's experience (Guercini, 2014). Qualitative research traditions pursued an understanding of complex internal organizational processes where contextualization may not be readily apparent (Lee, 2014).

Garcia et al. (2013) found that qualitative research helps reveal different organizational phenomena enabling organizations to deal more effectively with ongoing change. My use of qualitative methods during this study allowed me to use standard and newer techniques to examine relationships, phenomena, and change processes found, even in multinational contexts. Nuanced and rigorous methods found in qualitative approaches enables researchers' assessments of multilevel analysis to reflect the constant shifts and changing dynamics found during organizational change (Garcia et al., 2013). Qualitative approaches offer bridges that enable researcher orientation and practitioner orientation to more closely align by creating shared language and commonly-understood contexts (Guercini, 2014).

Quantitative research advocates a separation between facts from values and allows a researcher to deductively study a phenomena without being influenced by it, or inadvertently influence the phenomena (Slevitch, 2011). Quantitative researchers often use an outsider approach, typically with structured surveys, to explain it and quantitatively formulate predictive, numeric, formalized conclusions (Marais, 2012). One disadvantage of surveys, however, is that interview subjects can be selectively

nonresponsive to certain items, particularly to experimental materials (Goodman, Cryder, & Cheema, 2013).

Mixed methods research uses qualitative measures that incorporate quantitative metrics (Marais, 2012). Marais (2012) showed how involving members of the studied population in actively learning and negotiating processes helped accomplish measures of organizational sustainability. Collecting quantitative data, using psychometrically valid quantitative instruments during a qualitative interview, helps a researcher effectively contextualize qualitative findings with enhanced interpretations (Frels et al., 2013). Combining qualitative and quantitative methodologies often work in complementary roles and expand the contextual perspective of the researcher (Lee P., 2014).

My choice to use a qualitative method for the topic was influenced by an understanding that qualitative researchers search for an understanding of phenomena from the insider viewpoint of the individual or subject under analysis. Qualitative methods allowed pursuit of understanding of phenomena, using less specific methodologies than more structured methods found in quantitative research (Lee, 2014; Marais, 2012; Trautrims, Grant, Cunliffe, & Wong, 2012). The qualitative tradition closely matched the requirements for challenge approaches and was effective with some groups of professionals that exhibit a strong affinity for autonomy.

The qualitative approach included an inherent focus on understanding "why" and "how," which allows data gathering and analysis about layers of processes (micro practices) within an organization (Trautrims et al., 2012). From the data analysis, organizational leaders derived analytical protocols, allowing them to review unique cases

and develop generalizable principles for the organization as a whole. Trautrims et al. (2012) acknowledged traditional concerns about methodological soundness and the amount of rigor associated with qualitative studies, particularly in the minds of quantitative methodology advocates, can be addressed by consistency of methodology with data collection and analysis.

Research Design

Of the five types of qualitative research methods, narrative, ethnographic, phenomenological, grounded theory and case study methods, I used a multiple case study design. Exploring effective competitive approaches, designed to provide assistance for physician in solo practice and small medical group primary care practices to retain their small business medical practices, aligned well with explanatory case study methodology. The case study method is appropriate when the researcher conducts an examination of the dynamics that surround radical change (Chreim et al., 2012), the environment of a rapidly shifting health care marketplace in which the physicians I interviewed must operate their medical practices. Case study methods are particularly useful with studies in health services research, enabling targeted focus on individual phenomenon in real life contexts (Yin, 1999). Case study design allows for adaptation to the type of available sources and procedures in a business environments and often results in developing new models or modifying existing organizational structures (Zivkovic, 2012). Use of case study methodology offers an ability to examine *how* and *why* inquiries about contemporary environments (Yin, 2014).

Klonoski (2013) pointed out how the development of best practices, after employing a case study approach, evolved during the 1920s and remains in common use for management case studies. An additional capability offered by business case studies is an ability to understand the underlying mechanisms that influence social, organizational, and cultural interactions and strategic relationships (Klonoski, 2013). An ability for inquiry at multiple levels, and in different contexts, opens the door for intensive examination of the *why* and *how* factors surrounding a phenomena (Lokke & Dissing-Sorensen, 2014). Following the multi-level path can place the phenomenon under study in a secondary, supportive role, permitting discovery of new and expanded venues.

Lokke et al. (2014) debunked any assumption that case studies lack credibility for supporting analytic generalization of results by using an examination of rival explanations and mitigating the risk of ignoring conflicting information. Maintaining a focus on the range of unit characteristics and the range of conditions under investigation deflects concerns about smaller sample sizes or the legitimacy of generalization. Yin (1999) saw that a series of desired characteristics which enhance case study research in health services begins with using a design-oriented focus rather than an inordinate amount of concern for data collection methods and controlling the environmental context. Researchers can avoid controversy associated with developing generalizations from case studies by basing replication on theory or conceptual framework instead of sampling size.

Learning from past successes and missteps is a key driver for performance improvement efforts. True experimental designs offer minimal assistance when analyzing complex organizational phenomena. Case study research is an effective tool that enables

organizational leaders to capture information about workgroups and generalize results in a manner useful to other relevant workgroups (Turner & Danks, 2014). Case study designs allow for study of a phenomenon in a natural setting, provide multiple venues and means for data collection, and focus on contemporary events and *how* and *why* questions that can be traced backward or forward in time.

Turner and Danks (2014) presented a series of steps useful when designing a case study. Articulating a theory or conceptual framework that addresses what, how, why, who, where, and when is the first step in case study design. The second step involves presenting a clear, unambiguous description of the research problem. The description should include background, symptoms, and recommended actions for problem resolution. The third step requires selection of either single or multiple cases for study that are real, are available for careful research and study, and foster examination of multiple perspectives. Subsequent steps include data collection, data evaluation, data analysis, and data presentation. Effective case study research enables organizational leaders to make informed decisions and take suitable actions toward achieving growth and improvement within their organizational environments.

Case study methodology adapts to the type of available sources and procedures in a business environment and often results in developing new models or modifying existing organizational structures. When investigators perform research in real-life event environments such as managerial and organizational processes, business environmental changes, maturation of industries, or small group behavior, case study methodologies seem best suited to garner more information than other research methodologies might

provide (Zivkovic, 2012). Researchers often use case study methods when seeking multiple perspectives, particularly when reviewing interactions of workgroups within an organization. The same approach is useful when examining the interactions of individuals or groups affected by actions taken by an organization.

Qualitative investigation allows for different methodologies including narrative, ethnography, phenomenological, grounded theory, in addition to case study. A narrative methodology involves inquiries about the experiences of selected individuals who narrate stories about their lives (Wolgemuth, 2013). Ethnographic research often explores phenomena and communication practices within social groups created by the shared set of values, beliefs, and a culture (Lichterman & Reed, 2014). Grounded theory methodology produces an inductive theory derived from a set of diverse, yet conceptually-related hypotheses (Chamberlain-Salaun, Mills, & Usher, 2013). Phenomenological research contextualizes experiences through a complex use of themes seeking to provide clarification of the studied phenomenon (Bevan, 2014).

Narrative methodology has a very specific application that was inconsistent with the focus of my study. Ethnographic, grounded theory and phenomenological methodologies are well-suited for building theories; yet, theory-building was not the intent of my study. Case study methodology emanated from an early 20th Century business world environment, with a focus toward understanding business-related problems and issues (Klonoski, 2013), and thus, was the methodology best suited for my doctoral study.

Data saturation occurs when the information gathered becomes repetitive and reveals no new data (Roy et al., 2015). I conducted an adequate number of interviews, with attention to all relevant factors needed for proper analytical development, covering all concepts and groupings. Concerns about achieving data saturation, or about methodological soundness and the amount of rigor associated with qualitative studies can be addressed by consistency of methodology with data collection and analysis (Trautrims et al., 2012). Traditionally, sample size was associated with study goal integrity, data depth, and alignment with the appropriate theory (Roy et al., 2015). Care should be taken to avoid a myopic focus, with misdirected concerns about small sample sizes, but rather seek achieving results that support analytic generalizations, especially when conducting case study research (Yin, 2014).

Population and Sampling

My choice of sampling method for this study was purposeful. The use of purposeful selection allowed access to data that help support the framework of 'what is' and 'who are' critical elements for this study (Reybold et al., 2012) and development of rich sources for detailed information (Dayna, 2013). Deliberately choosing individuals with qualifications, expertise, and experience that are pertinent to the area of study helped yield data that was relevant to the issue being researched (Loh, 2012). An additional advantage of purposeful sampling selection was allowance for acquiring an illustrative overview while limiting bias (Nijmeijer, Huijsman, & Fabbricotti, 2014).

The initial decision to pursue up to 20 interview participants for this qualitative case study was based upon the concept that sample size enhances study goal integrity,

alignment with the appropriate theory, and data depth (Roy et al., 2015). A sample size of 20 physicians was considered adequate when examining physician experiences during a period of significant changes and shifting roles within their medical practices (Lockyer et al., 2011). Loh (2012) used the same number of interviewees to conduct research about physicians experiencing dramatic environmental transitions while Chambers et al. (2013) used as few as ten medical provider interviewees. After consultation with my doctoral study committee, the new target was set for 12. Ultimately, I achieved data saturation after eight interviews but continued until completing 11 interviews, just to confirm achievement of data saturation.

Saturation occurred when the input received from interviewees became superfluous (Malterud, Siersma, & Guassora, 2015) and repetitive (Battista, Godfrey, Soo, Catroppa, & Anderson, 2015). Adequacy and appropriateness were the two key factors driving qualitative research sampling methods (O'Reilly & Parker, 2014), especially when considering that saturation achievement occurred when the depth and breadth of information was reached. Using purposive sampling, if the information gathered became repetitive and revealed no new data with a set of 12 study participants, data saturation occurred. If data saturation were not achieved with the set of 12 participants, new participants would have been sought and interviewed until achieving data saturation.

Each of the interview participants were primary care providers. Most had experience as solo or small medical practice physicians, however for contrast, I included some employed physicians. The employed physicians had an awareness of the challenges

faced by small medical practice physicians and offered strategic insight about the challenges from a different perspective. Selecting interviewees, using a wide range of backgrounds and roles within a related profession (Loh, 2012), offered multiple, broader perspectives which yielded additional insight on complex, unique issues (Chambers et al., 2013) with knowledge relevant to the researched area (Bristowe et al., 2015). Interviews either took place in the physicians' offices during selected times that minimized disruptions (Peikes et al., 2015) to workflow and productivity or in the relaxed environment of their private homes.

Ethical Research

Participants in this study understood the parameters of voluntary participation when exploring effective competitive approaches designed to provide assistance for physicians in solo practice and small medical group primary care practices to retain their small business practices. One method of controlling for unethical research was to ensure that participation in a research project was conditional, based on informed consent (Rhodes & Miller, 2012) and with a meaningful assurance of confidentiality. For my doctoral study, each of the research subjects were voluntary participants who read, understood, and signed an informed consent form. A copy of the form is in Appendix A. The consent form provided some sample questions so that the interviewee had a clear indication of the substance and direction of the questions asked during the interview.

Before beginning the interview, each was informed that if during the interview, or later, a participant felt any qualms or discomfort, the individual had the option to immediately withdraw from the study, consistent with the approach articulated by Nunan

et al. (2013). Ethical research principles and protocols establish normative standards of conduct that delineate acceptable behavior patterns from unacceptable behavior patterns (Mikesell & Bromley, 2013). The principles establish parameters for researchers so that research participants receive fair treatment that balances research risks with research benefits.

Davidson et al. (2012) recognized that in some circumstances minimal payment levels for participation in research might be appropriate. Voluntary participation in this study, without compensation, may have appealed to physicians because participation could benefit other members of their profession (Jordan, 2014). For this doctoral study, I did not offer any financial incentives to participants.

During the 20th century, ethical lapses during the conduct of research was evident before and after World War II. The Nuremberg Code, the Declaration of Helsinki, and the Belmont Report all served to rectify the damage done by unethical researchers (Davidson, 2012). Protocols and principles also serve to ensure that researchers respect the privacy implications inherent with data collection (Nunan & Di Domenico, 2013). Guidelines established within the Belmont Report emphasized three basic ethical principles: respect for persons, beneficence, and justice (US Department of Health and Human Services, 1979). Davidson and Page (2012) pointed out that the Belmont Report addressed unethical research practices that occurred in the United States.

The interview questions were designed to be inoffensive, non-threatening, and structured in a manner that avoided any harm to participants' reputations or financial standing. The current American organized medicine institution's structure is cumbersome

and slowly reacts to changing socio-economic conditions (McGuinness, 2014) and physician groups, similar to other social, political, or professional groups, exercise a degree of solidarity that benefits their interests (Jordan, 2014). The interview questions took those factors into account in way that elicited insight that benefits the physician community and society equally.

Audio recordings from the interviews, along with all other data related to the interviewees or their organizations, is stored on a thumb drive data storage device that is password-protected. The thumb drive and any related paper documents will be retained for five years in a locked safe. After five years, data on the thumb drive will be securely erased, and any paper documents will be shredded, to protect confidentiality of the study participants (Jackson & Lim, 2011; Kwon & Johnson, 2013).

Evidence of consent for the study protocol was the Walden University IRB approval number 04-21-16-0486044. By not using participants' true name in any of the transcripts, or in the doctoral study, an additional layer of confidentiality was given to each interviewee (Rhodes & Miller, 2012). Rather than using names, a coding scheme that represented individuals or organizations helped protect privacy and confidentiality (Winters & Cudney, 2010; Kwon & Johnson, 2013).

Data Collection Instruments

I served as the primary data collection instrument while exploring effective competitive approaches designed to provide assistance for physician in solo practice and small medical group primary care practices to retain their small business medical practices. I conducted semistructured interviews. Cognitive interview approaches often

elicit an in-depth, wide-ranging, rich degree of material, particularly when time availability and quantity of interview participants is limited (Guercini, 2014; Humphrey, 2014; Parker, 2014).

While I conducted the interviews and served as the primary data collection instrument, my processes conformed to the requirements of my interview protocol. Yin (2014) suggested using a case study protocol bolsters reliability of the case study research effort. Trautrims, Grant, Cunliffe, and Wong (2012) also pointed out that the technique, when coupled with consistency of methodology in data collection and analysis, addresses concerns about methodological soundness and the amount of rigor associated with qualitative studies, particularly in the minds of quantitative methodology advocates. The protocol should include an overview of the case study, specification of the data collection procedures used, the specific data collection questions, and an outline of the case study report. Use of the protocol helps the researcher retain focus on the case study topic, proactively anticipate potential problems (Yin, 2014) and establish normative standards of conduct that clearly delineate acceptable behavior patterns from unacceptable behavior patterns (Mikesell & Bromley, 2013). The protocol also serves to ensure that researchers respect the privacy implications of data collection (Nunan & Di Domenico, 2013).

I used member checking and transcript review to establish trustworthiness with study participants. The member checking technique required the researcher to interact with study participants in a way that the study participants can confirm the plausibility of data gathered and tentative interpretations drawn by the researcher (Morse & McEvoy, 2014). Member checking reduces the likelihood of researcher misinterpretation and

allows study participants to provide additional relevant information (Winter & Collins, 2015). I had my recorded interviews transcribed into text documents, allowing for qualitative transcript review/analysis for accuracy (Morse et al., 2014) and inductive thematic analysis (Sinden et al., 2013). The consent form found in Appendix A of this document outlines the case study protocol.

Data Collection Technique

I used one-on-one interviews to explore effective competitive approaches designed to provide assistance for physician leaders of solo practice and small medical group primary care practices to retain their small business medical practice. The process included having the audio recordings of the interviews transcribed into text documents. The text documents allowed for qualitative transcript review/analysis for accuracy (Morse et al., 2014) and inductive thematic analysis (Sinden et al., 2013; Turner & Danks, 2014).

One-on-one interviews, conducted in a face-to-face environment, ranked highest among the range of data collection methods as the most valid technique for data collection (Morse et al., 2014). Using interviews to collect data from study participants helped encourage the contributors to share their experiences about the studied phenomenon (Wahyuni, 2012). During a qualitative interview, a researcher more effectively contextualizes qualitative findings with enhanced interpretations particularly when collecting quantitative data, using psychometrically valid quantitative instruments (Frels et al., 2013).

Disadvantages associated with semistructured one-on-one interviews potentially include the frequent need for clarification of terminology when the interviewee and the interviewer are from different professional disciplines (Parker, 2014). Guercini (2014) shared that the interview style can present a disadvantage of encouraging interview participants to stray from the topic focus. Humphrey (2014) observed how the in-depth structure of cognitive interviews can bring in wide-ranging, but sometimes unnecessary information.

Caven (2012) shared that the disadvantages of the interview data collection method also include the need for flexibility, which can require an interviewer to assume as many as four different personas when interviewing different personalities. First, as an agonizing aunt forced to exercise patience, provide positive reinforcement by just sitting there and listening to an effusive interviewee. Second, being perceived as an intruder, for whom the interviewee endures the interview but discloses little, if anything at all. Third, having to endure hostage status, because an aggressive interviewee perceives the interviewer as vulnerable and tries to seize control of the direction and duration of the interview. A fourth persona is that of a friend where the interviewee is genuinely hospitable, in a non-manipulative manner, and usually produces some very effective, useful interview data.

I included member checking and transcript review as a part of my data collection technique. Member checking required the researcher to interact with study participants in a way that the study participants have an opportunity to confirm the plausibility of data gathered by and tentative interpretations drawn by the researcher (Morse et al., 2014).

Member checking reduced the likelihood of researcher misinterpretation, and just as important, allowed study participants to provide additional relevant information (Winter & Collins, 2015). I had my recorded interviews transcribed into text documents, allowing for qualitative transcript review/analysis for accuracy (Morse et al., 2014) and inductive thematic analysis (Sinden et al., 2013).

Data Organization Technique

I stored all raw data derived from the digital audio recordings of interviews (as well as the resulting electronic transcriptions) in password-protected computer files. All of the electronic files were transferred from my computer to an external hard drive, as primary storage. I copied the files to a thumb drive as a secondary backup storage device. The data on the storage devices were properly labeled in a main data folder, with appropriate labeling of subfolders for expediting any needed data searches. The use of proper data records management processes facilitates planning and decision-making and reduces the amount of time needed for evaluation and ensuring the development of more accurate results (Alalwan & Thomas, 2012). Protecting data from identity or attribute disclosure can be a complex task (Di Vimercati, Foresti, Livraga, & Samarati, 2012). Maintaining an individual respondent's confidentiality is critical so that potential respondents during future data collection initiatives have high levels of confidence in data protection measures (Kwon & Johnson, 2013).

I used a professional transcriptionist to translate the digital audio recordings to electronic copies. Within the health care delivery services arena, use of audio recordings and transcription services is common and valued because of a need for economic

prudence (Kreamer, Rosen, Susie-Lattner, & Baker, 2015), productivity (Bank et al., 2013), and quality (Adler-Milstein & Jha, 2012). A confidentiality agreement, common to transcription services, helps protect against inappropriate disclosures. The electronic files, paper transcripts, and notes generated during the data collection for this doctoral study was stored in a locked file cabinet in a secure location, and by Walden University directives, all of the material will be retained for a five-year period.

Data Analysis

Although the focus of my proposed doctoral study was solo/small medical group practices, I included some employed physicians, who did not all fall into the category of solo practitioner or small medical group practices, to apply theory triangulation. Physicians of this type allowed for theory triangulation of the data set (Yin, 2014) through input from related diverse multiple-lens data sources (Burau & Andersen, 2014) and allowed for a more complete representation of circumstances surrounding the phenomena (Houghton, Casey, Shaw, & Murphy, 2013). Critically important to accurately interpreting the findings of a qualitative case study was the need to recognize, evaluate, and discuss potential rival explanations that may impact a study's findings (Yin, 2014). Theory triangulation opened a door to receive strategic perspectives about the small business environment of solo/small group practice from physicians who chose employee status in other health care services delivery environments. The perspectives proved useful in helping understand the strategic worldview of the small business solo/small group physicians, by way of contrast.

The central research question guiding this study aligned with the specific business problem and asked: What competitive approaches help physicians in solo practice and small medical group PCPs retain their small business medical practices?

Interview Questions

1. From a strategic thinking perspective, to retain their small business medical practices, what 5-year and 10-year goals should PCPs set for the practice?
2. From your strategic thinking perspective, what behavior patterns and personal characteristics are necessary for physicians to retain their small business medical practices and achieve the 5-year and 10-year goals you identified?
3. Strategically thinking, how and when would you measure whether or not you achieve each of the goals you identified to help retain small business medical practices?
4. From a strategically adaptive perspective how would you go about achieving the identified goals to help retain small business medical practices?
5. From a strategically adaptive perspective, what past medical practice business behaviors might prevent you from achieving the stated goals associated with retaining small business medical practices?
6. Strategically thinking, what current medical practice business policies and procedures are useful in helping you continue toward the stated goals associated with retaining small business medical practices?
7. From a strategically adaptive perspective, how do innovations and new ideas and medical practices, such as accountable care organizations or patient-

centered medical homes affect goals associated with retaining small business medical practices?

8. Strategically thinking, how do factors like the country's economic state, technology advances, changing demographics, government policies affect goals associated with retaining small business medical practices? Specifically, address each factor.
9. From a strategically adaptive perspective, how do a different set of factors such as competitive rivalry, increased patient sophistication, and bargaining power, increased use of physician-extender providers, and potential barriers to entry of new competitive markets affect goals associated with retaining small business medical practices? Specifically, address each factor.
10. Considering the factors in the prior two questions, how would you strategically adapt and adjust the goals and measures you identified earlier in the interview, in a way that adequately responds to all the factors that can affect efforts associated with retaining small business medical practices?

Analysis of data collected using qualitative methods, regardless of method used, should encompass one of three analytic strategies whether it is an interpretative framework, a systematic approach or a traditional approach, particularly with ethnographic and case study approaches. Renz, Conrad, and Watts (2013) and Yin (2014) demonstrated how core elements of qualitative data analysis include: (a) data organization, (b) reading transcripts and making memos of key concepts, (c) classifying, coding, and creating thematic designations for the data, (d) data interpretation, and (e)

visual representation of the data. Collecting, categorizing qualitative textual data into small, discrete groups, and then applying individual labels to each group describes the process of code development (Gale, Heath, Cameron, Rashid, & Redwood, 2013).

From the codes, I aggregated themes that coalesced around common ideas and concepts. Computer software programs are available for use in all phases of qualitative data analysis, i.e., coding, mapping, and theme identification. I used a Computer-assisted qualitative data analysis software (CAQDAS), specifically NVivo 11 Pro and received help with the analysis, but viewed CAQDAS as a supportive tool. Avoiding viewing CAQDAS as the essence of expertise (Yin, 2014) was critical, although using it offered additional clarity when contextual research was of greater complexity than initially expected (Sinkovics & Alfoldi, 2012) and a need for thematic analysis existed (Angus, Rintel, & Wiles, 2013). Case study data analysts can use one of four general strategies: emphasis on theoretical propositions, a from the ground up strategy rather than reliance on theoretical concepts, using a case descriptive framework for the collected data, and developing plausible rival explanations that work in coordination with any of the other three strategies (Angus et al., 2013; Sinkovics et al., 2012; Yin, 2014).

Strategic thinking and dynamic capabilities were the components of my two-pronged conceptual framework. Both concepts aligned with data triangulation to address the central research question: What competitive strategies help solo practice and small medical group primary care practice physicians retain their small business medical practices? The ten interview questions aligned with the two-pronged conceptual

framework so that interviewee responses to all the questions addressed elements of strategic thinking and dynamic capabilities.

The literature review aligned with the conceptual framework and supported analysis for the central research question. Reviewing the historic, current, and projected sustainability models of physician medical practices, and adding an examination of issues surrounding change paradigms with discussion of new affiliation options, established alignment with each of the two conceptual frameworks. During the data collection and data analysis stages of this doctoral study, I identified emerging, current literature aligned with the key themes and conceptual framework, and incorporated new references.

Reliability and Validity

My qualitative explanatory case study exploration of effective competitive approaches, designed to provide assistance for physician leaders of solo practice and small medical group primary care practices to retain their small business medical practice, had enhanced credibility because I demonstrated efforts to assure the reliability and validity. I used the multiple techniques available for use as quality assurance methods to establish reliability, validity, and scholarly research (Denzin, 2012; Mulligan, Hall, & Raphael, 2013). The techniques were designed to help show that the data analysis was accurate, credible, valid, transferable, and confirmable. Researchers should conduct data analysis in a manner that allows for independent replication study results (Rahmandad & Sterman, 2012), and demonstrates reflective examination and evaluation of the researchers' qualitative data analysis (Lamb, 2013).

Yin (2014) suggested that reliability of the case study research effort increases by using a case study protocol. The protocol should include an overview of the case study, specification of the data collection procedures used, the specific data collection questions, and an outline of the case study report. Use of the protocol helps the researcher retain focus on the case study topic and proactively anticipate potential problems (Yin, 2014).

Dependability

One technique often used for establishing dependability of qualitative research analysis is member checking of data interpretation (Welch, Grossaint, Reid, & Walker, 2014). I used member checking by asking each participant (members of the interviewed cohort) to review my conclusions from the individual interview and verify that I accurately represented the intended meanings. As an additional technique of establishing dependability, I used transcript review after having my recorded interviews transcribed into text documents. The transcript review process allowed for qualitative transcript review/analysis for accuracy (Morse et al., 2014) and inductive thematic analysis (Sinden, et al., 2013).

Creditability

I used member checking of the data interpretation, transcript review by participants, and theory triangulation to bolster the credibility of the study. Establishing trustworthiness in a qualitative study helps support the findings produced by the study as having merit that is worthy of attention. Member checking (Welch, Grossaint, Reid, & Walker, 2014) and transcript review (Morse et al., 2014) were two techniques to help establish trustworthiness (Elo et al., 2014). Theory triangulation is another technique that

helps bolster the level of trustworthiness accorded the data analysis (Awad, 2014). By choosing physicians who are solo practitioners and employed physicians, I obtained theory-triangulated interview data from closely-related, relevant sources. Using a broader base of physicians reduced the potential for bias or groupthink feedback (Welch et al., 2014).

Transferability

I carefully documented the methodological processes and taxonomy used during data analysis to help enhance transferability and usefulness of my results. Qualitative approaches offer bridges that enable researcher-orientation and practitioner-orientation to more closely align by creating shared language and commonly-understood contexts (Guercini, 2014). Documenting statistical analysis, so that the results are thematically relevant (Sinden et al., 2013) and accurate (Morse et al., 2014), is a technique that helps justify transferability of the analysis for future research (Ball & Medeiros, 2012; Gutierrez et al., 2015).

Confirmability

I used several processes, including extensive documentation and external peer review, to elevate the degree of confirmability for the study. Even though each researcher brings a unique perspective to the subject under study, the need for confirmability, or the ability to corroborate remains preeminent (Lofgren, 2014). Peer review is a widely embraced, highly regarded method considered as an essential quality assurance method for scholarly research (Mulligan et al., 2013). A related element of research quality assurance is documentation because it enables peer reviewers to independently replicate

study results (Rahmandad et al., 2012). Audio recording of interviews, accompanied by written transcripts, are mediums that enhance reflective examination and evaluation of the researchers qualitative data analysis (Lamb, 2013). As a part of my audit strategy, I identified individuals with doctoral-level credentials and fellow doctoral students who were willing, to serve as informal reviewers of my data analysis.

Data Saturation

Through the use of purposive sampling, I anticipated achieving data saturation, when the information gathered becomes repetitive and reveals no new data, with a set of 12 study participants. If data saturation were not achieved with the set of 12 participants, new participants would have been sought and interviewed until data saturation. Concerns about methodological soundness and the amount of rigor associated with qualitative studies, particularly in the minds of quantitative methodology advocates (Denzin, 2012), can be addressed by consistency of methodology with data collection and analysis (Trautrims et al., 2012). Researchers should conduct an adequate number of interviews, with attention to all relevant factors needed for proper analytical development, covering all concepts and groupings. Traditionally, sample size was associated with study goal integrity, data depth, and alignment with the appropriate theory (Roy et al., 2015).

Researchers should avoid a myopic focus, with misdirected concerns about small sample sizes, but rather seek achieving results that support analytic generalizations, especially when conducting case study research (Yin, 2014). Purposive sampling allows for selection of participants specific characteristics or knowledge that has relevance to the study's research questions (Bristowe et al., 2015). Two key considerations, adequacy, and

appropriateness should be the primary concerns for qualitative data analysis (O'Reilly et al., 2013). Researchers reach data saturation when the information gathered becomes repetitive and reveals no new data (Roy et al., 2015).

Transition and Summary

In Section 2, I provided an overview of the proposed steps for use while conducting my doctoral study. Discussion included role of the researcher, characteristics of the study participants, research method, research design, population and sampling, ethical research, data collection instruments and techniques, data organization techniques and data analysis and, reliability and validity. The conception and development of the qualitative case study will have a focus of establishing baseline understandings of the adaptive capabilities, strategic initiatives, and operational decisions available to small business solo practice or small group practice physicians.

In Section 3, I provided discussion covering presentation of findings, application to professional practice, an identification of implications for social change, recommendations for action and further study, reflections, and a concluding statement. My goal within this section was lessening the existing gap and lack of a cohesive synthesis of past, current, and future environments, in a way that establishes a clear, decisive path for achieving stability of solo and small medical group primary care practices in a rapidly changing health care environment. Ultimately, I determined whether the overarching goal of offering assistance through the organizational self-assessment focus interview helped develop effective competitive approaches to retain their small business medical practice physicians in solo practice and small medical group

PCPs.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative, explanatory collective case study was to explore effective competitive approaches designed to help physicians in solo practice and small medical group primary care providers (PCPs) retain their small business medical practices. The specific business problem was that many physicians in solo practice and small medical group PCPs are unaware of effective methods for retaining small business medical practices. The participants in this study included a mix of physicians with PCP experience, a few of whom later expanded their skill sets to other additional specialties. Some of the participants had spent their entire career in solo or small medical group practices; others had experience that included solo/small group practice and time spent as employees of larger group practices or large health care service delivery organizations.

The primary data collection method used in this study was face-to-face interviews with participants. When possible, I supplemented interviews of employee physicians with marketing material from the employing organization. During interviews with participants, four major themes emerged, which I describe later in Section 3. Additionally, participants offered perceptions and specific recommendations about how small medical practices can cope effectively in the current highly competitive health care delivery marketplace. Discussion includes a set of tables with the compiled recommendations from the participants. The recommendations have direct application to professional practice, include implications for social change and action, and add to the body of knowledge that supports positive change for small business medical practices.

Presentation of the Findings

The overarching research question was: What competitive approaches help physicians in solo practice and small medical group PCPs retain their small business medical practice? During analysis of interview data from participants, four major themes emerged: (a) need for flexibility and adaptability, (b) need for higher levels of business acumen, (c) need to fully embrace automation, and (d) a focus on pursuing financial stability before pursuing growth and expansion of the medical practice. Descriptions of each theme include supportive quotes obtained from interview transcripts. The four themes are shown in Figure 1 in an interlocking circles model because each theme represents an interactive, overlapping component of strategic thinking.

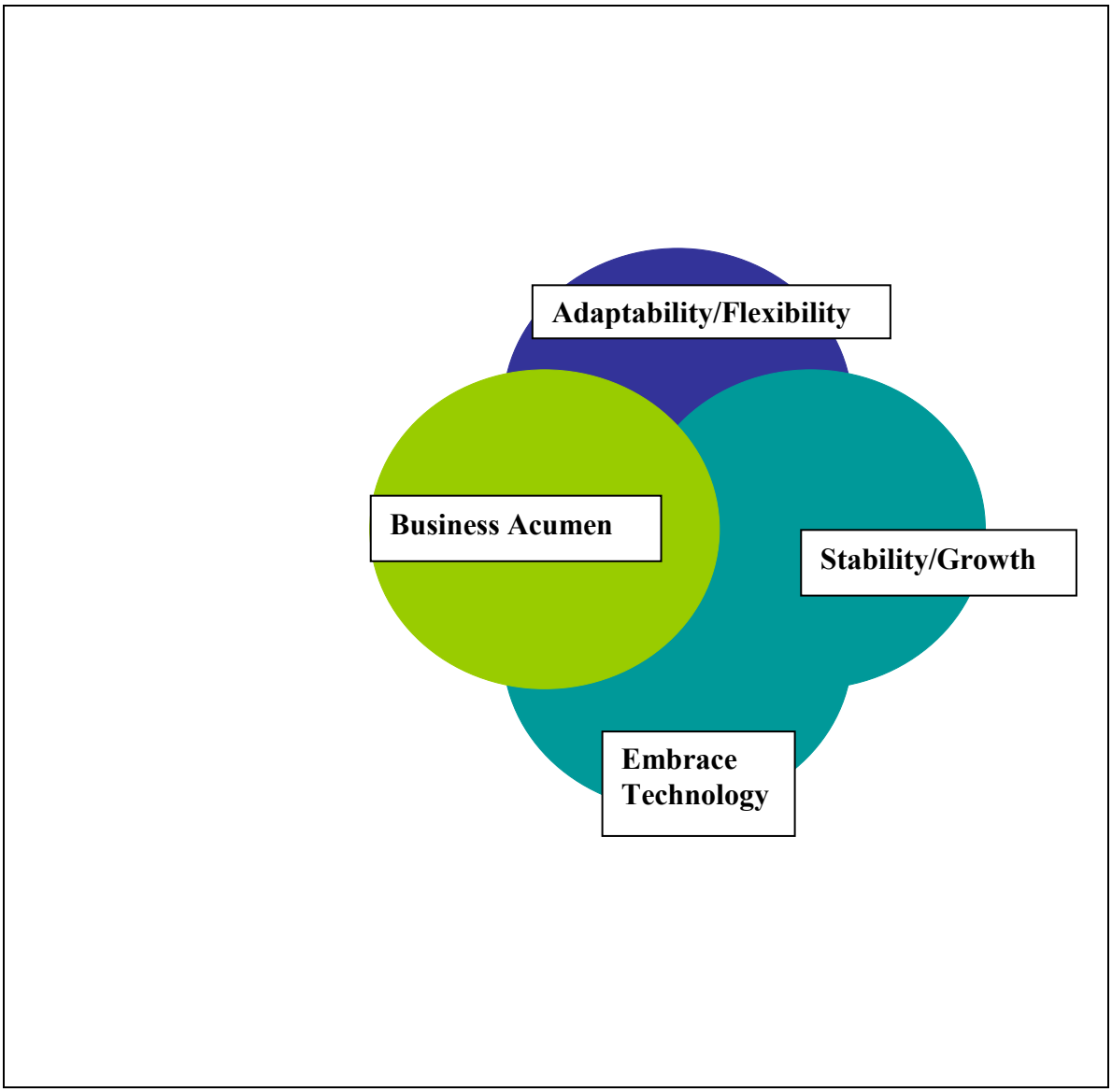

Figure 1. Four major themes

Data analysis software allowed me to create the word cloud, shown in Figure 2, demonstrating the frequency of word usage during the interview that lent support to identification of the four major themes.

Figure 2. Word cloud supporting identification of themes

Theme 1: Need for Flexibility and Adaptability

Lewis, Andriopoulus, and Smith (2014) saw flexibility as representing short-term, temporary actions that enable recalibration to changing conditions; adaptability, however, included long-term, permanent adjustments to a new environment. Narcissism and overconfidence can be major impediments to effectively practicing flexibility and adaptability (Navis & Ozbek, 2016). During the interview process, a recurring theme was evident that when confronted with a need for change, the physician must identify and assess the problem, fully evaluate contributing conditions, and be willing to adapt appropriately. Quotes from participants include the following:

- (From D-3) "Adjusting goals, as needed, is important for me as a doctor to use effective strategic adaptation. For example, adjusting financial outlays by the medical practice is appropriate to respond to changes in the country's economic conditions."

- (From D-6) "Developing a strategically adaptive perspective means that we physicians must avoid having a 'God- complex,' which may make us unwilling to adapt and wind up being 'stuck in the past' which will doom a medical practice to failure."

The major theme of the need for flexibility and adaptability meshes with the idea that working within complex systems and competitive environments requires adaptability and application of systems thinking (Thibodeau, McPherson, Stroink, & Stroink, 2015). Albert et al. (2015) suggested that organizations must continually adapt to

environmental conditions while concurrently pursuing opportunities that enhance product or service delivery productivity. Organization leaders should view change as the constant but with the goal of developing a balanced relationship between continuity and change (By et al., 2015). Findings derived from analysis of the participant quotes demonstrated advocacy for flexibility and adaptability with a direct linkage to the conceptual frameworks for this study: the strategic thinking component of the systems theory concept and the dynamic capabilities concept.

Austin (2013) identified three characteristics that small business owners need for effective strategic thinking: willingness to create a new mindset, ability to transform ideas in sustained actions, and being at ease, in an environment of shifting contexts. Awareness by the study participants of the importance of flexibility and adaptability demonstrated support for the effective strategic thinking characteristics as a part of effective business practice.

Theme 2: Need for Higher Levels of Business Acumen

Ellner et al. (2015) pointed to the need for expertise in the initiation and understanding of performance improvement, skills in conflict resolution, financial proficiency, and innovation as being among the skills that physicians need to operate effectively in new models of health care delivery and work effectively in those new models. Change management, the skill traditionally attributed to business professionals is now seen as an imperative for medical professionals as they lead medical quality improvement initiatives (Hart, Dykes, Thienprayoon, & Schmit, 2015). A second theme that emerged from the interviews was an acceptance of the level of importance that

having a greater degree of business knowledge was critical for the small business medical practice to achieve organizational sustainability. Quotes from participants include the following:

- (From D-1) "Using the best legal and financial advisors, in addition to effective medical practice managers, are among the policies and procedures available to assist in helping achieve stated goals."
- (From D-4) "Changes in the country's economic state requires us as physicians to leverage knowledge from quality indicators and financial factors using dashboard tools, accompanied by cost controls designed to realize costs savings. Viewing health care as a utility or commodity is necessary, all while being careful to assure that a capitalistic mindset does not run rampant or unfettered."
- (From D-2) "Understanding time management and money management means that I need to take business courses, probably leading to an MBA. Knowing what my time is really worth is critical, and I have to develop a business mindset that views my medical practice as a small business that happens to provide health care."
- (From D-11) "Negative changes in the country's economic state can be mitigated by my realization that medical care will always be needed; so, I have to position my medical practice to respond to contractions or expansions of the economy, and to do that effectively, I either need a good

CPA or take some good business classes myself."

The theme of expressing a need for higher levels of business acumen reflects Chauvet's (2013) observation that no business entity can afford to neglect strategic value analysis, regardless of the field of endeavor or size of the business entity, and especially so within the health care delivery services arena. More recently, Chauvet (2015) argued that despite the risks and uncertainties that characterize the business environment, the business person should not feel constrained to conduct analysis and decision-making if the knowledge base and information used is current and relevant. Participant quotes supporting a need for a higher level of business acumen links with the conceptual frameworks for this study, the strategic thinking component of the systems theory concept and the dynamic capabilities concept. The value of strategic thinking and planning is critical in business climates where decreasing resources require short and long-term points of view, and adaptability (Zuckerman, 2014), and is considered effective business practice.

Theme 3: A Need to Fully Embrace Automation

Health care -related information systems offer significant benefits through improvements in patient care timeliness, health-recordkeeping, financial accounting, and management reports generation (Mohapatra, 2015). Additional benefits include significant reduction of medical errors, cost containment, and streamlined clinical processes (Peng, Dey, & Lahiri, 2014). A third theme that emerged from the interviews was a nearly unanimous degree of enthusiasm for the need to fully embrace automation by the small business medical practice to achieve organizational sustainability. Quotes

from participants include the following:

- (From D-9) “Technology advances have given us doctors the ability to communicate faster to more people and have global access to patient records.”
- (From D-7) “Technology advances have vastly increased my ability to provide quality care.”
- (From D-4) “Implementation of the electronic medical record and electronic prescription systems can be very expensive although the increased use of email has some advantages and some disadvantages for me.”
- (From D-10) “Implementation of the electronic medical record can be disadvantageous to me is the provider, but it sure helps with my billing team.”
- (From D-3) “Technology advances such as the use of equipment for distance teaching of patients, telemedicine, and sleep studies are very useful for my medical practice.”
- (From D-5) “Bedside ultrasound, electronic medical records that help improve chart legibility and enhance care delivery, telemedicine that allows distance based psychiatric, neurological, and radiological consults, electronic portable multilingual translators are all examples of positive effects for my practice from technological advances.”
- (From D-1) “Some of the technological advances have created an environment for new innovations, for example, personalized medicine, which means I can develop

a therapy specifically and uniquely designed for my patient."

The theme of a need to embrace automation is congruent with the importance of sharing patient health information among of health care providers and depends upon effectiveness of the new technologies that support health information exchange (HIE) organizations (Langabeer & Champagne, 2016). An added benefit that HIE's brings is an ability to achieve two key success factors for any organization: an understanding of the right markets in which to provide service, and the right set of data necessary for the organization to win in the markets in which it operates an effective business practice. Full utilization of health care automation represents an understanding of the dynamic capabilities conceptual framework. Zuckerman (2014) saw the importance of organizational dynamic strategic thinking and planning, and equally important, the avoidance of static thinking.

Theme 4: Pursue Financial Stability Before Growth and Expansion

Seitan (2015) presented the concept of financial stability as an organization having achieved financial balance and having the ability to withstand stressors caused by external market changes and internal management processes. Growth and expansion in a competitive market requires constant innovation to achieve a sustainable competitive advantage (Kunttu & Torkkeli, 2015). A fourth theme that emerged from the interviews was unanimous agreement that pursuit of financial stability should come first, after which the small business medical practice should look for growth and expansion to achieve organizational sustainability. Quotes from participants include:

- (From D-1) “I would recommend performing enough medical procedures to achieve financial stability and then grow the practice patient base to attain profitability.”
- (From D-11) “My medical practice gravitates around thinking about the future of medicine in which fee-for-service billing has gone away, and the total focus is now on dealing with patients and something similar to the patient-centered medical home model.”
- (From D-2) “For me, creating collaborative alliances with other primary care providers allows nearly 24-hour patient accessibility which encourages greater patient retention which results in practice stability and profitability.”
- (From D-4) “Build and expand my patient base, while gradually expanding the number of providers (with physician or physician extender) seems like a viable path to achieve financial stability and profitability.”
- (From D-3) “Without necessarily demarcating five year and ten-year goals, a medical practice should seek to build and expand its patient base, install an electronic medical records systems, gradually expand the number of providers, and expand the scope of medical practice new procedures.”
- (From D-5) ”Achieving financial stability is possible if personal material or extravagant acquisitions are deferred, especially during the beginning years of practice. Expand and grow the practice, but only with an informed cadre of colleagues. Exercise patience develop business acumen with formal coursework, maintain professional proficiency and exercise consistent self-

discipline."

- (From D-3) "Within my medical practice, my entire team and I reflect a mindset of a service business; as a physician, I see myself as a servant to the patient, and it is critical for that mindset to be present in each member of my medical practice team."
- (From D-10) "Accessibility, professionalism, and an ability to understand the degree of focus needed to achieve the established goals are what I found to be necessary to achieve stability and growth for my medical practice."
- (From D-6) "Every doctor must remember the real estate mantra of location, location, location. The mantra is very relevant to strategic thinking for private practice goal-setting when considering the actual physical location of his or her medical practice."

The theme of pursuing financial stability before pursuing growth and expansion of a medical practice is compatible with operating in a competitive environment that is subject to change. Erwin (2015) identified a number of major forces of change that he felt have had an effect and will continue to affect health care delivery and public health issues in the United States: (a) Patient Protection and Affordable Care Act (ACA), (b) rising accreditation standards, (c) climate change, (d) new opportunities for partnership development, (e) social media, (f) demographic transitions, and (g) globalized travel. Each of the seven factors can have an impact on a medical practice's financial stability and potential for growth and expansion. Both elements of this study's conceptual framework, strategic thinking, and dynamic capabilities, should be applied when a

physician seeks to establish financial stability and later pursue growth and expansion for his or her medical practice. The two concepts offer an opportunity to apply effective business practices with evaluation methods, strategic adaptation to changes, and develop courses of action for holding competitive advantage within a changing and challenging health-care environment.

Applications to Professional Practice

Kunc (2012) proposed that having an awareness of systems dynamics helps physicians, and all other small business owners, understand how to measure strategy performance, determine potential difficulties for strategy implementation, and decide which mitigation strategies allow for increased performance levels that ultimately achieve medical practice's strategic goals. The nature of the interview questions and the semistructured interview format allowed the interview participants to provide specific counsel and recommendations for what they perceived as ways to suggest competitive approaches to help small medical group primary care physicians retain their small business medical practices. Table 1 lists what the participants thought to be past behaviors that might impede success for a medical practice.

Table 1

Impeding Behaviors

Behavior Codes	Narrative
Noncollaboration	Not finding ways to collaborate with other physicians to cost share practice expenses, medical equipment purchases and loss of increased group bargaining power.
Lack of financial and political awareness	Nor understanding or having the necessary business knowledge needed to run a medical practice, and not maintaining an awareness of political conditions
Inflexibility	Rigid, static thinking, and reflexive-reactive-Pavlovian thinking, rather than strategic anticipatory flexibility.
Weak billing operations	Inaccurate charting, coupled with a nonassertive billing component of the operation.
Materialism	Trying to achieve a high professional profile too early with appearances of material success and mistaking income levels as a milepost of success.
Unscrupulous behavior	Unscrupulous behavior by physician or other members in his or her medical practice

Note. Narratives are derived from direct quotes during the interviews.

Table 2

Measures for Addressing Competitive Pressures

Measure Codes	Narrative
Competency	Maintaining medical competency will help offset some of the negative effects associated with competition.
Differentiation	Recognize that competitive rivalry is inherent in the environment, so embrace the challenge by responding through differentiation and extension of the scope of services provided.
Collaboration	Viewing other physicians and health care providers as competitors is not the best approach; instead, developing collaborative confederations or associations is a better approach.
Effective provider/patient relationships	Effective provider/patient relationships and an awareness of patient satisfaction levels are critical to promote patient loyalty. A physician's personality is a huge factor for engendering patient loyalty.
Situational awareness	View competition in the context that physician services will always be needed because there will always be sick people. So, follow your own path, while exercising a constant awareness of the environmental, demographic, and political changes taking place.

Note. Narratives are derived from direct quotes during the interviews.

Table 2 lists what the participants thought to be effective measures to address some of the competitive pressures in the current health care delivery marketplace.

This study is of value to business because the findings provided strategic value analysis, done by physicians, that can assist other physicians in solo practice and small medical group PCPs retain their small business medical practices. The interview questions offered a structure for a modified strategic assessment tool that revealed useful competitive approaches. No business entity can afford to neglect strategic value analysis, especially within the health care delivery services arena, regardless of the field of endeavor or size of the business entity. Using the systems theory concept (especially the strategic thinking elements) in this study, paired with the dynamic capabilities concept offered study participants an opportunity to apply effective business practices with evaluation methods, strategic adaptation to changes, and courses of action for holding competitive advantage within a changing health care environment.

Making fundamental transformative changes that involve health care professionals can be difficult because of human inclinations to fight change and retain that which is familiar, despite availability of better alternatives. Gravitating away from a desire to regenerate former comfort zone modes of operation, and instead, embracing roles to help reinvent health care delivery models along with the accompanying financial and business model ramifications, helps move practitioners toward enhancing practice stability (Howell, 2010; Trousdale, 2015). Developing transformational mindsets helps physicians enhance their practice models and establish critical productive working relationships with third-party health insurance payers (Saxton et al., 2013). Physicians,

along with many other types of professionals, who embrace strategic change as beneficial, rather than a threat to the professional identify, enhance income production opportunities (Marek, 2014; Schilling et al., 2012).

Implications for Social Change

Although declining in number, the one-physician model still constitutes a sizable proportion of the total number of primary care medical practices. As of 2013, the percentage of family physicians who operate as solo practitioners is only 11%, a noticeable drop from the 13.9% that solo practitioners represented in 1993 (Peikes et al., 2015). In rural areas of the United States, a decline in the number of primary care solo practitioners threatens the level of access to care for the population. So, a need remains for the small business medical practice model. However, organizational owners and leaders must maintain an awareness that just as all products have specific life cycles, so too do all services (Sychrova, 2012). Peikes et al. (2015) suggested that the location and effectiveness of small practices should be the deciding factors that determined the value of preserving that particular health care services delivery model.

Small medical practice owners must use strategically-based techniques continuously, to assess progress of the product lifecycle to improve business performance. Even though a business, whether product or service, may have at one point held a competitive advantage, in the absence of innovative responses, marketplace changes ultimately degrade any competitive advantage gained (Langdon, 2013). All components of the health care delivery system, from major medical centers to individual physician practices, can flourish if the component leaders understand the principles of

retail competition. Most important, though, is a willingness to respond appropriately and fully implement retail competition principles because operational sustainability of the system component depends upon the competition principles (Grube et al., 2014).

Enhancing and stabilizing the solo and small medical practice primary care-focused practices, benefits society by preserving and strengthening a source of patient-centered, effective, affordable health care delivery for the communities served by the small business medical practices. The interview questions contributed to positive social change by revealing opportunities and competitive methods that enhance stability of small business medical practices. Political and academic leaders readily acknowledge the importance of small businesses and the positive impact, socially and economically, that small business has upon the country. Establishment and sustainment of small businesses, including small business medical practices, is a major factor in job opportunity generation and economic development for the communities in which the businesses operate. The primary emphasis remains, however, preserving a source of patient-centered, effective, affordable health care delivery for the communities served by the small business medical practices.

Recommendations for Action

The findings that emanated from this study, coupled with findings from related studies found in academic literature offered insight from which recommendations for action could be drawn. Strategic thinking has three key elements: creativity, well-rounded understanding of the organization and its surrounding environment, and an ability to create a futuristic vision for the organization (Kalali, Momeni, & Heydari, 2015).

Physicians are now more readily acknowledging that their medical educations did not equip them with the requisite business, marketing, strategic thinking, and management proficiencies needed in today's highly competitive health care delivery marketplace (Sousa, 2015). While conducting the interviews for this study, I found that the participants expressed willingness to concede that the needed business skill sets had not been a part of their formal medical education. Most of the participants had acquired varying degrees of familiarity with business skill sets either through work experience in the medical practice or a variety of self-education efforts.

Sousa (2015) recommended establishing online business education courses leading to academic degrees or professional certifications, tailored specifically for practicing physicians. Based on the input I received during the interviews, my first recommendation would be to develop a business-focused curriculum that would become a part of physician training during their medical residencies. The curriculum would include coursework that addressed the impeding behaviors shown in Table 1 and the measures for addressing competitive pressures shown in Table 2. My second recommendation interfaces with the first recommendation, in that the courses developed occur in academic settings with MBA students as fellow students. Having students from different disciplines as classmates helps develop a degree of understanding and sensitivity between the disciplines, and builds alliances early across each career discipline, that will be needed to establish networks in the future.

The third recommendation entails a conscious effort to build business content courses into continuing medical education (CME) curriculum. Physicians, along with

other medical professionals, usually attend CME sessions throughout the course of their careers. Just as the medical content of the sessions is structured toward continued medical proficiency, the business content of the sessions would offer the same benefit of continued business proficiency within the health care services delivery arena.

A fourth recommendation involves creating programs at the Federal, state, and local government levels, which provide attractive incentives that directly encourage legitimate collaborative grouping of small business medical practices. Currently, accountable care organizations and patient-centered medical homes offer incentives for physicians to affiliate, however, the focus is on delivery of quality care to the patient. The intent of the fourth recommendation is to create business-focused advantages to the physician.

The results of this study should be of interest to a wide spectrum of actors within the health care services delivery arena. The actors include: small business medical practice owners, leaders of large medical practices, leaders of health care systems, leaders within health care academia, and leaders of government agencies, such as the federal Agency for Healthcare Research and Quality, the Center for Medicare and Medicaid Services, and the Health Resources and Services Administration, each of which has a mission that includes health care services. The four recommendations offered each have applicability, or some degree of appeal, for segments of the different groups of actors within the spectrum. My intent is to disseminate the findings from this study by submitting an article for publication in peer-reviewed journals such as Group Practice Journal, Journal of the American Medical Association, and Journal of Healthcare

Management. As a member of the American College of Healthcare Executives, I will pursue the opportunity to make a presentation for a session of the Annual Congress.

Recommendations for Further Research

Discussion of concepts surrounding collaboration were evident during the interviews and shown in Table 2 as a measure to address competitive pressures. Conversely, noncollaboration appeared in Table 1 as an impeding behavior that could limit success by small business medical practices. Collaborative efforts by physicians should be approached carefully, to avoid violation of the federal antitrust laws and regulations, or repeating behaviors during the 1970s that led to application of the antitrust statutes to medical providers. The highly competitive health care marketplace of the 2010s is vastly different than what existed during the 1970s. Because of the changed environment, I recommend further research on the issue of legitimate collaboration among small business medical practices in ways that enhances quality health care delivery to patients but does not unnecessarily constrict innovative arrangements among medical providers.

One limitation of this study was the geographic boundaries associated with the urban region, the Baltimore-Washington regional area, selected for examination. I recommend that further research be conducted in a different urban region in the United States, in addition to conducting research in selected rural areas of the country. After the research is complete, efforts should be made to determine if there is basis for generalizability through extrapolation.

Reflections

My interest in understanding strategies of organizational sustainability for solo and small business medical practices dates back to the late 1980s. At that time, I worked as a Medicare health maintenance organization compliance officer for what was then the federal Health Care Financing Administration (HCFA), which is now known as the Center Medicare and Medicaid Services (CMS). Conducting audits of organizations with contracts to provide services to Medicare recipients included site visits to large regional medical centers, neighborhood health clinics, large medical groups, and solo practice physicians. I observed significant differences in the way some medical practices operated, some successful and others not very successful.

The requirements of the DBA doctoral study process compelled me to conduct an exhaustive literature search and broaden my knowledge and perspective about the topic. I brought no particular bias to the process. Instead, my motivation was driven by a desire to understand more of what physicians thought about the topic. My opportunity to conduct interviews, in a format that had been formally approved by an accredited academic body, offered the set of physician participants a forum to provide open, unvarnished input.

The structure of the questions and style of the interview allowed the participants to understand that their involvement would be helpful to others in their profession. Several of the participants suggested that going through the interview did not necessarily change their thinking about some issues, but that interview questions did precipitate thoughts about how to improve conditions for small business medical practices. I

conducted the interviews in a way that enabled participants to speak freely and feel that the interviewer valued their input and used in a manner that would benefit members of the medical profession.

Conclusion

While recent trends point toward a decline in solo and small business medical practices, the need for and demand still exists for this model of health care delivery. Three characteristics that small business owners, especially small business medical practices, need for effective strategic thinking are: willingness to create a new mindset, ability to transform ideas in sustained actions, and being at ease, in an environment of shifting contexts. By applying the measures for addressing competitive pressures and avoiding the impeding behaviors highlighted by the participants in this study, can survive and even thrive in this turbulent, highly-competitive health care delivery services arena.

All components of the health care delivery system, from major medical centers to individual physician practices, can flourish if the component leaders understand the principles of retail competition. Most important, though, is a willingness to respond appropriately and fully implement retail competition principles because operational sustainability of the system component depends upon the competition principles. Retail health care is consumer-driven, based on retail principles, and sensitive to market forces. Demographic transitions, financial pressures, changing political and social expectations have all converged and require that health care systems, of all sizes throughout the world, practice cost containment while improving the quality of health care services delivery.

References

Adler-Milstein, J., & Jha, A. (2012). Organizational complements to electronic health records in ambulatory physician performance: The role of support staff. *Journal of the American Medical Informatics Association, 19*, 537-540. Retrieved from http://jamia.oxfordjournals.org/

Aizer, A., Paly, J., Zeitman, A., Nguyen, P., Beard, C., Rao, S., . . . Efstathiou, J. (2012). Multidisciplinary care and pursuit of active surveillance in low-risk prostate cancer. *Journal of Clinical Oncology, 30*, 3071-3076. doi:10.1200/JCO.2012.42.8466

Alalwan, J., & Thomas, M. (2012). An ontology-based approach to assessing records management systems. *e-Service Journal, 8*(3), 24-41. Retrieved from https://muse.jhu.edu/journals/eservice_journal/toc/esj.8.3.html

Albert, D., Kreutzer, M., & Lechner, C. (2015). Resolving the paradox of interdependency and strategic renewal in activity systems. *Academy of Management Review, 40*, 210-234. doi:10.5465/amr.2012.0177

Albert, S., & Grzeda, M. (2014). Reflection in strategic management education. *Journal of Management Education, 39*, 650-669. doi:10.1177/1052562914564872

Alyahya, M. (2012). Changing organizational structure and organizational memory in primary care practices: A qualitative interview study. *Health Services Management Research, 25*(1), 35-40. doi:10.1258/hsmr.2011.011023

Anderson, R., Ayanian, J., Zaslavsky, A., & McWilliams, M. (2014). Quality of care and racial disparities in Medicare among potential ACOs. *Journal of General Internal Medicine, 29*, 1296-1304. doi:10.1007/s11606-014-2900-3

Angood, P., & Shannon, D. (2014). Unique benefits of physician leadership: An American perspective. *Leadership in Health Services, 27*(4), 272-282. doi:10.1108/LHS/-03-2014-0020

Angus, D., Rintel, S., & Wiles, J. (2013). Making sense of big text: A visual-first approach for analysing text data using Leximancer and Discursis. *International Journal of Social Research Methodology, 16*, 261-267. doi:10.1080/13645579.2013.774186

Austin, J. (2013). Making knowledge actionable: Three key translation moments. *Journal of Organization Design, 2*, 29-37. doi:10.7146/jod.2.3.15580

Awad, G. (2014). Motivation, persistence, and cross-cultural awareness: A study of college students learning foreign languages. *Academy of Educational Leadership Journal, 18*(4), 97-116. Retrieved from http://www.alliedacademies.org/academy-of-educational-leadership-journal/

Baker, R., Washington, H., Olakanmi, O., Savitt, T., Jacobs, E., Hoover, E., & Wynia, M. (2009). Creating the segregated medical profession: African Americans physicians and organized medicine, 1846-1910. *Journal of the National Medical Association, 101*, 501-512. Retrieved from http://www.nmanet.org/

Ball, R., & Medeiros, N. (2012). Teaching integrity in empirical research: A protocol for documenting data management and analysis. *The Journal of Economic Education, 43*, 182-189. doi:10.1080/00220485.2012.659647

Bank, A., Obetz, C., Konrardy, A., Khan, A., Pillai, K., McKinley, B., . . Kenney, W. (2013). Impact of scribes on patient interaction, productivity, and revenue in a cardiology clinic: A prospective study. *Clinicoeconomic Outcomes Research, 5*(Aug), 399-406. doi:10.2147/CEOR.S49010. eCollection 2013.

Battilana, J., & Casciaro, T. (2012). Change agents, networks, and institutions: A contingency theory of organizational change. *Academy of Management Journal, 55*(2), 381-398. doi:10.5465/amj.2009.0891

Battista, A., Godfrey, C., Soo, C., Catroppa, C., & Anderson, V. (2015). Does what we measure matter? Quality of life defined by adolescents with brain injury. *Brain Injury, 29*, 573-582. doi:10.3109/02699052.2014.989905

Beauchamp, M., Benson, S., & Daniel, L. (2014). Why the doctor will not see you now: The ethics of enforcing covenants not to compete in physician employment contracts. *Journal of Business Ethics, 119*, 381-398. doi:10.1007/s10551-013-1638-x

Bekhet, A., & Zauszniewski, J. (2012). Methodological triangulation: An approach to understanding data. *Nurse Researcher, 20*(2), 40-43. doi:10.7748/nr2012.11.20.2.40.c9442

Bengry-Howell, A., & Griffin, C. (2012). Negotiating access in ethnographic research with 'hard to reach' young people: Establishing common ground or a process of

methodological grooming? *International Journal of Social Research Methodology, 15*, 403-416. doi:10.1080/13645579.2011.600115

Berry, L., & Beckham, D. (2014). Team-based care at Mayo Clinic. *Journal of Healthcare Management, 59*(1), 9-13. Retrieved from https://ache.org/pubs/jhm/jhm_index.cfm

Berry, L., Beckham, D., Dettman, A., & Mead, R. (2014). Toward a strategy of patient-centered access to primary care. *Mayo Clinic Proceedings, 89*, 1406-1415. doi:10.1016/j.mayocp.2014.06.011

Bevan, M. (2014). A method of phenomenological interviewing. *Qualitative Health Research, 24*, 136-144. doi:10.1177/1049732313519710

Bitton, A., Schwartz, G., Stewart, E., Henderson, D., Keohane, C., Bates, D., & Schiff, G. (2012). Off the hamster wheel? Qualitative evaluation of a payment-linked patient-centered medical home (PCMH) pilot. *The Milbank Quarterly, 90*, 484-515. doi:10.1111/j.1468-0009.2012.00672.x

Blix, S., & Wettergren, A. (2014). The emotional labour of gaining and maintaining access to the field. *Qualitative research*, 1-17. doi:10.1177/1468794114561348

Bradbury, C. (2015). Determinants of physicians' acceptance of new Medicaid patients. *Atlantic Economic Journal, 43*, 247-260. doi:10.1007/s11293-015-9454-6

Bristowe, K., Selman, L., & Murtagh, F. (2015). Qualitative research methods in renal medicine: An introduction. *Nephrology Dialysis Transplantation: NDT Perspectives, 0*, 1-8. doi:10.1093/ndt/gfu410

Brunt, C., & Bowblis, J. (2014). Health IT adoption, productivity, and quality in primary care. *Applied Economics, 46*, 1716-1727. doi:10.1080/00036846.2014.884705

Burau, V., & Andersen, L. (2014). Professions and professionals: Capturing the changing role of expertise through theoretical triangulation. *American Journal of Economics & Sociology, 73*, 264-293. doi:10.1111/ajes.12062

By, R., Armenakis, A., & Burnes, B. (2015). Organizational change: A focus on ethical cultures and mindfulness. *Journal of Change Management, 15*(1), 1-7. doi:10.1080/14697017.2015.1009720

Cacari-Stone, L., Wallerstein, N. G., & Minkler, M. (2014). The promise of community-based participatory research for health equity: A conceptual model for bridging evidence with policy. *American Journal of Public Health, 104*, 1615-1623. doi:10.2105/AJPH.2014.301961

Carpenter, C. (2013). The answer to every question. *Journal of Financial Service Professionals, 67*, 36-39. Retrieved from http://www.financialpro.org/pubs/journal_index.cfm

Caven, V. (2012). Agony aunt, hostage, intruder or friend? The multiple personas of the interviewer during fieldwork. *Intangible Capital*, 548-563. doi:10.3926/ic.276

Chamberlain-Salaun, J., Mills, J., & Usher, K. (2013). Linking symbolic interactionism and grounded theory methods in a research design: From Corbin and Strauss' assumptions to action. *SAGE Open, Jul-Sep*, 1-10. doi:10.1177/215824013505757

Chambers, N., Sheaf, R., Mahon, A., Byng, R., Mannion, R., Charles, N., . . . Llewellyn, S. (2013). The practice of commissioning healthcare from a private provider:

Learning from an in-depth case study. *BMC Health Services Research, 13 (Suppl 1)*(54), 1-10. Retrieved from http://www.biomedcentral.com/1472-6963/13/51/54

Chauvet, E. (2013). Value, a way out of uncertainties: A physical model for ethics and freedoms. *Journal of Business Ethics, 113*, 395-413. doi:10.1007/s10551-012-1311-9

Chauvet, E. (2015). Industrialization value, market maturity and ethics. *Journal of Business Ethics, 129*, 180-195. doi:10.1007/s10551-014-2086-y

Checkland, P. (2012). Four conditions for serious systems thinking and action. *Systems Research and Behavioral Science, 29*, 465-469. doi:10.1002/sres.2158

Chreim, S., Williams, B., & Coller, K. (2012). Radical change in healthcare organization: Mapping transition between templates, enabling factors, and implementation processes. *Journal of Health Organization and Management, 26*(2), 215 – 236. doi:10.1108/14777261211230781

Coleman, K., Phillips, K., Van Borkula, N., Daniel, d., Johnson, K., Wagner, E., & Sugarman, J. (2014). Unlocking the black box: Supporting practices to become patient-centered medical homes. *Medical Care, 52*(11-Suppl 4), S 11-S 17. Retrieved from www.lww-medicalcare.com

Cunningham, T., Sinclair, R., & Schulte, P. (2014). Better understanding the small business construct to advance research on delivering workplace health and safety. *Small Enterprise Research, 21*, 148-160. doi:10.5172/ser.2014.21.2.148

CVS Caremark. (2014, May 13). *Minute Clinic.* Retrieved from CVS Minute Clinic: http://info.cvscaremark.com/better-health-care/minuteclinic

D'Alvano, L., & Hildago, A. (2012). Innovation management techniques and development degree of innovation process in service organizations. *R & D Management, 42*, 60-70. doi:10.1111/j.1467-9310.2011.00663.x

Damiani, G., Silvestrini, G., Federico, B., Cosentino, M., Marvulli, M., Tirabassi, F., & Ricciardi, W. (2013). A systematic review on the effectiveness of group versus single-handed practice. *Health Policy, 113*, 180-187. doi:10.1016/j.healthpol.2013.07.008

Davidson, P. P. (2012). Research participation as work: Comparing the perspectives of researchers and economically marginalized populations. *American Journal of Public Health, 102*, 1254-1259. doi:10.2105/AJPH.2011.300418

Dayna, J. (2013). Toward a model of purposeful participant inclusion: Examining deselection as a participant risk. *Qualitative Research Journal, 13*, 253-264. doi:10.1108/QRJ-01-2013-0007

Delmatoff, J., & Lazarus, I. (2014). The most effective leadership style for the new landscape of healthcare. *Journal of Healthcare Management, 59*, 245-249. Retrieved from http://www.ache.org/pubs/jhmtoc.cfm

Denzin, N. (2012). Triangulation 2.0. *Journal of Mixed Methods Research, 6*(2), 80-88. doi:10.1177/1558689812437186

deShazo, R., Smith, R., & Skipworth, L. (2014). Black physicians and the struggle for Civil Rights: Lessons from the Mississippi Experience: Part 1: The forces for and against change. *The American Journal of Medicine, 127*, 920–925. doi:10.1016/j.amjmed.2014.05.038

DHHS. (1979). *The Belmont Report.* Washington DC: United States Department of Health and Human Services. Retrieved from http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html

Di Vimercati, S., Foresti, S., Livraga, G., & Samarati, P. (2012). Data privacy: Definitions and techniques. *International Journal of Uncertainty, Fuzziness, and Knowledge-based Systems, 20*, 793-817. doi:10.1142/S0218488512400247

Diaz-Foncea, M., & Marcuello, C. (2012). Social enterprises and social markets: Models and new trends. *Service Business, 6*(1), 61-83. doi:10.1007/s11628-011-0132-8

Downey, L., Zun, L., Burke, T., & Jefferson, T. (2014). Who pays? How reimbursement impacts the emergency department. *Journal of Health and Human Services Administration, 36*, 400 416. Retrieved from http://www.spaef.com/jhhsa.php

Dunford, R., Cuganesan, S., Grant, D., Palmer, I., Beaumont, R., & Steele, C. (2013). Flexibility as the rationale for organizational change: A discourse perspective. *Journal of Organizational Change Management, 26*(1), 83-97. doi:10.1108/09534811311307923

Elder, K., & Miller, N. (2006). Minority physicians and selective contracting in competitive market environments. *Journal of Health and Social Policy, 21*(4), 21-49. doi:10.1300/J045v21n04_02

Ellner, A., Stout, S., Sullivan, E., Griffiths, E., Mountjoy, A., & Phillips, R. (2015). Health systems innovation at academic health centers: Leading in a new era of health care delivery. *Academic Medicine, Mar*, 1-9. doi:10.1097/ACM.0000000000000679

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

Epstein, A., Jha, A., Orav, J., Liebman, D., Audet, A., Zezza, M., & Guterman, S. (2014). Analysis of early accountable care organizations defines patient, structural, cost, and quality-of-care characteristics. *Health Affairs, 33*, 95-102. doi:10.1377/HLTHAFF.2013.1063

Erwin, P. (2015). Forces of Change. *American Journal of Public Health, 105*, 836-837. doi:10.2105/AJPH.2015.302575

Evangelista, F., Poon, P., & Albaum, G. (2012). Using response behaviour theory to solicit survey participation in consumer research: An empirical study. *Journal of Marketing Management, 28*, 1174-1189. doi:10.1080/0267257X.2011.619148

Ewing, M. (2013). The patient-centered medical home solution to the cost-quality conundrum. *Journal of Healthcare Management, 58*, 258-266. Retrieved from http://ache.org/pubs/jhm/

Faezipour, M., & Ferreira, S. (2013). A system dynamics perspective of patient satisfaction in healthcare. *Procedia Computer Science, 16*, 148-156. doi:10.1016/j.procs.2013.016

Fairweather, J., & Rinne, T. (2012). Clarifying a basis for qualitative generalization using approaches that identify shared culture. *Qualitative Research, 12*, 473-485. doi:10.1177/1468794111433000

Feldstein, P. (2012). *Health Care Economics.* Clifton Park, NY: Delmar.

Fenton, J., Jerant, A., Bertakis, K., & Franks, P. (2012). The cost of satisfaction: A national study of patient satisfaction, health care utilization, expenditures, and mortality. *Archive of Internal Medicine, 172*, 405-411. doi:10.1001/archinternmed.2011.1662

Ferreira de Lara, F., & Neves Guimaraes, M. (2014). Competitive priorities and innovation in SMEs: A Brazil multi-case study. *Journal of Technology Management and Innovation, 9*(3), 51-64. Retrieved from http://www.jotmi.org

Firmin, M., Bouchard, V., Flexman, J., & Anderson, D. (2014). A qualitative analysis of students' perceptions of pursuing Pharmacy as a potential vocation. *The Qualitative Report, 19*(40), 12. Retrieved from http://nsuworks.nova.edu/tqr/vol19/iss40/2

Fisher, E., & Corrigan, J. (2014). Accountable health communities: Getting there from here. *Journal of the American Medical Association, 312*, 2093 – 2094. doi:10.1001/JAMA.2014.13815

Frels, R., & Onwuegbuzie, A. (2013). Administering quantitative instruments with qualitative interviews: A mixed research approach. *Journal of Counseling and Development, 91*, 184-194. doi:10.1002/j.1556-6676.2013.00085.x

Gale, N., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*(117). doi:10.1186/1471-2288-13-117

Garbutt, J., Mandrell, K., Sterkel, R., Epstein, J., Stahl, K., Kreusser, K., . . . Strunk, R. (2013). Pediatric providers' attitudes toward retail clinics. *Journal of Pediatrics, 163*, 1384-1388. doi:10.1016/j.jpeds.2013.05.008

Garcia, D., & Gluesing, J. (2013). Qualitative research methods in international organizational change research. *Journal of Organizational Change Management, 26*, 423-444. doi:10.1108/09534811311328416

Gilbert, F., Denis, J., Lamothe, L., Beaulieu, M., D'Amour, D., & Goudrea, J. (2015). Reforming primary healthcare: From public policy to organizational change. *Journal of Health Organization and Management, 29*(1), 92-110. doi:10.08/JHOM-12-2012-0237

Gilson, L., Elloker, S., Olckers, P., & Lehmann, U. (2014). Advancing the application of systems thinking in health: South African examples of a leadership of sense making for primary health care. *Health Research Policy and Systems, 12*(30), 1-13. Retrieved from http://www.health-policy-systems.com/content/12/1/30

Ginzberg, E., & Ostrow, M. (1997). Managed care: A look back and a look ahead. *New England Journal of Medicine, 336*, 1018-1020. doi:10.1056/NEJM1997040336140

Goodman, J., Cryder, C., & Cheema, A. (2013). Data collection in a flat world: The strengths and weaknesses of Mechanical Turk samples. *Journal of Behavioral Decision Making, 26*, 213-224. doi:10.1002/bdm.1753

Grube, M., Cohen, A., & Clarin, D. (2014). Preparing to succeed in a retail healthcare environment. *Healthcare Financial Management, 2014*(November), 1-14. Retrieved from https://www.hfma.org/Content.aspx?id=25734

Guercini, S. (2014). New qualitative research methodologies in management. *Management Decision, 52*(4), 662-674. doi:10.1108/MD-11-2013-0592

Gunning, T., & Sickles, R. (2013). Competition and market power in physician private practices. *Empirical Economics, 44*, 1005-1029. doi:10.1007/s00181-011-0540-6

Guo, L., & Hanriharan, S. (2012). Patients are not cars and staff are not robots: Impact of differences between manufacturing and clinical operations on process improvement. *Knowledge and Process Management, 19*(2), 53-68. doi:10.1002/kpm.1386

Gutierrez, J., Terwiesch, C., Heller, A., Pelak, M., Pettit, A., & Marcus, S. (2015). Characterizing primary care visit activities at Veterans Health Administration clinics. *Journal of Healthcare Management, 60*(1), 30-42. Retrieved from http://www.ache.org/pubs/jhm/jhm_index.cfm

Hakkarainen, K., & Talonen, T. (2014). The innovation funnel fallacy. *International Journal of Innovation Science, 6*(2), 63-72. doi:10.1260/1757-2223.6.2.63

Hammersley, M. (2013). On the ethics of interviewing for discourse analysis. *Qualitative Research, 14*, 529-541. doi:10.1177/1468794113495039

Hariharan, S. (2014). Physician recruitment and retention: A physician's perspective. *Physician Executive Journal, March-April*, 44-48. Retrieved from http://acpe.physicianleaders.org/publications/pej

Harris, M., von Keudell, A., McMahon, G., & Bierer, B. (2014). Physician self-assessment of leadership skills. *Physician Executive Journal*(March-April), 30-36. Retrieved from http://acpe.physicianleaders.org/publications/pej

Hart, C., Dykes, C., Thienprayoon, R., & Schmit, J. (2015). Change management in quality improvements: The softer skills. *Current Treatment Options in Pediatrics, 1*, 372-379. doi:10.1007/s40746-015-0028-2

Harvard Business School. (2005). *Harvard business essentials: Strategy: Create and implement the best strategy for your business.* Boston, MA: Harvard Business School Publishing.

Hausman, L., Kwoh, C., Hannon, M., & Ibrahim, S. (2013). Perceived racial discrimination in health care and race differences in physician trust. *Race and Social Problems, 5*(2), 113-120. doi:10.1007/s12552-013-9092-z

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

Hill, C., Hunter, A., Johnson, L., & Coustasse, A. (2014). Medicare fraud in the United States: Can it ever be stopped? *Health Care Manager, 33*, 254-260. doi:10.1097/HCM.0000000000000019

Hing, E., & Burt, C. (2007). Office-based medical practice: Methods and estimates from the national ambulatory medical care survey. *Advance Data, 383*, 1-15. doi:10.1056/NEJMsa0802005

Hinojosa, A., McCauley, K., Seng, B., & Gardner, W. (2014). Leader and follower attachment styles: Implications for authentic leader–follower relationships. *The Leadership Quarterly, 25*, 595-610. doi:10.1016/j.leaqua.2013.12.002

Hollingsworth, J., Sanjay, S., Sakshaug, J., Hayward, R., Zhang, L., & Miller, D. (2012). Physician practices and readiness for medical home reforms: Policy, pitfalls, and possibilities. *Health Services Research, 47*, 486-508. doi:10.1111/j.1475 – 6773-2011.01332.x

Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigor in qualitative case study research. *Nurse Researcher*, 12-17. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23520707

Howell, J. (2010). Reflections on the past and future of primary care. *Health Affairs, 29*, 760-765. doi:10.1377/hlthaff.2010.0014

Howell, J. (2013). The changing meaning of a healthcare workforce. *Academic Medicine, 88*, 1795 – 1797. doi:10.1097/ACM.0000000000000019

Huang, B., Zhu, P., & Wu, C. (2012). Customer-centered care flow modeling based on guidelines. *Journal of Medical Systems, 36*, 3307-3319. doi:10.1007/s10916-012-9823-5

Humphrey, C. (2014). Qualitative research: Mixed emotions. *Qualitative Research in Accounting and Management, 11*(1), 51-70. doi:10.1108/QRAM-03-2014-0024

Jackson, L., & Lim, M. (2011). Knowledge and practice of confidential data handling in the Welsh Deanery: A brief report. *Journal of Medical Ethics: Journal of the Institute of Medical Ethics, 37*(1), 58-60. doi:10.1136/jme.2010.036533

Jacobides, M., Winter, S., & Kassbarger, S. (2012). The dynamics of wealth, profit, and sustainable advantage. *Strategic Management Journal, 33*, 1384-1410. doi:10.1002/smj.1985

Jakielo, D. (2011). How to survive and thrive in today's medical practice. *The Journal of Medical Practice Management, 26*, 267-269. Retrieved from www.ncbi.nlm.nih.gov/pubmed/21595373

Jordan, S. (2014). Solidarity, political theory, and the place of social benefits in administrative ethics. *Administrative Theory & Praxis, 36*, 414-420. doi:10.1080/10841806.2014.11029967

Kaissi, A., & Charland, T. (2013). How satisfied are hospital systems with their ownership of retail clinics? *Journal of Healthcare Management, 58*, 143-153. Retrieved from http://technews.tmcnet.com/news/2013/05/04/7111723.htm

Kaissi, A., & Charland, T. (2013). The evolution of retail clinics in the United States, 2006-2012. *The Health Care Manager, 32*, 336-342. doi:10.1097/HCM.0b013e3182a9d73f

Kalali, N., Momeni, M., & Heydari, E. (2015). Key elements of thinking strategically. *International Journal of Management, Accounting, and Economics, 2*, 801-809. Retrieved from www.ijmae.com

Kash, B., Spaulding, A., Johnson, C., & Gamm, L. (2014). Success Factors for strategic change initiatives: A qualitative study of healthcare administrators' perspectives. *Journal of Healthcare Management, 59*(1), 65-82. Retrieved from www.ache.org/pubs/jhmsub.cfm

Kennedy, D., & Nordrum, J. (2015). The Mayo model of community care: Integrating population and patient experience initiatives for efficient reform. *Journal of Healthcare Management, 60*, 91-95. Retrieved from http://www.ache.org/pubs/jhm/jhm_index.cfm

Kennedy, D., Nordrum, J., Edwards, F., Caselli, R., & Berry, L. (2015). Improving service quality in primary care. *American Journal of Medical Quality, 30*(1), 45-51. doi:10.1177/1062860613518098

Khatri, S., Wilson, B., & Dalmat, M. (2013). Waistlines will continue to rob bottom lines until physicians lead by example with their own employee wellness programs. *Journal of Management Policy and Practice, 14*(5), 30-38. Retrieved from https://www.yumpu.com/en/document/view/20651603/journal-of-management-policy-and-practice

Kirchhoff, S. L. (2013). *Physician practices: Background, organization, and market consolidation.* Washington, DC: Congressional Research Service. Retrieved June 22, 2014, from www.crs.gov

Klein, D., Laugesen, M., & Liu, N. (2013). The patient-centered medical home: A future standard for American health care. *Public Administration Review, 73*, 582-592. doi:10.1111/puar.12082

Klonoski, R. (2013). The case for case studies: Deriving theory from evidence. *Journal of Business Case Studies, 9*, 261-266. Retrieved from http://www.cluteinstitute.com/ojs/index.php/JBCS/article/view/7805

Knapp, C., Madden, V., Lane, H., Kairys, S., Pelaez-Valez, C., Sanders, L., & Thompson, L. (2014). Congruence between staff and lead physician's ability to adapt to change in a pediatric medical home project. *Primary Health Care, 4*(1), 1-6. doi:10.4172/2167 – 1079.1000147

Kooskora, M. (2013). Change, values and sustainability networking, and researcher bias. *Journal of Mangement and Change, 30/31*, 11-15. Retrieved from http://www.ebs.ee/en/research-and-doctoral-studies/journal-of-management-and-change

Kreamer, J., Rosen, B., Susie-Lattner, D., & Baker, R. (2015). The economic impact of medical scribes in hospitals. *Physician Leadership Journal, 2*(3), 38-41. Retrieved from http://www.physicianleaders.org/shop/journals/plj

Krzakiewicz, K., & Cyfert, S. (2014). The concept of management by flexible goals. *Management, 18*, 124-135. doi:10.2478/manment-2014-0010

Kunc, M. (2012). Teaching strategic thinking using system dynamics: Lessons from a strategic development course. *System Dynamics Review, 28*, 28-45. doi:10.1002/sdr.471

Kunttu, A., & Torkkeli, L. (2015). Service innovation and internationalization in SMEs: Implications for growth and performance. *Management Revue, 26*(2), 83-100. doi:10.1688/mrev-2015-02-Kunttu

Kwon, J., & Johnson, E. (2013). Health-care security strategies for data protection and regulatory compliance. *Journal of Management Information Systems, 30*(2), 41-66. doi:10.2753/MIS0742-1222300202.

Lamb, D. (2013). Promoting the case for using a research journal to document and reflect on the research experience. *The Electronic Journal of Business Research Methods, 11*(2), 84-91. Retrieved from www.ejbrm.com

Langabeer, J., & Champagne, T. (2016). Exploring business strategy in health information exchange organizations. *Journal of Healthcare Management, 61*(1), 15- 26. Retrieved from www.ache.org

Langdon, M. (2013). Three dimensions of innovation. *International Management Review, 9*(2), 5-10. Retrieved from http://www.usimr.org/

Laugesen, M., Wada, R., & Chen, E. (2012). In setting doctors' Medicare fees, CMS almost always accepts the relative value update panel's advice on work values. *Health Affairs, 31*, 965-972. doi:10.1377/hlthaff.2011.0557

Lawrence, P. (2015). Leading change: Insights into how leaders actually approach the challenge of complexity. *Journal of Change Management -online, Mar*. doi:10.1080/14697017.2015.1021271

Lazlo, K. (2012). From systems thinking to systems being: The embodiment of evolutionary leadership. *Journal of Organizational Transformation & Social Change, 9*(2), 95-108. doi:10.1386/jots.9.2.95_1

Lee, D., Fiack, K., & Knapp, K. (2013). A profile of solo/two-physician practices. *Journal of Health and Human Services Administration, 36*, 297-322. doi:24597431

Lee, P. (2014). Qualitative perspectives: through a methodological lens. *Qualitative Research in Accounting and Management, 11*(1), 13-28. doi:10.1108/QRAM-02-2014-0013

Lewis, M., Andriopoulos, C., & Smith, W. (2014). Paradoxical leadership to enable strategic agility. *California Management Review, 56*(3), 58-77. doi:10.1525/cmr.2014.56.3.58

Liaw, W., Jetty, A., Petterson, S., Peterson, L., & Bazemore, A. (2016). Solo and small practices: A vital, diverse part of primary care. *Annals of Family Medicine, 14*(1), 8-15. doi:10.1870/AFM.1889

Libby, A., & Thurston, N. (2001). Effects of managed care contracting on physician labor supply. *International Journal of Health Care Finance Economics, 1*, 139-157. doi:10.1023/A:1012826611323

Lichterman, P., & Reed, I. (2014). Theory and contrastive explanation in Ethnography. *Sociological Methods & Research, October*, 1-51. doi:10.1177/0049124114554458

Lin, K. (2014). Physicians' perceptions of autonomy across practice types: Is autonomy in solo practice a myth? *Social Science & Medicine, 100*, 21-29. doi:10.1016/j.socscimed.2013.10.033

Liu, N., Finkelstein, S., & Poghosyan, L. (2014). A new model for nurse practitioner utilization in primary care: Increased efficiency and implications. *Healthcare Management Review, 39*(1), 10-20. doi:10.1097/HMR.0b 013e318276fadf

Lockyer, J., Wycliffe-Jones, K., Raman, M., Sandhu, A., & Fidler, H. (2011). Moving into medical practice in a new community: The transition experience. *Journal of Continuing Education in the Health Professions, 31*, 151-156. doi:10.1002/chp.20120

Lofgren, O. (2014). Routinising research: academic skills in analogue and digital worlds. *International Journal of Social Research Methodology, 17*(1), 73-86. doi:10.1080/13645579.2014.854022

Loh, E. (2012). How and why doctors transition from clinical practice to senior hospital management: A case research study from Victoria, Australia. *The International Journal of Clinical Leadership, 17*, 235-244. Retrieved from http://www.ingentaconnect.com/content/rmp/ijcl

Lokke, A., & Dissing-Sorensen, P. (2014). Theory testing using case studies. *The Electronic Journal of Business Research Methods, 12*(1), 66-74. Retrieved from www.ejbrm.com

MacCarrick, G. (2014). Professional medical leadership: A relational training model. *Leadership in Health Services, 27*(4), 343-354. doi:10.1108/LHS-03-2014-0024

Macfarlane, M. (2014). Sustainable competitive advantage for accountable care organizations. *Journal of Healthcare Management, 59*, 263-271. Retrieved from http://www.ache.org/Publications/

MacKinney, T., Visotcky, A., Tarima, S., & Whittle, J. (2013). Does providing care for uninsured patients decrease emergency room visits and hospitalizations? *Journal*

of Primary Care & Community Health, 4, 135-142. doi:10.1177/2150131913478981

Malewska, K., & Sajdak, M. (2014). The intuitive manager and the concept of strategic leadership. *Management, 18*(2), 44-58. doi:10.2478/manment-2014-0041

Malterud, K., Siersma, V., & Guassora, A. (2015). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*(November). doi:10.1177/1049732315617444

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

Marek, P. (2014). A critical analysis of the concept of marketing strategies for small and midsized companies. *Economics, Management, & Financial Markets, 9*, 255 – 261. Retrieved from http://www.addletonacademicpublishers.com/economics-management-and-financial-markets

Martin, A., Hartman, M., Whittle, L., & Catlin, A. (2014). National health spending in 2012: Rate of health spending growth remained low for the fourth consecutive year. *Health Affairs, 33*(1), 67-77. doi:10.1377/hlthaff.2013.1254

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

Martin, K., & Parmar, B. (2012). Assumptions in decision-making scholarship: Implications for business ethics research. *Journal of Business Ethics, 105*, 289-306. doi:10.1007/s10551-011-0965-z

Martinez, M. (2014). Co-creation of value by open innovation: Unlocking new sources of competitive advantage. *Agribusiness, 30*, 132-147. doi:10.1002/AGR

Matejun, M. (2014). The role of flexibility in building the competitiveness of small and medium enterprises. *Management, 18*, 154-168. doi:10.2478/manment-2014-0012

Matthews, M., Seguin, M., Chowdhury, N., & Card, R. (2012). Generational differences in factors influencing physicians to choose a work location. *The International Electronic Journal of Rural and Remote Health Research, Education, Practice, and Policy, 12*, 1-11. Retrieved from www.rrh.org.au

McAlearney, A., Robbins, J., Garman, A., & Song, P. (2013). Implementing high performance work practices in the healthcare organizations: Qualitative and conceptual evidence. *Journal of Healthcare Management, 58*, 446 – 462. Retrieved from https://ache.org/pubs/jhm/jhm_index.cfm

McCullough, J. (2012). The influence of positive psychological factors on small business owners' retirement planning activities. *Financial Services Review, 21*(1), 1-18. Retrieved from http://academyfinancial.org/financial-services-review/

McGuinness, K. (2014). Institutional decision-making: Empowering of health system and economic transformation. *American Psychologist, 69*, 817-827. doi:10.1037/a0037620

McKinlay, J., & Marceau, L. (2012). From cottage industry to a dominant mode of primary care: Stages in the diffusion of a healthcare innovation (retail clinics). *Social Science & Medicine, 75*, 1134-1141. doi:10.1016/j.soscimed.2012.04.039

McNellis, R., Genevro, J., & Meyers, D. (2013). Lessons learned from the study of primary care transformation. *Annals of Family Medicine, 11*, 51-55. doi:10.1370/AFM.1548

Mehrotra, A. (2013). The convenience revolution for treatment of low-acuity conditions. *Journal of the American Medical Association, 310*(1), 35-36. Retrieved from http://jama.jamanetwork,com/

Meli, C., Khalil, I., & Tari, Z. (2014). Load-sensitive dynamic workflow re-orchestration and optimisation for faster patient healthcare. *Computer Methods and Programs in Biomedicine, 113*(1), 1-14. doi:10.1016/j.cmpb.2013.06.019

Mikesell, L., & Bromley, E. K. (2013). Ethical community-engaged research: A literature review. *American Journal of Public Health, 103*(12), e7-e14. doi:10.2105/AJPH.2013.301605

Modestino, A. (2013). The impact of managed care on the gender earning gap among physicians. *Research Review, 19*, 18-21. Retrieved from http://www.bostonfed.org/economic/ResearchReview/index.htm.

Mohapatra, S. (2015). Using integrated information system for patient benefits: A case study in India. *International Journal of Healthcare Management, 8*, 262-271. doi:10.1179/2047971915Y.0000000007

Moon, C. (2015). The unchanging role of the researcher. *International Journal of Market Research, 57*(1), 15-16. doi:10.2501/IJMR-2015-002

Morse, A., & McEvoy, C. (2014). Qualitative research in sport management: Case study as a methodological approach. *The Qualitative Report, 19*(17), 1-13. Retrieved from http://ssrn.com/abstract=2458106

Morse, J. (1999). Qualitative generalizability. *Qualitative Health Research, 9*(1), 5-6. doi:10.1177/104973299129121622

Morse, J. (2015). What use is it anyway? Considering modes of application and contributions of qualitative inquiry. In K. Olson, R. Young, & I. Schultz, *Hand book of Qualitative Health Research for Evidence Based Practice* (pp. 429-440). New York, New York: Springer Science and Business Media. doi:10.1007/978-1-4939-2920-7_25

Mulligan, A., Hall, L., & Raphael, E. (2013). Peer review in a changing world: An international study measuring the attitudes of researchers. *Journal of the American Society for Information Science and Technology, 64*, 132-161. doi:10.1002/asi.22798

Navis, C., & Ozbek, O. (2016). The right people in the wrong places: The paradox of entrepreneurial entry and successful opportunity realization. *Academy of Management Review, 41*, 109-129. doi:10.5465/amr.2013.0175

Nijmeijer, K., Huijsman, R., & Fabbricotti, I. (2014). Creating advantages through franchising in healthcare: A qualitative, multiple embedded case study on the role

of the business format. *BMC Human Services Research, 14*, 1-15. Retrieved from http://www.biomedcentral.com/1472-6963/485

Nolsoe-Grunbaum, N., & Stenger, M. (2013). Dynamic capabilities: Do they lead to innovation performance and profitability? *IUP Journal of Business Strategy, 10*(4), 68-85. Retrieved from http://www.iupindia.in/Business_Strategy.asp

Norback, F. (2013). Engaging physicians in organizational improvement work. *Journal of Health Organization and Management, 27*, 479-497. doi:10.1108/JHOM-02-2012-0043

Nunan, D., & Di Domenico, M. (2013). Market research and the ethics of the data. *International Journal of Market Research, 55*(4), 2-13. Retrieved from http://www.warc.com

O'Reilly, M., & Parker, N. (2013). 'Unsatisfactory Saturation': The critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research, 3*, 190-197. doi:10.1177/148794112446106

Parker, L. (2014). Qualitative perspectives: Through a methodological lens. *Qualitative Research in Accounting and Management, 11*(1), 13-28. doi:10.1108/QRAM-02-2014-0013

Parl, U. (2013). Learning about a social system in the change process of your organization: An analysis of an analysis. *Journal of Management & Change, 30/31*, 105-123. Retrieved from http://www.ebs.ee/en/research-and-doctoral-studies/journal-of-management-and-change

Patwardhan, A., Davis, J., Murphy, P., & Ryan, S. (2012). Comparison of waiting and consultation times in convenient care clinics and physician offices: A cross-sectional study. *Journal of Primary Care and Community Health, 4*, 124-128. doi:10.1177/2150131912450030

Paul, D. (2014). The PGP demonstrations: Were they sufficient to justify accountable care organizations? *Hospital Topics, 92*, 7-13. doi:10.1080/00185868.2014.875313

Peikes, D., & Dale, S. (2015). Solo practitioners remain important contributors to primary care. *Journal of the American Board of Family Medicine, 28*(1), 7-10. doi:10.3122/jabfm.2015.01.140316

Peng, G., Dey, D., & Lahiri, A. (2014). Healthcare IT adoption: An analysis of knowledge transfer in socioeconomic networks. *Journal of Management Information Systems, 31*(3), 7-34. doi:10.1080/07421222.2014.994672

Peterson, K., & Rutledge, M. (2014). Creating adaptive leaders and organizations. *Organizational Development Practitioner, 46*(2), 10-18. Retrieved from http://www.odnetwork.org/?Publications

Peterson, L., Baxley, E., Jaen, C., & Phillips, R. (2015). Fewer family physicians are in solo practices. *Journal of the American Board of Family Medicine, 28*(1), 11-12. doi:10.3122/jabfm.2015.01.1400217

Petit, V., & Bollaert, H. (2012). Flying too close to the sun? Hubris among CEOs and how to prevent it. *Journal of Business Ethics, 108*, 265-283. doi:101007/s10551-011-1097-1

Petterson, S., Liaw, W., Tran, C., & Bazemore, A. (2015). Estimating the residency expansion required to avoid projected primary care physician shortages by 2035. *Annals of Family Medicine, 13*, 107-114. Retrieved from 10.1370/afm.1760

Porter, M. (2008, January). The five competitive forces that shape strategy. *Harvard Business Review*, 79-93. doi:10.1225/R0801E

Prades, J., Remue, E., van Hoof, E., & Borras, J. (2015). Is it worth reorganising cancer services on the basis of multidisciplinary teams (MDTs)? A systematic review of the objectives and organisation of MDTs and their impact on patient outcomes. *Health Policy, 119*, 464-474. doi:10.1016/j.healthpol.2014.09.006

Qazi, K. (2012). Healthcare reform in the United States; fact, fiction, and drama: Act II. *British Journal of Medical Practitioners, 5*, 32-535. Retrieved from http://www.bjmp.org/content/healthcare-reform-united-states-facts-fiction-and-dramaact-ii

Rahmandad, H., & Sterman, J. (2012). Reporting guidelines for simulation-based research in social sciences. *Systems Dynamics Review, 28*, 396-411. doi:10.1002/sdr.1481

Renz, A., Conrad, D., & Watts, C. (2013). Stakeholder perspectives on the implementation of shared decision-making; A qualitative data analysis. *International Journal of Healthcare Management, 6*, 122-131. doi:10.1179/2047971912Y.0000000027

Reybold, I., Lammert, J., & Stribling, S. (2012). Participant selection as a conscious research method: thinking forward and the deliberation of emergent findings. *Qualitative Research, 13*, 699-716. doi:10.1177/1468794112465634

Rhodes, K., & Miller, F. (2012). Simulated patient studies: An ethical analysis. *The Milbank Quarterly, 90*, 706-724. doi: 10.1111/j.1468-0009.2012.00680.x

Robinson, A. (2014). Innovation activity in entrepreneurial firms: Technological firm attributes and environmental dynamism as determinants. *Academy of Business Research Journal, 1*, 87-103. Retrieved from http://www.aobronline.com/#!abrj/cdlu

Robinson, O. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology, 11*(1), 25-41. doi:10.1080/14780887.2013.801543

Rohrer, J., Angstman, K., Garrison, G., Maxson, J., & Furst, J. (2013). Family medicine patients who use retail clinics have lower continuity of care. *Journal of Primary Care and Community Health, 4*, 150-153. doi:10.1177/215013912471683

Rohrer, J., Angstman, K., Garrison, G., Pecina, J., & Maxson, J. (2013). Nurse practitioners and physician assistants are complements to family medicine physicians. *Population Health Management, 16*, 242-245. doi:10.1089/pop.2012.0092

Roulston, K., & Shelton, S. (2015). Reconceptualizing bias in teaching qualitative research methods. *Qualitative Inquiry, 21*, 332-342. doi:10.1177/1077800414563803

Roy, K., Zvonkovic, A., Goldberg, A., Sharp, E., & La Rossa, R. (2015). Sampling richness and qualitative integrity: Challenges for research with families. *Journal of Marriage and Family, 77*, 243-260. doi:10.1111/jomf.12147

Saba, G., Villela, T., Chen, E., Hammer, H., & Bodenheimer, T. (2012). The myth of the lone physician: Toward a collaborative alternative. *Annals of Family Medicine, 10*(Mar/Apr 2012), 169-173. doi:10.1370/afm.1353

Sanford, K. (2013). Understanding the business of employed physician practices. *Healthcare Financial Management*(September 2013), 44-47. Retrieved from https://www.hfma.org

Saxton, J., Pawlson, G., & Finkelstein, M. (2013). How physicians can survive the "perfect storm" developing in healthcare today:And thrive. *The Journal of Medical Practice Management: MPM, 29*, 167-171. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/24765734

Schilling, A., Werr, A., Gand, S., & Sardas, J. (2012). Understanding professionals' reactions to strategic change: The role of threatened professional identities. *The Services Industries Journal, 32*, 1229-1245. doi:10.1080/02642069.2010.531269

Seitan, S. (2015). Financial stability in the micro economic field: Theoretical aspects and proposals. *Economic Insights - Trends & Challenges, 67*(4), 53- 62. Retrieved from http://www.upg-bulletin-se.ro/archive-4-2015-en.html

Self, D., Self, T., Matuszek, T., & Scharaeder, M. (2015). Improving organizational alignment by enhancing strategic thinking. *Development and Learning in Organizations, 29*(1), 11-14. doi:10.1108/DLO-08-2013-0053

Senge, P., Smith, B., Kruschwitz, N., Schley, S., & Laur, J. (2010). *The necessary revolution: Working together to create a sustainable world.* New York, NY: Broadway Books.

Shmueli, A., Stam, P., Wasem, J., & Trottmann, M. (2015). Managed care in four managed competition OECD health systems. *Health Policy, 119*(July), 860-873. doi:10.1016/j.healthpol.2015.02.013

Shortell, S., McClellan, S., Ramsay, P., Casalino, L., Ryan, A., & Copeland, K. (2014). Physician practice participation in accountable care organizations: The emergence of the unicorn. *Health Services Research, 49*, 1519-1536. doi:10.1111/1475-6773.12167

Shrank, W., Krumme, A., Tong, A., Spettell, C., Matlin, O., Sussman, A., . . Choudhry, N. (2014). Quality of care at retail clinics for 3 common conditions. *American Journal of Managed Care, 20*, 794-801. Retrieved from www.ajmc.com

Sinden, K., MacDermid, J., Buckman, S., Davis, B., Matthews, T., & Viola, C. (2013). A qualitative study on the experiences of female firefighters. *Work, 45*, 97-105. doi:10.3233/WOR-121549

Sinkovics, R., & Alfoldi, E. (2012). Progressive focusing and trustworthiness in qualitative research: The enabling role of Computer-Assisted Qualitative Data Analysis Software (CAQDAS). *Management International Review (MIR), 52*, 817-845. doi:10.1007/s11575-012-0140-5

Skinner, D. (2013). Defining medical necessity under the Patient Protection and Affordable Care Act. *Public Administration Review, 73*, S49-S59. doi:10.1111/puar.12068

Slevitch, L. (2011). Qualitative and quantitative methodologies compared: Ontological and epistemological perspectives. *Journal of Quality Assurance in Hospitality & Tourism, 12*, 73-81. doi:10.1080/1528008X.2011.541810

Smith, R., & Rennie, D. (2014). Evidence-based medicine: An oral history. *The Journal of the American Medical Association, 311*, 365-367. doi:10.1001/jama.2013.286182

Snell, A., Eagle, C., & Van Aerde, J. (2014). Embedding physician leadership development within health organizations. *Leadership in Health Services, 27*(4), 330-342. doi:10.1108/LHS-04.2014-0033

Sousa, L. (2015). The business management knowledge needs of physicians: And online education. *International Journal of Economics & Management Sciences, 4*(2). doi:10.4172/2162-6359.1000229

Stacey, R. (2011). *Strategic management and organisational dynamics: The challenge of complexity.* Boston, MA: Pearson Learning Solutions.

Stange, K. (2016). In this issue: Size matters. *Annals of Family Medicine, 14*(1), 2-3. doi:10.1370/afm.1895

Starr, M. (2014). Qualitative and mixed methods research in economics: Surprising growth, promising future. *Journal of Economic Surveys, 28*, 238-264. doi:10.1111/joes.12004

Suarin, T., Rooke, J., & Koskela, L. (2013). A complex systems theory perspective of lean production. *International Journal of Production Research, 51*, 5824-5838. doi:10.1080/00207543.2013.796420

Surdez, E., Aguilar, N., Sandoval, M., & Lamoyi, C. (2012). The profile of small business owners: Evidence from Mexico. *International Journal of Management & Marketing Research, 5*(1), 43-53. Retrieved from http://www.theibfr.com/ijmmrsample.htm

Sussman, A., Dunham, L., Snower, K., Hu, M., Matlin, O., Shrank, W., . . Brennan, T. (2013). Retail clinic utilization associated with lower total cost of care. *American Journal of Managed Care, 19*, e148-157. Retrieved from www.ajmc.com

Sychrova, L. (2012). Evaluation of approaches using the product lifecycle. *Economics and Management, 17*, 1479-1483. doi:10.5755/j0 1.cm. 17.4.3017

Takhar-Lail, A., & Chitakunye, P. (2015). Reflexive introspection: Methodological insights from four ethnographic studies. *Journal of Business Research, 68*, 2383-2394. doi:10.1016/j.jbusres.2015.03.020

Teece, D., & Pisano, G. (1994). The dynamic capabilities of enterprises: An introduction. *Industrial and Corporate Change, 3*, 537-556. doi: 10.1093/icc/3.3.537-a

Teece, D., Pisano, G., & Shuen, A. (1997). Dynamic capabilities and strategic management. *Strategic Management Journal, 18*, 509-533. doi:10.1002/(SICI)1097-0266(199708)18:7<509::AID-SMJ882>3.0.CO;2-Z

Thibodeau, P., McPherson, C., Stroink, F., & Stroink, M. (2015). Situating a measure of systems thinking in a landscape of psychological constructs. *Systems Research and Behavioral Science*. doi:10.1002/sres.2388

Tideman, S., Arts, M., & Zandee, D. (2013). Sustainable leadership: Towards a workable definition. *Journal of Corporate Citizenship, 49*(March), 17-33. doi:10.9774/GLEAF.4700.2013.ma.00004

Trautrims, A., Grant, D., Cunliffe, A., & Wong, C. (2012). Using the documentary method to analyze qualitative data in logistics research. *International Journal of Physical Distribution &amp, 42*, 828-842. doi:10.1108/09600031211269776

Trousdale, L. (2015). Using self assessments to enhance business continuity programs. *Journal of Business Continuity and Emergency Planning, 9*(1), 6-9. Retrieved from http://www.henrystewartpublications.com/jbcep

Tsai, T., Eliasziw, M., & Chen, D. p. (2012). The demand of physician workforce: An international model based on "crowd behaviors". *BMC Health Services Research, 12*(79), 1-10. Retrieved from http://www.biomedcentral.com/

Tseng, J. (2013). Medical health care tourism: Why patients go overseas and what nurse practitioners need to know. *International Journal of Healthcare Management, 6*, 132-135. doi:10.1179/2047971912Y.0000000026

Tsu, S. (2009). *Sun Tsu: The art of war.* New Delhi, India: Pentagon Press.

Turner, J., & Danks, S. (2014). Case study research: A valuable learning tool for performance improvement professionals. *Performance Improvement, 53*(4), 24-31. doi:10.1002/pfi.21406

Ullrich, F., MacKinney, C., & Mueller, K. (2013). Are primary care practices ready to become patient-centered medical homes? *Journal of Rural Health, 29*, 180-187. doi:10.1111/j.1748-0361.2012.00433.x

United States Government Accountability Office (GAO). (2012). *Types of providers involved in Medicare, Medicaid, and the Children's Health Insurance Program cases (GAO-12-820).* Washington DC: United States Government Accountability Office (GAO). Retrieved from http://www.gao.gov/products/GAO-12-820

United States Government Accountability Office (GAO). (2014). *Medicare fraud-progress made more action needed to address Medicare fraud, waste, and abuse (GAO 560T).* Washington DC: United States Government Accountability Office (GAO). Retrieved from http://www.gao.gov/products/GAO-14-560T

US Department of Health and Human Services. (1979). *The Belmont Report: Ethical principles and guidelines for the protection of human subjects of research.* Washington, DC: Office of the Secretary, US Department of Health and Human Services. Retrieved from http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html

Vaughan, A., & Coustasse, A. (2011). Accountable care organization musical chairs: Will there be a seat remaining for the small group or solo project? *Hospital Topics, 89*, 92-97. doi:10.1080/00185868.2011.627814

Volkman, J., & Parrott, R. (2012). Expressing emotions as evidence in osteoporosis narratives: Effects on message processing and intentions. *Human Communication Research, 38*, 429-458. doi:10.1111/j.1468-2958.2012.01433.x

von Bertalanffy, L. (1950). An outline of general system theory. *British Journal for the Philosophy of Science, 1*, 114-129. doi:10.1093/bjps/I.2.134

von Bertalanffy, L. (1968). *General Systems Theory.* New York, NY: Braziller.

Wahyuni, D. (2012). The research design maze: Understanding paradigms, cases, methods, and methodologies. *Journal of Applied Management Accounting Research, 10*(1), 69-80. Retrieved from http://www.cmawebline.org

Washington, H., Baker, R., Olakanmi, O., Savitt, T., Jacobs, E., Hoover, E., & Wynia, M. (2009). Segregation, civil rights, and health disparities: The legacy of African Americans physicians and organized medicine, 1910-1968. *Journal of the National Medical Association, 101*, 513-527. Retrieved from http://nmanet.org/

Weeks, R. (2012). Healthcare services management: A systems perspective. *Journal of Contemporary Management, 9*, 382-401. Retrieved from http://reference.sabinet.co.za/document/EJC127661

Welch, D., Grossaint, K., Reid, K., & Walker, C. (2014). Strengths-based leadership development: Insights from expert coaches. *Consulting Psychology Journal: Practice & Research, 66*(1), 20-37. doi:10.1037/cpb0000002

Wilensky, G. (2014). Developing a viable alternative to Medicare's physician payment strategy. *Health Affairs, 33*, 153-160. doi:10.377/hlthaff.2013.1086

Williams, C., Kahanfa, N., Harrington, C., & Loudon, D. (2011, Jul-Sep). Marketing retail health clinics: Challenges and controversies arising from a health care innovation. *Health Marketing Quarterly*, 270-285. doi:10.1080/07359683.2011.595648

Willis, C., Best, A., Riley, B., Herbert, C., Millar, J., & Howland, D. (2014). Systems thinking for transformational change in health. *Evidence & Policy, 10*, 113-126. doi:10.1332/174426413X662815

Winter, S., & Collins, D. (2015). Why do we do what we do? *Journal of Applied Sport Psychology, 27*(1), 35-51. doi:10.1080/10413200.2014.941511

Winters, C., & Cudney, S. S. (2010). The evolution of a coding schema in a paced program of research. *The Qualitative Report, 15*, 1415-1430. Retrieved from http://nsuworks.nova.edu/tqr/vol15/iss6/5

Wolgemuth, J. .. (2013). Analyzing for critical systems in narrative research. *Qualitative Research, 14*, 586-602. doi:10.1177/1468794113501685

Wolgemuth, J., Erdil-Moody, Z., Opsal, T., Cross, J., Kaanta, T., Dickmann, E., & Colomer, S. (2015). Participants' experiences of the qualitative interview: Considering the importance of research paradigms. *Qualitative Research, 15*, 351-372. doi:10.1177/1468794114524222

Wolinsky, F. (1982). Why physicians choose different types of practice settings. *Health Services Research, 17*, 399-419. Retrieved from http://www.hsr.org/

Wong, A., & Wu, L. (2012). Teaching consumer-oriented ethnographic research. *Marketing Education Review, 22*(1), 15-19. doi:10.2753/MER1052-8008220103

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

Yin, R. (1999). Enhancing the quality of case studies in health services research. *Health Services Research, 34*, 1209 – 1224. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1089060/

Yin, R. (2014). *Case study research: Design and methods* (5th ed.). Thousand Oaks, CA: SAGE.

Zivkovic, J. (2012). Strengths and weaknesses of business research methodologies: Two disparate case studies. *Business Studies Journal, 4*, 91-99. Retrieved from http://www.alliedacademies.org/public/journals/JournalDetails.aspx?jid=26

Zuckerman, A. (2014). Successful strategic planning for a reformed delivery system. *Journal of Healthcare Management, 59*, 168-172. Retrieved from http://www.ache.org/Publications/

Appendix A: Participant Consent Form

*You already know me as a retired health care executive, a former work peer, or simply as an acquaintance; but my performance of this study is a bit different from either of those roles***.**

I invite you to take part in a research study of exploring optimal strategies designed for physician leaders of solo and small medical group practices to determine what approaches can stabilize market share percentages. *Anticipated outcomes will concentrate on helping me, the researcher, explore effective tactics for organizational profitability and sustainability of the practices.* I am inviting a set of 15-20 primary care practitioner physicians, having some degree of familiarity with the challenges faced by solo practice and small medical group physicians in the Baltimore-Washington metropolitan region, to be in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher, Gerald L. Anderson, who is a doctoral student at Walden University

Background Information:
The purpose of this qualitative, explanatory collective case study is exploring effective competitive approaches designed to help physicians in solo practice and small medical group PCPs retain their small business medical practices. Insight generated from responses to the interview questions, and the participant-derived perspectives should reveal competitive approaches that help physicians in solo practice and small medical group PCPs retain their small business medical practices.

Although the focus of this study is solo/small medical group practices, for application of data source triangulation, included are some organizationally-employed physicians, who do not all fall into the category of solo practitioner or small medical group practices. Physicians of this type allows for data source triangulation of the data set through input from related diverse multiple-lens data sources and allows for a more complete representation of circumstances surrounding the phenomena. Organizationally-employed PCP physicians are aware of many competitive issues faced by solo practice and small medical group practice PCPs but from a different, convergent viewpoint. The data source triangulation approach opens a door to strategic perspectives of physicians who chose employee status in other health care services delivery environments, about the small business environment of solo/small group practice. The perspectives may prove useful in helping better understand the strategic worldview of the small business solo/small group physicians, by way of contrast, if there is, in fact, a difference.

Procedures:
If you agree to be in this study, you will be asked to:

- Agree to one semistructured interview that can range from 30 – 45 minutes, but longer, if you desire.
- Allow for interview recording with a digital audio recorder and written notes
- Here are some sample questions:

1. To keep a medical practice viable and competitive, what 5-year and 10-year goals would you set for the practice?
2. From your perspective, what behavior patterns and personal characteristics are necessary for physicians to keep their medical practices viable and competitive to achieve the 5-year and 10-year goals you identified?
3. How and when would you measure whether or not you achieve each of the goals you identified?
4. How would you go about achieving the identified goals?

- *Within three (3) days after the interview, I will email you a summary of your responses to the interview questions. This process, called member checking, helps confirm the plausibility of data gathered, avoids misinterpretation, and allows you an opportunity to provide additional relevant information. After you receive the email, I will call you for a brief 5-to-10 minute follow-up, or longer, if you desire, as a close out to the interview.*
- *Your practice (or organization) experienced successes in a very competitive environment. If you received strategic planning, marketing, or management guidance (internal or external), and there is written documentation that outlines the steps that were taken to help bolster the medical practice's competitive and financial sustainability, may I briefly review the document?*

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. If you decide to join the study now, you can still change your mind later. *You may stop and withdraw from the interview or the study at any time. Declining to participate, or discontinuing, will not negatively impact our relationship in any way.*

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minor discomforts encountered in daily life, such as fatigue. Being in this study would not pose risk to your safety or well-being.

Benefits derived from this study will allow an *internal, self-directed* assessment of individual participants' past medical practice business management behavior patterns, and will show how the patterns impact current and future conditions. If participation in the study *stimulates an in-house* evaluation of existing policies and procedures that reveals a need for restructure, an opportunity is available for *internal, self-directed exploration and collaborative development, within the medical practice,* of new ideas geared toward establishing or maintaining organizational sustainability, tailored for each participant's separate small medical group practice. The positive social impact is that physician leaders, especially for participants in my age cohort, may make strides toward maintaining peace of mind by developing current business-focused processes and knowledge sets, and helping establish paths toward organizational sustainability.

Payment:
There is no payment for participation in this study.

Privacy:
Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Copies of the audio recordings from the interview, along with all other data related to you or your organization, will be stored on a thumb drive data storage device that is password-protected. The thumb drive and any related paper documents will be retained for five years in a locked safe. After five years, data on the thumb drive will be securely erased, and any paper documents will be shredded, to protect your confidentiality.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via telephone (301) 931-0867 or e-mail Gander0128@aol.com. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210. Walden University's approval number for this study is **04-21-16-0486044** and it expires on **April 20, 2017.**

The researcher will give you a copy of this form to keep.

Statement of Consent:

I have read the above information, and I feel I understand the study well enough to make a decision about my involvement. By signing below, I understand that I am agreeing to the terms described above.

Printed Name of Participant _____

Date of consent _____

Participant's Signature _____

Researcher's Signature _____

Appendix B: Interview Questions

1. From a strategic thinking perspective, to retain their small business medical practices, what 5-year and 10-year goals should PCPs set for the practice?

2. From your strategic thinking perspective, what behavior patterns and personal characteristics are necessary for physicians to retain their small business medical practices and achieve the 5-year and 10-year goals you identified?

3. Strategically thinking, how and when would you measure whether or not you achieve each of the goals you identified to help retain small business medical practices?

4. From a strategically adaptive perspective how would you go about achieving the identified goals to help retain small business medical practices?

5. From a strategically adaptive perspective, what past medical practice business behaviors might prevent you from achieving the stated goals associated with retaining small business medical practices?

6. Strategically thinking, what current medical practice business policies and procedures are useful in helping you continue toward the stated goals associated with retaining small business medical practices?

7. From a strategically adaptive perspective, how do innovations and new ideas and medical practices, such as accountable care organizations or patient-centered medical homes affect goals associated with retaining small business medical practices?

8. Strategically thinking, how do factors like the country's economic state, technology advances, changing demographics, government policies affect goals

associated with retaining small business medical practices? Specifically, address each factor.

9. From a strategically adaptive perspective, how do a different set of factors such as competitive rivalry, increased patient sophistication, and bargaining power, increased use of physician-extender providers, and potential barriers to entry of new competitive markets affect goals associated with retaining small business medical practices? Specifically, address each factor.

10. Considering the factors in the prior two questions, how would you strategically adapt and adjust the goals and measures you identified earlier in the interview, in a way that adequately responds to all the factors that can affect efforts associated with retaining small business medical practices?