FLORIDA INTERNATIONAL UNIVERSITY

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ADVANCING U.S. HEALTHCARE EXCELLENCE: EXPLORING ORGANIZATIONAL INTENTION TO ADOPT OPERATIONAL QUALITY IMPROVEMENT

A dissertation submitted in partial fulfillment of

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by

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To: Dean William G. Hardin
College of Business

This dissertation, written by Liliya R. Yausheva, and entitled Advancing U.S. Healthcare Excellence: Exploring Organizational Intention to Adopt Operational Quality Improvement, having been approved in respect to style and intellectual content, is referred to you for judgment.

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DEDICATION

I dedicate this dissertation to my family, whose unwavering support, encouragement, and love have been the foundation of my journey. To my father, who instilled in me the values of education, persistence, hard work, and the belief that you can achieve anything you put your mind to. To my daughter, Josephine, who inspires me every day to strive for excellence and to never stop learning.

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ABSTRACT OF THE DISSERTATION

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The research study investigated the factors influencing the intention to adopt Operational Quality Improvement (OQI) in U.S. healthcare organizations. It underscored the critical need for business process improvement in healthcare, a sector that represents 18% of the U.S. GDP with costs projected to reach $12 trillion by 2040. The study investigated key factors that drive the adoption of OQI, including awareness of organizational performance, rivalry intensity, patient-focused culture, top management support, process-oriented culture, and IT personnel business knowledge. The research was built on established theories such as the Theory of Planned Behavior, emphasizing the importance of organizational perceptions of need and readiness in OQI adoption. A cross-sectional survey was conducted (N=300), targeting employees from U.S. healthcare companies.

The result indicated that rivalry intensity ($p=.002$), and patient focus ($p<.001$) influence the organization's perception of need for OQI, and top management support ($p<.001$) and process-oriented culture ($p<.001$) were predictors for the perception of readiness. The findings implied that healthcare organizations with higher perceptions of need ($p<.001$) and readiness ($p<.001$) are more likely to adopt OQI. Factors such as IT personnel's business knowledge

(p=.312) and awareness of organizational performance (ß= -.663, p=.001) did not support the predicted relationships. The study makes valuable contributions to theory and practice. The study expands the scope of the previous research focus by identifying the antecedents of OQI adoption in healthcare. It provides insights into the factors that drive the successful adoption of quality improvements and contributes to managerial strategic decision-making.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER PAGE

LIST OF FIGURES

CHAPTER PAGE

INTRODUCTION

Staggering results by the Harris Poll, in partnership with the American Academy of Physician Associates, reported that nearly 70% of adults say the healthcare system fails to meet their needs in at least one way ("The patient experience: perspectives on today's healthcare," 2023). Health is complete physical, mental, and social well-being, a fundamental human right. Achieving the highest level of health is the most crucial global social goal (Declaration of ALMA-ATA, 2015). One of the world's most expensive healthcare systems is in the United States, with costs representing 18% of the gross domestic product (GDP) (Shrank et al., 2019). Over the past four decades, healthcare spending in the U.S. has increased despite efforts to control costs and reduce waste. These high costs are projected to triple nearly $12 trillion by 2040, or 26% of the GDP (Davis, 2021). Shrank et al. (2019) reported that prior studies estimated that approximately 30% of healthcare spending resulted from waste. Despite efforts to improve care and address overspending, waste costs are projected to remain in the U.S. healthcare system (Shrank et al., 2019). Similarly, Essila & Motwani (2023) reported that since 2006, a 40% increase in healthcare supply chain costs resulted in inefficient primary care and limited access to quality care (Essila & Motwani, 2023).

Today's healthcare system is complex and often contradictory. While it offers remarkable technological and treatment advancements, it is frequently hindered by inefficiencies, errors, resource limitations, and other issues that jeopardize patient care accessibility and safety (Tolga Taner, 2007). The healthcare system remains substantially below acceptable standards in ensuring patient safety and addressing patient needs

(Wolfe, 2001). In 1998, the Institute of Medicine released an assessment stating that adverse events such as errors in healthcare delivery contributed to the deaths of 98,000 patients annually, stressing the necessity for quality improvement and patient safety. These errors are costly for hospitals and patients, resulting in patients losing trust in the system and decreased satisfaction of both patients and healthcare professionals (Donaldson et al., 2000).

Over the past decade, the focus on efficiency has become a top priority for numerous healthcare organizations, including hospitals (Al Amin et al., 2016). Huerta et al. (2016) found a positive relationship between quality and efficiency, resulting in increased patient satisfaction and lower costs (Huerta et al. 2016). Al Amin et al. (2016) also argued that efficient organizations are more agile and well-suited to effectively improve their processes (Al Amin et al., 2016). The healthcare industry considers Quality Improvement (QI) a crucial element in achieving operational effectiveness. QI involves systematically examining and refining existing healthcare procedures to enhance patient outcomes, gain operational excellence, cut costs, and boost efficiency (Wainana, 2023). Healthcare managers are challenged with delivering effective, efficient, high-quality healthcare services at low cost. Quality initiatives are proven to yield benefits to maximize efficiency and minimize poor performance; however, many healthcare organizations struggle with QI implementations to achieve desired outcomes (Abdallah, 2014; Akmal et al., 2021; Mohammad Mosadeghrad, 2013).

Significance of the Problem

The Institute of Medicine defines health care quality as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with professional knowledge." Furthermore, effectiveness, efficiency, equity, patient-centeredness, safety, and timeliness are the properties or domains of quality (Understanding Quality Measurement, 2020). Implementing operations quality improvements in healthcare using traditional methods can be challenging; therefore, improvements require considerable process redesign based on knowledge of how people interact with processes and products. One of the most important aspects of QI is measuring defects (Varkey et al., 2007). As a systematic, data-driven approach to achieving immediate, beneficial changes in healthcare delivery, QI focuses on specific systems, processes, or outcomes and uses particular tools and methodologies (Kaplan et al., 2010). QI ensures that improvement efforts result in the desired change, bring the process back to its acceptable ranges, and control for unintended results in different parts of the system (Varkey et al., 2007). The widespread use of common QI approaches and methods now combines traditional quality assurance with proactive approaches such as Six Sigma, Lean, Total Quality Management (TQM), Continuous Improvement, and The PDSA (plan-do-study-act) cycle (Akmal et al., 2021, Varkey et al., 2007). Yet, much research claims that the evidence of the QI impact ranges from significant improvements to little or no improvements (Akmal, 2021). Bessant et al. (2001) stated that although programs such as 'kaizen' or continuous improvement involving employee engagement are started, the failure rate is high (Bessant et al., 2001). Companies achieve short-term benefits; however, continuous improvement doesn't

materialize in the long term. Despite the wide application of TQM in the last 15 years, two out of every continuous improvement initiative fail to deliver the desired performance (Lillrant et al., 2001). The literature on failure rates is also consistent with quality improvement projects involving Information Technology (IT) in healthcare. Despite the U.S. government's focus on improving healthcare and efforts to leverage the numerous benefits of health information technology for healthcare quality and cost savings, reports highlight the complexity and challenges of implementing even smaller-scale systems. IT implementation projects frequently fail, with at least 40% of projects being abandoned or struggling to meet business requirements. Some reports suggest failure rates as high as 70% (Kaplan & Harris-Salamone, 2009).

Research Gap

Much recent research on QI in healthcare continues to emerge. Boyer et al. (2012) pointed out that emerging literature examines the impact of operations and quality tools in healthcare. However, application in hospital settings, for example, still needs to be more extensive (Boyer et al., 2012). Furthermore, most QI methodologies, by their general nature, were designed for the manufacturing sector. Therefore, there are questions regarding QI's applicability to the healthcare sector (Abdallah, 2014; Mohammad Mosadeghrad, 2013). For example, Tolga Taner et al. (2007) pointed out that applying Six Sigma in healthcare services is a relatively new topic, and more research should be done in this area (Tolga Taner et al., 2007). The existing literature evaluates the success and failure factors of QI implementation for various reasons (Abdallah, 2014). The primary focus in past empirical literature publications has been primarily on describing

quality improvement methodologies (e.g., Lean Six Sigma), their benefits, implementation experience or usage, and success stories in healthcare (Sohal et al., 2022). Limited attention is given to evaluating the anteceding behavioral intentions that influence the success or failure of the QI initiative. As many organizations report disappointment and failure with improvement programs, one of the resulting failure factors is the lack of understanding of the behavioral dimension (Bessant et al., 2001). Ljungström and Klefsjö (2002) stressed the importance of considering human factors to achieve the objectives of quality improvement practices such as TQM (Ljungström & Klefsjö, 2002). The successful implementation of the QI lies in its adoption by the organization. An individual's willingness to adopt a new healthcare initiative can be achieved by understanding behavioral intentions to adopt or start a new initiative (Sintonen & Immonen, 2013). The literature provides a limited narrative on adopting QI in the context of operations in U.S. healthcare organizations. There is a growing need for further research on factors contributing to the behavioral intention to adopt operations quality improvement. Such research is essential as it can enhance healthcare service quality and, ultimately, lead to better patient health outcomes.

Research Question

To further the existing knowledge and help close the literature gap on operational quality improvement, this research study seeks to answer the overarching question: What factors influence the intention to adopt Operational Quality Improvement (OQI) in U.S. healthcare organizations?

Research Contributions

The U.S. healthcare organizations are challenged with delivering quality care and sustaining operational efficiencies. The findings from this research provide some guidance to healthcare professionals and leaders. This study offers insights into the relationship between employee perceptions and intention to adopt OQI. When there is a high need, and the employees in the organization feel ready, there is a more likely chance of the successful adoption of OQI. This knowledge will equip healthcare leaders to foster positive attitudes toward QI practices that lead to the adoption of improvements. By identifying critical determinants of successful OQI adoption, healthcare managers can be more equipped to develop effective implementation strategies to address specific barriers and leverage facilitators. The main goal of healthcare organizations is to enhance patients' health. With improved OQI, healthcare managers can achieve higher standards of care, leading to better patient outcomes such as patient safety, satisfaction, and overall healthcare system performance. QI is crucial in achieving operational effectiveness and reducing waste and inefficiencies. The study's findings can help healthcare organizations cut unnecessary costs, especially given projections that healthcare costs in the U.S. could reach $12 trillion by 2040.

The research study contributes to the literature and theory in several ways. Prior studies on QI in healthcare focused on evaluating the success or failure factors for QI implementation for various reasons or describing QI methodologies. With this research study, the attention to anteceding behavioral intention to adopt OQI extends the Theory of Planned Behavior, enriching the theoretical framework. The study's novelty is in introducing a two-dimensional relationship between employees' perception of need and

readiness and the organizational intention to adopt OQI. The research will provide empirical evidence on the factors influencing perceptions that drive behavioral intentions to adopt OQI, contributing to the theoretical understanding of organizational behavior. Lastly, questions about their applicability in healthcare operations still challenge emerging research on QI methodologies. This research will empirically analyze contextual factors influencing more substantial OQI adoption in the healthcare industry.

BACKGROUND LITERATURE REVIEW AND THEORY

Walter Shewhart was an American physicist in the 1900s who first introduced the work on quality control statistics. He is referred to as the "father of statistical quality control." Shewhart worked at Hawthorne's manufacturing plant, which produced telephone equipment. In 1924, Shewhart described the first control chart, which was the beginning of statistical process control and quality improvement. A series of research projects started, later known as the Hawthorne studies. The essence of statistical process control lies in reducing variation to improve quality. A control chart is a tool to distinguish between two variation categories, Shewhart called "assignable-cause" and "chance-cause." The goal is to bring a process into a statistical control state where there is only chance-cause variation, and keeping it in control was needed to reduce waste and improve quality. Shewhart proposed using the statistical control charts to his supervisors at Hawthorne. For the next 50 years, other industries embraced Shewhart's ideas. Clinical laboratories incorporated statistical process control into standard operating procedures and proficiency testing. Motorola developed the philosophy for quality improvement based on statistical process control, which we now know as "Six Sigma." It is a statistical measurement unit that describes the distribution of the mean of any process. If a process reaches plus or minus six-sigma capacity, it can expect a few parts per million of a defect rate, achieving zero defects. Companies such as General Electric also started using Six Sigma methods (Best & Neuhauser, 2006). In his book, "Statistical Method from the Viewpoint of Quality Control," Shewhart laid the foundation for quality improvement by describing three steps in the quality control process: the specification of what is wanted,

the production of things to satisfy the specification, and the inspection of the things produced to see if they fulfill the specification (Shewhart, 1939).

Dr. W. Edwards Deming, an American statistician, expanded Shewhart's three-step model and developed the "plan, do, study/check, and act" (PDSA or PDCA) cycle that was applied to management practice in manufacturing (Endalamaw, 2024). The Deming cycle has four stages: 1. Plan: identify what can be improved and what change is needed; 2. Do: implement the design change; 3. Study: measure and analyze the process or outcome; and 4. Act: if the results are not as hoped for. This never-ending cycle is used to make changes that lead to continuous improvement (Best & Neuhauser, 2006). Deming's work does not only encompass quality control and productivity. It encapsulates a broad vision of the nature of organizations and how they should be changed. Observation of variability that exists everywhere in everything is the basis of Deming's theory. A phenomenon can be understood through statistical study and analysis of variability to make changes. Deming's ideas did not receive much recognition in the United States post-World War II (Gartner & Naughton, 1988). American industry had the best position in the world compared to Europe, Russia, and Japan. American industry executives were not interested in changing methods of production or management practices. Therefore, Deming took his ideas to Japan, where manufacturing production was reduced dramatically. He collaborated with executives of major companies such as Sony, advocating that improving quality would reduce expenses and increase productivity and market share. In the next 25 years, Japan became the country that exported the highest quality automobiles and electronics, which did not exist anywhere in the world. Companies like Honda and Sony have become a threat to competition in large

industries in the United States. After nearly three decades, Deming's ideas began to show interest in his home country (Smith, 2021). The statistical process control by Shewhart and Deming's theory served as the baseline for the foundation of principles for quality improvement. These principles are rooted in production and manufacturing but gradually transitioned to the healthcare setting (Endalamaw et al., 2024).

Quality improvement projects have been adopted in the healthcare industry and are critical in enhancing quality in health systems. The growing spread of QI initiatives has generated research interest in understanding QI better. Kuperman et al. (1991) applied a continuous improvement approach to healthcare, using the five steps: selecting a process to be improved, assembling a team of expert clinicians who understand the process, determining key steps in the process, collecting data, and providing data feedback to the practitioners. The authors challenged the traditional quality assurance in hospitals that primarily focused on monitoring and reviewing low-frequency adverse events, tracking the occurrence of unacceptable events, and bringing them to the attention of a reviewing subcommittee. Quality assurance gained a negative and defensive posture among physicians because of the focus on low-quality outliers, often leading to disciplinary action. Through the five-step approach, the data continue to be collected and routinely fed back to the physicians for quality improvement. (Kuperman et al., 1991).

The existing literature on quality improvement in the healthcare industry investigates the success, failure, and readiness factors of quality improvement initiatives. Studies on adopting improvement methodologies such as Lean, Six Sigma, and similar have gained popularity in research. Al-Balushi et al. (2014) conducted a comprehensive literature review on lean practices in healthcare to determine the critical readiness factors

for the success of lean improvements. The authors categorized readiness factors into seven categories: strong leadership's support for lean, identifying lean with the strategic agenda, customer orientation/value, process focus, employee training, measurement, rewards system, and demand for improvements. The study highlighted the key takeaways, stating that lean implementation requires a change in the culture of a healthcare setting and that leadership must have strong support and commitment. The changes must be communicated to employees as a long-term strategy and what value the change brings to the customers and the company. The focus on the process will enable the identification of what needs to be improved or waste and value within the healthcare environment. Training, encouragement of employees, and reward systems are ways to achieve sustainability of improvements and reduce turnover. Lastly, matching patient demand with a company's capacity will improve patient and staff satisfaction (Al-Balushi et al., 2014).

Similarly, Vaishnavi and Suresh (2020) identified and categorized readiness factors for implementing Lean Six Sigma (LSS) in healthcare organizations using the total interpretive structural modeling technique. 16 readiness factors were identified for the successful implementation of LSS. The results indicated that management commitment and leadership were among the most influential factors in implementing LSS. Another critical factor was customer focus, identifying customer needs and requirements, and overall communication. Other readiness factors included technology resources and organizational structure. The study outcomes guided healthcare managers in implementing LSS successfully. The key takeaways suggested prioritizing customer-oriented and goal management culture, management support and commitment, and

organizational infrastructure. Understanding the readiness of these factors is valuable for managers before starting the implementation of LSS (Vaishnavi and Suresh, 2020).

In another study, Kaplan et al. (2010) systematically reviewed forty-seven articles to identify contextual factors influencing QI success. The authors discuss the theoretical concepts of organizational change, innovation, implementation, knowledge translation, and dissemination, which are affected by context in the success of QI. The outer setting, the inner setting, and the characteristics of individuals are areas that can be considered aspects of context. The outer setting represents the organization's economic, political, and social context. The inner setting comprises structural characteristics, network, communication, culture, implementation climate, and readiness for implementation. The individual characteristics include knowledge, self-efficacy, identification with the organization, and other personal attributes. These dimensions of the context influence the QI initiative and its success. Furthermore, the essential five elements of successful organizational transformation to improve patient care include motivation to transform, leadership commitment to quality, improvement initiatives that engage staff, alignment to achieve consistent goals and resource allocation, and integration across the organization's boundaries. These fundamental elements drive change and, in turn, impact the mission, strategy, culture, operational processes, and infrastructure (Kaplan et al., 2010).

Solomons and Spross (2011) examined the barriers and facilitators to adopting evidence-based practice (EBP) in nursing management. The authors discussed the barriers and facilitators of EBP adoption at the individual and organizational levels. The study was based on Shortell's dimensions of continuous quality improvement, which include strategic, cultural, technical, and structural dimensions. The strategic dimension

represents aligning quality improvement goals with mission and priorities. Time constraints, leadership de-prioritization, resource constraints, and heavy workload are barriers to EBP adoption within the strategic dimension. Cultural barriers such as resistance to change and lack of authority to change practice hinder the adoption of EBP. The technological dimension barriers include poor information systems, difficulty accessing resource materials, lack of ongoing training on EBP, information-seeking skills, and understanding of technical resources. Lastly, the structural dimension included a lack of awareness of the research, information unavailable in one place, or difficulties with the information format (Solomons & Spross, 2011).

The healthcare environment is dynamic; healthcare activities and changes must be managed. Technological advancements, rapid growth, and innovations in healthcare services create the need for improvements and require ongoing change. To succeed, healthcare organizations must recognize opportunities and be ready for change (Al-Hussami et al., 2018). Change management starts with identifying the need for change and initiating process change (Yildirim Saatçi & Ovacı, 2022). Moran and Brightman (2001) discussed the change cycle as a motion of resisting change, acknowledging the need for change, identifying required changes, and developing implementation strategies. Change can be costly; however, leaders admit to taking action when it is evident that the change is needed. The authors' observations about change indicate that the change is nonlinear, and often, there is no clear definition of the beginning and end. When improvements are successful in one area, it usually triggers the need to initiate a change effort in another area. Leading change is organization-wide and is everyone's shared responsibility in an organization. One of the failure factors of a change effort is the lack

of support of the whole organization. The authors also pointed out that organizational change has critical personal dimensions. Creating a more profound organizational change will allow employees to assess and alter their values and belief systems about the change (Moran and Brightman, 2001). Kwahk and Lee (2008) pointed out that organizations must constantly change their structures, objectives, processes, and technologies to sustain their competitive advantage (Kwahk & Lee, 2008). To accept change, the employees must be aware of the need for change, be open to it, and understand its underlying reasons (Yildirim Saatçi & Ovacı, 2022). Backer (1995) discussed that organizational assessments typically focus on the needs of individuals or groups for a particular innovation. However, these needs assessments are not the same as readiness assessments. There might be a high perceived need but low readiness to implement a change initiative (Backer, 1995).

Organizational Readiness

Creating organizational readiness for change has been identified as a significant factor in reducing resistance to change and successful implementation (Kwahk & Lee, 2008; Weiner et al., 2008). Failure to implement large-scale organizational change happens when leaders don't create sufficient readiness. Organizational readiness is "the extent to which organizational members are psychologically and behaviorally prepared to implement organizational change." When organizational readiness is high, employees are more empowered to accept change (Weiner et al., 2008). Employees' perceptions, defined as "the cognitive precursor to the behaviors of either resistance to or support for a change effort," have been identified as one crucial factor in understanding sources of resistance to change (Eby et al., 2000). Previous studies applied readiness for change to

evaluate the change implementation process in different industries, including healthcare. In a cross-sectional survey, Paré et al. (2011) investigated factors associated with clinicians' perceptions of readiness for adopting an electronic medical record (EMR) system. The authors based the study on the assumptions of the change management theory that argues that there are four classes of antecedents that have a direct effect on perceived organizational readiness for change: the attributes of the change, the extent of the leadership support, the organizational context, and the characteristics of the change. Variables, such as attributes of the change (vision clarity, change appropriateness, change efficacy), leadership support (top-management support, presence of an effective champion), internal context (organizational history of change, conflicts, flexibility), and attributes of the change targets (collective self-efficacy) were identified as facilitators of clinician's interpretation of organizational readiness for change during the EMR pre-implementation phase. The study revealed that change attributes significantly and positively influenced clinicians' perceptions of organization readiness for EMR. This indicates that articulating vision clarity and change appropriateness before introducing change can have greater success in accepting change. The presence of an effective project champion and collective self-efficacy also had a positive and significant relationship with clinicians' perceptions of readiness. However, there was minimal support for the organizational context within which change is implemented (Paré et al., 2011). Holt et al. (2007) discussed the development and evaluation of an instrument that can be used to measure readiness for organizational change at an individual level. The authors evaluated 900 employees from the public and private sectors. The proposed conceptual framework included the change content, process, internal context, and individual characteristics. The

authors defined readiness as a "comprehensive attitude that is influenced simultaneously by the content (i.e., what is being changed), the process (i.e., how the change is being implemented), the context (i.e., circumstances under which the change is occurring), and the individuals involved (i.e., characteristics of those being asked to change). Collectively, readiness is the extent to which individuals are cognitively and emotionally inclined to accept, embrace, and adopt a particular plan. The analysis identified that the belief that a change was necessary, could be implemented, was organizationally beneficial, and that leaders were committed to change were the most influential factors on readiness for change (Holt et al., 2007). Readiness involves being fully prepared to take action. This occurs when organizational members are receptive to change, and attitudes are favorable. As a precursor, readiness is crucial for successfully adopting QI. Understanding an individual's behavioral intentions to embrace a new healthcare improvement initiative can influence their willingness to adopt change (Gfrerer et al., 2021; Sintonen & Immonen, 2013).

Theory of Planned Behavior (TPB)

Human behavior is goal-oriented, and intentions control our actions (Ajzen, 1985). As an extension of the theory of reasoned action, an individual's intention to perform a given action is a central factor in TPB. Intentions involve motivations influencing behavior, indicating the willingness and effort an individual plans to put into performing an actionable act. The stronger the intention, the more likely the action will be performed. The determinants of intention in TPB assume our attitude toward the behavior, subjective norm, and perceived behavioral control. Attitude toward the behavior is the degree to which a person has a favorable or unfavorable evaluation of the

behavior. Subjective norm is the perceived social pressure to perform or not to perform the behavior. Perceived ease or difficulty in performing the behavior is perceived behavioral control, which reflects an individual's past experiences and challenges. The more positive an individual's attitude and subjective norm are, and the greater their perceived control over the behavior, the stronger the intention to take action (Ajzen, 1991).

The empirical studies that use the adoption intention concept and theory primarily investigate specific healthcare technological innovation adoption (Saheb, 2020; Zhang et al., 2023; Sintonen & Immonen, 2013; Page, 2015). The application of the TPB in healthcare as it relates to the adoption of OQI is limited in empirical research. Previous research evaluates specific behaviors in healthcare settings. In one study, researchers surveyed nurses at selected hospitals to identify what influenced nurses' intention to implement patient safety behaviors. The study was based on the TPB model, and the results indicated that normative beliefs and subjective norms were the most influential factors in the safety behavior of nurses (Javadi et al., 2013). In a qualitative study by Zielińska-Tomczak et al. (2021), TPB was used as a theoretical framework to understand the interprofessional collaboration between pharmacists and physicians. The results provided insights into how the partnership was perceived and the barriers to collaboration and opportunities. For example, positive attitudes influenced the intention to establish a professional partnership. On the other hand, subjective norms were presented as hindrances in willingness to collaborate (Zielińska-Tomczak et al., 2021). Jackson and Mazur (2011) used mixed methods to evaluate healthcare participants' behaviors for a Lean improvement initiative in another research study. Quantitative data was obtained

through the survey about employees' satisfaction with lean work and assessment of process flow improvement. Qualitative data was gathered through direct observations and interviews. The results indicated that the interplay of perceived behavioral control, attitude toward the behavior, and subjective norms resulted in successes and failures of lean efforts on behavioral changes. For example, incorporating a specific improvement aspect, such as a whiteboard, was not dependent on attitudes or subjective norms. Low perceived behavioral control was observed with the new procedure documentation and communication, resisting lean improvement until sufficient training was provided (Jackson & Mazur, 2011).

The literature on adopting OQI in healthcare reveals several gaps. Much research has focused on the success factors of implementing improvement methodologies, such as Lean Six Sigma practices. Fewer studies have specifically applied the theory of planned behavior to the broader context of OQI adoption. The existing studies often concentrate on individual behaviors within specific healthcare settings rather than exploring the comprehensive application of TPB to organizational readiness and the need for quality improvement initiatives. While the literature review provides a baseline, this research extends the empirical research to understand how these factors collectively influence the intention to adopt OQI in healthcare organizations.

RESEARCH MODEL AND HYPOTHESES DEVELOPMENT

The ultimate goal of all healthcare systems is to improve the quality of patient care (Nicolay et al., 2012). Healthcare organizations turn to QI as a primary approach to measuring performance and implementing change (Colton, 2000). Specifically, OQI is designed to systematically evaluate, optimize operations, and enhance efficiency to improve overall performance (Brown, 2024). The healthcare environment is complex, with interconnections between external, internal, and human factors. This research will investigate factors influencing U.S. healthcare organizations' behavior in adopting OQI. Figure 1 below presents the conceptual model and hypotheses that will be examined in this research. It includes six independent variables (Awareness of Organizational Performance, Rivalry Intensity, Patient Focus, Management Support for OQI, Process-Oriented Culture, and Information Technology (IT) Personnel Business Knowledge), two mediators (Perception of Need and Perception of Readiness), and one dependent variable (Intention to Adopt OQI). Through the lens of the theory of planned behavior, it is assumed that an individual's intentions influence human behavior in taking certain actions. Furthermore, specific belief systems include attitudes, subjective norms, and perceived behavioral controls influencing individuals' intentions. The research model suggests that these belief systems shape individual perceptions such as need and readiness, which are precursors of the intention to adopt OQI.

Conceptual Framework

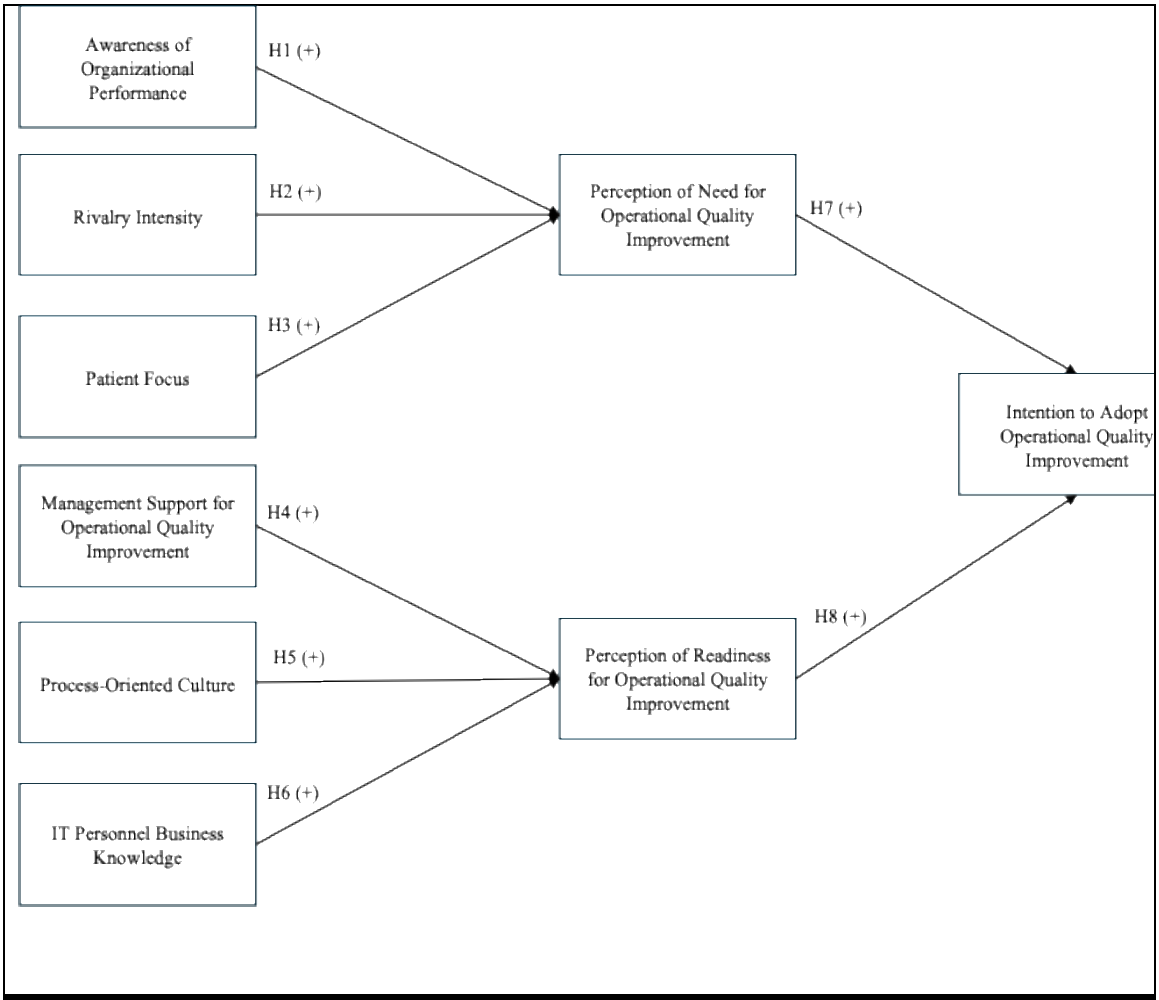


Figure 1 The Conceptual Research Model

Theoretical Development and Hypotheses

Awareness of Organizational Performance

Organizational performance, measurement, and reporting are essential in healthcare. They play a crucial role in management accountability and contribute to improvements. Insights obtained from performance measures guide organizations in achieving outcomes, improving care efficiency, and pinpointing areas for improvement. Reporting

performance yields potential benefits and securing change among clinicians and delivery organizations (Levesque & Sutherland, 2017). Fung et al. (2008) conducted a systematic review of peer-reviewed articles assessing the effects of public release of performance data on the selection of providers, quality improvement activity, and clinical outcomes (effectiveness, patient safety, and patient-centeredness). The evidence suggested that releasing performance data publicly stimulates quality improvement activity at the hospital level (Fung et al., 2008).

In healthcare, measuring performance means quantifying achievements by healthcare organizations and professionals regarding services delivered relative to patient needs and expectations, patient outcomes, processes, and models of care (Levesque & Sutherland, 2017). McCracken et al. (2001) discussed the difficulty of measuring the effectiveness and efficiency of performance in healthcare organizations due to its complexity. Therefore, the best indicators of healthcare organization performance are financial measures that address the profitability and growth of the organization. This includes sales, return on investment, and earnings per share. Another criterion believed to be a determinant of profitability is market share, which includes operational and financial performance (McCracken et al., 2001). Law & Ngai (2007) defined organizational performance as an individual's perceptual rating on customer satisfaction of products and services, customer retention rate, sales growth, profitability, and overall performance of the organization (e.g., financial performance, customer employee engagement, operational efficiency, and market position) (Law & Ngai, 2007). While empirical research is limited in the context of OQI for the awareness of organizational performance and the need for OQI, similar topics have been researched previously. A study by

Mutonyi et al. (2022) emphasized that healthcare employees are more likely to perceive the need for innovative behavior when they are aware of organizational performance effectiveness (Mutonyi et al., 2022). Another research by Atalla et al. (2024) investigated the moderating role of ethical awareness between nurses' artificial intelligence perceptions, attitudes, and innovative work behaviors. The results indicated a statistical significance between attitudes, ethical awareness, and innovative work behaviors (Atalla et al., 2024). To achieve a transformational process, employees must be aware of the need for change (Yildirim Saatçi & Ovacı, 2022). Building on the above, it can be inferred that when individuals within an organization have an awareness of their organization's performance, they are more likely to identify the necessity for improvement; thus, the proposed hypothesis is stated as follows:

H1: There is a positive relationship between awareness of organizational performance and the perception of need for OQI, such that organizations with higher levels of awareness of organizational performance will also have higher levels of perceived need for OQI.

Rivalry Intensity

One of the critical factors influencing organizations' drive for improvement is competitive advantage and position in the market. Porter (2008) stated that the basic components of competitive advantage are the various activities involved in creating, producing, selling, and delivering products or services. Performing these activities better, faster, and with fewer inputs and defects than rivals constitute operational effectiveness. The strength of rivalry reflects the intensity and the basis of competition (Porter, 2008). Pecotich et al. (1999) defined the intensity of rivalry as "the extent to which firms in the

industry frequently and vigorously engage in outwardly manifested competitive actions and reactions in their search for competitive advantage in the marketplace." The authors suggested that executives' perceptions of industry dynamics offer an empirical position for the hypothesis that as competitive rivalry intensifies, so does the need for firms to pursue enhancements and innovation. As rivalries sharpen, firms are pressured to distinguish themselves through improvements in efficiency, product quality, and market positioning to maintain or achieve a competitive edge (Pecotich et al., 1999). Lascelles and Dale (1988) also discussed that the evolving dynamics of the marketplace, driven by rising customer expectations and intensified competition, strongly emphasize the need for organizational change. Companies must adjust their organizational objectives as the market demands quality and stricter adherence to high standards. Competition and demanding customers drive transformational change (Lascelles & Dale, 1988).

The healthcare industry in the United States is more competitive than any other country (Blackstone & Fuhr, 2007). Patients are becoming more demanding, seeking better health information and sharing decision-making with their healthcare providers. For example, consumer behavior, such as the tendency to use technology and digital tools, influences the demand on the market. Various medical apps have been offered to help manage patients' health or services such as telehealth. Healthcare organizations must sense these trends and act on these opportunities (Vrontis et al., 2022). A company can outperform rivals only if it can establish a difference and preserve it through operational effectiveness, as the primary goal of any enterprise is superior performance. To achieve this, the company must create and deliver greater value for customers or offer comparable value at a lower cost (Porter, 2008). Based on the notion that competitive pressures

influence healthcare organizations to improve their operations, the proposed hypothesis suggests that:

H2: There is a positive relationship between rivalry intensity and the perception of the need for OQI, such that organizations that experience high levels of rivalry intensity will also perceive a greater need for OQI.

Patient Focus

The healthcare industry is becoming consumer-centered, and nowadays, every patient is considered a unique case with different needs at different times. Patients with more access to health information are more willing to explore different options if unsatisfied with their healthcare services (Vrontis et al., 2022). Different care models, such as the Chronic Care Model and Patient-Centered Medical Home, recognize patients as active participants in healthcare delivery. Patients' feedback on care experiences, complaints, and comments are used to improve service (Kumah et al., 2020). Measuring patient satisfaction impacts the quality improvement of care. Patients' evaluation of care becomes a tool for identifying opportunities for improvement (Al-Abri & Al-Balushi, 2014). Denison and Neale (1999) stated that a customer-focused organization "understands and reacts to their customer and anticipates their future needs. It reflects the degree to which the organization is driven by a concern to satisfy their customer." An organization that is focused on customer/patient service can facilitate the identification of the key elements that are acting as barriers. These key elements include whether or not individuals at all levels of the organization embrace and own customer service as a performance priority, being accountable for providing quality customer service, empowered, and trained to act on the

customer's behalf, and whether customers' concerns are addressed and accounted for into strategic decisions and goals (Denison & Neale, 1999).

Patient feedback gathered through satisfaction surveys provides insights into patients' needs and expectations. In a study by Cucchiaro et al. (2022), a retrospective analysis of patients' complaints, surveys, and adverse events was performed to identify improvement areas. The study collected 4695 questionnaires and interviewed 1269 patients. As a result, points to improvement were revealed in several areas, such as schedule and punctuality, reception, comfort and environment, treatment unit reliability, staff behavior, quality of care process, side effects, and staff changes. The survey allowed the active involvement of patients as key players in the quality and safety of their own healthcare treatment (Cucchiaro et al., 2022). Grob et al. (2024) conducted a qualitative study of patient experience narratives and how middle managers in outpatient clinics value and use narrative feedback in their daily work. Patient narratives are descriptions of care experiences expressed by patients in their own words. This type of feedback provides details to guide improvement efforts in patient experience and cultivate a service-oriented workplace culture that responds to the patient's needs. Examples of improvement projects identified through the input of patient narratives are providing test results in a complete and timely manner, improving workflow for paperwork completion, keeping patients in exam rooms informed regarding wait times, addressing long wait times, and renovating the space. Patient narratives enable better assessment of patient experience by collecting data directly from the patient. It also provides a deeper understanding of relationships with patients and identifies needs for improvement by learning about operational issues and potential solutions (Grob et al., 2024). Based on the

prior literature and evidence from empirical studies, there is an indication that organizations that focus on patients' feedback and satisfaction are more likely to recognize the need for operational improvements. Therefore, the proposed hypothesis is as follows:

H3: There is a positive relationship between an organization's patient focus and its perception of the need for OQI. Organizations with higher levels of patient focus will also have higher levels of perceived need for OQI.

Management Support for OQI

Top management support has been recognized as an essential success factor for adopting improvement initiatives. Umble & Umble (2002) identified poor management as one of the reasons many improvement projects fail. When top management does not fully commit to supporting the system, anticipates and plans needed changes, and does not recognize it as a transformational effort, implementing the improvement is more likely to be unsuccessful (Umble & Umble, 2002). Results in a quantitative study by Zabjek et al. (2009) also shared similar outcomes. The study found that top management support positively impacted implementing the Enterprise Resource Planning system as an improvement initiative. Authors argued that the leadership's solid support and persistent involvement in every implementation step indicate success (Zabjeck et al., 2009). A systematic review by Bader et al. (2023) of 49 articles examining the critical failure factors of process improvement (PI) projects such as Kaizen, Lean, Six Sigma, and Agile revealed management and leadership-related factors as the main categories. The review identified a lack of top management support, commitment, and involvement as PI projects' most frequently cited factor. Specifically, a lack of top management support was

reported as a common challenge for all types of PI initiatives. Without support from the top management during the project, meeting the overall objectives is at risk. It can also lead to issues such as exceeding the budget and not completing the project on time (Bader et al., 2023). Pare et al. (2011) evaluated organizational readiness for an IT improvement project in healthcare settings. Leadership support was described as support from upper management. The authors indicated that the need for strong leadership is generally accepted wisdom among academics and managerial practitioners. The study presented evidence that top management's actions and commitment were more influential on an organization's perception of readiness than just the presence of a project champion. This suggests that top management support is critical in adopting an improvement initiative. On this basis, the proposed hypothesis is as follows:

H4: There is a positive relationship between top management support for OQI and readiness for OQI, such that organizations with higher levels of top management support will have higher levels of perceived readiness for OQI.

Process-Oriented Culture

Processes are at the core of any organization and continuously need to be evaluated, improved, and implemented in the organizational structure within a framework that supports process-oriented human resources and information systems. Managing processes is important for organizations that want to foster a process-oriented mindset. Lack of adequate management of business processes leads to increased inefficiency, complexity, and waste, ultimately impacting business operations (Kasim et al., 2018). Organizations choose to be process-oriented, focusing on business processes instead of functional or hierarchical structures. A process-oriented organization is concerned with

managing its cross-functional processes regardless of whether or not it has incorporated process improvement initiatives or reengineering. Kohlbacker and Reijers (2013) examined the effects of process orientation on the organization's overall performance in 132 Austrian manufacturing firms. The results indicated that process-oriented dimensions such as performance measurement, structure, continuous improvement methods, and culture positively and significantly affected the firm's overall performance (Kohlbacker & Reijers, 2013). Previous studies on the role of business process orientation and effective improvement implementations, such as digital innovation initiatives and enterprise resource planning, showed positive and significant relationships. Studies identified the business process focus as a success factor for process improvement implementations (Van Looy, 2021; Jarrar et al., 2000). Corporate strategy must inspire a process-oriented culture of continuous learning and improvement (Willaert et al., 2007). Van Looy (2020) defined process-oriented culture as values that favor processes and their translation into attitudes and behaviors. The importance of abstract ideas (i.e., beliefs or principles) within the organization to facilitate the modeling, deployment, optimization, and management of business processes, as well as feelings and activities of organizational members that express process-oriented values beyond the context of individual business processes (Van Looy, 2020). Organizational culture has been identified as one of the influential factors in adopting improvements, organizational change, and performance; therefore, process orientation must be a part of the organizational culture (Willaert et al., 2007; Hribar & Mendling, 2014; Kotter & Heskett, 2008).

Like any other sector, healthcare organizations rely heavily on process management to ensure efficiency, quality of care delivery, and operational excellence. Healthcare operations involve cross-functional processes and the complexity of various functions (e.g., administration, patient care, operations, billing, etc.). As discussed previously, studies in other sectors have shown that if an organization embraces a process-oriented culture, there is tremendous success with improvement implementations and, ultimately, better organizational performance. Healthcare organizations that captivate process-oriented values will likely be more prepared to implement quality improvements, ensuring processes are continuously evaluated, and employees embrace a processes-oriented mindset. Thus, the proposed hypothesis will test the impact of process-oriented culture and perception of readiness for OQI:

H5: There is a positive relationship between the process-oriented culture of an organization and the perception of readiness for OQI, such that organizations with higher levels of process-oriented culture will also have higher levels of perceived readiness for OQI.

Information Technology (IT) Personnel Business Knowledge

The expertise and skills of information technology (IT) personnel have become crucial as IT's strategic importance in modern organizations continues to grow. In addition to technical skills expected from IT personnel, organizational and managerial knowledge becomes mandatory in technical roles. Earlier literature on IT personnel was focused on the types of knowledge and skills. The main argument was whether IT personnel require technical, managerial, or both skills. The notion was that IT personnel needed technical skills, especially in positions such as IT programmers and system

analysts. Managerial and business skills were secondary. This view started to shift as IT value was portrayed more strategically, and the skills needed for IT personnel began to change (Byrd et al., 2004). Todd et al. (1995) argued that IT professionals must acquire knowledge of information technology, systems business, and operating in a business environment to solve problems. The authors classified business knowledge as functional and industry expertise, leadership, project management, planning, and communication skills (Todd et al., 1995). A research study by Nelson (1991) suggested that information system personnel were deficient in general business knowledge such as policies, plans, goals, objectives, and critical success factors. The author concluded that organizations need to identify ways to improve training and education to increase the business knowledge of IT practitioners (Nelson, 1991). Byrd and Turner (2000) described IT personnel business knowledge as "business skills that relate to the ability of IT personnel to understand the business processes they are to support and to apply appropriate technical solutions to a given business problem." The authors stated that the effectiveness of IT infrastructure can be measured by the magnitude and quality of IT personnel's knowledge, skills, and experience (Byrd & Turner, 2000). An exploratory study by Byrd et al. (2004) investigated the relationship between IT personnel knowledge and skills and their contribution to information system infrastructure's competitive advantage and flexibility. The authors hypothesized that a high breadth and depth of IT personnel knowledge and skills is positively related to competitive advantage and flexibility of information system infrastructure. The results in both cases supported the hypotheses, indicating the relationships were positive and significant (Byrd et al., 2004). Another study by Denis et al. (1995) suggested that industry demand will require organizations to

employ information system personnel with knowledge and skills in technology, business operations, management, and interpersonal skills. This allows for effective process improvement activities and system integrations (Denis et al., 1995). If the IT personnel have strong knowledge of business, goals, and objectives, the organization will be better positioned to implement a change; therefore, on these bases, the proposed hypothesis is as follows:

H6: There is a positive relationship between the IT personnel's business knowledge and the organization's perception of readiness for OQI, such that organizations with IT personnel who exhibit higher levels of business knowledge will also have a higher organizational level of perceived readiness for OQI.

Perception of Need for OQI

The need for change is a compelling force that drives individuals and organizations to abandon the status quo and seek improvement. It stems from recognizing that current methods, beliefs, or conditions are no longer conducive to success or satisfaction. The need for change often emerges from external pressures such as evolving market demands, competitive advantage, technological advancements, and internal realizations, including underperformance, inefficiencies, or missed opportunities. It is the extent to which one feels there are or not legitimate reasons and needs for the prospective change (Holt et al., 2007). At its core, the need for change is a proactive acknowledgment that adaptation is crucial for growth, relevance, and survival. It is a deliberate move away from complacency towards transformation. Embracing this need is the first critical step towards meaningful, sustained innovation and development.

H7: There is a positive relationship between the perception of the need for OQI and intention to adopt OQI, such that organizations with a higher need for OQI will also have higher levels of intention to adopt OQI.

Perception of Readiness for OQI

Weiner (2009) describes organizational readiness as a multi-level construct that can be on an individual level, unit, department, or organizational level. The author defines organizational readiness as "members' commitment and change efficacy to implement organizational change" (Weiner, 2009). Building on the readiness theory that suggests that learning can occur when the learner is ready to perceive and process information, organizational readiness involves employees' psychological and behavioral readiness to take action. Holt et al. (2007) offered a more detailed definition of organizational readiness as a "comprehensive attitude that is influenced simultaneously by the content (i.e., what is being changed), the process (i.e., how the change is being implemented), the context (i.e., circumstances under which the change is occurring), and the individuals (i.e., characteristics of those being asked to change) involved. Furthermore, readiness collectively reflects how individuals are cognitively and emotionally inclined to accept, embrace, and adopt a particular plan to alter the status quo purposefully" (Holt et al., 2007). Gfrerer et al. (2021) discussed readiness as being fully prepared to take action. Readiness occurs when organizational members are receptive to accepting change when the environment, structure, and attitudes are favorable (Gfrerer et al., 2021). The successful implementation of the QI lies in its adoption by the organization. An individual's willingness to adopt a new healthcare initiative can be achieved by understanding behavioral intentions to adopt or start a new initiative

(Sintonen & Immonen, 2013). The Theory of Planned Behavior (TPB) explains that intention is a good predictor of actual behavior (Ajzen, 1991). Individual perceptions of the characteristics of improvement influence adoption intentions (Sintonen & Immonen, 2013).

H8: There is a positive relationship between the perception of readiness for OQI and intention to adopt OQI, such that organizations with higher levels of readiness for OQI will also have higher levels of intention to adopt OQI.

RESEARCH METHODOLOGY

Participants and Procedure

The research study evaluated factors contributing to the intention to adopt OQI in U.S. healthcare organizations through a cross-sectional survey. It included an informed pilot to obtain participant feedback on the survey instrument. The input was used to refine the measurement instrument and its format. After the informed pilot, the data was collected in a pilot study to further validate the measurement instrument. The data analysis included performing Explanatory Factor Analysis (EFA) and Reliability Testing on the survey instrument. The final version was used in the study. Hypothesis testing was performed, and the results were summarized.

The unit of analysis for this research was on the organizational level representing U.S. Healthcare companies. The unit of observation was an individual employee of the U.S. Healthcare organization. The focus of the study was to evaluate a causal relationship between several factors and their influence on the intention to adopt OQI.

The initial analysis included data clean-up and revisions after the informed and full pilots to test the questions and survey format. After the questionnaire revision, the factor and reliability analyses were performed on the remaining questions. The survey results were collected, and basic statistics were performed, including overall descriptives for aggregates measuring each construct, normality tests, and plots.

Research Design

The sample population consisted of 150 participants employed by U.S.-based healthcare companies. Participants were selected randomly, assuming that attributes were

to be normally distributed. The measurement instrument for each construct included questions adopted from established measurement scales to ensure validity. Qualtrics platform was used for the survey development. CloudResearch platform was used to recruit participants and deliver the survey.

The survey included questions measuring constructs: Awareness of Organizational Performance, Rivalry Intensity, Patient Focus, Management Support for OQI, Process-Oriented Culture, IT Personnel Business Knowledge, Perception of Need for OQI, Perception of Readiness for OQI, and Intention to Adopt OQI.

The questionnaire was designed for each construct, including at least three indicators to measure each factor effectively on a 5-point Likert Scale.

Informed Pilot

An informed pilot was conducted before the survey development in Qualtrics, and pilot delivery was given to participants. The purpose of the informed pilot was to obtain feedback from selected participants on the survey instrument to ensure its face, content, and construct validity. Informed pilot participants were requested to review and evaluate the questionnaire (Appendix B). Specifically, they were asked to evaluate each question and the overall flow of the survey and provide additional feedback. The reviewer version of the survey contained a list of potential questions along with an input box where reviewers provided feedback related to each question. Definitions for each construct were also provided. Reviewers were asked to consider the potential issues in evaluating whether or not each question was clear and understandable, targeted to organizational

contributors, rightly measuring the variable of interest, double-barreled, leading, loaded, confusing, ambiguous, and easy to understand and answer.

The informed pilot ran between July 17, 2024, and August 3, 2024, and included three industry subject matter experts and three doctoral research students in FIU's DBA Cohort 5.7. The synchronous review was conducted in a single meeting with the three industry participants, and the three DBA student participants completed the asynchronous review via email. The researcher conducted the informed pilot with participants and reviewed the survey questions according to instructions (Appendix C). Participants provided feedback on overall clarity, wording, and whether or not the questions were appropriate for each construct. Issues were brought up for double-barreled, loaded, and confusing questions. Reviewers presented several recommendations on sentence re-wording, simplification, and splitting into two questions. As a result, the survey instrument was adjusted by re-wording questions for clarification, removing double-barreled questions, and, for some questions, splitting them into separate ones or combining two questions into one with re-wording for clear understanding.

Pilot

The final version of the survey was published in Qualtrics and integrated into CloudResearch, a platform to recruit participants for research. The survey was launched on September 23, 2024, and achieved a 100% completion rate for the target goal of 150 participants. The following target criteria were selected: Country: United States; Industry of employment: Healthcare; Supervisory role: C-Level, Owner, Partner, President, Director, Manager, Analyst, Assistant or Associate, Administrative, Consultant, Internal, and None of the above; Employment sector: Government, For Profit, Nonprofit.

The target criteria for participation focused on recruiting individuals from the U.S. healthcare industry, as the research aims to investigate the adoption of quality improvement initiatives within U.S. healthcare organizations. Criteria were set to include both management and non-management roles to ensure a broad sample representation. Employment sector information was gathered to understand the distribution of participants across government, for-profit, and non-profit organizations. An informational statement provided an overview of the study, advising participants that the survey was voluntarily anonymous and that responses would remain confidential. Before accessing the survey, participants completed a CAPTCHA to confirm authenticity. Following CAPTCHA verification, participants were prompted to answer background and demographic questions before proceeding to the main survey questions. All questions were required to be answered to advance through the survey. A $4 monetary incentive was offered upon completion to thank participants for their time.

Data Cleaning and Exclusions

Data was uploaded from Qualtrics and included 150 responses. Of these, 13 were excluded from the analysis due to duplicate responses, failed attention-check questions, and survey duration outliers. Two responses had the same IP address but different participant IDs. This indicated a duplicate response; therefore, one of the responses was excluded from the analysis. The following attention-check questions were included in the survey: ATT1, ATT2: “To ensure you are a real person, please select 'Neither agree nor disagree' to this statement”, and ATT3: “To ensure you're paying attention, please select "Pizza" from the list: Burger, Salad, Pizza, Pasta, Sandwich”. Three participants failed attention-check questions ATT1 and ATT2 and were excluded from the analysis. All participants passed the attention-check question ATT3. After making exclusions, 137 responses remained in the study.

The average duration time for the survey was 647.25 seconds with a standard deviation of 543.72 seconds (Table 1). Nine responses deviated significantly from the rest of the data plotted beyond the upper boxplot whisker and were excluded from the analysis (Figure 2-3; Table 2).

Table 1 Statistics – Pilot Survey Time Statistics

Statistics

Duration (in seconds)

N	Valid	150
	Missing	0
Mean		674.25
Median		485.50
Std. Deviation		543.721
Range		3291
Minimum		149
Maximum		3440

Figure 2 Histogram – Pilot Survey Duration

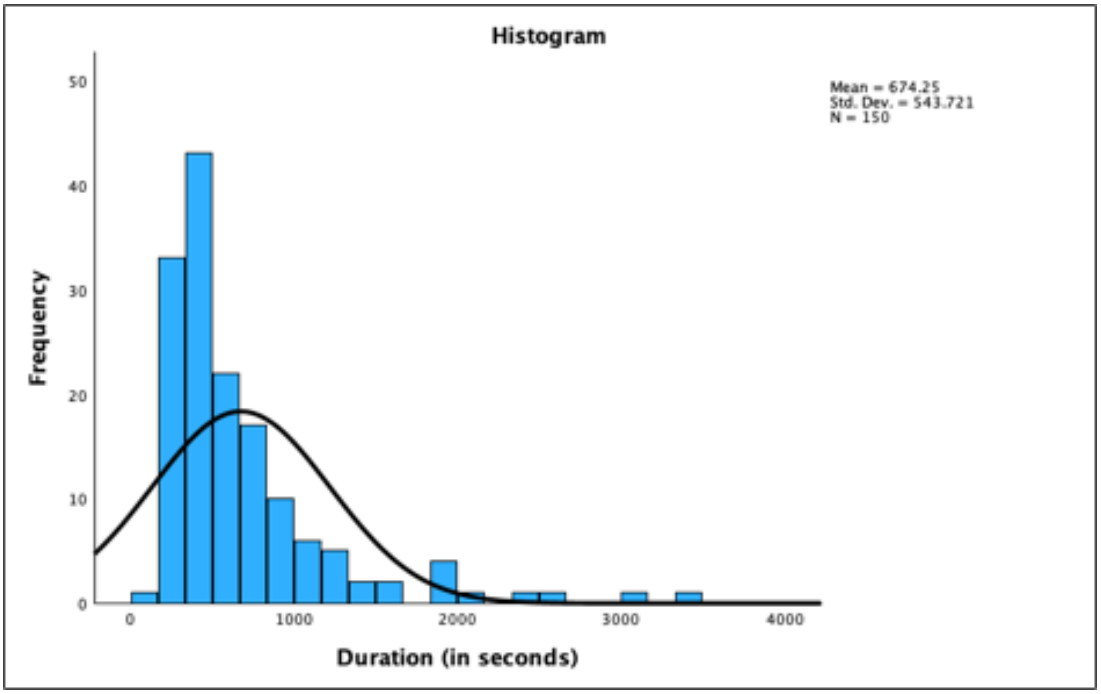


Figure 3 Boxplot – Pilot Survey Time Outliers

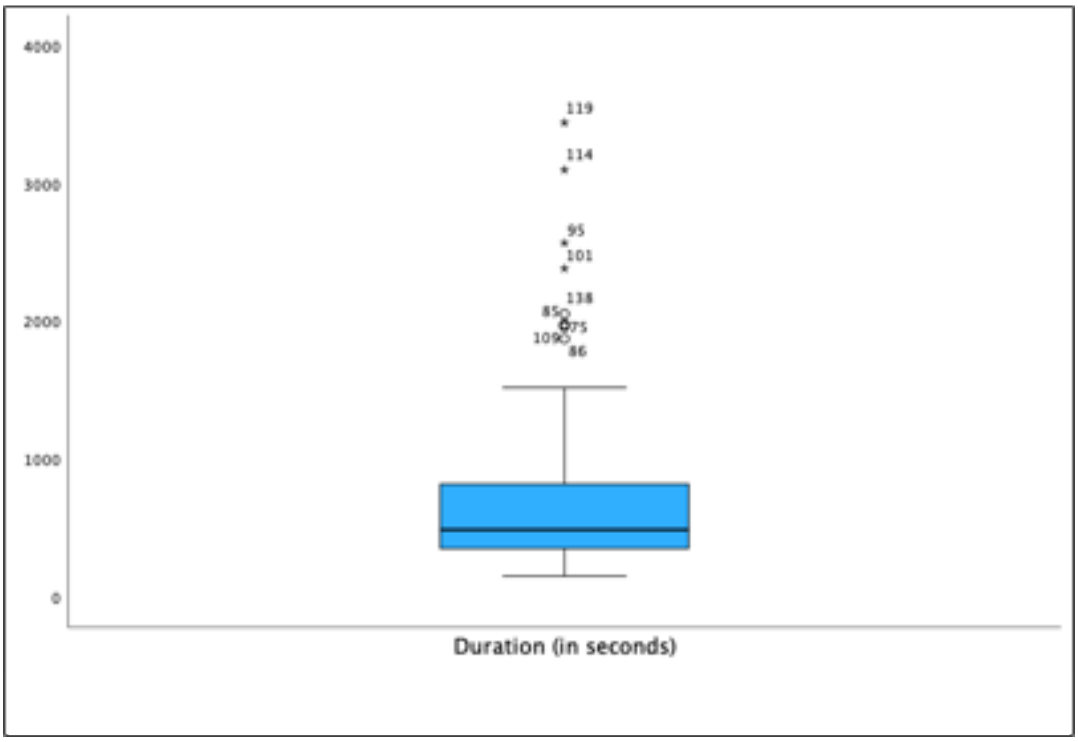


Table 2 Pilot Survey Time Outliers

Outlier No.	Survey Time (seconds)
1	1872
2	1975
3	1075
4	1959
5	2052
6	2382
7	2567
8	3098
9	3440

Data and Variables

The survey instrument included background and demographic questions. Background questions gathered information on participants' organizational profiles to assess their involvement in quality improvement initiatives, the types of initiatives in

place, the use of CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys as input for quality improvement, and the role of government-funded programs in supporting these efforts. Demographic questions collected general information on respondents' age, gender, organization type, size, tenure, department, and role, providing insight into the characteristics of the participants. The measurement items for independent, mediating, and dependent variables used a 5-point Likert scale, anchoring: 1= Strongly disagree; 2= Somewhat disagree; 3= Neither agree nor disagree; 4= Somewhat agree; and 5= Strongly agree. The complete survey is listed in the Appendix C.

Participants' Gender

The pilot data consisted of 137 participants, of which 52 (or 38%) were males, 82 (or 59.9%) were females, and 3 (or 2.2%) were non-binary (Table 3).

Table 3 Frequencies – Pilot Participants' Gender

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	52	38.0	38.0	38.0
	2	82	59.9	59.9	97.8
	3	3	2.2	2.2	100.0
	Total	137	100.0	100.0	

Note: 1= Male**;** 2= Female**;** 3= Non-binary

Participants' Age

The average age of participants was 38 years old, with a standard deviation of 10. The participants' age group ranged from 21 to 65 years old, with the majority falling between age 30-50 years old (Table 4-5, Figure 4).

Table 4 Statistics – Pilot Participants' Age

Statistics

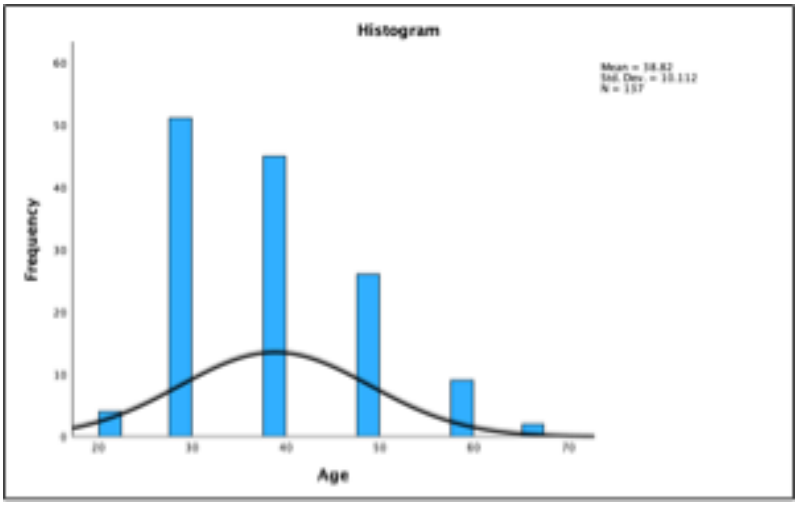
Age		
N	Valid	137
	Missing	0
Mean		38.82
Std. Deviation		10.112
Range		44
Minimum		21
Maximum		65

Table 5 Frequencies – Pilot Participants' Age

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	21	4	2.9	2.9	2.9
	30	51	37.2	37.2	40.1
	40	45	32.8	32.8	73.0
	50	26	19.0	19.0	92.0
	60	9	6.6	6.6	98.5
	65	2	1.5	1.5	100.0
	Total	137	100.0	100.0	

Figure 4 Histogram – Pilot Participants' Age



Participant's Organization Size

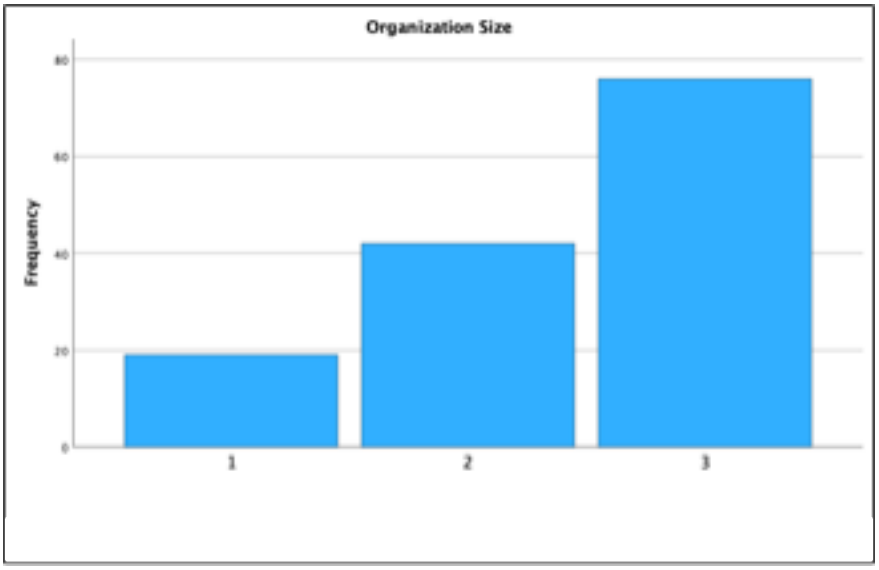
The majority of participants 55.5% (or 76) were employed by large healthcare organizations (with more than 1,000 employees), 30.7% (or 42) by medium-sized

organizations (100-999 employees), and 13.9% (or 19) by small organizations (1-99 employees) (Table 6, Figure 5).

Table 6 Frequencies – Pilot Participants' Organization Size

OrgSize		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	19	13.9	13.9	13.9
	2	42	30.7	30.7	44.5
	3	76	55.5	55.5	100.0
	Total	137	100.0	100.0	

Figure 5 Pilot Participants' Organization Size



Note: Employees Size. 1= Small (1-99); 2= Medium (100-999); 3= Large (>1,000)

Participants' Employment Sector

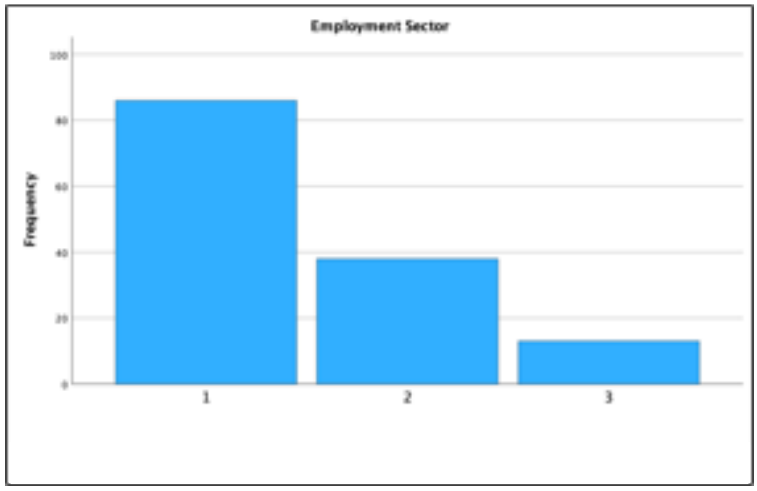
The majority, 62.8%, were employed in the for-profit sector, accounting for 86 participants. Participants from the non-profit sector made up 27.7% (or 38), while those working in government organizations constituted 9.5% (or 13) (Table 7, Figure 6).

Table 7 Frequencies – Pilot Participants' Employment Sector

Employment Sector

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	86	62.8	62.8	62.8
	2	38	27.7	27.7	90.5
	3	13	9.5	9.5	100.0
	Total	137	100.0	100.0	

Figure 6 Pilot Participants' Employment Sector



Note: 1= For Profit; 2=Nonprofit; 3= Government

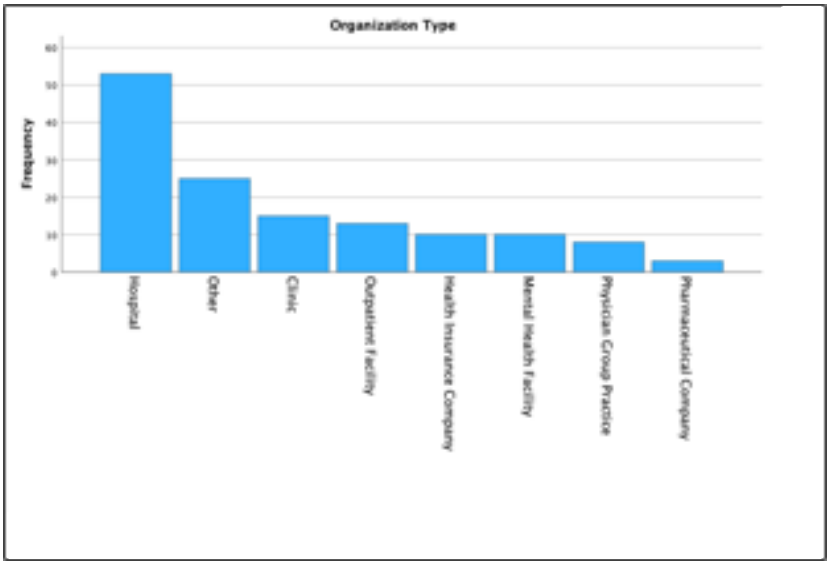
Organization Type

Participants represented various healthcare organizations, including hospitals, clinics, specialty facilities, health insurance companies, and other healthcare specialty companies. The most common types of organizations were hospitals (38.7%), other healthcare-related companies (18.2%), and clinics (10.9%). Examples of other healthcare-related companies included home healthcare, retail pharmacies, medical equipment suppliers, laboratories, and public health organizations. The remaining 32.1% of organizations were outpatient, health insurance, mental health facilities, physician group practices, and pharmaceutical companies (Table 8, Figure 7).

Table 8 Frequencies – Pilot Participants' Organization Type

OrgType					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hospital	53	38.7	38.7	38.7
	Other (Please indicate below)	25	18.2	18.2	56.9
	Clinic	15	10.9	10.9	67.9
	Outpatient Facility	13	9.5	9.5	77.4
	Health Insurance Company	10	7.3	7.3	84.7
	Mental Health Facility	10	7.3	7.3	92.0
	Physician Group Practice	8	5.8	5.8	97.8
	Pharmaceutical Company	3	2.2	2.2	100.0
	Total	137	100.0	100.0	

Figure 7 Pilot Participants' Organization Type



Participants' Department

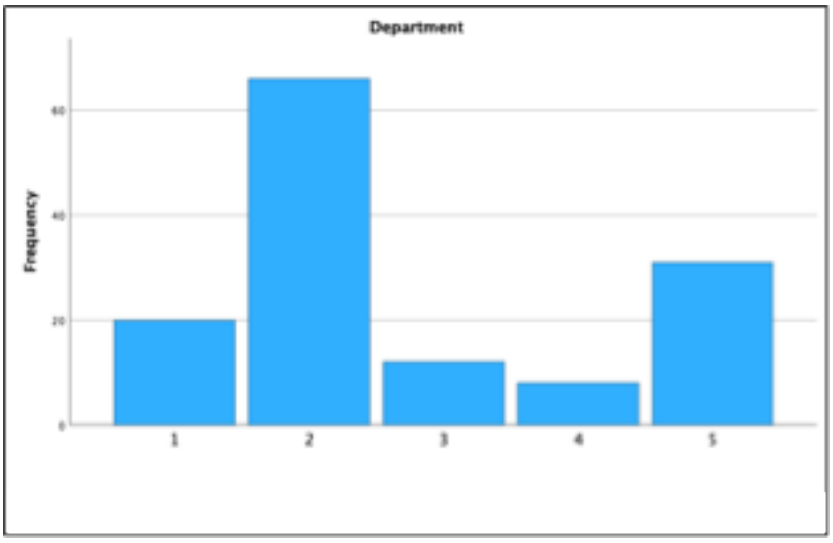
Participant departments were categorized as follows: (1) Administrative, (2) Clinical (e.g., nursing, healthcare providers, specialty care), (3) Financial (e.g., billing, financial management, pricing), (4) Information Technology (IT), and (5) Other Operational Departments (e.g., supply chain, operations, communications, training, human resources, social work, management, client services). The majority of participants were from Clinical departments (48.2%), followed by Other Operational (22.6%) and

Administrative departments (14.6%). The remaining departments included Financial (8.8%) and IT (Table 9, Figure 8).

Table 9 Frequencies – Pilot Participants' Department

Dept					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	66	48.2	48.2	48.2
	5	31	22.6	22.6	70.8
	1	20	14.6	14.6	85.4
	3	12	8.8	8.8	94.2
	4	8	5.8	5.8	100.0
	Total	137	100.0	100.0	

Figure 8 Pilot Participants' Department



Note: 1= Admin; 2= Clinical; 3= Financial; 4= IT; 5= Other Ops

Participants' Role

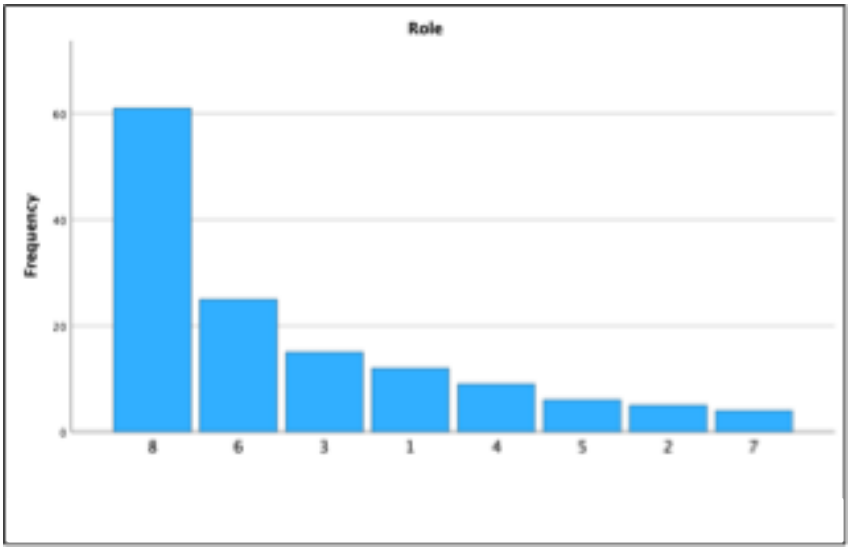
Participants' job titles/roles were categorized as follows: (1) Registered Nurse, (2) Physician, (3) Administrative Role, (4) Financial Specialist, (5) IT Analyst, (6) Manager, (7) Analyst, and (8) Other Operational Roles. The most commonly represented roles were Other Operational Roles (44.5%), followed by Management (18.2%), Administrative (10.9%), and Registered Nurse roles (8.8%). The remaining roles included Financial

Specialists (6.6%), IT Analysts (4.4%), Physicians (3.6%), and Analysts (2.9%). (Table 10, Figure 9).

Table 10 Frequencies – Pilot Participants' Role

Role					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	8	61	44.5	44.5	44.5
	6	25	18.2	18.2	62.8
	3	15	10.9	10.9	73.7
	1	12	8.8	8.8	82.5
	4	9	6.6	6.6	89.1
	5	6	4.4	4.4	93.4
	2	5	3.6	3.6	97.1
	7	4	2.9	2.9	100.0
	Total	137	100.0	100.0	

Figure 9 Pilot Participants' Role



Note: 1= Registered Nurse; 2= Physician; 3= Admin Role; 4=Financial Specialist; 5= IT Analyst; 6= Manager; 7= Analyst; 8= Other Operational Roles

Participants' Tenure

The average tenure of respondents was 1.58 years (SD= .88 years), ranging from less than 1 year to more than 10 years. Respondents' tenure at their current organization

was distributed as follows: 7.3% had less than 1 year, 47.4% had 1-5 years, 25.5% had 5-10 years, and 19.7% had more than 10 years (Table 11, 12).

Table 11 Statistics – Piot Participants' Tenure

Statistics

Tenure

N	Valid	137
	Missing	0
Mean		1.58
Std. Deviation		.889
Minimum		0
Maximum		3

Table 12 Frequencies – Pilot Participants' Tenure

Tenure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	10	7.3	7.3	7.3
	1	65	47.4	47.4	54.7
	2	35	25.5	25.5	80.3
	3	27	19.7	19.7	100.0
	Total	137	100.0	100.0	

Note: 0= Less than 1 year; 1= 1-5 years; 2= 5-10 years; 3= More than 10 years

Background Questions

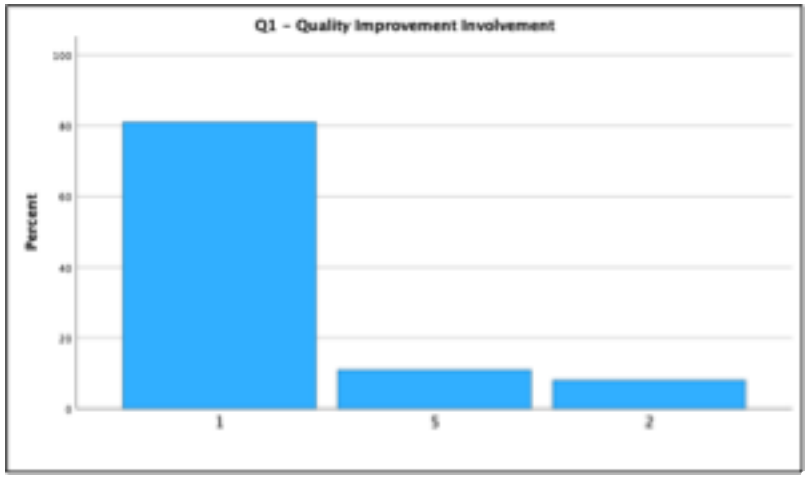
Participants were asked whether their organization was currently involved in quality improvement initiatives. The results indicated that 111 (or 81%) out of 137 respondents reported that their organization was involved in quality improvements, signifying active involvement in quality improvement efforts. The top selections for quality improvement initiatives were patient care improvement, organizational process improvement, and patient experience and satisfaction. A smaller portion (8% or 11) responded that their organization is not currently involved in quality improvements, while 10.9% (or 15) of respondents were unsure about their organization's participation in such an initiative (Table 13, Figure 10).

Table 13 Frequencies – Quality Improvement Involvement - Pilot

Q1

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	111	81.0	81.0	81.0
	5	15	10.9	10.9	92.0
	2	11	8.0	8.0	100.0
	Total	137	100.0	100.0	

Figure 10 Quality Improvement Involvement - Pilot



Note: Q1 - Is your organization currently involved in quality improvement initiative/s? 1=Yes, 2=No; 5=Unsure

Use of CAHPS Survey

Participants were asked whether their organization uses CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys. CAHPS is a program overseen by the Agency for Healthcare Research and Quality that develops standardized surveys for assessing patients' experience with healthcare providers and health plans. The surveys focus on quality aspects, such as providers' communication skills and ease of access to healthcare services (About the CAHPS Program and Survey, 2024). The responses indicated that 43.1% (or 59) of participants were unsure about their organization's use of CAHPS surveys, indicating that they were unaware of such an initiative. 34.3% (or 47) of participants indicated that their organization uses CAHPS

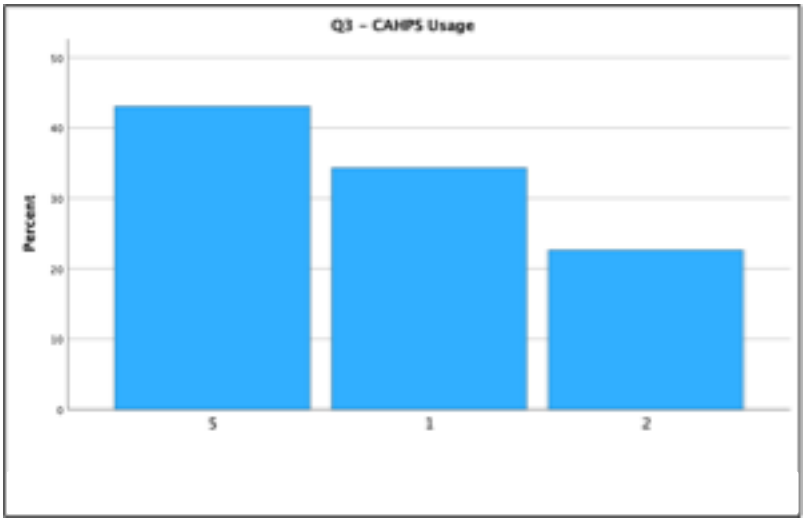
surveys for various reasons. The most common reasons were quality improvement initiatives, patient experience improvement, and public reporting of healthcare quality data. Lastly, 22.6% (or 31) of participants stated that their organization does not participate in the CAHPS survey (Table 14, Figure 11).

Table 14 Frequencies - CAHPS Usage - Pilot

Q3

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	5	59	43.1	43.1	43.1
	1	47	34.3	34.3	77.4
	2	31	22.6	22.6	100.0
	Total	137	100.0	100.0	

Figure 11 CAHPS Usage - Pilot



Note: Q3 - Does your organization use CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys? 1= Yes; 2= No; 5= Unsure

Government Funding

Survey questions about government funding were included to assess participants' organizations' involvement in programs such as Medicare and Medicaid, the percentage of operations reliant on these programs, and whether the organization must submit quality data for government-funded programs. The results showed that 77.4% (or 106) reported

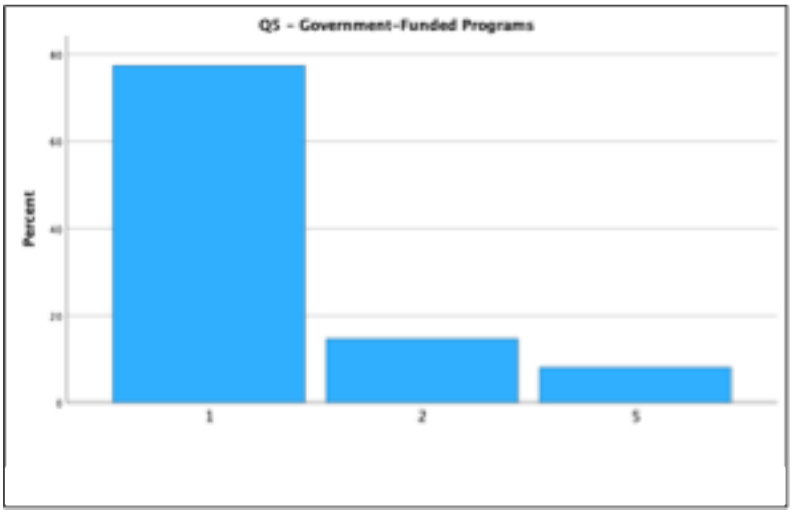
their organization's engagement in government-funded programs. A smaller percentage, 14.6% (or 20), indicated that their organization does not participate in these programs, while 8% (or 11) were unsure of their organization's involvement (Table 15, Figure 12).

Table 15 Frequencies - Government-Funded Programs - Pilot

Q5

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	106	77.4	77.4	77.4
	2	20	14.6	14.6	92.0
	5	11	8.0	8.0	100.0
	Total	137	100.0	100.0	

Figure 12 Government-Funded Programs - Pilot



Note: Q5 - Is your organization currently engaged in any Government-funded (e.g., Medicare, Medicaid) programs? 1= Yes; 2= No; 5= Unsure

Percentage of Government-funded Programs

Among participants who indicated that their organization's operations rely on government-funded programs (77.4%, or 106 respondents), the reported levels of dependency were as follows: 28.3% (or 30) reported a dependency of 21-50%, 22.6% (or 24) reported 51-80%, 13.2% (or 14) reported 81-100%, and 8.5% (or 9) reported 0-20%.

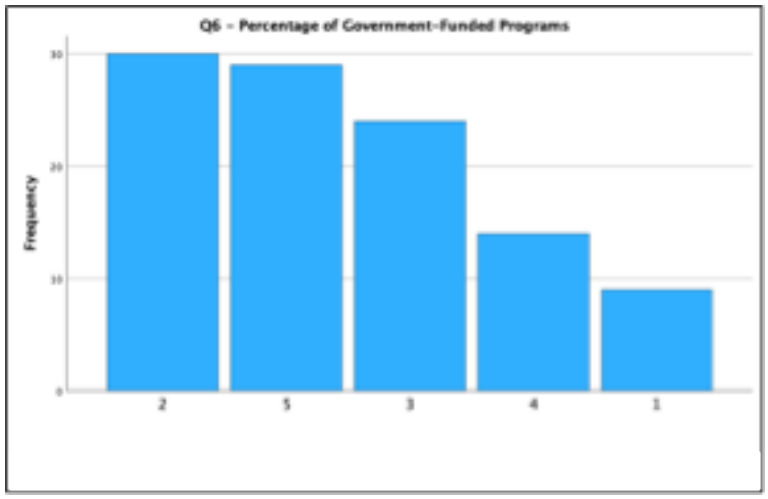
Additionally, 27.4% (or 29) were unsure of their organization's dependency on government-funded programs (Table 16, Figure 13).

Table 16 Frequencies - Percentage of Government-Funded Programs - Pilot

Q6

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	30	28.3	28.3	28.3
	5	29	27.4	27.4	55.7
	3	24	22.6	22.6	78.3
	4	14	13.2	13.2	91.5
	1	9	8.5	8.5	100.0
	Total	106	100.0	100.0	

Figure 13 Percentage of Government-Funded Programs- Pilot



Note: Q6 - What percentage of your organization's operations depend on Government-funded programs? 1= 0-20%; 2= 21-50%; 3= 51-80%; 4= 81-100%; 5= Unsure

Reporting of Quality Data

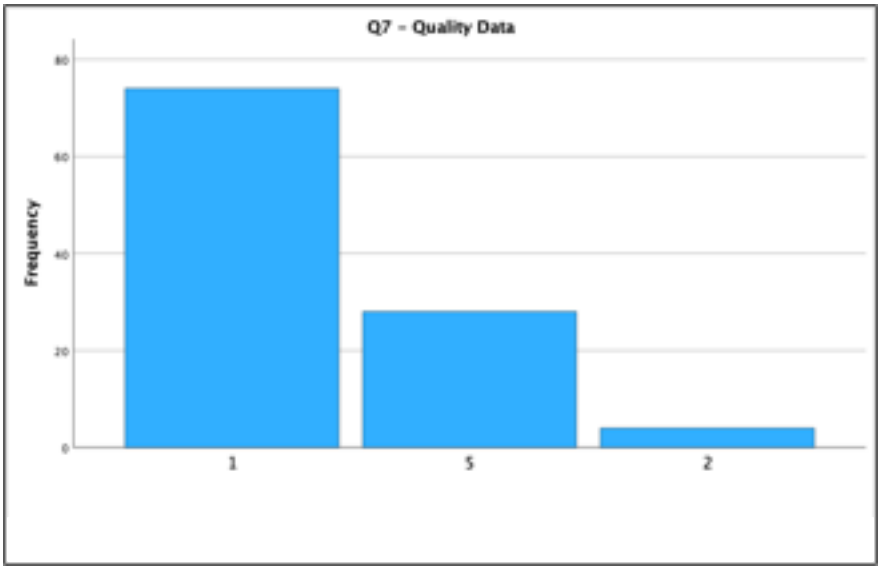
Participants were asked if their organization must submit quality data or performance metrics for government-funded programs. The responses were as follows: 69.8% (or 74) answered 'Yes,' 26.4% (or 28) answered 'Unsure,' and 3.8% (or 4) answered 'No.' (Table 17, Figure 14).

Table 17 Frequencies - Requirement to Submit Quality Data- Pilot

Q7

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	74	69.8	69.8	69.8
	5	28	26.4	26.4	96.2
	2	4	3.8	3.8	100.0
	Total	106	100.0	100.0	

Figure 14 Requirement to Submit Quality Data - Pilot



Note: Q7 - Is your organization required to submit quality data or performance metrics for Government-funded programs? 1=Yes; 2=No; 5=Unsure

Test of Normality

Normality tests using Kolmogorov-Smirnov (K-S) and Shapiro-Wilk (S-W) were performed to evaluate the sample data for normal distribution. A p-value <.05 would indicate a significant departure from normality, and a p-value >.05 would indicate that the data is normally distributed. Overall, K-S and S-W tests showed a significance of <.05 on all constructs.

Awareness of Organizational Performance (AOP)

The mean of AOP scale was 3.85 (SD .623). An examination of boxplot indicated one outlier (data point 53). The K-S and W-S tests indicate that the data was not normally distributed $p<.05$ ($p<.001$, $p<.001$). The Q-Q plot showed a skew of the observed values, with those more concentrated at the upper-right side of the normal distribution with the outlier on the lower left side (Appendix C4.1).

Rivalry Intensity (RI)

The mean of RI scale was 3.67 (SD .745). An examination of boxplot indicated one outlier (data point 29). The K-S test indicates that the data was normally distributed $p>.05$ ($p=.20$). The W-S test indicated that the data was not normally distributed $p<.05$ ($p=.03$). The Q-Q plot showed observed values following similar distribution to the expected normal values. A few points at the lower and upper ends deviate slightly from the normal distribution line, indicating minor skewness. (Appendix C4.2).

Patient Focus (PF)

The mean of PF scale was 5.09 (SD .715). An examination of boxplot indicated four outliers (data points 19, 10, 135, 130). The K-S and W-S tests indicated that the data was not normally distributed $p<.05$ ($p<.001$, $p<.001$). The Q-Q plot showed a skew of the observed values at the lower and upper ends, where a few data points deviate from the normal distribution line (Appendix C4.3).

Top Management Support (TMS)

The mean of TMS scale was 4.07 (SD .760). An examination of boxplot indicated four outliers (data points 68, 130, 62, 136). The K-S and W-S tests indicated that the data was not normally distributed $p<.05$ ($p<.001$, $p<.001$). The Q-Q plot showed a skew of the

observed values at the upper and lower ends, indicating a slight deviation from the normal distribution (Appendix C4.4).

Process-Oriented Culture (POC)

The mean of POC scale was 3.80 (SD .618). An examination of boxplot indicated three outliers (data points 34, 19, 130). The K-S and W-S tests indicated that the data was not normally distributed $p<.05$ ($p=.05$, $p=.006$). The Q-Q plot showed a skew of the observed values, where a few points fall below the normal distribution line and at the upper end, where a few points are slightly above the line. This indicates minor skewness departure at the tails (Appendix C4.5).

IT Personnel Business Knowledge (ITPBK)

The mean of ITPBK scale was 4.10 (SD .721). An examination of boxplot indicated five outliers (data points 57, 60, 30, 70, 130). The K-S and W-S tests indicated that the data was not normally distributed $p<.05$ ($p<.001$, $p<.001$). The Q-Q plot showed a skew of the observed values, with those more concentrated at the upper and lower ends indicating a slight deviation from the normal distribution (Appendix C4.6).

Perception of Readiness (PR)

The mean of PR scale was 3.51 (SD .425). An examination of boxplot indicated three outliers (data points 111, 126, 130). The K-S and W-S tests indicated that the data was not normally distributed $p<.05$ ($p<.001$, $p=.002$). The Q-Q plot showed a skew of the observed values at the upper and lower ends, indicating a slight deviation from the normal distribution (Appendix C4.7).

Perception of Need (PN)

The mean of PN scale was 4.19 (SD .722). An examination of boxplot did not indicate outliers. The K-S and W-S tests indicated that the data was not normally distributed $p<.05$ ($p<.001$, $p=.002$). The Q-Q plot showed that observed values are skewed and do not fall perfectly along the normal distribution line (Appendix C4.8).

Intention to Adopt (INT)

The mean of INT scale was 4.13 (SD .644). An examination of boxplot indicated one outlier (data points 136). The K-S and W-S tests indicated that the data was not normally distributed $p<.05$ ($p<.008$, $p<.001$). The Q-Q plot showed a skew at the upper and lower ends, indicating a slight deviation from the normal distribution (Appendix C4.9).

Explanatory Factor Analysis (EFA)

Prior to performing an EFA, the recoding of 2 items for construct Perception of Need (PN) was completed to ensure consistency with the scale (Table 18). The items were recorded into different values: PN3 ("It doesn't make sense for my organization to make quality improvements at this time") recoded to PN3_rec, and PN4 ("No one has explained to me why quality improvement/s must be made") recorded to PN4_rec.

Table 18 Recording Values

Original value	Recorded value
1	5
2	4
3	3
4	2
5	1

A principal axis factor analysis was conducted on 61 items with Oblimin rotation. The Kaiser-Meyer-Olkin measure verified the sampling adequacy for the analysis, KMO=.865 (Table 19).

Table 19 KMO Value

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.865
Bartlett's Test of Sphericity	Approx. Chi-Square	3811.692
	df	903
	Sig.	<.001

All KMO values for individual items were greater than .695 (> the bare minimum of .5) (Appendix C5). The initial analysis was run to obtain eigenvalues for each factor in the data. Nine factors had eigenvalues over Kaiser's criterion of 1 and, in combination, explained 69.13% of the variance (Table 20). The scree plot showed nine factors retained (Figure 15).

Table 20 Total Variance Explained

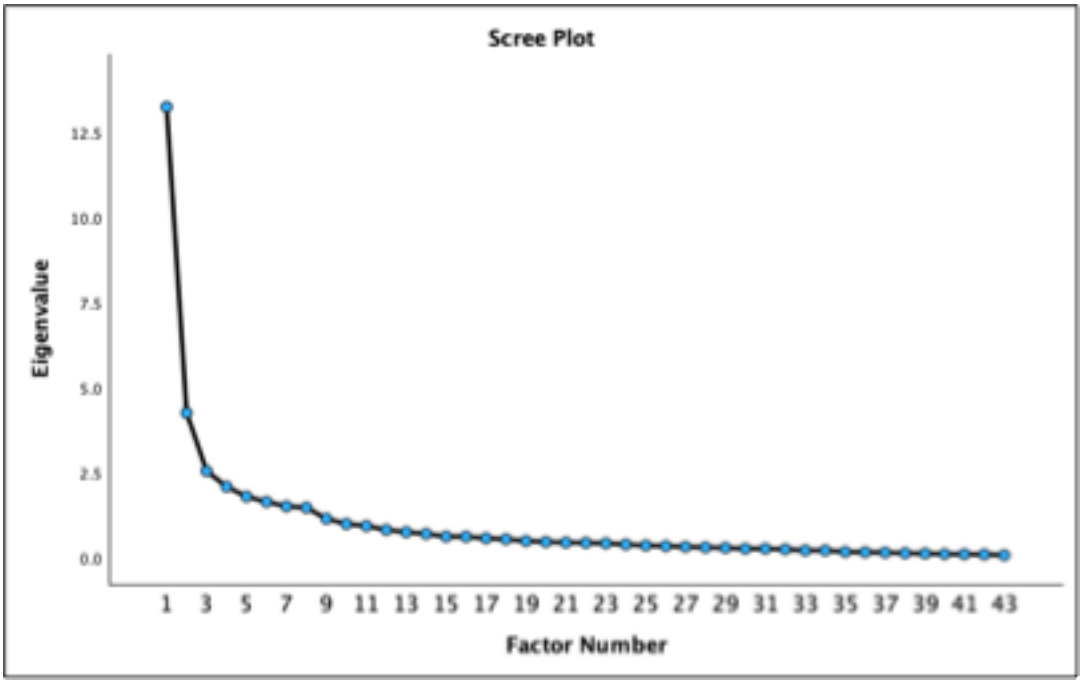
Total Variance Explained

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings[a]
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	13.249	30.812	30.812	12.890	29.976	29.976	6.815
2	4.264	9.917	40.729	3.943	9.170	39.146	7.307
3	2.348	5.926	46.655	2.164	5.032	44.178	5.169
4	2.090	4.860	51.514	1.652	3.843	48.021	4.539
5	1.799	4.185	55.699	1.396	3.247	51.268	5.819
6	1.645	3.825	59.524	1.211	2.817	54.084	5.002
7	1.513	3.518	63.042	1.085	2.524	56.608	3.868
8	1.472	3.424	66.466	1.047	2.435	59.043	3.836
9	1.148	2.671	69.137	.787	1.831	60.874	4.307
10	.998	2.317	71.454				
11	.936	2.178	73.631				
12	.822	1.911	75.542				
13	.755	1.756	77.297				
14	.705	1.640	78.938				
15	.626	1.456	80.393				
16	.621	1.445	81.838				
17	.575	1.336	83.174				
18	.547	1.271	84.447				
19	.495	1.150	85.597				
20	.468	1.089	86.686				
21	.451	1.048	87.734				
22	.442	1.028	88.762				
23	.427	.994	89.756				
24	.393	.913	90.669				
25	.363	.843	91.513				
26	.346	.805	92.318				
27	.324	.753	93.071				
28	.307	.713	93.786				
29	.293	.681	94.467				
30	.269	.625	95.092				
31	.268	.623	95.715				
32	.250	.582	96.297				
33	.218	.508	96.805				
34	.218	.506	97.311				
35	.175	.408	97.719				
36	.166	.387	98.105				
37	.156	.361	98.467				
38	.138	.320	98.788				
39	.128	.299	99.086				
40	.113	.263	99.349				
41	.108	.247	99.597				
42	.100	.233	99.829				
43	.073	.171	100.000				

Extraction Method: Principal Axis Factoring.

a. When factors are correlated, sums of squared loadings cannot be added to obtain a total variance.

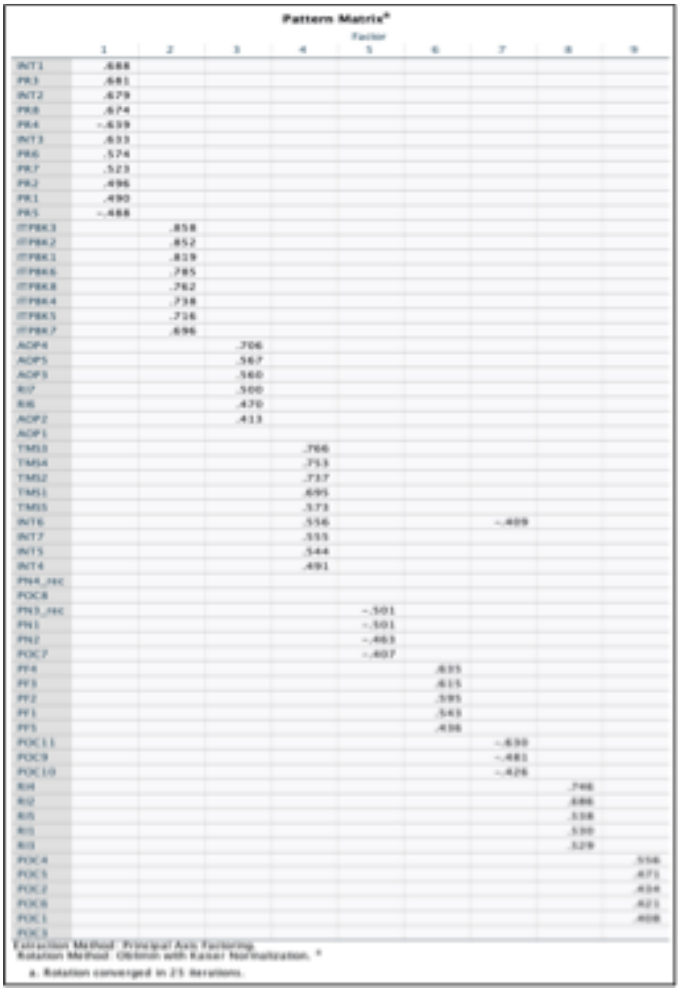
Figure 15 Scree Plot



Pattern Matrix

The initial Pattern Matrix showed nine factors with the following loadings: Items AOP1, PNC4_rec, POC8, and POC3 did not load on any factor; Items INT1, INT2, and INT3 loaded on the same factor 1 as PR items; Items RI7 and RI6 loaded on the same factor 3 as AOP items; Item POC7 loaded on the same factor 5 as PN items; item INT6 loaded on two factors; Items POC9, POC10, and POC11 loaded on factor 7, and the rest of items POC1, POC2, POC3, POC4, POC5, and POC6 loaded on factor 9 (Table 21).

Table 21 Initial Pattern Matrix



Pattern Matrix[a]

	Factor								
	1	2	3	4	5	6	7	8	9
INT1	,688								
PR3	,681								
INT2	,679								
PR8	,674								
PR4	-,639								
INT3	,633								
PR6	,574								
PR7	,523								
PR2	,496								
PR1	,490								
PR5	-,488								
ITPBK3		,858							
ITPBK2		,852							
ITPBK1		,819							
ITPBK6		,785							
ITPBK8		,762							
ITPBK4		,738							
ITPBK5		,716							
ITPBK7		,696							
AOP4			,706						
AOP5			,567						
AOP3			,560						
RI7			,500						
RI6			,470						
AOP2			,413						
AOP1									
TMS3				,766					
TMS4				,753					
TMS2				,737					
TMS1				,695					
TMS5				,573					
INT6				,556			-,409		
INT7				,555					
INT5				,544					
INT4				,491					
PN4_rec									
POC8									
PN3_rec					-,501				
PN1					-,501				
PN2					-,463				
POC7					-,407				
PF4						,635			
PF3						,615			
PF2						,595			
PF1						,543			
PF5						,436			
POC11							-,630		
POC9							-,481		
POC10							-,426		
RI4								,746	
RI2								,686	
RI5								,538	
RI1								,530	
RI3								,529	
POC4									,556
POC5									,471
POC2									,434
POC6									,421
POC1									,408
POC3									

Extraction Method: Principal Axis Factoring.
Rotation Method: Oblimin with Kaiser Normalization. [a]

a. Rotation converged in 21 iterations.

After performing several iterations that included removing factors (AOP1, AOP2, INT1, INT2, INT3, PR4, PR5, POC1, POC2, POC8, POC9, POC10, POC11, RI1, RI3, RI6, RI7 and PN4_rec) due to not loading on any factor or cross-loading on multiple factors, all items were loaded appropriately on nine factors. The final table is listed below (Table 22).

Table 22 Final Pattern Matrix

Pattern Matrix[a]

	Factor								
	1	2	3	4	5	6	7	8	9
INT6	.810								
INT4	.650								
INT7	.639								
INT5	.544								
ITPBK3		.870							
ITPBK2		.834							
ITPBK1		.803							
ITPBK6		.754							
ITPBK8		.738							
ITPBK7		.721							
ITPBK4		.718							
ITPBK5		.666							
TMS4			.717						
TMS1			.682						
TMS3			.670						
TMS2			.665						
TMS5			.605						
PN1				-.756					
PN2				-.737					
PN3_rec				-.593					
PF2					-.756				
PF4					-.676				
PF1					-.662				
PF3					-.629				
PF5					-.459				
AOP4						-.845			
AOP3						-.575			
AOP5						-.486			
POC6							.615		
POC4							.608		
POC3							.471		
POC7							.471		
POC5							.414		
RI4								.690	
RI2								.637	
RI5								.595	
PR7									.625
PR1									.616
PR6									.602
PR8									.589
PR3									.529
PR2									.446

Extraction Method: Principal Axis Factoring.
Rotation Method: Oblimin with Kaiser Normalization. [a]

a. Rotation converged in 14 iterations.

Reliability Analysis

The next step was a reliability test and analysis. The results indicated that eight out of nine factors had high reliability, with Cronbach Alpha greater than a threshold of .70. One factor (RI) had slightly lower reliability with Cronbach Alpha .69 (< .70) (Table 23, Appendix C6).

Table 23 Reliability Test Results

Factor	Construct	Cronbach Alpha
1	Intention to Adopt (INT)	.90
2	IT Personnel Business Knowledge (ITPBK)	.93
3	Top Management Support (TPS)	.88
4	Perception of Need (PN)	.76
5	Patient Focus (PF)	.85
6	Awareness of Organizational Performance (AOP)	.74
7	Process-Oriented Culture (POC)	.75
8	Rivalry Intensity (RI)	.69
9	Perception of Readiness (PR)	.85

Pilot Summary

The pilot study was completed between September and November 2024. The survey was distributed through Qualtrics and CloudResearch, and 150 participants were recruited. After data cleaning, which included removing duplicates, failed attention checks, and outliers in survey completion time, the final sample was 137 participants.

The data analysis included descriptives on background and demographic questions, normality tests, EFA, and reliability tests. Participants represented a range of departments and roles in the healthcare industry, with most coming from clinical, administrative, and operational areas. Demographic data captured age, gender, organization type, size, and participant tenure. Key questions assessed participants'

awareness of quality improvement initiatives, use of CAHPS surveys, and involvement in government-funded programs.

The normality tests were performed to evaluate the sample data for normal distribution. Based on the K-S and W-S tests, the sample data was not normally distributed for all constructs. The exploratory factor analysis and reliability tests validated the survey instrument. After performing the EFA and removing items that either did not load on any factor or were cross-loading on more than one factor, all items loaded appropriately on nine key factors. Most constructs demonstrated strong reliability (Cronbach's Alpha > 0.70), with the exception of one factor (RI- Rivalry Intensity) that had reliability slightly below the threshold (.69).

Based on the pilot study's results, the survey instrument was modified in preparation for the main study. Several questions were reworded for clarity (AOP1, AOP2, AOP5, RI1, RI3, RI6, RI7, PF5, POC1, POC3-11, PR2, PR3, PR5, PN4, INT1-2), three were removed (POC2, PR4, INT3) because they were duplicative, two were added (INT7, PN5) to ensure the appropriate number of questions were covered to measure the construct, and questions with high reliability were retained. Another modification was creating categories for departments and roles, as the respondents were prompted to type and provide their specific departments and roles in a text box. The departments were grouped into categories: administrative, clinical, financial, IT, and other operational departments. Roles were categorized as registered nurse, physician, administrative, financial specialist, IT analyst, manager, analyst, and other operational roles.

DATA ANALYSIS AND RESULTS

The main study was launched on November 25, 2024, and achieved a 100% completion rate for the target goal of 300 participants. The target criteria included participants from United States, working in the Healthcare industry, with the supervisory role of C-Level, Owner, Partner, President, Vice President, Director, Manager, Analyst, Assistant or Associate, Administrative, Consultant or Volunteer, and the employment sector of Government, For Profit, and Nonprofit. The target criteria for participation focused on recruiting individuals from the U.S. healthcare industry, as the research aims to investigate the adoption of quality improvement initiatives within U.S. healthcare organizations. Criteria were set to include both management and non-management roles to ensure a broad sample representation. Employment sector information was gathered to understand the distribution of participants across government, for-profit, and non-profit organizations. An informational statement provided an overview of the study, advising participants that the survey was voluntarily anonymous and that responses would remain confidential. Before accessing the study, participants completed a CAPTCHA to confirm authenticity. Following CAPTCHA verification, participants were prompted to answer background and demographic questions before proceeding to the main survey questions. All questions were required to be answered to advance through the survey. Upon completion, a $4 monetary incentive was offered to thank participants for their time.

Data was uploaded from Qualtrics and included a total of 300 responses. The survey included three attention-check questions: ATT1, ATT2 – “To ensure you are a real person, please select 'Neither agree nor disagree' to this statement” and ATT3 – “To ensure you're paying attention, please select "Pizza" from the list below: Burger; Salad;

Pizza; Pasta; Sandwich". Eleven participants failed attention-check questions ATT1 (6 participants), ATT2 (5 participants), and were excluded from the analysis. All participants passed the attention-check question ATT3.

Outliers were identified by means of a Mahalanobis distance analysis, as follows. First, the squared Mahalanobis distance for the multivariate responses of each participant in the survey (considering only the questions measuring the constructs of interest and excluding others, such as demographics, attention checks, etc.) was calculated. Second, a cutoff was determined, based on the appropriate degrees of freedom for the number of variables involved, with probability of 0.999. Third, the squared Mahalanobis distance for each row of data was compared to the cutoff to identify which observations lay outside of the specified limits. Twenty one responses were flagged as outliers and removed from any subsequent analyses. After making exclusions, 268 responses remained in the study.

The average duration time for the survey was 570.23 seconds with a standard deviation of 465.12 seconds. No responses were identified below the reasonable threshold; therefore, all data was retained in the study for analysis (Table 24). Figure 16 shows the distribution of time taken to complete the survey, and Figure 17 shows survey time outliers.

Table 24 Survey Time Statistics

Statistics

Duration (in seconds)

N	Valid	268
	Missing	0
Mean		570.23
Median		424.00
Std. Deviation		465.127
Range		3300
Minimum		123
Maximum		3423

Figure 16 Histogram – Duration

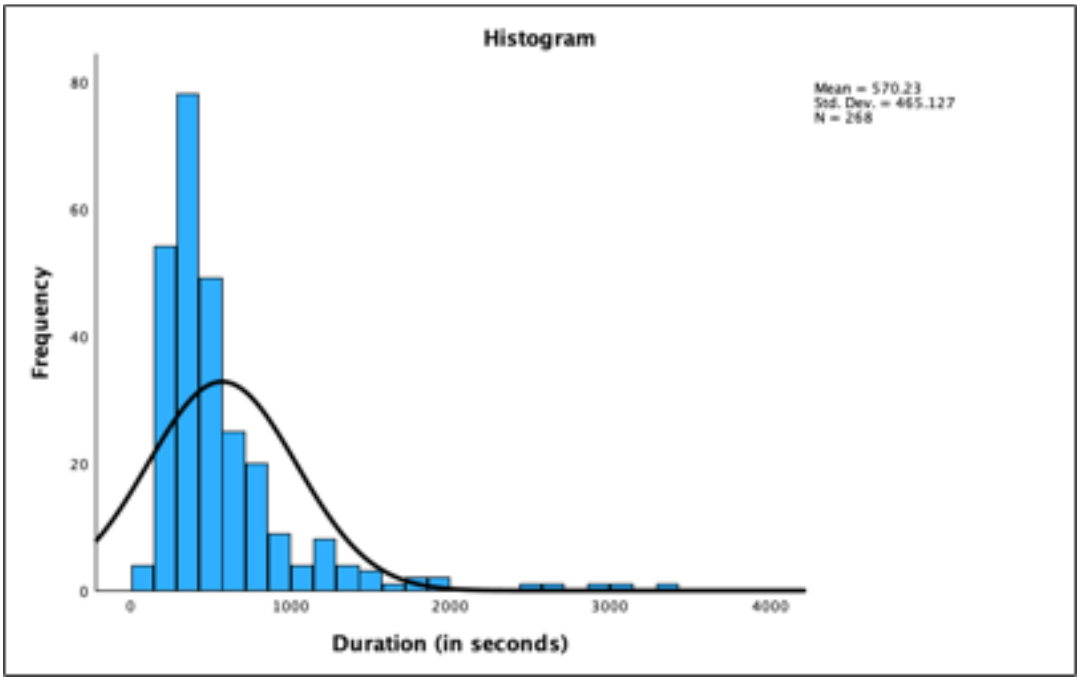
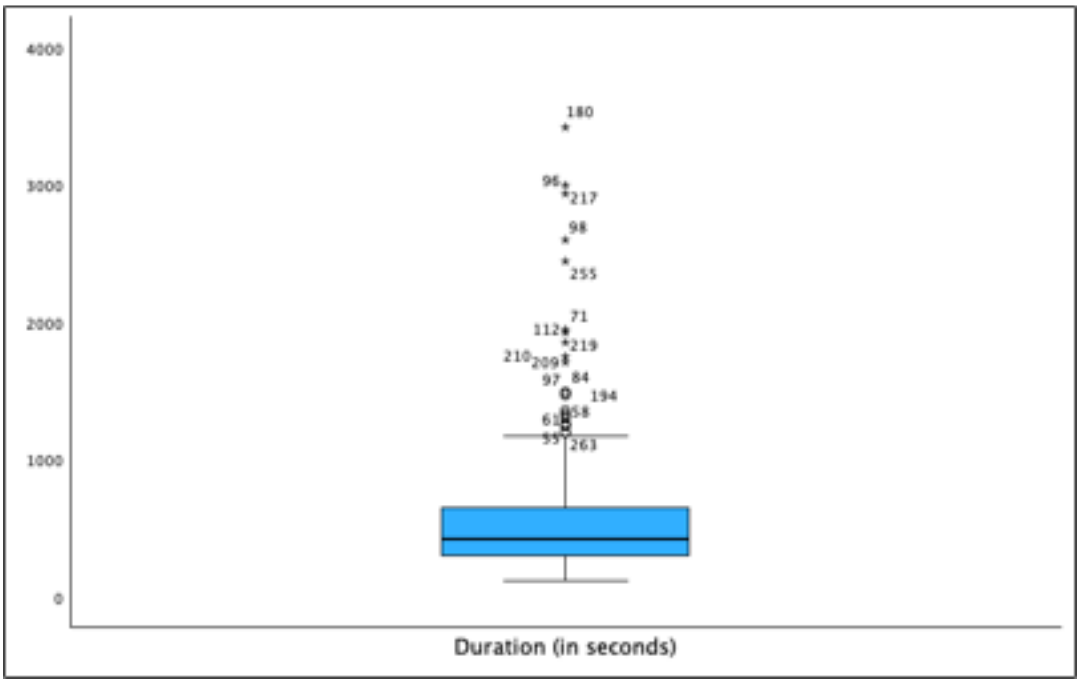


Figure 17 Boxplot - Survey Time Outliers



Data and Variables

The survey instrument included background and demographic questions. Background questions gathered information on participants' organizational profiles to assess their involvement in quality improvement initiatives, the types of initiatives in place, the use of CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys as input for quality improvement, and the role of government-funded programs in supporting these efforts. Demographic questions collected general information on respondents' age, gender, organization type, size, tenure, department, and role, providing insight into the characteristics of the participants. The measurement items for independent, mediating, and dependent variables used a 5-point Likert scale, anchoring 1= Strongly disagree; 2= Somewhat disagree; 3= Neither agree nor disagree; 4= Somewhat agree; and 5= Strongly agree.

The survey was modified based on the pilot study's results. First, several questions were reworded for clarity. Three questions (POC2, PR4, and INT3) were removed from the survey because they were duplicates or similar in wording to other questions. Two new questions were added (INT7 and PN5). Other changes included creating categories for departments and roles. Several selections for the type of organization were removed to simplify the options for the participants. The complete survey is listed in Appendix D.

Descriptive Analysis

Participants' Gender

The main data consisted of 268 participants, of which 64.6% (or 173 participants) were females, 34.7% (or 93 participants) were males, and .7% (or 2 participants) were non-binary (Table 25).

Table 25 Participants' Gender

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	93	34.7	34.7	34.7
	2	173	64.6	64.6	99.3
	3	2	.7	.7	100.0
	Total	268	100.0	100.0	

Note: 1= Male**;** 2= Female**;** 3= Non-binary

Participants' Age

The average age of participants was 38.64 years old, with a standard deviation of 10.99. The participants' ages ranged from 19 to 81 years old (Table 26), with the majority falling between age 30 and 45 years old (Table 27, Figure18).

Table 26 Statistics - Participants' Age

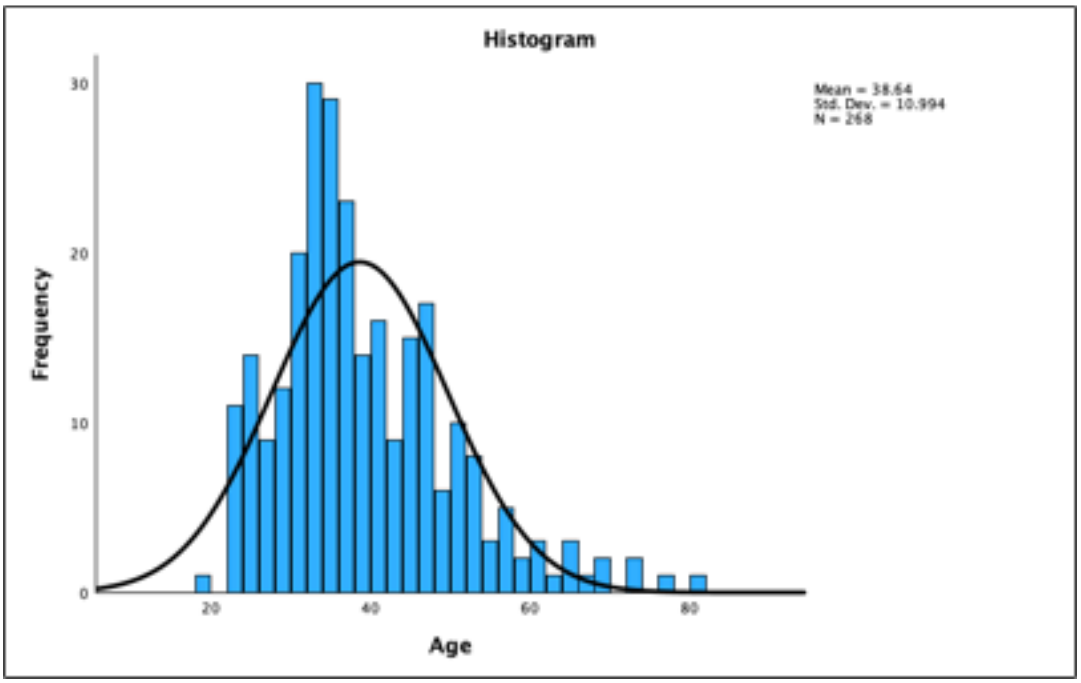
Statistics		
Age		
N	Valid	268
	Missing	0
Mean		38.64
Std. Deviation		10.994
Range		62
Minimum		19
Maximum		81

Table 27 Frequencies - Participants' Age

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	19	1	.4	.4	.4
	22	4	1.5	1.5	1.9
	23	7	2.6	2.6	4.5
	24	7	2.6	2.6	7.1
	25	7	2.6	2.6	9.7
	26	6	2.2	2.2	11.9
	27	3	1.1	1.1	13.1
	28	4	1.5	1.5	14.6
	29	8	3.0	3.0	17.5
	30	13	4.9	4.9	22.4
	31	7	2.6	2.6	25.0
	32	17	6.3	6.3	31.3
	33	13	4.9	4.9	36.2
	34	18	6.7	6.7	42.9
	35	11	4.1	4.1	47.0
	36	11	4.1	4.1	51.1
	37	12	4.5	4.5	55.6
	38	8	3.0	3.0	58.6
	39	6	2.2	2.2	60.8
	40	10	3.7	3.7	64.6
	41	6	2.2	2.2	66.8
	42	6	2.2	2.2	69.0
	43	3	1.1	1.1	70.1
	44	5	1.9	1.9	72.0
	45	10	3.7	3.7	75.7
	46	8	3.0	3.0	78.7
	47	9	3.4	3.4	82.1
	48	2	.7	.7	82.8
	49	4	1.5	1.5	84.3
	50	5	1.9	1.9	86.2
	51	5	1.9	1.9	88.1
	52	6	2.2	2.2	90.3
	53	2	.7	.7	91.0
	54	2	.7	.7	91.8
	55	1	.4	.4	92.2
	56	3	1.1	1.1	93.3
	57	2	.7	.7	94.0
	59	2	.7	.7	94.8
	60	3	1.1	1.1	95.9
	63	1	.4	.4	96.3
	64	1	.4	.4	96.6
	65	2	.7	.7	97.4
	67	1	.4	.4	97.8
	68	2	.7	.7	98.5
	72	1	.4	.4	98.9
	73	1	.4	.4	99.3
	77	1	.4	.4	99.6
	81	1	.4	.4	100.0
	Total	268	100.0	100.0	

Figure 18 Histogram – Participants' Age



Participants' Race

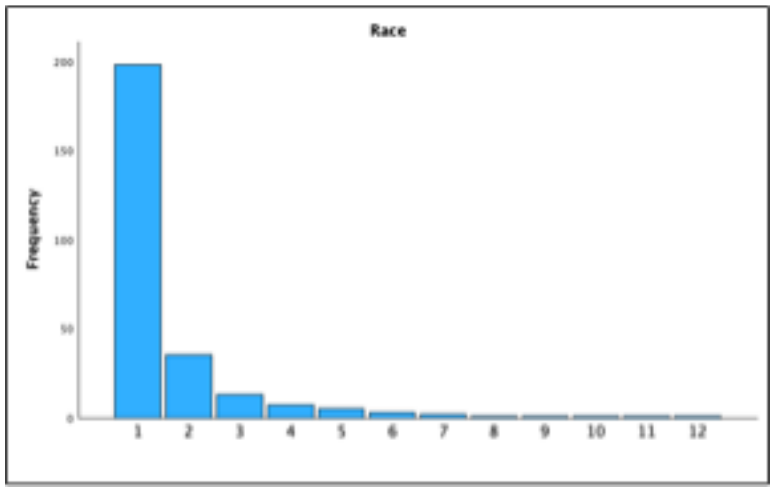
The largest racial group of participants was white, representing 73.9% (or 198 participants), followed by 13.1% (or 35 participants) of Black or African Americans. Smaller proportions of participants identified with other racial or ethnic categories, such as Chinese, 2.6% (or 7 participants), Vietnamese, 1.9% (or 5 participants), Korean, 1.1% (or 3 participants), American Indian or Alaska Native, .7% (or 2 participants), Asian Indian, .4% (or 1 participant), Filipino, .4% (or 1 participant), and Japanese, .4% (or 1 participant). A notable proportion of participants selected "An ethnicity not listed here," 4.9% (or 13 participants) or "Other," .4 (or 1 participant), indicating a diversity of unlisted ethnic backgrounds. Additionally, some participants opted not to disclose their race, as reflected in the "Prefer not to say" .4% (or 1 participant) category (Table 28, Figure 19).

Table 28 Frequencies - Participants' Race

Race

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	198	73.9	73.9	73.9
	2	35	13.1	13.1	86.9
	3	13	4.9	4.9	91.8
	4	7	2.6	2.6	94.4
	5	5	1.9	1.9	96.3
	6	3	1.1	1.1	97.4
	7	2	.7	.7	98.1
	8	1	.4	.4	98.5
	9	1	.4	.4	98.9
	10	1	.4	.4	99.3
	11	1	.4	.4	99.6
	12	1	.4	.4	100.0
	Total	268	100.0	100.0	

Figure 19 Participants' Race



Note: 1= White; 2= Black or African American; 3= An ethnicity not listed here; 4= Chinese; 5= Vietnamese; 6= Korean; 7= American Indian or Alaska Native; 8= Asian Indian; 9= Prefer not to say; 10= Filipino; 11= Japanese; 12= Other

Participants' Education

Participants' educational background showed that the largest group, 38.4% (or 103 participants), held a Bachelor's degree. This was followed by 17.9% (or 48 participants) who completed some college coursework without earning a degree, and 16.8% (or 45 participants) attained a Master's degree. Additionally, 10.8% (or 29

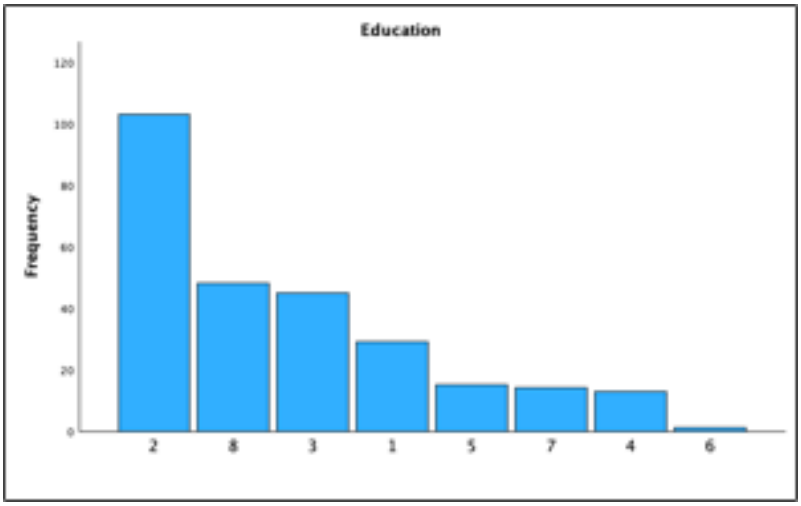
participants) held an Associate degree, while 5.6% (or 15 participants) earned a high school diploma or equivalent. A small minority, 5.2% (or 14 participants), had a professional degree such as MD, DDS, DVM, LLB, or JD, 4.9% (or 13 participants) had a Doctorate, and .4% (or 1 participant) had less than a high school diploma (Table 29, Figure 20).

Table 29 Frequencies - Participants' Education

Education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	103	38.4	38.4	38.4
	8	48	17.9	17.9	56.3
	3	45	16.8	16.8	73.1
	1	29	10.8	10.8	84.0
	5	15	5.6	5.6	89.6
	7	14	5.2	5.2	94.8
	4	13	4.9	4.9	99.6
	6	1	.4	.4	100.0
	Total	268	100.0	100.0	

Figure 20 Participants' Education



Note: 2= Bachelor degree; 8= Some college, but no degree; 3= Master degree; 1= Associate degree; 5= High school graduate – high school diploma or the equivalent; 7= Professional degree (for example: MD, DDS, DVM, LLB, JD); 4= Doctorate degree; 6= Less than a high school diploma

Participants' Household Income

Participants' household income levels represent a broad range, capturing various socioeconomic backgrounds in lower, middle, and high-level brackets. 2.6% (or 7 participants) chose not to disclose their household income.

Lower-Income Bracket

The lower-income categories, such as less than $10,000 (1.5% or 5 participants), $10,000-$19,999 (.7% or 2 participants), $20,000-$29,999 (2.6% or 7 participants), and $30,000-$39,999 (11.2% or 30 participants) are less frequently reported. This indicates a relatively smaller proportion of participants from lower socioeconomic backgrounds.

Middle-Income Bracket

Several participants reported household incomes in the middle range, such as $40,000-$49,000 (7.1% or 19 participants), $50,000-$59,999 (8.6% or 23 participants), $60,000-$69,999 (6.3% or 17 participants), $70,000-$79,999 (9.7% or 26 participants), $80,000-$89,999 (3.7% or 10 participants), $90,000- $99,999 (5.2% or 14 participants), $100,000-$124,999 (9.0% or 24 participants), and $125,000-$149,999 (10.8% or 29 participants). These categories collectively represent a significant portion of the sample, representing the middle-class demographic.

High-Income Bracket:

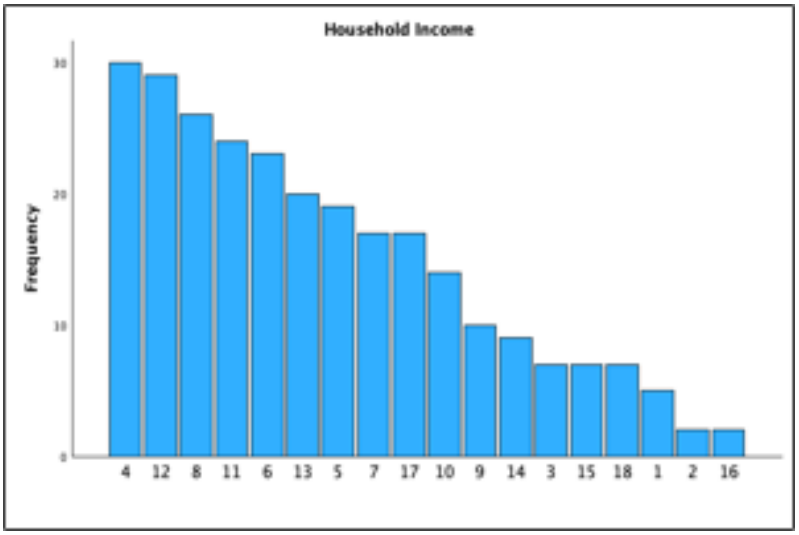
Participants in the high-income bracket reported household income as follows: $150,000-$174,999 (7.5% or 20 participants), $179,000-$199,999 (3.4% or 9 participants), $200,000-$224,000 (2.6% or 7 participants), $225,000-$249,999 (.7% or 2 participants), and $250,000 or more (6.3% or 17 participants) (Table 30, Figure 21).

Table 30 Frequencies - Participants' Household Income

Household Income

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	30	11.2	11.2	11.2
	12	29	10.8	10.8	22.0
	8	26	9.7	9.7	31.7
	11	24	9.0	9.0	40.7
	6	23	8.6	8.6	49.3
	13	20	7.5	7.5	56.7
	5	19	7.1	7.1	63.8
	7	17	6.3	6.3	70.1
	17	17	6.3	6.3	76.5
	10	14	5.2	5.2	81.7
	9	10	3.7	3.7	85.4
	14	9	3.4	3.4	88.8
	3	7	2.6	2.6	91.4
	15	7	2.6	2.6	94.0
	18	7	2.6	2.6	96.6
	1	5	1.9	1.9	98.5
	2	2	.7	.7	99.3
	16	2	.7	.7	100.0
	Total	268	100.0	100.0	

Figure 21 Participants' Household Income



Note: 4= $30,000-$39,999; 12= $125,000-$149,999; 8= $70,000-$79,999; 11= $100,000-$124,999; 6= $50,000-59,999; 13= $150,000-$174,999; 5= $40,000-$49,999; 7= $60,000-$69,999; 17=$250,000 or more; 10= $90,000- $99,999; 9= $80,000-$89,999; 14= $179,000-$199,999; 3= $20,000-$29,999; 15= $200,000-$224,000; 18= Prefer not to say; 1= Less than $10,000; 2= $10,000-$19,999; 16= $225,000-$249,999

Participants' Employment Status

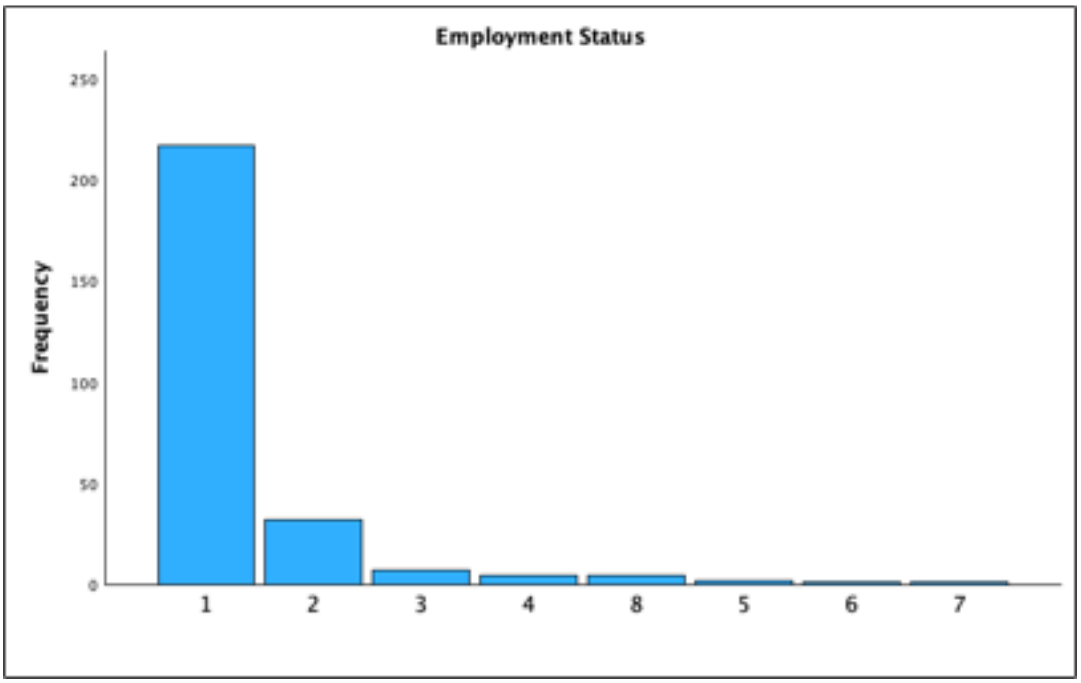
The majority of participants (81% or 217) were employed full-time. A moderate number of participants, 11.9% (or 32), were working part-time or identified as students (2.6% or 7 participants). A considerably smaller number of participants were categorized as business owners (1.5% or 4 participants), retired (.7% or 2 participants), unemployed (.4% or 1 participant), and not in paid work (e.g., homemaker, disabled). Several participants (1.4% or 4) chose "Prefer not to say," indicating a preference not to disclose their employment status (Table 31, Figure 22).

Table 31 Frequencies - Participants' Employment Status

Employment Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	217	81.0	81.0	81.0
	2	32	11.9	11.9	92.9
	3	7	2.6	2.6	95.5
	4	4	1.5	1.5	97.0
	8	4	1.5	1.5	98.5
	5	2	.7	.7	99.3
	6	1	.4	.4	99.6
	7	1	.4	.4	100.0
	Total	268	100.0	100.0	

Figure 22 Participants' Employment Status



Note: 1= Full-time; 2= Part-time; 3= Student; 4= Business Owner; 8= Prefer not to say; 5= Retired; 6= Unemployed; 7= Not in paid work (e.g., homemaker, disabled)

Participants' Organization Size

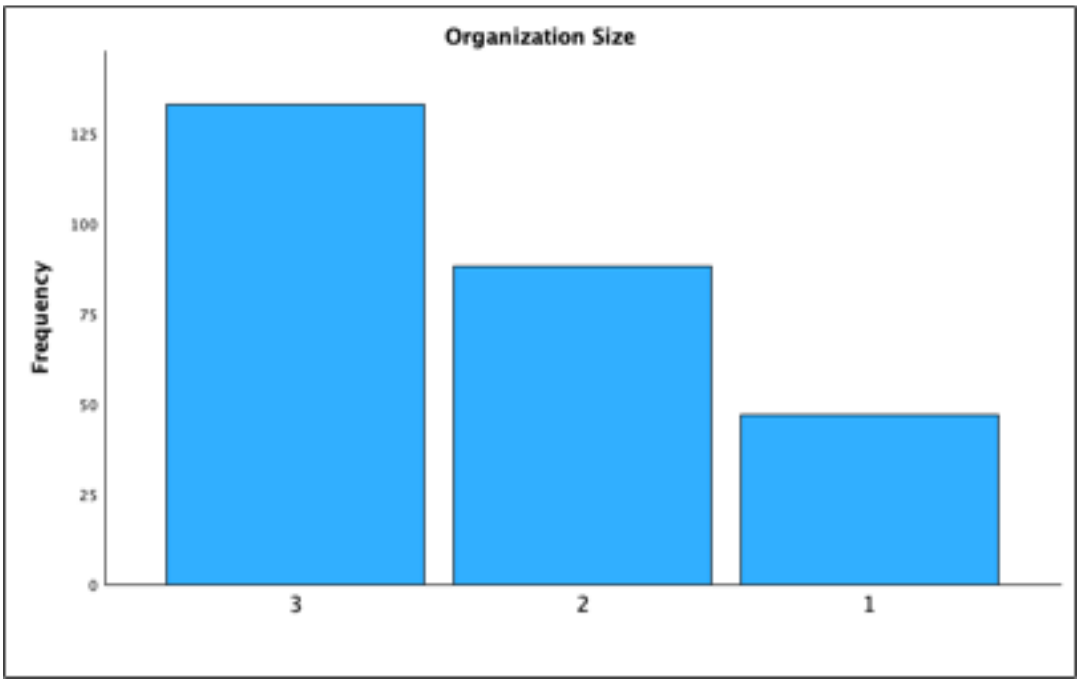
The majority 49.6% (or 133 participants) were employed by large healthcare organizations (with more than 1,000 employees), 33.8% (or 88 participants) by medium-sized organizations (100-999 employees), and 17.5% (or 47 participants) by small organizations (1-99 employees) (Table 32, Figure 23).

Table 32 Frequencies - Participants' Organization Size

Organization Size

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	133	49.6	49.6	49.6
	2	88	32.8	32.8	82.5
	1	47	17.5	17.5	100.0
	Total	268	100.0	100.0	

Figure 23 Participants' Organization Size



Note: 3= Large (>1,000); 2= Medium (100-999); 1= Small (1-99)

Participants' Employment Sector

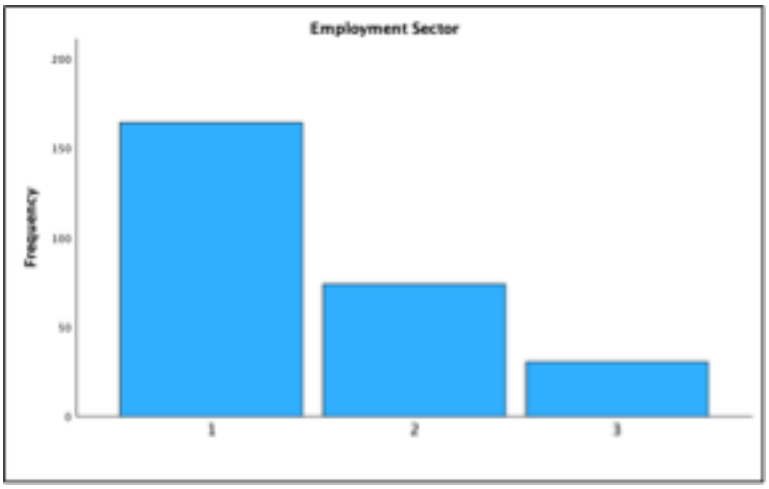
The majority, 61.2%, were employed in the for-profit sector, accounting for 164 participants. Participants from the non-profit sector made up 27.6% (or 74), while those working in government organizations constituted 11.2% (or 30) (Table 33, Figure 24).

Table 33 Frequencies - Participants' Employment Sector

Employment Sector

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	164	61.2	61.2	61.2
	2	74	27.6	27.6	88.8
	3	30	11.2	11.2	100.0
	Total	268	100.0	100.0	

Figure 24 Participants' Employment Sector



Note: 1= For Profit; 2=Nonprofit; 3= Government

Participants' Organization Type

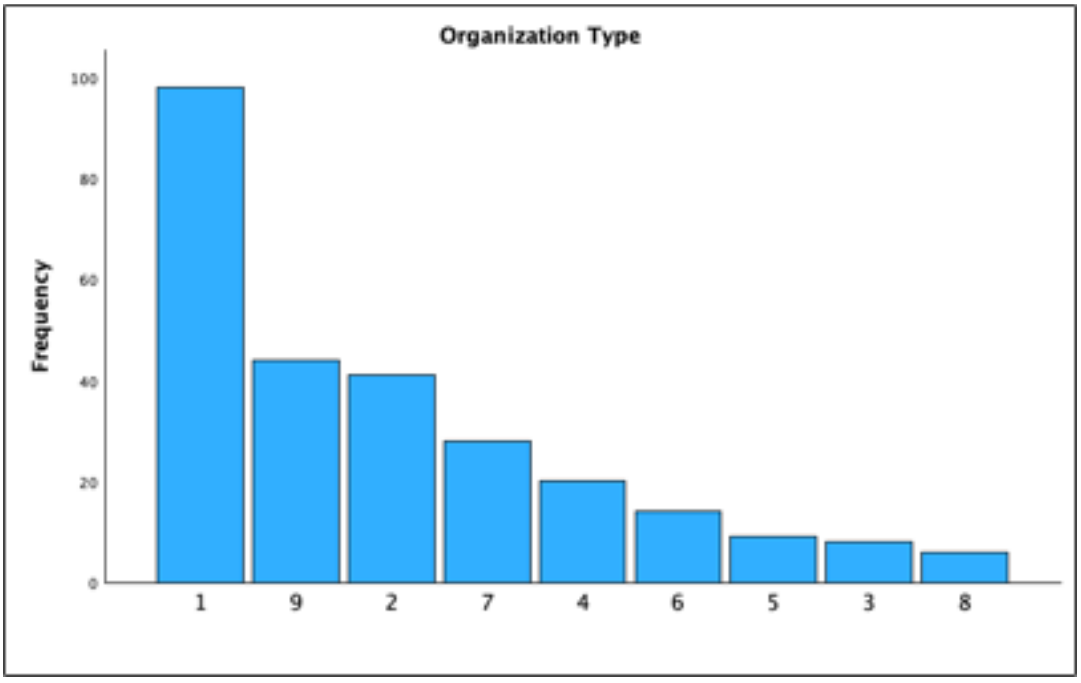
Participants represented various healthcare organizations, including hospitals, clinics, specialty facilities, health insurance companies, and other healthcare companies. The most common types of organizations were hospitals (36.6%), other healthcare-related companies (16.4%), clinics (15.2%) and outpatient facilities (10.4%). Examples of other healthcare-related companies included home health care, medical records and research, healthcare consultancy, and other health-specialty facilities. The remaining 21.3% of organizations were health insurance companies, mental health facilities, laboratories, pharmacies, and medical equipment companies (Table 34, Figure 25).

Table 34 Frequencies - Participants' Organization Type

Organization Type

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	98	36.6	36.6	36.6
	9	44	16.4	16.4	53.0
	2	41	15.3	15.3	68.3
	7	28	10.4	10.4	78.7
	4	20	7.5	7.5	86.2
	6	14	5.2	5.2	91.4
	5	9	3.4	3.4	94.8
	3	8	3.0	3.0	97.8
	8	6	2.2	2.2	100.0
	Total	268	100.0	100.0	

Figure 25 Participants' Organization Type



Note: 1= Hospital**;** 9= Other; 2= Clinic; 7= Outpatient Facility; 4= Health Insurance Company; 6= Mental Health Facility; 5= Laboratory; 3= Pharmacy; 8= Medical Equipment

Participants' Department

Participant departments were categorized as follows: (1) Administrative (e.g., human resources, patient scheduling, records, etc.), (2) Clinical (e.g., nursing, emergency, lab & diagnostics, specialty care, pharmacy, mental health, etc.), (3) Financial & Accounting (e.g., billing, accounts receivable, payroll, etc.), (4) Information Technology (e.g., tech support, implementation, development, data analytics, etc.), and (5) Other.

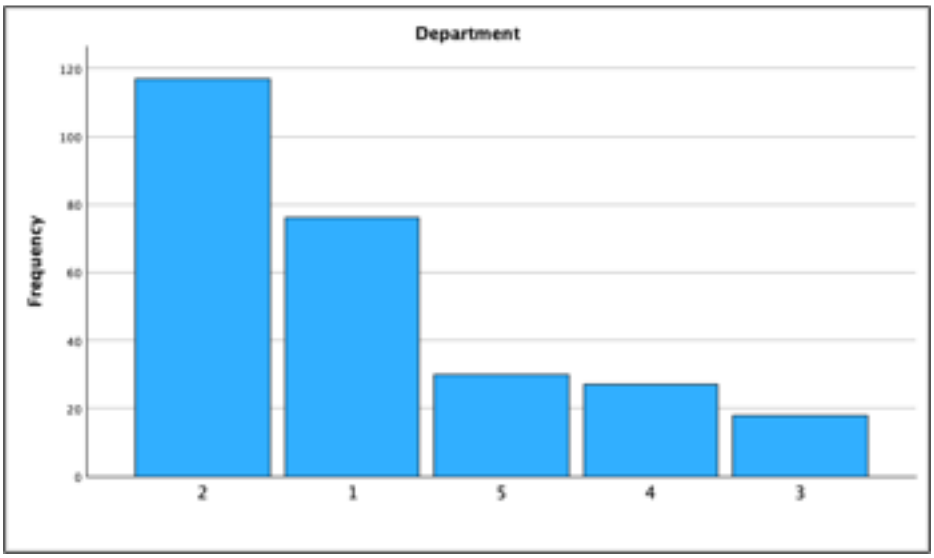
The majority of participants were from Clinical departments (43.7% or 117 participants), followed by Administrative (28.4% or 76 participants) and Other departments accounted for 11.2% (30 participants), and included Research, Social Services, Procurement, Home Aid, Executive Clinical Administration, and other miscellaneous departments. The remaining participants were from Information Technology (10.1% or 27 participants) and Financial & Accounting (6.7% or 18 participants). (Table 35, Figure 26).

Table 35 Frequencies - Participants' Department

Department

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	117	43.7	43.7	43.7
	1	76	28.4	28.4	72.0
	5	30	11.2	11.2	83.2
	4	27	10.1	10.1	93.3
	3	18	6.7	6.7	100.0
	Total	268	100.0	100.0	

Figure 26 Participants' Department



Note: 2= Clinical; 1= Administrative; 5= Other; 4= Information Technology; 3= Financial & Accounting

Participants' Role

Participants' roles were categorized as follows: (1) Administrative (e.g., assistant, coordinator, scheduler, secretary, etc.), (2) Financial Specialist (e.g., billing specialist, financial analyst, pricing manager, etc.) (3) IT Professional (e.g., data analyst, system engineer, quality assurance, etc.) (4) Manager/Director (e.g., project manager, team lead, supervisor, office manager, research director, etc.) (5) Medical Technician (e.g., lab, radiology, pharmacy, emergency medical, surgical, medical equipment, etc.), (6) Physician (e.g., therapist, primary care, clinical dietitian, chiropractic, etc.), (7) Registered Nurse (e.g., LPN, nurse practitioner, case manager, etc.) and (8) Other.

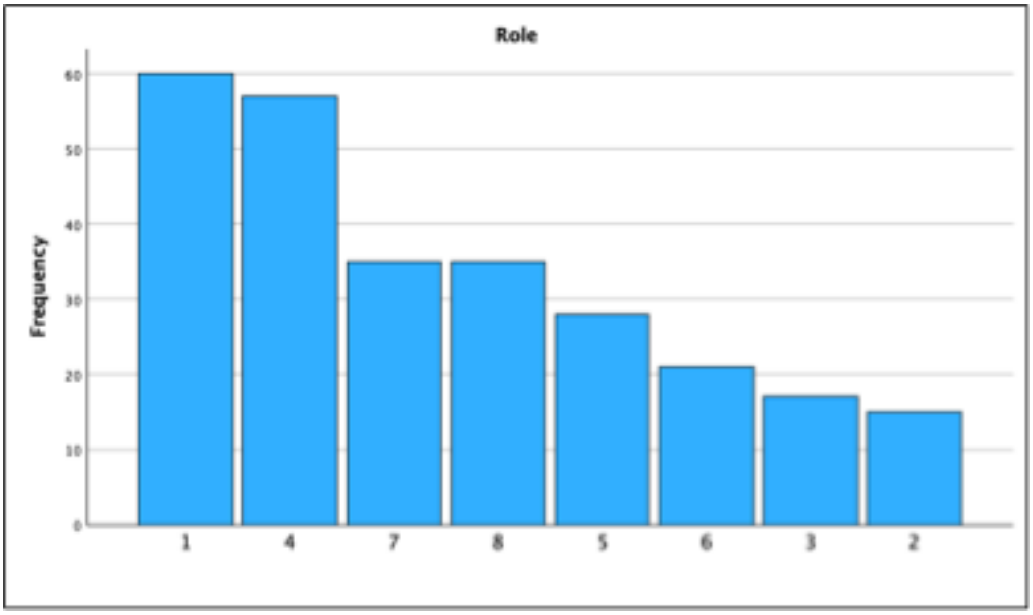
The most commonly represented roles were Administrative (22.4% or 60 participants), followed by Manager/Director roles (21.3% or 57 participants), Registered Nurse (13.1% or 35 participants), and Other roles accounted for 13.1% (or 35

participants) and included Home Health Aid, Customer Service, Research Scientist, Quality Professional and other miscellaneous roles. The remaining roles included Medical Technician (10.4% or 28 participants), Physicians (7.8% or 21 participants), IT Professional (6.3% or 17 participants) and Financial Specialist (5.6% or 15 participants) roles. (Table 36, Figure 27).

Table 36 Frequencies - Participant Role

Role					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	60	22.4	22.4	22.4
	4	57	21.3	21.3	43.7
	7	35	13.1	13.1	56.7
	8	35	13.1	13.1	69.8
	5	28	10.4	10.4	80.2
	6	21	7.8	7.8	88.1
	3	17	6.3	6.3	94.4
	2	15	5.6	5.6	100.0
	Total	268	100.0	100.0	

Figure 27 Participants' Role



Note: 1= Administrative; 4= Manager/Director; 7= Registered Nurse; 8= Other; 5= Medical Technician; 6= Physician; 3= IT Professional; 2= Financial Specialist

Participants' Tenure

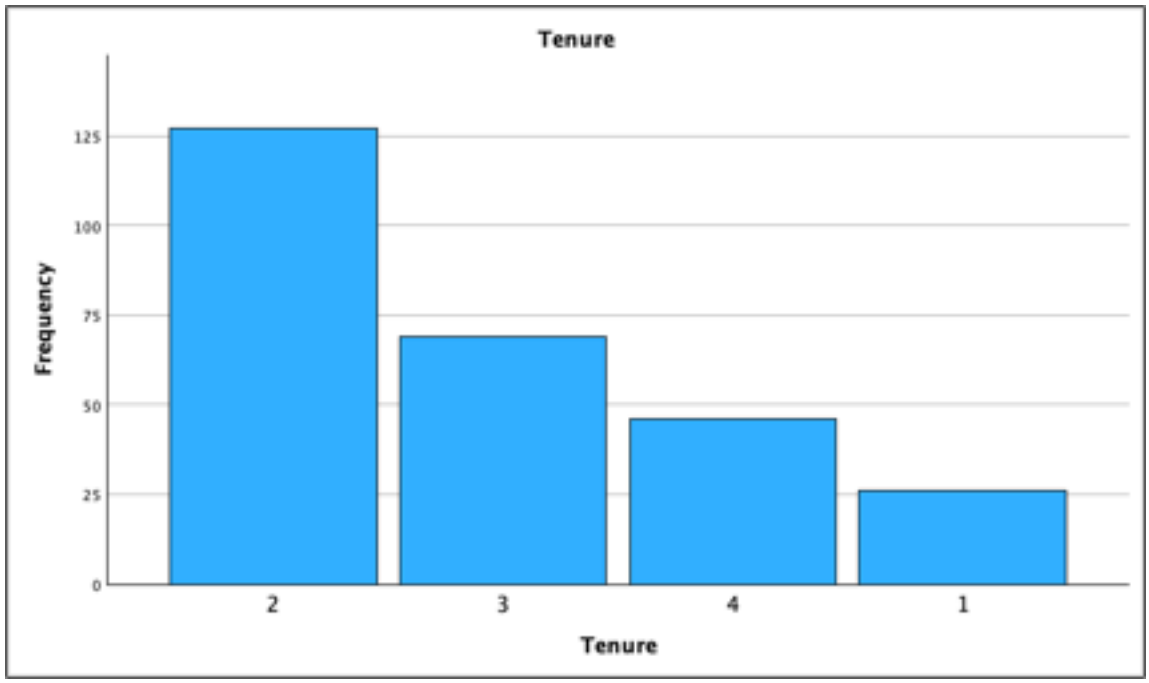
Respondents' tenure at their current organization was distributed as follows: 9.7% (or 26 participants) had less than 1 year, 47.4% (or 127 participants) had 1-5 years, 25.7% (or 69 participants) had 5-10 years, and 17.2% (or 46 participants) had more than 10 years (Table 37, Figure 28).

Table 37 Frequencies - Respondent's Tenure

Tenure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	127	47.4	47.4	47.4
	3	69	25.7	25.7	73.1
	4	46	17.2	17.2	90.3
	1	26	9.7	9.7	100.0
	Total	268	100.0	100.0	

Figure 28 Respondent's Tenure



Note: 2= 1-5 years; 3= 5-10 years; 4= More than 10 years; 1= Less than 1 year

Participants' Organization Quality Improvement Involvement

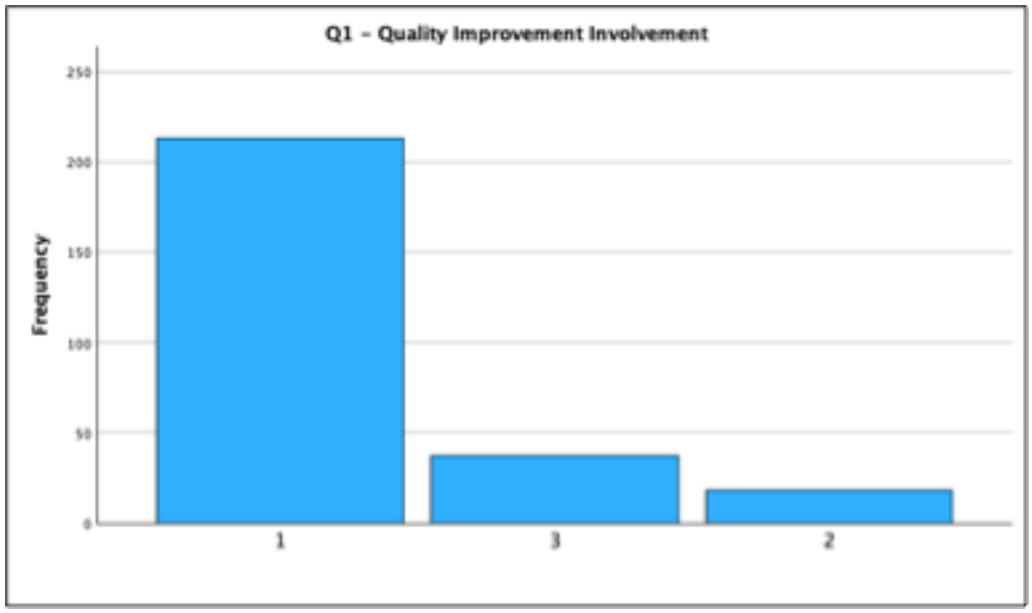
Participants were asked whether their organization was currently involved in quality improvement initiatives. The results indicated that 213 (or 79.5%) out of 268 respondents reported that their organization was involved in quality improvements, signifying active involvement in quality improvement efforts. A smaller portion (6.7% or 18 participants) responded that their organization is not currently involved in quality improvements, while 13.8% (or 18 participants) of respondents were unsure about their organization's participation in such an initiative (Table 38, Figure 29). The top selections for quality improvement initiatives were organizational process improvement (32.5% or 87 participants), patient care improvement (31% or 83 participants), patient experience and satisfaction improvement (15.3% or 41 participants), and other (.7% or 2 participants) (Table 39, Figure 30).

Table 38 Frequencies - Participants' Organization Quality Improvement Involvement

Q1 – Quality Improvement Involvement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	213	79.5	79.5	79.5
	3	37	13.8	13.8	93.3
	2	18	6.7	6.7	100.0
	Total	268	100.0	100.0	

Figure 29 Participants' Organization Quality Improvement Involvement



Note: Q1 - Is your organization currently involved in quality improvement initiative/s?

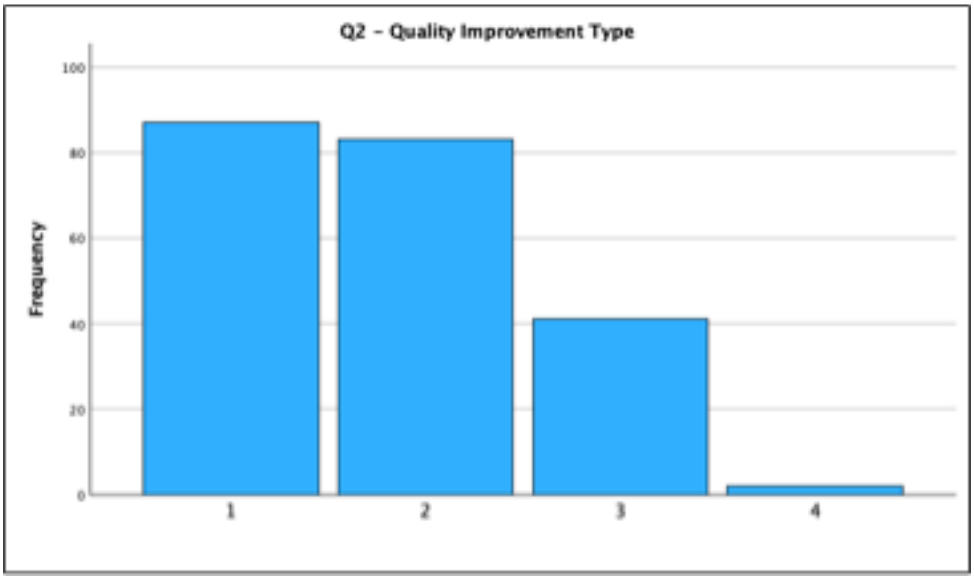
1=Yes, 2=No, 3=Unsure

Table 39 Frequencies - Participants' Organization Quality Improvement Type

Q2 - Quality Improvement Type

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	87	32.5	40.8	40.8
	2	83	31.0	39.0	79.8
	3	41	15.3	19.2	99.1
	4	2	.7	.9	100.0
	Total	213	79.5	100.0	
Missing	System	55	20.5		
Total		268	100.0		

Figure 30 Participants' Organization Quality Improvement Type



Note: 1= Organizational process improvement (e.g., workflows, efficiency, automation, optimization), 2= Patient care improvement (e.g., clinical protocols, safety), 3= Patient experience and satisfaction improvement, 4= Other

Use of CAHPS Survey

Participants were asked whether their organization uses CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys. CAHPS is a program overseen by the Agency for Healthcare Research and Quality that develops standardized surveys for assessing patients' experience with healthcare providers and health plans. The surveys focus on quality aspects, such as providers' communication skills and ease of access to healthcare services (About the CAHPS Program and Survey, 2024). The responses indicated that 42.5% (or 114) of participants were unsure about their organization's use of CAHPS surveys, indicating that they were unaware of such an initiative. 32.1% (or 86) of participants indicated that their organization uses CAHPS surveys for various reasons (Table 40, Figure 31). The participants were asked about the

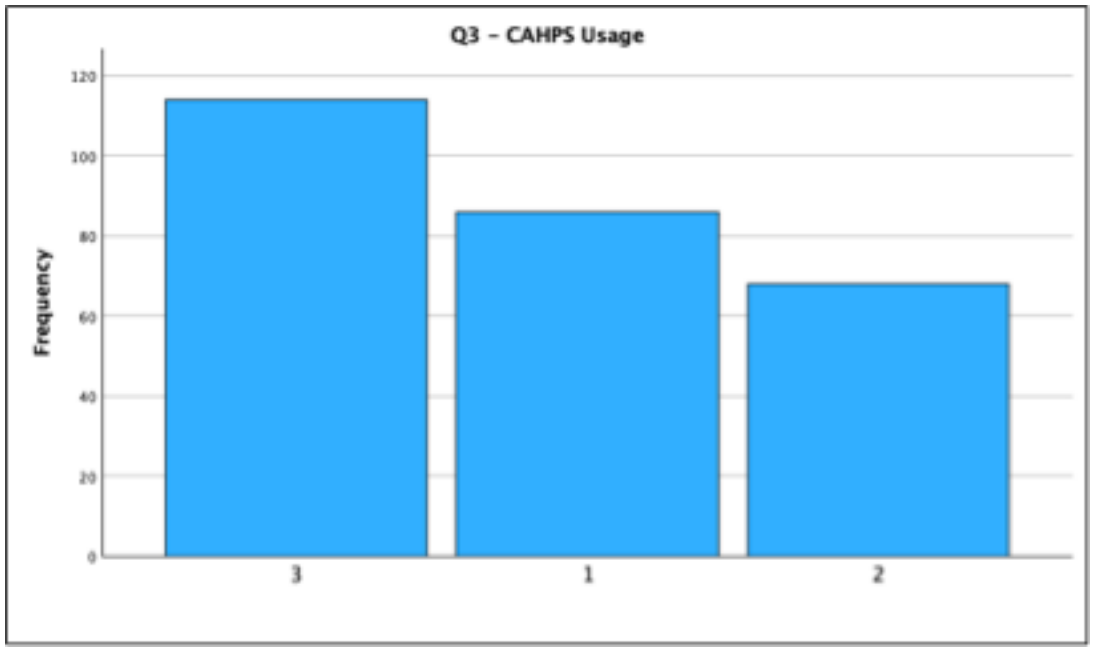
purpose of CAHPS data usage for their organizations. The results showed that quality improvement initiatives represented the top choice (12.3% or 33 participants), public reporting of healthcare quality data (3% or 8 participants), government funding (2.6% of 7 participants), accreditation or certification (2.2% or 6 participants), and compensation and performance reviews (1.1% or 3 participants) (Table 41, Figure 32).

Table 40 Frequencies - CAHPS Usage

Q3 – CAHPS Usage

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	114	42.5	42.5	42.5
	1	86	32.1	32.1	74.6
	2	68	25.4	25.4	100.0
	Total	268	100.0	100.0	

Figure 31 CAHPS Usage

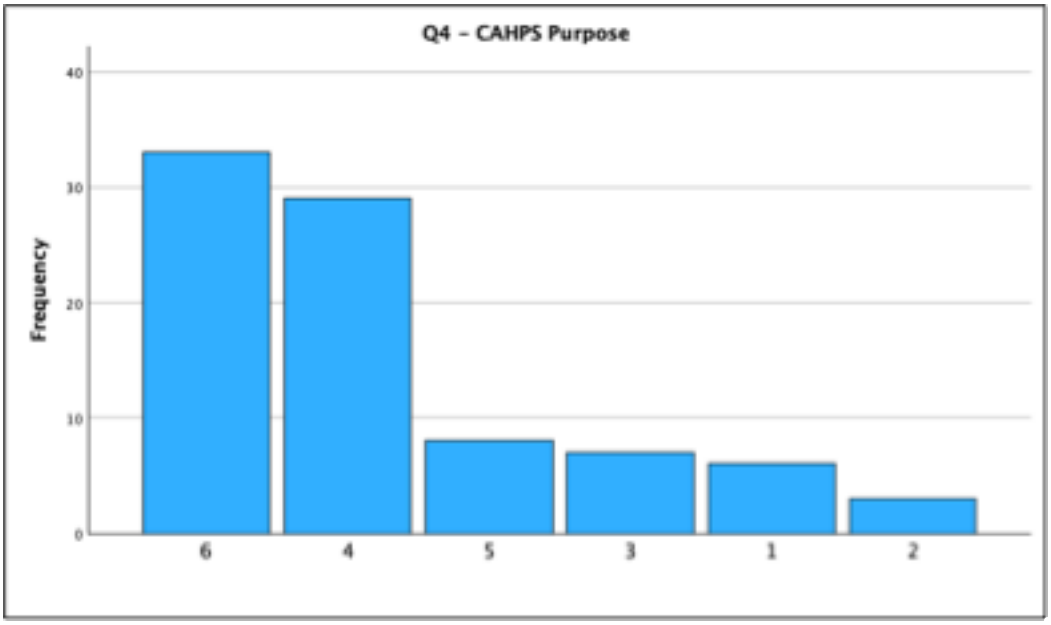


Note: Q3 - Does your organization use CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys? 1= Yes; 2= No; 3= Unsure

Table 41 Frequencies - CAHPS Purpose

Q4 – CAHPS Purpose					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	6	33	12.3	38.4	38.4
	4	29	10.8	33.7	72.1
	5	8	3.0	9.3	81.4
	3	7	2.6	8.1	89.5
	1	6	2.2	7.0	96.5
	2	3	1.1	3.5	100.0
	Total	86	32.1	100.0	
Missing	System	182	67.9		
Total		268	100.0		

Figure 32 CAHPS Purpose



Note: Q4 - For what purpose does your organization use CAHPS data? 6= Quality Improvement initiatives; 4= Patient experience improvement; 5= Public reporting of healthcare quality; 3= Government funding; 1= Accreditation or certification; 2= Compensation and performance reviews

Government Funding

Survey questions about government funding were included to assess participants' organizations' involvement in programs such as Medicare and Medicaid, the percentage

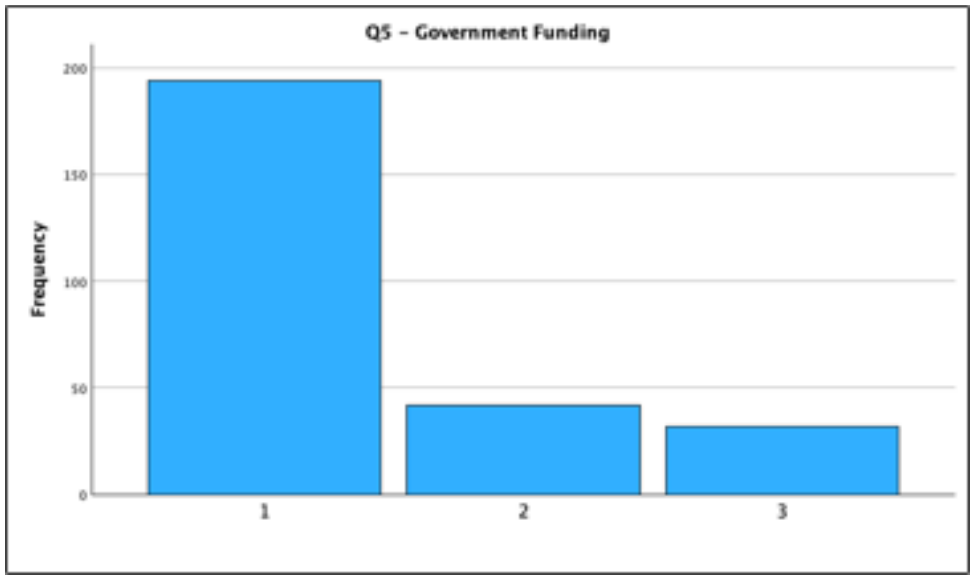
of operations reliant on these programs, and whether the organization must submit quality data for government-funded programs. The results showed that 72.4% (or 194 participants) reported their organization's engagement in government-funded programs. A smaller percentage, 15.7% (or 42 participants), indicated that their organization does not participate in these programs, while 11.9% (or 32 participants) were unsure of their organization's involvement (Table 42, Figure 33).

Table 42 Frequencies - Government-Funded programs

Q5 – Government Funding

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	194	72.4	72.4	72.4
	2	42	15.7	15.7	88.1
	3	32	11.9	11.9	100.0
	Total	268	100.0	100.0	

Figure 33 Government-Funded Programs



Note: Q5 - Is your organization currently engaged in any Government-funded (e.g., Medicare, Medicaid) programs? 1= Yes; 2= No; 3= Unsure

Percentage of Government-funded Programs

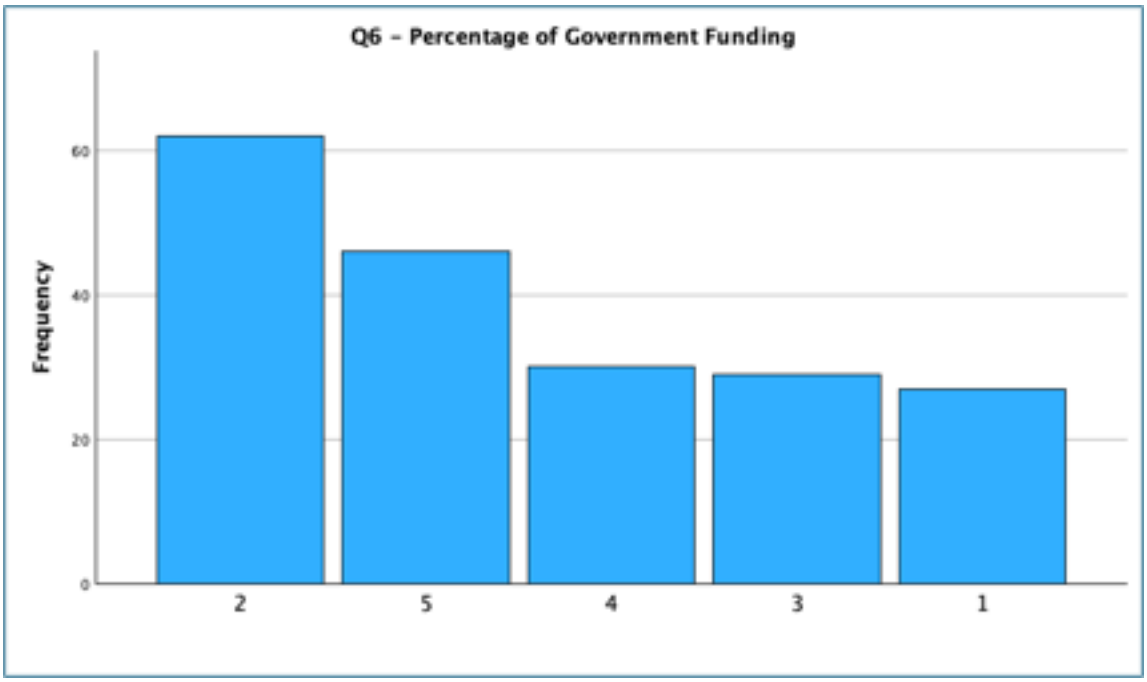
Among participants who indicated that their organization's operations rely on government-funded programs (72.4%, or 196 respondents), the reported levels of dependency were as follows: 23.1% (or 60 participants) reported a dependency of 21-50%, 17.2% (or 46 participants) were unsure about the percentage of government funding, 11.2% (or 30 participants) reported 81-100%, 10.8% (or 29 participants) reported 51-80% and 10.1% (or 27 participants) reported 0-20% (Table 43, Figure 34).

Table 43 Frequencies - Percentage of Government-Funded Programs

Q6 – Percentage of Government Funding

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	62	23.1	32.0	32.0
	5	46	17.2	23.7	55.7
	4	30	11.2	15.5	71.1
	3	29	10.8	14.9	86.1
	1	27	10.1	13.9	100.0
	Total	194	72.4	100.0	
Missing	System	74	27.6		
Total		268	100.0		

Figure 34 Percentage of Government-Funded Programs



Note: Q6 - What percentage of your organization's operations depend on Government-funded programs? 1= 0-20%; 2= 21-50%; 3= 51-80%; 4= 81-100%; 5= Unsure

Reporting of Quality Data

Participants were asked if their organization must submit quality data or performance metrics for government-funded programs. The responses were as follows: 48.9% (or 131 participants) answered 'Yes,' 20.9% (or 56 participants) answered 'Unsure,' and 2.6% (or 7 participants) answered 'No.' (Table 44, Figure 35).

Table 44 Frequencies - Requirement to Submit Quality Data

Q7 – Quality Data Reporting

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	131	48.9	67.5	67.5
	3	56	20.9	28.9	96.4
	2	7	2.6	3.6	100.0
	Total	194	72.4	100.0	
Missing	System	74	27.6		
Total		268	100.0		

Figure 35 Requirement to Submit Quality Data

Note: Q7 - Is your organization required to submit quality data or performance metrics for Government-funded programs? 1=Yes; 2=No; 3=Unsure

Test of Normality

Normality tests using Kolmogorov-Smirnov (K-S) and Shapiro-Wilk (S-W) were performed to evaluate the sample data for normal distribution. A p-value <.05 would indicate a significant departure from normality, and a p-value >.05 would indicate that the data is normally distributed. Overall, K-S and S-W tests showed a significance of <.05 on all constructs.

Awareness of Organizational Performance (AOP)

The mean of the AOP scale was 4.01 (SD .636). An examination of boxplot indicated one outlier (data point 244). The K-S and W-S tests indicate that the data was not normally distributed p<.05 (p<.001, p<.001). The Q-Q plot showed a skew of the observed values, with those more concentrated at the upper-right side of the normal distribution with the outlier on the lower left side (Appendix D4.1).

Rivalry Intensity (RI)

The mean of the RI scale was 3.66 (SD .762). An examination of boxplot did not indicate outliers. The K-S and W-S tests indicate that the data was not normally distributed p<.05 (p<.001, p<.001). The Q-Q plot showed a skew of the observed values, with points deviating in the upper right and lower tails (Appendix D4.2).

Patient Focus (PF)

The mean of PF scale was 4.03 (SD .806). An examination of boxplot indicated one outlier (data points 251). The K-S and W-S tests indicated that the data was not normally distributed p<.05 (p<.001, p<.001). The Q-Q plot showed a skew of the observed values at the lower left ends, where a few data points deviate from the normal distribution line (Appendix D4.3).

Top Management Support (TMS)

The mean of TMS scale was 4.16 (SD .716). An examination of boxplot indicated six outliers (data points 49, 6, 254, 109, 16, 251). The K-S and W-S tests indicated that the data was not normally distributed $p<.05$ ($p<.001$, $p<.001$). The Q-Q plot showed a skew of the observed values at the lower left ends, where a few data points deviate from the normal distribution line (Appendix D4.5).

Process-Oriented Culture (POC)

The mean of POC scale was 3.98 (SD .739). An examination of boxplot indicated four outliers (data points 18, 251, 47, 122). The K-S and W-S tests indicated that the data was not normally distributed $p<.05$ ($p=.05$, $p=.006$). The Q-Q plot showed a skew of the observed values, where a few points fall above the normal distribution line, and at the lower left end. This indicates minor skewness departure at the tails (Appendix D4.6).

IT Personnel Business Knowledge (ITPBK)

The mean of ITPBK scale was 4.08 (SD .848). An examination of boxplot indicated six outliers (data points 189, 221, 171, 23, 198, 251). The K-S and W-S tests indicated that the data was not normally distributed $p<.05$ ($p<.001$, $p<.001$). The Q-Q plot showed a skew of the observed values, with those more concentrated at the upper and lower ends indicating a slight deviation from the normal distribution (Appendix D4.7).

Perception of Readiness (PR)

The mean of PR scale was 4.14 (SD .638). An examination of boxplot indicated four outliers (data points 129, 72, 739, 9). The K-S and W-S tests indicated that the data was not normally distributed $p<.05$ ($p<.001$, $p=.002$). The Q-Q plot showed a skew of the

observed values at the upper and lower ends, indicating a slight deviation from the normal distribution (Appendix D4.8).

Perception of Need (PN)

The mean of PN scale was 4.43 (SD .551). An examination of boxplot did not indicate outliers. The K-S and W-S tests indicated that the data was not normally distributed $p<.05$ ($p<.001$, $p<.001$). The Q-Q plot showed that observed values are skewed on both upper and lower ends, and do not fall perfectly along the normal distribution line (Appendix D4.9).

Intention to Adopt (INT)

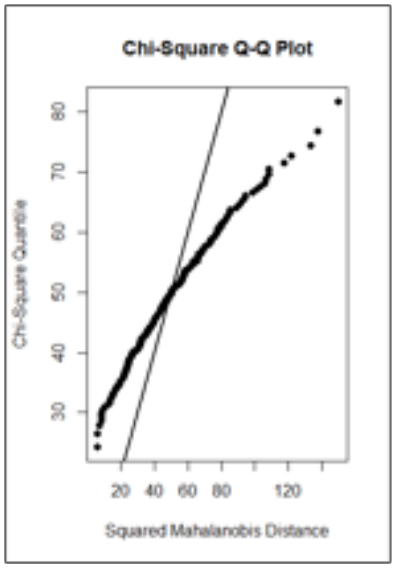
The mean of the INT scale was 4.24 (SD .643). An examination of boxplot indicated three outliers (data points 102, 42, 251). The K-S and W-S tests indicated that the data was not normally distributed $p<.05$ ($p<.001$, $p<.001$). The Q-Q plot showed a skew at the upper and lower ends, with data points falling above the normal distribution line on the lower left side (Appendix D4.10).

Multivariate Normality Analysis

In addition to examining the univariate normality of each individual construct, a multivariate normality analysis was conducted with the MVN R package (Korkmaz et al., 2014). Results indicate departures of multivariate normality per the Mardia, Henze-Zirkler, Anderson-Darling and Royston tests; see also the multivariate Q-Q plot presented in Figure 36, based on squared Mahalanobis distances. In order to take into account these deviations from multivariate normality, subsequent analyses employed the MLM estimator, which incorporates robust standard errors and a Satorra-Bentler scaled test

statistic, instead of the default ML estimator, which assumes multivariate normality in the distribution of the data (Figure 36).

Figure 36 Chi-Square Q-Q Plot



Confirmatory Factor Analysis (CFA)

CFA of the data was performed to establish an acceptable measurement model. The data included a total of 48 items for nine factors. All 48 items loaded significantly ($p<.001$) in a respective factor, and the overall strength of the loadings ranged from mild to strong (Table 45). Factor covariances (Table 46) represent relationships between factors. All factors correlate significantly ($p<.001$) with the respective factor. The correlations between factor RI and PF, TMS, POC, ITPBK, PR, PN, and INT show standard estimates, ranging from .244 to .423, indicating the correlations are not strong. Correlations between factors PR and PN, INT and PN with INT show high standard estimates (.716, .607, and .748), indicating the presence of strong correlations.

Table 45 Factor Loadings

Factor Loadings

				95% Confidence Interval				
Factor	Indicator	Estimate	SE	Lower	Upper	Z	p	Stand. Estimate
AOP	AOP1	0.439	0.0505	0.340	0.538	8.68	<.001	0.560
	AOP2	0.533	0.0622	0.411	0.655	8.57	<.001	0.536
	AOP3	0.568	0.0570	0.456	0.679	9.97	<.001	0.642
	AOP4	0.615	0.0568	0.503	0.726	10.82	<.001	0.679
	AOP5	0.648	0.0480	0.554	0.742	13.49	<.001	0.783
RI	RI1	0.830	0.0591	0.714	0.946	14.04	<.001	0.764
	RI2	0.747	0.0541	0.641	0.853	13.82	<.001	0.756
	RI3	0.807	0.0599	0.690	0.925	13.48	<.001	0.743
	RI4	0.777	0.0645	0.651	0.903	12.06	<.001	0.684
	RI5	0.635	0.0667	0.504	0.765	9.52	<.001	0.568
	RI6	0.455	0.0591	0.339	0.571	7.70	<.001	0.474
	RI7	0.670	0.0489	0.574	0.766	13.72	<.001	0.752
PF	PF1	0.792	0.0461	0.701	0.882	17.19	<.001	0.863
	PF2	0.816	0.0449	0.728	0.904	18.17	<.001	0.895
	PF3	0.816	0.0561	0.706	0.926	14.54	<.001	0.775
	PF4	0.595	0.0507	0.496	0.694	11.74	<.001	0.667
TMS	TMS1	0.678	0.0403	0.599	0.757	16.82	<.001	0.845
	TMS2	0.784	0.0444	0.697	0.871	17.65	<.001	0.871
	TMS3	0.735	0.0414	0.654	0.816	17.77	<.001	0.875
	TMS4	0.619	0.0405	0.539	0.698	15.29	<.001	0.794
	TMS5	0.545	0.0623	0.423	0.667	8.75	<.001	0.515
POC	POC1	0.546	0.0692	0.411	0.682	7.89	<.001	0.483
	POC2	0.513	0.0790	0.358	0.668	6.49	<.001	0.406
	POC3	0.763	0.0479	0.669	0.857	15.92	<.001	0.831
	POC4	0.685	0.0414	0.604	0.766	16.52	<.001	0.853
	POC5	0.584	0.0489	0.488	0.680	11.94	<.001	0.678
ITPBK	ITPBK1	0.819	0.0460	0.729	0.909	17.81	<.001	0.872
	ITPBK2	0.887	0.0441	0.780	0.953	19.66	<.001	0.923
	ITPBK3	0.821	0.0441	0.735	0.908	18.61	<.001	0.894
	ITPBK4	0.736	0.0494	0.639	0.833	14.90	<.001	0.776
	ITPBK5	0.850	0.0492	0.754	0.947	17.29	<.001	0.856
PR	PR1	0.648	0.0422	0.565	0.731	15.35	<.001	0.816
	PR2	0.438	0.0360	0.368	0.509	12.17	<.001	0.691
	PR3	0.555	0.0402	0.476	0.634	13.80	<.001	0.757
	PR4	0.642	0.0632	0.518	0.766	10.16	<.001	0.600
	PR5	0.570	0.0546	0.463	0.677	10.45	<.001	0.616
PN	PN1	0.390	0.0287	0.334	0.446	13.59	<.001	0.742
	PN2	0.482	0.0322	0.419	0.545	14.98	<.001	0.794
	PN3_rec	0.455	0.0735	0.311	0.599	6.19	<.001	0.384
	PN4	0.520	0.0324	0.457	0.584	16.08	<.001	0.832
	PN5	0.545	0.0375	0.471	0.618	14.51	<.001	0.776
INT	INT1	0.570	0.0416	0.488	0.651	13.69	<.001	0.731
	INT2	0.628	0.0417	0.546	0.709	15.06	<.001	0.782
	INT3	0.634	0.0393	0.558	0.711	16.16	<.001	0.819
	INT4	0.646	0.0351	0.578	0.715	18.42	<.001	0.889
	INT5	0.653	0.0407	0.573	0.732	16.05	<.001	0.815
	INT6	0.554	0.0406	0.474	0.634	13.65	<.001	0.730
	INT7	0.640	0.0355	0.571	0.710	18.04	<.001	0.878

Table 46 Factor Covariances

Factor Estimates

Factor Covariances

				95% Confidence Interval				
		Estimate	SE	Lower	Upper	Z	p	Stand. Estimate
AOP	AOP	1.000*						
	RI	0.378	0.0669	0.247	0.510	5.66	<.001	0.378
	PF	0.487	0.0585	0.370	0.604	8.19	<.001	0.487
	TMS	0.491	0.0584	0.376	0.605	8.39	<.001	0.491
	POC	0.609	0.0528	0.506	0.713	11.53	<.001	0.609
	ITPBK	0.445	0.0586	0.330	0.560	7.58	<.001	0.445
	PR	0.558	0.0582	0.443	0.672	9.58	<.001	0.558
	PN	0.438	0.0627	0.315	0.561	6.98	<.001	0.438
	INT	0.533	0.0540	0.427	0.638	9.86	<.001	0.533
RI	RI	1.000*						
	PF	0.351	0.0618	0.230	0.472	5.68	<.001	0.351
	TMS	0.423	0.0579	0.309	0.536	7.30	<.001	0.423
	POC	0.382	0.0622	0.260	0.504	6.15	<.001	0.382
	ITPBK	0.244	0.0640	0.118	0.369	3.81	<.001	0.244
	PR	0.353	0.0641	0.228	0.479	5.51	<.001	0.353
	PN	0.339	0.0637	0.214	0.464	5.33	<.001	0.339
	INT	0.416	0.0573	0.303	0.528	7.26	<.001	0.416
PF	PF	1.000*						
	TMS	0.596	0.0461	0.506	0.687	12.95	<.001	0.596
	POC	0.588	0.0497	0.491	0.686	11.82	<.001	0.588
	ITPBK	0.425	0.0558	0.315	0.534	7.61	<.001	0.425
	PR	0.608	0.0485	0.513	0.703	12.52	<.001	0.608
	PN	0.456	0.0564	0.345	0.567	8.08	<.001	0.456
	INT	0.552	0.0480	0.458	0.646	11.50	<.001	0.552
TMS	TMS	1.000*						
	POC	0.664	0.0426	0.581	0.748	15.60	<.001	0.664
	ITPBK	0.432	0.0543	0.326	0.539	7.96	<.001	0.432
	PR	0.620	0.0465	0.529	0.711	13.33	<.001	0.620
	PN	0.639	0.0439	0.553	0.725	14.54	<.001	0.639
	INT	0.740	0.0329	0.675	0.804	22.50	<.001	0.740
POC	POC	1.000*						
	ITPBK	0.564	0.0485	0.469	0.659	11.63	<.001	0.564
	PR	0.614	0.0493	0.517	0.710	12.46	<.001	0.614
	PN	0.540	0.0531	0.436	0.644	10.18	<.001	0.540
	INT	0.604	0.0463	0.513	0.695	13.05	<.001	0.604
ITPBK	ITPBK	1.000*						
	PR	0.470	0.0552	0.362	0.578	8.52	<.001	0.470
	PN	0.462	0.0544	0.355	0.568	8.48	<.001	0.462
	INT	0.419	0.0542	0.313	0.525	7.73	<.001	0.419
PR	PR	1.000*						
	PN	0.716	0.0412	0.635	0.797	17.37	<.001	0.716
	INT	0.607	0.0467	0.515	0.698	13.00	<.001	0.607
PN	PN	1.000*						
	INT	0.748	0.0339	0.682	0.815	22.10	<.001	0.748
INT	INT	1.000*						

* fixed parameter

Model Indices

The initial model fit indices suggest mixed results regarding how well the model fits the data. The Tucker-Lewis Index (TLI) is .877 and The Comparative Fit Index (CFI) is .886, and both do not meet the acceptable range of >=.90. The Root Mean Square Error of Approximation (RMSEA) is .0575 and slightly above the threshold of <.05. However, the Standardized RMR (SRMR) is .0643 and within the acceptable range of <=.10. Overall, based on the model fit indices of CFI, TLI and RMSEA, the model does not represent an adequate fit and required modifications to align the data better (Table 47). To improve the model fit, factors with low loadings were removed. That included factors PN3_rec, POC2, POC1, and RI6. Another modification was to allow residuals PF1 and PF2 to correlate. After these modifications, the model indices TLI, CFI, SRMR, and RMSEA fell within the acceptable thresholds (Table 48).

Table 47 Model Indices – Before Modifications

Model Fit

Test for Exact Fit

χ^2	df	p
1970	1044	<.001

Fit Measures

				RMSEA 90% CI	
CFI	TLI	SRMR	RMSEA	Lower	Upper
0.886	0.877	0.0643	0.0575	0.0536	0.0614

Table 48 Model Indices – After Modifications

Model Fit

Test for Exact Fit

χ^2	df	p
1569	865	<.001

Fit Measures

				RMSEA 90% CI	
CFI	TLI	SRMR	RMSEA	Lower	Upper
0.910	0.901	0.0585	0.0551	0.0507	0.0594

Summary

The results of the CFA showed that model fit indices CFI and TLI were not within the acceptable thresholds, while the SRMR and RMSEA were within the standards. This indicated the model did not fit the data well and needed modifications. The model modifications were performed, such as removing factors with low loading (RI6, POC1, POC2, PN3_rec) and allowing for the residuals to correlate (PF1 and PF2). The CFI, TLI, SRMR, and RMSEA model indices were within the acceptable thresholds, indicating the model fit the data well. After the model modifications, the next step was to complete the Structural Equation Modeling analysis.

Structural Equation Modeling (SEM)

The CFA model showed a good fit after modifications, and the next step was SEM analysis to test the hypotheses. The SEM analysis was performed using the Maximum Likelihood (ML) method. The model fit indices of the results show the CFI of .994, TLI of .993, SRMR of .066, and RMSEA of .054, all of which are within the acceptable thresholds and indicate a good fit (Table 49). Table 50 reports covariances

between constructs. The squared multiple correlations (R-squared) indicate the variance in endogenous latent variables. The results showed that R^2=.72 for the PN construct, suggesting that its predictors explain 72% of the variance. For construct PR, the R^2=.65, indicating 65% of the variance was explained by its predictors. Finally, for the dependent variable INT, the R^2=.78, or 78% of the variance explained by the construct's predictors (Table 51).

Table 49 Model Indices – ML

Model tests

Label	X^2	df	p
User Model	1553	878	<.001
Baseline Model	109123	946	<.001
Scaled User	1637	878	<.001
Scaled Baseline	20857	946	<.001

Fit indices

			95% Confidence Intervals		
Type	SRMR	RMSEA	Lower	Upper	RMSEA.p
Classical	0.066	0.054	0.049	0.058	0.085
Robust	0.061				
Scaled	0.061	0.057	0.053	0.061	0.004

User model versus baseline model

	Model
Comparative Fit Index (CFI)	0.994
Tucker-Lewis Index (TLI)	0.993
Bentler-Bonett Non-normed Fit Index (NNFI)	0.993
Relative Noncentrality Index (RNI)	0.994
Bentler-Bonett Normed Fit Index (NFI)	0.986
Bollen's Relative Fit Index (RFI)	0.985
Bollen's Incremental Fit Index (IFI)	0.994
Parsimony Normed Fit Index (PNFI)	0.915

Table 50 Covariances and Correlations

Covariances and correlations

Model-implied Covariances for latent variables

	AOP	RI	PF	TMS	POC	ITPBK	PN	PR	INT
AOP	0.644	0.462	0.879	0.586	0.718	0.495	0.570	0.564	0.531
RI	0.294	0.630	0.381	0.483	0.431	0.274	0.468	0.401	0.426
PF	0.530	0.227	0.564	0.863	0.845	0.612	0.775	0.749	0.720
TMS	0.425	0.346	0.585	0.815	0.717	0.501	0.830	0.764	0.764
POC	0.492	0.293	0.542	0.553	0.730	0.616	0.704	0.733	0.663
ITPBK	0.367	0.201	0.424	0.417	0.486	0.852	0.516	0.515	0.482
PN	0.379	0.308	0.482	0.621	0.498	0.395	0.686	0.678	0.879
PR	0.406	0.285	0.504	0.618	0.561	0.426	0.503	0.803	0.689
INT	0.357	0.284	0.453	0.578	0.475	0.373	0.610	0.518	0.702

Table 51 R-squared

R^2

Variable	R^2
PN	0.728
PR	0.656
INT	0.789

Robust Maximum Likelihood (MLM)

The SEM analysis was performed again with the MLM method to evaluate whether or not the deviation from normality impacted the outcomes. The MLM method SEM analysis showed results similar to those of the ML method. The CFI was .908 (compared to ML CFI .994), the TLI was .901 (compared to ML TLI .993), the SRMR was .084 (compared to ML SRMR .066), all of which were within the acceptable thresholds (Table 52).

Table 52 Model Indices – MLM

Model tests

Label	X^2	df	p
User Model	1733	878	<.001
Baseline Model	8725	946	<.001
Scaled User	1459	878	<.001
Scaled Baseline	6844	946	<.001

Fit indices

			95% Confidence Intervals		
Type	SRMR	RMSEA	Lower	Upper	RMSEA p
Classical	0.084	0.060	0.056	0.064	<.001
Robust	0.084	0.054	0.049	0.059	0.083
Scaled	0.084	0.050	0.046	0.054	0.547

User model versus baseline model

	Model	Scaled	Robust
Comparative Fit Index (CFI)	0.890	0.902	0.908
Tucker-Lewis Index (TLI)	0.882	0.894	0.901
Bentler-Bonett Non-normed Fit Index (NNFI)	0.882	0.894	0.901
Relative Noncentrality Index (RNI)	0.890	0.902	0.908
Bentler-Bonett Normed Fit Index (NFI)	0.801	0.787	
Bollen's Relative Fit Index (RFI)	0.786	0.770	
Bollen's Incremental Fit Index (IFI)	0.891	0.903	
Parsimony Normed Fit Index (PNFI)	0.744	0.730	

Hypotheses Summary

The construct relationship paths summarized below were tested using the ML analysis. Table 53 includes parameter estimates of the relationship between the constructs, and Table 54 represents the final results of the hypothesis testing.

Hypothesis 1 (H1) examined the relationship between Awareness of Organization Performance (AOP) and Perception of Need (PN) for Operational Quality Improvement. Specifically, H1 predicted a positive relationship between AOP and PN, such that organizations with higher levels of awareness of organizational performance will also have higher levels of perceived need for operational quality improvement. The results show a negative and significant relationship between AOP and PN (ß= -.663, p=.001), which does not provide support for the relationship predicted by H1.

Hypothesis 2 (H2) examined the relationship between Rivalry Intensity (RI) and Perception of Need (PN) for Operational Quality Improvement. Specifically, H2 predicted a positive relationship between RI and PN, such that organizations that experience high levels of rivalry intensity will also perceive a greater need for operational quality improvement. The results show a positive and significant relationship between RI and PN (ß=.301, p=.002), which provides support for the relationship predicted by H2.

Hypothesis 3 (H3) examined the relationship between an organization's Patient Focus (PF) and Perception of Need (PN) for Operational Quality Improvement. Specifically, H3 predicted a positive relationship between PF and PN, such that organizations with higher levels of patient focus will also have higher levels of perceived need for operational quality improvement. The results show a positive and significant relationship between PF and PN (ß=1.244, p<.001), which provides support for the relationship predicted by H3.

Hypothesis 4 (H4) examined the relationship between Top Management Support (TMS) and Perception of Readiness (PR) for Operational Quality Improvement. Specifically, H4 predicted a positive relationship between TMS and PR, such that organizations with higher levels of top management support will also have higher levels of perceived readiness for operational quality improvement. The results show a positive and significant relationship between TMS and PR (ß=.483, p<.001), which provides support for the relationship predicted by H4.

Hypothesis 5 (H5) examined the relationship between Process-Oriented Culture (POC) and Perception of Readiness (PR) for Operational Quality Improvement. Specifically, H5 predicted a positive relationship between POC and PR, such that

organizations with higher levels of process-oriented culture will also have higher levels of perceived readiness for operational quality improvement. The results show a positive and significant relationship between POC and PR (ß=.351, p<.001), which provides support for the relationship predicted by H5.

Hypothesis 6 (H6) examined the relationship between IT Personnel's Business Knowledge (ITPBK) and Perception of Readiness (PR) for Operational Quality Improvement. Specifically, H6 predicted a positive relationship between ITPBK and PR, such that organizations with IT personnel who exhibit higher levels of business knowledge will also have higher organizational levels of perceived readiness for operational quality improvement. The results show a positive and not significant relationship between ITPBK and PR (ß=.056, p=.312), which does not provide support for the relationship predicted by H6.

Hypothesis 7 (H7) examined the relationship between Perception of Need (PN) and Intention to Adopt (INT) Operational Quality Improvement. Specifically, H7 predicted a positive relationship between PN and INT, such that organizations with higher need for operational quality improvement also have higher levels of intention to adopt operational quality improvement. The results show a positive and significant relationship between PN and INT (ß=.762, p<.001), which provides support for the relationship predicted by H7.

Finally, Hypothesis 8 (H8) examined the relationship between Perception of Readiness (PR) and Intention to Adopt (INT) Operational Quality Improvement. Specifically, H8 predicted a positive relationship between PR and INT, such that organizations with higher levels of readiness for operational quality improvement also

have higher levels of intention to adopt operational quality improvement. The results show a positive and significant relationship between PR and INT (ß=.172, p<.001), which provides support for the relationship predicted by H8.

Table 53 Parameter Estimates

Parameters estimates

					95% Confidence Intervals				
Label	Dep	Pred	Estimate	SE	Lower	Upper	β	z	p
p45	PN	AOP	−0.6850	0.2109	−1.0983	−0.272	−0.6638	−3.25	0.001
p46	PN	RI	0.3144	0.1019	0.1148	0.514	0.3014	3.09	0.002
p47	PN	PF	1.3725	0.2075	0.9658	1.779	1.2443	6.61	<.001
p48	PR	TMS	0.4804	0.0694	0.3443	0.617	0.4839	6.92	<.001
p49	PR	POC	0.3682	0.0834	0.2047	0.532	0.3510	4.41	<.001
p50	PR	ITPBK	0.0553	0.0547	−0.0519	0.162	0.0569	1.01	0.312
p51	INT	PN	0.7711	0.0558	0.6617	0.881	0.7624	13.81	<.001
p52	INT	PR	0.1612	0.0570	0.0494	0.273	0.1724	2.83	0.005

Table 54 Hypotheses Summary

Hypotheses	Description	Supported/Not Supported
H1	Awareness of organization performance is positively related to perception of need for operational quality improvement.	Not supported
H2	Rivalry intensity is positively related to perception of need for operational quality improvement.	Supported
H3	Patient focus is positively related to perception of need for operational quality improvement.	Supported
H4	Top management support is positively related to perception of readiness for operational quality improvement.	Supported
H5	Patient-oriented culture is positively related to perception of readiness for operational quality improvement.	Supported
H6	IT personnel business knowledge is positively related to perception of readiness for operational quality improvement.	Not Supported
H7	Perception of need is positively related to intention to adopt operational quality improvement.	Supported

H8	Perception of readiness is positively related to intention to adopt operational quality improvement.	Supported

Additional Analysis

Additional analysis was performed on the respondents' organization's use of CAHPS and engagement in government-funded programs. The assumed hypotheses indicate a stronger intention to improve quality if the organization uses the CAHPS surveys and is currently involved in government-funded programs. The sample size for CAHPS analysis represented the respondents who answered Yes, No, and Unsure to the question, "Does your organization use CAHPS (Consumer Assessment of Healthcare Providers and System) survey?" The answer "Yes" was coded as 1 (32.1% or 86 respondents) and "No" as 2 (25.4% or 68 respondents). The respondents who answered "Unsure" (42.5% or 114 respondents) were excluded. A total of 154 respondents remained for the analysis. The sample size for Government-funded program engagement analysis represented the respondents who answered Yes, No, and Unsure to the question, "Is your organization currently engaged in any Government-funded (e.g., Medicare, Medicaid) programs?" The answer "Yes" was coded as 1 (72.4% or 194 respondents) and "No" as 2 (15.7% or 42 respondents). The respondents who answered "Unsure" (11.9% or 32 respondents) were excluded. A total of 236 respondents remained for the analysis.

The additional analysis examined the relationship between CAHPS (CHP) usage and Intention to Adopt (INT) Operational Quality Improvement. Specifically, the assumption is that there is a positive relationship between CHP and INT, such that organizations that utilize CAHPS surveys have higher intention for the operational quality

than organizations that don't. The results show a negative and significant relationship between CHP and INT (ß=-0.4699, p<.01) (Table 55), which provides support for the assumption of CAHPS being a predictor of the intention to adopt operational quality improvement.

Table 55 CAHPS Usage

Parameters estimates

					95% Confidence Intervals				
Label	Dep	Pred	Estimate	SE	Lower	Upper	β	z	p
p44	PN	AOP	−0.7083	0.2778	−1.25276	−0.164	−0.6438	−2.550	0.011
p45	PN	RI	0.2923	0.1539	−0.00931	0.594	0.2527	1.899	0.058
p46	PN	PF	1.3878	0.2607	0.87677	1.899	1.2109	5.323	< .001
p47	PR	TMS	0.4646	0.1066	0.25558	0.674	0.4268	4.356	< .001
p48	PR	POC	0.2132	0.1568	−0.09416	0.521	0.1732	1.360	0.174
p49	PR	ITPBK	0.2558	0.0850	0.08923	0.422	0.2425	3.010	0.003
p50	INT	PN	0.7230	0.0883	0.54996	0.896	0.7720	8.189	< .001
p51	INT	PR	0.0216	0.0691	−0.11385	0.157	0.0249	0.313	0.755
p52	INT	CHP	−0.5962	0.2322	−1.05136	−0.141	−0.4699	−2.567	0.010

The next additional analysis examined the relationship between Government-funded (GVN) programs and Intention to Adopt (INT) Operational Quality Improvement. Specifically, the assumption is that there is a positive relationship between GVN and INT, such that organizations that engage in government-funded programs have higher intentions for operational quality than organizations that don't engage. The results show the relationship between GNV and INT is not significant (p=.114) (Table 56), which does not provide support for the assumption that the Government-funded programs' engagement is a predictor of the intention to adopt operational quality improvement.

Table 56 Government-Funded Programs Engagement

Parameters estimates

					95% Confidence Intervals				
Label	Dep	Pred	Estimate	SE	Lower	Upper	β	z	p
p47	PN	AOP	−0.2021	0.1276	−0.4521	0.0480	−0.1989	−1.584	0.113
p48	PN	RI	0.2262	0.1025	0.0254	0.4271	0.1993	2.207	0.027
p49	PN	PF	0.9919	0.1216	0.7536	1.2303	0.8439	8.156	<.001
p50	PR	TMS	0.3904	0.0775	0.2385	0.5422	0.3894	5.039	<.001
p51	PR	POC	0.5175	0.0949	0.3315	0.7035	0.4781	5.453	<.001
p52	PR	ITPBK	0.0268	0.0639	−0.0984	0.1519	0.0274	0.419	0.675
p53	INT	PN	0.5331	0.1206	0.2967	0.7694	0.5679	4.421	<.001
p54	INT	PR	−0.0245	0.0893	−0.1995	0.1506	−0.0267	−0.274	0.784
p55	INT	GVN	1.6646	1.0534	−0.4000	3.7292		1.580	0.114

RESULTS, LIMITATIONS, FUTURE RESEARCH, IMPLICATIONS, AND CONCLUSION

The U.S. healthcare system remains the world's most expensive, with high costs projected to triple to nearly $12 trillion by 2040. Our health is essential for physical, mental, and social well-being, yet 70% of adults are unsatisfied with what U.S. healthcare offers. While the system continues to advance with technological innovations and medical capabilities, the costs continue to rise due to inefficiencies, errors, waste, and other issues that risk patient care and safety. Healthcare companies turn to quality improvement as a crucial part of achieving operational effectiveness. Organizations that focus on improvements are more successful in lowering costs and increasing patient satisfaction. Improvement efforts are proven to realize benefits such as process efficiencies, operational excellence, and better patient outcomes. On the flip side, implementing quality improvement is challenging due to the complexities of the healthcare system. Utilizing traditional methods such as Lean Six Sigma, Total Quality Management, and other tools is not enough. Research reports that nearly 50% of improvement projects fail to deliver favorable outcomes. The existing literature on quality improvement continues to emerge, mostly investigating implementation's success or failure factors. Bessant et al. (2001) stated that a lack of understanding of the behavioral dimension is one of the resulting failure factors. Behavioral intentions play a central role in the adoption of quality improvement initiatives. The previous research provides a limited narrative in addressing the adoption of quality improvement within healthcare operations. This creates an opportunity for further research on factors

contributing to the behavioral intentions to adopt operations quality improvement initiatives in healthcare organizations.

This study seeks to identify factors influencing the intention to adopt operational quality improvement in U.S. healthcare organizations through the Theory of Planned Behavior lens (Ajzen, 1985). As a result, this research is focused on answering the following research question:

What factors influence the intention to adopt Operational Quality Improvement in U.S. healthcare organizations?

Planned behavior theorists argue that an individual's intentions influence human behavior to take a certain action. When the intention is strong, it is more likely the action will be performed. Specific belief systems, such as motivations, attitudes, subjective norms, and perceived behavioral controls, encompass intentions and shape an individual's willingness to complete an action (Ajzen, 1991). Our research suggests that these belief systems shape individual perceptions, such as perceptions of need and readiness, and serve as precursors to the intention to adopt operations quality improvement.

The findings imply that healthcare organizations with higher perceptions of need and readiness are more likely to adopt operations quality improvement. More specifically, the results of this study indicate that two dimensions – perception of need and readiness have a significant and positive influence on adoption intentions. In other words, the results support the idea that healthcare organizations have greater success implementing quality improvements when there is a compelling reason or necessity. In addition to believing that improvements are needed, organizations that perceive

themselves as ready or prepared for changes are more likely to adopt quality improvements successfully.

For the first dimension, the study hypothesized a positive and significant relationship between awareness of organizational performance, patent focus, rivalry intensity, and perception of need. Change theorists argue that the need for change challenges organizations to recognize the necessity for improvements. Opportunities arise from external and internal pressures such as market demands, competitive advantage, company underperformance, inefficiencies, and other opportunities.

Organizational performance is vital as many improvements arise from insights from performance measures that shape an individual's perceptual rating of the overall organizational performance. Healthcare employees are believed to be more likely to perceive the need for innovation when they are aware of organizational performance effectiveness. In other words, when individuals within an organization are aware of how well their organization performs, they are more likely to perceive the need for quality improvement. For example, poor financial metrics can influence employees' perception of the necessity to make changes. The effect of the awareness of organizational performance on the perception of need was not supported by this study. One possible explanation may be that the definition of the awareness of organizational performance is too broad or the participants had little knowledge of their organization's overall performance.

External forces such as rivalry intensity influence organizations to make improvements to sustain competitive advantage in the market. Firms must differentiate themselves through product and service quality efficiencies to achieve a competitive

edge. The intensity of rivalry is the degree to which companies exhibit competitive actions. Establishing operational effectiveness and creating greater customer value can help a company outperform its rivals. Economist theorists hypothesized that as competitive advantage intensifies, so does the need for companies to engage in improvements. The study's findings supported the hypothesis related to the rivalry intensity and the perception of need. Rivalry intensity was positively and significantly related to the perception of the need for operational quality improvement. This implies that as competitive rivalry intensifies in the healthcare industry, it creates a greater need for organizations to seek improvements. Companies must constantly pay attention to competition and be agile with improvements to maintain market share.

The third predictor of the perception of need was patient focus. Every healthcare organization's ultimate goal is patient satisfaction, and every patient is a unique and active participant in healthcare delivery. Gathering patient feedback, complaints, and comments are used to improve care. To be patient-focused, organizations must understand and react to their customer in anticipation of their needs. A customer-driven organization is more effective in facilitating the identification of improvement opportunities. For this to happen, everyone in the organization must embrace and own customer service, be accountable for providing quality service, and address customer concerns. Patient feedback reveals areas for improvement for healthcare organizations to address. Examples include reducing wait times, enhancing the quality of care process, and improving staff behavior, which has proven effective in improving customer satisfaction. Healthcare organizations prioritizing patient feedback and satisfaction are better positioned to recognize operational improvement areas. In line with this notion,

this study found a positive and significant relationship between patient focus and the organization's perception of need. This suggests that organizations that put patients first are more likely to perceive a greater need for operational quality improvement.

For the second dimension, the study hypothesized a positive and significant relationship between top management support, process-oriented culture, information technology personnel business knowledge, and the organization's perception of readiness for operational quality improvement.

Top management support is a success factor in adopting improvement initiatives, and previous research provides strong evidence of its contribution to organizational readiness and adoption behaviors. When management is fully supportive of the change, committed, and involved throughout the change initiative, implementing improvements is more likely to be successful. This study's findings supported the hypotheses related to top management support and the perception of readiness for operational quality improvement. The results showed a positive and significant relationship, indicating that strong leadership support is the precursor of an organizational readiness to adopt improvements. With managers and senior leaders effectively involved in the improvement efforts, the organization is better positioned to adopt quality improvements successfully.

The study also hypothesized that process-oriented culture is positively and significantly related to the organization's perception of readiness for quality improvement. Processes are fundamental to organizational success, and a process-oriented approach has been linked to improved efficiency and performance across different industries, including healthcare. Studies have shown that organizations with

strong process orientation are more effective with innovation implementation. A culture that values process orientation, continuous learning, and improvement fosters positive attitudes and behaviors aligned with organizational goals. Adopting a process-oriented mindset in healthcare, where operations are highly complex and cross-functional, can significantly improve efficiency, quality of care, and readiness for quality improvement initiatives. Embracing such a culture enables healthcare organizations to manage complexity, reduce waste, and enhance overall performance. The results of our study supported the notion that organizations that embrace the process-oriented culture are more prepared to implement quality improvement. That is to say that organizations with a process-oriented mindset are better positioned to accept a change. That means that employees are committed to continuous improvement, understand the organization's goals, adhere to processes, and know how to execute and measure the processes.

The last predictor, IT personnel business knowledge, was tested to determine an effect on readiness for operational quality improvement. As most improvement projects involve technology, the IT personnel play a strategic role. It is imperative for IT employees to not only have technical expertise but also strong business knowledge. That includes understanding the business environment, functions, and goals and being well-informed about quality improvement. Empirical evidence from previous research indicates that broader and deeper IT knowledge contributes significantly to an organization’s competitive advantage and flexibility. In turn, organizations with IT personnel who demonstrate higher levels of business knowledge will perceive themselves as more ready to adopt operational quality improvement. Despite the research findings in the literature, this study did not support the impact of IT personnel’s business knowledge

on the perception of readiness for quality improvement. There may be several explanations. One reason could be that traditionally, information technology is perceived as technical; therefore, survey participants could have been biased in that way. Another explanation may be that participants did not know enough about their organization's IT staff regarding business knowledge.

Lastly, additional analysis was completed to evaluate the effects of CAHPS surveys and Government-funded programs on the organization's intention to adopt quality improvement. The participants were asked to answer questions regarding their organization's involvement in CAHPS survey and Government-funded programs. CAHPS surveys must be collected by some healthcare organizations, such as hospitals, and the results are used to make improvements in patient care and quality. In other words, CAHPS survey outcomes may serve as input into quality improvement initiatives. Similarly, if an organization participates in the Government-funded programs, there might be requirements to provide quality data; therefore, organizations focus on implementing various improvement programs and initiatives.

The additional analysis findings found that organizations that use CAHPS surveys are more intentional about implementing improvements. This is consistent with evidence that the CAHPS survey encompasses quality aspects such as evaluating providers' communication skills, ease of access to healthcare services, and other metrics.

On the other hand, the organization's involvement in the Government-funded programs did not impact the intention to adopt quality improvement. The study's results failed to support the idea that healthcare organizations participating in programs such as Medicare or Medicaid have stronger intentions for quality improvement adoption. This

could be due to the small sample size or the fact that most participants reported a smaller percentage of their organizations' dependency on government-funded programs.

Limitations

This study has certain limitations that should be considered when interpreting results. First, the nature of the research design (e.g., cross-sectional survey) is a snapshot at a point in time; therefore, how these relationships evolve and change over time is unknown. Also, the participants were recruited from the CloudResearch platform and offered monetary compensation for completing the survey. This introduces a potential for response bias as participants might be driven by getting the reward rather than a genuine and honest interest in the survey, compromising the reliability and authenticity of the responses. Another issue with that is sampling bias, as participants may be motivated by monetary reward rather than those representative of the target population. Also, healthcare was selected as the targeted industry; however, it is unclear how CloudResearch verifies the participants' legitimacy regarding their demographics. An opportunity for future research would be recruiting directly from healthcare organizations to ensure appropriate representation of the targeted audience.

Another limitation is mixed results in predictors in the perception of need, such as awareness of organizational performance. The data did not provide support for the positive and significant relationship. As mentioned in the discussion, it could be due to the lack of clarity in the construct's definition and survey questions. Even though the questions in the survey were used from an existing scale and the reliability tests were performed, an opportunity in the future is to refine the survey questions and the definition

of this construct. Similarly, another mixed results were predictors for the perception of readiness, such as IT personnel business knowledge. While the construct showed high reliability, and all the survey questions were clear and appropriate, the findings were surprising. The relationship did not show significance, which indicates that IT personnel's business knowledge does not affect the organization's perception of readiness. Future research could be focused on refining the construct differently. Perhaps the IT predictor should be defined differently, encompassing all aspects of IT, including the technical and business side.

Moreover, a limitation to consider is the broadness of the operations quality improvement topic. Even though it is specific to operations, narrowing the research question to a certain type of quality improvement could be a possibility for further research. Also, comparing different types of healthcare organizations may reveal nuances of how intentions to adopt quality improvement vary.

Lastly, the additional analysis of the CAHPS survey indicated that organizations have greater intentions of adopting quality improvement when using CAHPS survey results. This implies that CAHPS is another predictor of the intention to adopt quality improvement. Further research could be considered by adding the CAHPS construct to the research model.

Future Research

Other directions for future research stem from the research findings. A significant and positive relationship was found between rivalry intensity, patient focus, and perception of need. Future research could focus on evaluating drivers of rivalry intensity

and patient focus. In other words, research could explore external factors contributing to the organization's competition rivalry. Similarly, for patient focus, future research could evaluate influencing factors that drive organizations to prioritize patient-oriented values and how they impact the perception of the need for operational quality improvement. Top management support and process-oriented culture had a significant and positive relationship with perception of readiness. Future studies could delve into different types of leadership styles and how they impact the perception of organizational readiness. For a process-oriented culture, further research could evaluate the impact of specific elements such as continuous improvement, Lean Six Sigma, optimization, etc., on the readiness for operational quality improvement. Lastly, both the perception of need and readiness were strong predictors of the intention to adopt. Further research could examine the strength of the relationship with the moderating effect (for example, change management strategies or organization type).

As stated earlier, further research could be considered by adding the CAHPS construct to the research model. Specifically, exploring the influence of political factor on the intention to adopt OQI in U.S. healthcare organizations. The broader political environment, including healthcare policy changes, regulatory requirements, reimbursement structures, and government incentives, shapes organizational behavior (Berwick et al., 2008). Medicare and Medicaid funding could act as an external driver influencing both the perception of need and organizational readiness for OQI. Many organizations, specifically those that depend on government-funded programs tied to compliance and performance. The financial dependence on federal reimbursements often shapes priorities, with operational improvements pursued strategically to meet regulatory

demands, enhance reimbursement levels, and protect organizational revenue streams (Curry et al., 2018). Future studies might investigate how varying political climates and the Government funding incentives influence the organization's intentions to adopt OQI.

Theoretical Implications

The findings of this research provide both theoretical and practical implications. The study makes several important contributions to the academic literature on quality improvement and organizational behavior. The study expands the scope of the previous research focus by investigating the antecedents of quality improvement adoption in healthcare operations. Specifically, it builds on the theory of Planned Behavior and further expands the knowledge by exploring how healthcare employees' perceptions of need and readiness influence the intention to adopt operational quality improvement. The study advances theory by identifying key drivers for the perception of need and readiness. For the perception of need, the study confirms the role of external pressures such as rivalry intensity and patient-focused approach as significant influencers for adopting quality improvement. The effects of top management support and a process-oriented culture were also found to be significant for adopting quality improvement. These findings provide empirical validation for extending the body of knowledge for the theory of planned behavior. Furthermore, this research offers additional opportunities for future research, such as refining constructs for the IT personnel's business knowledge and awareness of organizational performance and/or incorporating additional predictors, such as the CAHPS survey, into the research model.

Practical Implications

Practical implications for healthcare leaders, managers, and policymakers include providing insights into the factors that drive the successful adoption of quality improvements. These insights are valuable, as previous research reports show that more than half of improvement projects fail to deliver results. Therefore, informing healthcare leaders about success drivers would help with strategic decision-making for improvement implementation. For example, incorporating and prioritizing patient feedback can increase the need for improvement, influencing the organization to enhance operations. The importance of top management support and a process-oriented culture can provide some areas for organizational development. For example, leaders can increase employee readiness for change by fostering commitment and support, stimulating cross-functional collaboration, and building a culture that embraces continuous improvement. Knowing what makes employees perceive a strong need for change and believe that the organization is ready to act increases the likelihood of successful adoption of quality improvement.

Conclusion

Due to medical advances, technological innovations, and external pressures, healthcare organizations face many challenges. Quality improvement becomes essential as it improves patient outcomes and helps an organization maintain a competitive advantage. The organization must adopt changes to realize the benefits of quality improvement. Therefore, healthcare companies must consider factors influencing the successful adoption of improvements.

This research identified factors contributing to the organization's intentions to adopt operations quality improvement using Behavioral Intentions as the main theory.

The research study evaluated what drives organizations' perceptions of need and readiness for quality improvement. The findings implied that healthcare organizations with higher perceptions of need and readiness are more likely to adopt operations quality improvement. Identifying needs for improvement, whether through internal identification of opportunities or external pressures, and being ready for improvement, are indicators of successful adoption of improvements.

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APPENDICES

Appendix A

1. Construct Definitions

Table 1.1. Construct Definitions

Construct	Definition	Source
Awareness of Organizational Performance	Respondent's perceptual rating of customer satisfaction on products and services, customer retention rate, sales growth rate, profitability and overall performance of the organization.	Law & Ngai (2007)
Rivalry Intensity	The extent to which firms in this industry frequently and vigorously engage in outwardly manifested competitive actions and reactions in their search for competitive advantage in the market place.	Pecotich et al. (1999)
Patient Focus	The organization understands and reacts to their customer, and anticipates their future needs. It reflects the degree to which the organization is driven by a concern to satisfy their customer.	Denison & Neale (1999)
Management Support for OQI	The extent to which organizational members felt senior leaders support the change.	Holt et al. (2007)
Process-Oriented Culture	Values that favor business processes and their translation in attitudes and behaviors. The importance of abstract ideas (i.e. beliefs or principles) within the organization to facilitate the modeling, deployment, optimization and management of business processes, as well as feelings and activities of organizational members that express the process-oriented	Looy (2020)

Construct	Definition	Source
	values beyond the context of individual business processes.	
Information Technology (IT) Personnel Business Knowledge	Business skills relate to the ability of IT personnel to understand the business processes they are to support and to apply the appropriate technical solutions to a given business problem.	Byrd & Turner (2000)
Perception of Readiness	The extent to which an individual or individuals are cognitively and emotionally inclined to accept, embrace and adopt a particular plan to purposefully alter the status quo.	Holt et al. (2007)
Perception of Need	The extent to which one feels that there are or are not legitimate reasons and needs for the prospective change.	Holt et al. (2007)
Intention to Adopt OQI	An individual's readiness and conscious plan to adopt Operations Quality Improvement initiative.	Venkatesh (2003)

Appendix B

1. Informed Pilot

Table 1.1. Measurement Instrument

INTENTION TO ADOPT OPERATIONS QUALITY IMPROVEMENT (OQI) SURVEY INSTRUMENT			Survey Instrument Evaluation Criteria INSTRUCTIONS: Read each question/statement and indicate (by placing an X) whether the statement meets any of the criteria listed in the columns. Add your feedback in the comments row of the associated section.								
			Clear and understandable?	Targeted to construct(s)?	Measuring the variable of interest?	Double-barreled?	Leading?	Loaded?	Confusing?	Ambiguous?	Easy to understand and answer?	Detailed Comments
Boundary Variables	**Items**	**Qualifiers**										
Healthcare Industry	QUL1	Do you work in a Health Care organization? (Yes / No)										
Location - United States	QUL2	Is your organization located in the United States? (Yes / No)										
Organization Size	QUL3	What employee size is your organization? (Selection: e.g., small, medium, large)										
Experience with OQI	QUL4	Have you been involved in any operations quality improvement projects within your organization? (Yes / No)										
Independent Variable 1	**Items**	**Variable Definition / Scale / Questions**										
Awareness of Organizational Performance	AOP	**Respondent's perceptual rating of customer satisfaction of products and services, customer retention rate, sales growth rate, profitability and overall performance of organization (Low & Ngak, 2007).** **On scale from 1-5, where 1=Strongly Disagree, 2=Disagree, 3=Neither Agree or Disagree, 4=Agree, 5=Strongly Agree** **Answer the following statements:** **Your company's...**										
	AOP1	customer satisfaction perceive that they receive their money's worth for purchasing your services and/or related products.										
	AOP2	customer retention rate is as high as or higher than that of your competitors.										
	AOP3	sales growth rate is as high as or higher than that of your competitors.										
	AOP4	profitability is a good compared to the overall performance of your business sector.										
	AOP5	overall performance is strong, considering all key aspects (e.g., financial performance, customer satisfaction, employee engagement, operational efficiency, and market position).										
Independent Variable 2	**Items**	**Variable Definition / Scale / Questions**										
Rivalry Intensity	RI	**The extent to which organizations in this industry frequently and vigorously engage in outwardly manifested competitive actions and reactions in their search for competitive advantage in the marketplace (Porathi et al., 1999).** **On scale from 1-5, where 1=Strongly Disagree, 2=Disagree, 3=Neither Agree or Disagree, 4=Agree, 5=Strongly Agree** **Answer the following statements:**										
	RI1	Our company competes intensely to hold and/or increase its market share.										
	RI2	In our industry, competitive moves by one company noticeably affect other competing companies.										
	RI3	Our company typically responds aggressively to actions that competitors initiate.										
	RI4	In our industry, price competition is highly intense.										
	RI5	In our industry, there is a wide variety of competitors.										
	RI6	Our company has the resources for strong competition.										
	RI7	Our company has the resources for ongoing competition.										
Independent Variable 3	**Items**	**Variable Definition / Scale / Questions**										
Patient Focus	PC	**The organization understands and reacts to their patient/customer, and anticipates their future needs. It reflects the degree to which the organization is driven by a concern to satisfy its patients/customers (Davidson & Nealo, 1999).** **On scale from 1-5, where 1=Strongly Disagree, 2=Disagree, 3=Neither Agree or Disagree, 4=Agree, 5=Strongly Agree** **Answer the following statements:** **In your organization...**										
	PC1	patient comments and/or recommendations often lead to improvements.										
	PC2	patient input is incorporated into decision-making.										
	PC3	the patient's interests are always prioritized in decision-making.										
	PC4	employees have a deep understanding of patient wants and needs.										
	PC5	direct interaction between the staff and patients is actively promoted.										
Independent Variable 4	**Items**	**Variable Definition / Scale / Questions**										
Top Management Support for OQI	MS	**The extent to which organizational members felt senior leaders support the change (Holt et al., 2007).** **On scale from 1-5, where 1=Strongly Disagree, 2=Disagree, 3=Neither Agree or Disagree, 4=Agree, 5=Strongly Agree** **Answer the following statements:**										
	MS1	Your senior leaders have encouraged all employees to embrace the operations quality improvement.										
	MS2	Your organization's top management has put all their support behind the operations quality improvement.										
	MS3	Your senior leaders have emphasized the significance of operations quality improvement.										
	MS4	Your organization's most senior leader is committed to the operation's quality improvement.										
	MS5	Your top management communicated clearly that your organization is going to change.										
Independent Variable 5	**Items**	**Variable Definition / Scale / Questions**										
Process-Oriented Culture	POC	**Values that favor business processes and their translation into attitudes and behaviors. The importance of abstract ideas (i.e. beliefs or principles) within the organization to facilitate the modeling, deployment, optimization, and management of business processes, as well as feelings and activities of organizational members that express process-oriented values beyond the context of individual business processes (Lacey, 2020).** **On scale from 1-5, where 1=Strongly Disagree, 2=Disagree, 3=Neither Agree or Disagree, 4=Agree, 5=Strongly Agree** **Answer the following statements:** **In my organization...**										
	POC1	cross-functional teamwork is the norm among employees.										
	POC2	cross-functional teamwork is commonplace among managers.										
	POC3	process documentation (e.g., function descriptions, procedures, work instructions) is stored at one central location.										
	POC4	the central location for process documentation is accessible to all employees.										
	POC5	employees' commitment to continuous process improvement is constant.										
	POC6	employees' efforts to processes that deliver the results needed to achieve the organizational goals.										
	POC7	the overall process effectiveness and efficiency results are measured.										
	POC8	the overall process effectiveness and efficiency results are displayed for all employees to see.										
	POC9	employees' commitment to process objectives is very high.										
	POC10	employees are empowered to make process decisions.										
	POC11	employees show enthusiasm for process management.										
Independent Variable 6	**Items**	**Variable Definition / Scale / Questions**										
Information Technology Personnel Business Knowledge	ITPBK	**Business skills relate to the ability of IT personnel to understand the business processes they are to support and to apply the appropriate technical solutions to a given business problem (Byrd & Turner, 2000).** **On scale from 1-5, where 1=Strongly Disagree, 2=Disagree, 3=Neither Agree or Disagree, 4=Agree, 5=Strongly Agree** **Answer the following statements.** **Your company's IT personnel...**										
	ITPBK1	understand the organization's policies.										
	ITPBK2	understand the organization's objectives.										
	ITPBK3	understand the business environment they support.										
	ITPBK4	are able to analyze business problems.										
	ITPBK5	are able to develop appropriate technical solutions.										
	ITPBK6	are knowledgeable about business functions.										
	ITPBK7	understand the organization's environmental constraints (e.g. regulations, competition).										
	ITPBK8	are well-informed about the organization's operations quality improvement initiatives.										
Moderating Variable	**Items**	**Variable Definition / Scale / Questions**										
Transformational Leadership	TL	**Transformational leadership is a leadership style that involves inspiring and motivating followers to achieve extraordinary outcomes and, in the process, develop their own leadership capacity. Transformational leaders accomplish this by acting as role models, providing a clear vision, fostering an environment of trust, encouraging innovation, and recognizing individual contributions. This leadership style emphasizes the importance of a leader's ability to connect with their followers' values, emotions, and long-term goals, thereby transforming both the leader and the followers (Bass, 1985).** **On scale from 1-5, where 1=Strongly Disagree, 2=Disagree, 3=Neither Agree or Disagree, 4=Agree, 5=Strongly Agree** **Answer the following statements.** **During the Operations Quality Improvement, my direct manager...**										
	TL1	has a clear understanding of where our company is going.										
	TL2	has a clear sense of where he/she wants our business unit to be.										
	TL3	challenges us to think about old problems in new ways.										
	TL4	has ideas that have forced us to rethink some things that we have never questioned before.										
	TL5	says things that make employees proud to be a part of this organization.										
	TL6	encourages employees to see changes as situations that are full of opportunities.										
	TL7	considers employees' feelings before acting.										
	TL8	behaves in a manner that is thoughtful of employees' needs.										
	TL9	sees that the interests of employees are given due consideration.										
Mediating Variable 1	**Items**	**Variable Definition / Scale / Questions**										
Perception of Readiness	PR	**The extent to which an individual or individuals are cognitively and emotionally inclined to accept, embrace and adopt a particular plan to purposefully alter the status quo (Holt et al., 2007)** **On scale from 1-5, where 1=Strongly Disagree, 2=Disagree, 3=Neither Agree or Disagree, 4=Agree, 5=Strongly Agree** **Answer the following statements:**										
	PR1	I have a good feeling about the operations quality improvement.										
	PR2	I experience the change as a positive process.										
	PR3	I find the change refreshing.										
	PR4	I am somewhat resistant to change.										
	PR5	am hesitant to integrate changes into my work.										
	PR6	I think that most changes will have a negative effect on the patients/clients we serve.										
	PR7	The operations quality improvement initiative will simplify my work.										
	PR8	I want to devote myself to operations quality improvement.										
Mediating Variable 2	**Items**	**Variable Definition / Scale / Questions**										
Perception of Need	PN	**The extent to which one feels that there are or are not legitimate reasons and needs for the prospective change (Holt et al., 2007)** **On scale from 1-5, where 1=Strongly Disagree, 2=Disagree, 3=Neither Agree or Disagree, 4=Agree, 5=Strongly Agree** **Answer the following statements:**										
	PN1	There are legitimate business reasons for operations quality improvement.										
	PN2	Operations quality improvement is necessary to enhance our organization's overall efficiency.										
	PN3	It doesn't make sense for us to make operations quality improvements.										
	PN4	No one has explained why operations quality improvement must be made.										
Dependent Variable	**Items**	**Variable Definition / Scale / Questions**										
Intention to adopt OQI	INT	**An individual's readiness and conscious plan to adopt an Operations Quality Improvement initiative (Venkatesh, 2000).** **On scale from 1-5, where 1=Strongly Disagree, 2=Disagree, 3=Neither Agree or Disagree, 4=Agree, 5=Strongly Agree** **Answer the following statements:**										
	INT1	I intend to use operations quality improvements in my work.										
	INT2	I plan to use operations quality improvements more frequently in my work.										
	INT3	I will try to use operations quality improvements in my daily work.										
Control Variables	**Items**	**Demographic**										
Age	DEM1	What is your age group?										
Gender	DEM2	What is your gender?										
Department	DEM3	Which department do you work in?										
Title	DEM4	What is your title?										
Organization Type	DEM5	What type of organization do you work for? (Selection: e.g., hospitals, clinics, long-term facilities, insurance company, etc.)										
Duration of Experience	DEM6	How long have you been involved in operations quality improvement initiatives? (Selection: e.g., less than 1 year, 1-3 years, etc.)										

2. Cover Letter and Instructions for Informed Pilot Participants

Dear Informed Pilot Participant,

Thank you so much for your willingness to provide your insights regarding the "***Intention to Adopt Operations Quality Improvement in the U.S. Healthcare Organizations"*** study.

Introduction

One of the world's most expensive healthcare systems is in the United States, with costs representing 18% of the gross domestic product (GDP). Staggering results by the Harris Poll, in partnership with the American Academy of Physician Associates, reported that nearly 70% of adults say the healthcare system fails to meet their needs in at least one way. Today's healthcare system is complex and often contradictory. While it offers remarkable technological and treatment advancements, it is frequently hindered by inefficiencies, errors, resource limitations, and other issues jeopardizing patient care accessibility and safety. The healthcare system remains substantially below acceptable standards in ensuring patient safety and addressing patient needs. In 1998, the Institute of Medicine released an assessment stating that adverse events such as errors in healthcare delivery contributed to the deaths of 98,000 patients annually, stressing the necessity for quality improvement and patient safety. These errors are costly for hospitals and patients, resulting in patients losing trust in the system and decreased satisfaction of both patients and health care professionals.

Over the past decade, the focus on efficiency has become a top priority for numerous healthcare organizations. Prior studies found a positive relationship between quality and efficiency, increasing patient satisfaction and lower costs. The healthcare industry considers Quality Improvement (QI) a crucial element in achieving operational effectiveness. QI involves systematically examining and refining existing healthcare procedures to enhance patient outcomes, gain operational excellence, cut costs, and boost efficiency. Quality initiatives are proven to yield benefits to maximize efficiency and minimize poor performance; however, many healthcare organizations struggle with QI implementations to achieve desired outcomes.

Despite the wide application of QI in the last 15 years, two out of every continuous improvement initiative fail to deliver the desired performance. The literature reports that at least 40% of improvement projects fail and some reports suggest failure rates as high as 70%. Achieving the success of Operations Quality Improvement (OQI) lies in its adoption by the organization. By identifying the critical factors that lead to the adoption of OQI, healthcare organizations can work toward overcoming these challenges.

The findings of this research will contribute to the body of knowledge on quality improvement, guide healthcare practitioners, policymakers, and academics seeking to understand the complexity of quality improvement initiatives, develop effective strategies, and serve as a foundation for further research in the field.

About your Participation

In this study, you are asked to join other expert panel members to critique a draft of the survey instrument intended to be used for data collection in this study. We greatly appreciate your interest in sharing your expertise in survey design by assisting in developing the survey instrument.

To guide you in this task, please find below an overview of key elements of this study and specific directions for your tasks.

Please direct any questions regarding this study or the instructions provided herein to the following: Liliya Yausheva | Email: lyaus001@fiu.edu

Study Overview

This study explores how specific factors influence the intention to adopt OQI in healthcare organizations. It will investigate the mediating effects of Perception of Need and Perception of Readiness on the Intention to adopt OQI. The main objective is to understand the relationship between the critical factors and perceptions of need and readiness for OQI and how that influences the intention to adopt OQI.

Summary of Constructs

Construct	**Variable Type**	**Definition**	**Scale Source**
Intention to Adopt OQI	Dependent	An individual's readiness and conscious plan to adopt Operations Quality Improvement	Venkatesh, 2003
Perception of Need	Mediator	The extent to which one feels that there are or are not legitimate reasons and needs for the prospective change.	Holt et al., 2007
Perception of Readiness	Mediator	The extent to which an individual/s are cognitively and emotionally inclined to accept, embrace and adopt a particular plan to purposefully alter the status quo.	Holt et al., 2008

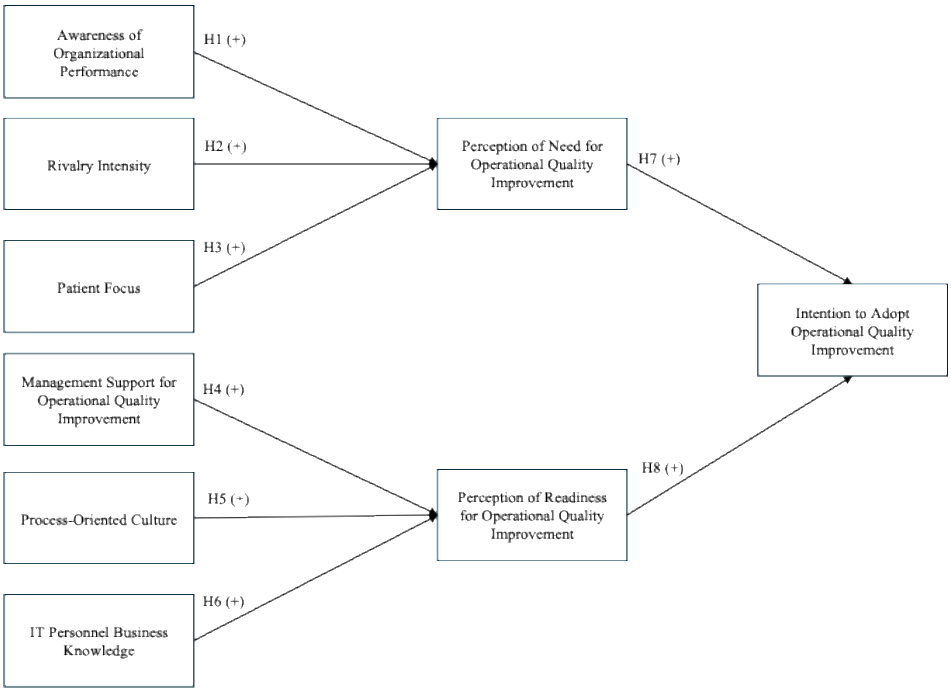
Awareness of Organizational Performance	Independent	Respondent's perceptual eating of customer satisfaction of products and services, customer retention rate, sales growth rate, profitability and overall performance of organization.	Law & Ngak, 2007
Rivalry Intensity	Independent	The extend to which organization in this industry frequently and vigorously engage in outwardly manifested competitive actions and reactions in their search for competitive advantage in the marketplace.	Pecotich et al., 1999
Patient Focus	Independent	The organization understands and reacts to their patient/customer, and anticipates their future needs. It reflects the degree to which the organization is driven by a concern to satisfy its patients/customers.	Denison & Neale, 2000
Top Management Support for OQI	Independent	The extent to which organizational members felt senior leaders supported the change.	Holt et al., 2007
Process-Oriented Culture	Independent	Values that favor business processes and their translation into attitudes and behaviors. The importance of abstract ideas (i.e. belief or principles) within the organization to facilitate the modeling, deployment, optimization, and management of business processes, as well as feelings and activities of organizational members that	Looy, 2020

		express process-oriented values beyond the context of individual business processes.	
IT Personnel Business Knowledge	Independent	Business skills relate to the ability of IT personnel to understand the business processes they are to support and to apply the appropriate technical solutions to a given business problem.	Byrd & Turner, 2000

To achieve this objective, the proposed measurement model (Figure 1) includes the factors influencing the intention to adopt OQI in U.S. healthcare organizations.

Measurement Model

Figure 1. Measurement Model



Research Context

The empirical study will employ a questionnaire to collect data to test the model's validity and research hypotheses. The independent and dependent variables are assessed via five-point Likert-type scales ranging from 'strongly disagree' to 'strongly agree.'

Data will be collected using the online survey tool Qualtrics, and responses will be collected anonymously. The survey will be distributed to a randomly selected sample of 300 healthcare employees in the United States with experience in operations quality improvement.

The responses and data will be analyzed using SPSS and the Jamovi software. Validity and reliability tests will be conducted to ensure the instrument measures what it is intended to measure and produces consistent results.

Instructions for Review of Survey

You have been selected as a distinguished member of a small, exclusive group of DBA candidates from Florida International University - Cohort 5.6 and 5.7 with academic research experience.

Your contribution to this study is significant, and I am privileged to have you on board. You will provide valuable insights that will help fine-tune the survey instrument for data collection. Your expertise in survey design is highly regarded, and your input will play an integral role in ensuring the success of this study.

As a reviewer, you are requested to review and evaluate the survey instrument. Specifically, we are asking you to assess each question and the overall flow of the survey and provide feedback on your evaluation directly on the survey instrument.

We ask for all suggestions to improve the overall survey instrument. You will receive the survey instrument listing each item. Read each question/statement and consider if there are potential issues when providing your feedback and suggestions on whether the information is:

Criteria for Evaluation:

ID	Criteria:	Definitions:

1	Clear and understandable?	Is the question or statement phrased clearly and easy to understand?
2	Targeted to contributors in an organization?	Is the question relevant and appropriate for the survey respondents?
3	Measuring the variable of interest?	Does the question accurately measure the construct or variable it is intended to assess?
4	Double-barreled?	Does the question ask about two or more issues at once, making it difficult to answer?
5	Leading?	Does the question suggest a particular answer or influence the respondent's answer?
6	Loaded?	Does the question contain assumptions or emotionally charged language that could bias the response?
7	Confusing?	Is the question difficult to understand due to complex wording or structure?
8	Ambiguous?	Is the question vague or open to multiple interpretations?
9	Easy to understand and answer?	Is the question straightforward, making it easy for respondents to provide an accurate answer?

Thank you once again for your valuable participation.

Appendix C

1. Pilot

Table 1.1. Measurement Instrument

Variable	Variable Type	Definition	Item	Survey Items
Awareness of Organizational Performance	Independent	Respondent's perceptual rating of customer satisfaction of products and services, customer retention rate, sales growth rate, profitability and overall performance of organization.	AOP1	My company's customers/patients perceive that they receive their money's worth when purchasing services and/or related health products.
			AOP2	My company's customers/patients retention rate is as high as or higher than that of our competitors.
			AOP3	My company's sales growth rate is as high as or higher than that of our competitors.
			AOP4	My company's profitability is good compared to the overall performance of our business sector.
			AOP5	My company's overall performance is strong, considering all key aspects (e.g., financial performance, customer satisfaction, employee engagement, operational efficiency, and market position).
Rivalry Intensity	Independent	The extent to which organizations in this industry frequently and vigorously engage in outwardly manifested competitive actions and reactions in their search for competitive advantage in the marketplace.	RI1	My company competes intensely to hold and/or increase its market share.
			RI2	In our industry, competitive moves by one company noticeably affect other competing companies.
			RI3	My company typically responds aggressively to actions that competitors initiate.
			RI4	In our industry, price competition is highly intense.
			RI5	In our industry, there is a wide variety of competitors.
			RI6	My company has the resources for strong competition.
			RI7	My company has the resources for ongoing competition.
Patient Focus	Independent	The organization understands and reacts to their patient/customer, and anticipates their future needs. It reflects the degree to which the organization is driven by a concern to satisfy its patients/customers.	PF1	In my organization, patient comments and/or recommendations often lead to improvements.
			PF2	In my organization, patient input is incorporated into decision-making.
			PF3	In my organization, the patient's interests are always prioritized in decision-making.
			PF4	In my organization, employees have a deep understanding of patient wants and needs.
			PF5	In my organization, direct interaction between staff and patients is actively promoted.
Top Management Support	Independent	The extent to which organizational members felt senior leaders support the change.	TMS1	My Senior Leaders have encouraged all employees to embrace Quality Improvement.
			TMS2	My organization's Top Management has put all their support behind Quality Improvement.
			TMS3	My Senior Leaders have emphasized the significance of Quality Improvement.
			TMS4	My organization's most Senior Leader is committed to Quality Improvement.
			TMS5	My Top Management communicated clearly that our organization is going to change.
Process-Oriented Culture	Independent	Values that favor business processes and their translation into attitudes and behaviors. The importance of abstract ideas (i.e. beliefs or principles) within the organization to facilitate the modeling, deployment, optimization, and management of business processes, as well as feelings and activities of organizational members that express process-oriented values beyond the context of individual business processes.	POC1	In my organization, cross-functional teamwork is the norm among employees.
			POC2	In my organization, cross-functional teamwork is commonplace among managers.
			POC3	In my organization, process documentation (e.g., function description, procedures, work instructions, etc.) is stored at one central location.
			POC4	In my organization, the central location for process documentation is accessible to all employees.
			POC5	In my organization, employees' commitment to continuous process improvement is evident.
			POC6	In my organization, employees adhere to processes that deliver the results needed to achieve organizational goals.
			POC7	In my organization, the overall process effectiveness and efficiency results are measured.
			POC8	In my organization, the overall process effectiveness and efficiency results are displayed for all employees to see.
			POC9	In my organization, employees' commitment to process objectives is very high.
			POC10	In my organization, employees are empowered to make process decisions.
			POC11	In my organization, employees show enthusiasm for process management.
IT Personnel Business Knowledge	Independent	Business skills relate to the ability of IT personnel to understand the business processes they are to support and to apply the appropriate technical solutions to a given business problem.	ITBK1	My company's Information Technology personnel are knowledgeable about business functions.
			ITBK2	My company's Information Technology personnel understand the organization's objectives.
			ITBK3	My company's Information Technology personnel understand the business environment they support.
			ITBK4	My company's Information Technology personnel are able to analyze business problems.
			ITBK5	My company's Information Technology personnel are able to develop appropriate technical solutions.
			ITBK6	My company's Information Technology personnel are knowledgeable about business functions.
			ITBK7	My company's Information Technology personnel understand the organization's environmental constraints (e.g., regulations, competition).
			ITBK8	My company's Information Technology personnel are well-informed about the organization's quality improvement initiative/s.
Perception of Readiness	Mediator	The extent to which an individual is cognitively and emotionally inclined to accept, embrace and adopt a particular plan to purposefully alter the status quo.	PR1	I have a good feeling about Quality Improvement/s.
			PR2	I experience change as a positive process.
			PR3	I find change refreshing.
			PR4	I am somewhat resistant to change.
			PR5	I am hesitant to integrate improvements into my work.
			PR6	I think that most changes will have a positive effect on the patients/clients we serve.
			PR7	I think that quality improvement/s will simplify my work.
			PR8	I want to devote myself to quality improvement.
Perception of Need	Mediator	The extent to which one feels that there are or are not legitimate reasons and needs for the prospective change.	PN1	There are legitimate business reasons for quality improvement initiative/s.
			PN2	Quality improvements are necessary to enhance my organization's overall efficiency.
			PN3	It doesn't make sense for my organization to make quality improvements at this time.
			PN4	No one has explained to me why quality improvement/s must be made.
Intention to Adopt Quality Improvements	Dependent	Individual and organizational readiness and conscious plan to adopt a particular plan.	INT1	I intend to use quality improvements in my work.
			INT2	I plan to use quality improvements more frequently in my work.
			INT3	I will try to use quality improvements in my daily work.
			INT4	My organization intends to adopt quality improvement initiatives in the near future.
			INT5	My organization is committed to implementing quality improvement initiatives.
			INT6	My organization is planning to allocate resources to adopt quality improvement initiatives.
			INT7	It is likely that my organization will adopt quality improvement initiatives within the next year.

2. Background and Demographic Questions

1. Is your organization currently involved in quality improvement initiative/s?

    a. Yes
    b. No
    c. Unsure
2. What type of quality improvement initiative/s is your organization currently involved in? (Select all that apply)
    a. Patient care improvement (e.g., clinical protocols, safety)
    b. Organizational process improvement (e.g., workflows, efficiency, automation)
    c. Process optimization
    d. Patient experience and satisfaction improvement
    e. Other (Please indicate below)
3. Does your organization use CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys?
    a. Yes
    b. No
    c. Unsure
4. For what purpose does your organization use CAHPS data? (Select all that apply)
    a. Quality Improvement initiatives
    b. Government funding
    c. Public reporting of healthcare quality
    d. Patient experience improvement
    e. Compensation and performance reviews
    f. Accreditation or certification
    g. Other (Please indicate below)
5. Is your organization currently engaged in any Government-funded (e.g., Medicare, Medicaid) programs?
    a. Yes
    b. No
    c. Unsure
6. What percentage of your organization's operations depend on Government-funded programs?
    a. 0-20%
    b. 21-50%
    c. 51-80%
    d. 81-100%
    e. Unsure
7. Is your organization required to submit quality data or performance metrics for Government-funded programs?
    a. Yes
    b. No
    c. Unsure
8. What is your age group?
    a. Less than 18
    b. 18-24
    c. 25-34

d. 35-44
e. 45-54
f. 55-64
g. Over 65

9. What is your gender?
    a. Male
    b. Female
    c. Non-binary
10. What employee size is your organization?
    a. Small (1-99)
    b. Medium (100-999)
    c. Large (> 1,000)
11. What type of healthcare organization do you work for?
    a. Clinic
    b. Hospital
    c. Physician Group Practice
    d. Health Insurance Company
    e. Pharmaceutical Company
    f. Mental Health Facility
    g. Outpatient Facility
    h. Other (Please indicate below)
12. Which department do you work in? (Type in the box below)
13. What is your current title? (Type in the box below)
14. How long have you been working at your current organization?
    a. Less than 1 year
    b. 1-5 years
    c. 5-10 years
    d. More than 10 years

3. Variables

1. AOP1-5: Items comprising the "Awareness of Organizational Performance" scale.
2. RI1-7: Items comprising the "Rivalry Intensity" scale.
3. PF1-5: Items comprising the "Patient Focus" scale.
4. TMS1-5: Items comprising the "Top Management Support" scale.
5. POC1-11: Items comprising the "Process-Oriented Culture" scale.
6. ITBK1-8: Items comprising the "IT Personnel Business Knowledge" scale.
7. PR1-8: Items comprising the "Perception of Readiness" scale.
8. PN1-4: Items comprising the "Perception of Need" scale.
9. INT1-7: Items comprising the "Intention to Adopt Quality Improvements" scale.

4. Normality Test

4.1 Awareness of Organizational Performance (AOP)

Table 1.1. Descriptives - AOP

Descriptives

			Statistic	Std. Error
AOP_avg	Mean		3.85	.053
	95% Confidence Interval for Mean	Lower Bound	3.74	
		Upper Bound	3.95	
	5% Trimmed Mean		3.86	
	Median		4.00	
	Variance		.388	
	Std. Deviation		.623	
	Minimum		1	
	Maximum		5	
	Range		4	
	Interquartile Range		1	
	Skewness		-.782	.207
	Kurtosis		2.260	.411

Table 1.2. Test of Normality - AOP

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
AOP_avg	.135	137	<.001	.950	137	<.001

a. Lilliefors Significance Correction

Figure 1.1. Histogram - AOP

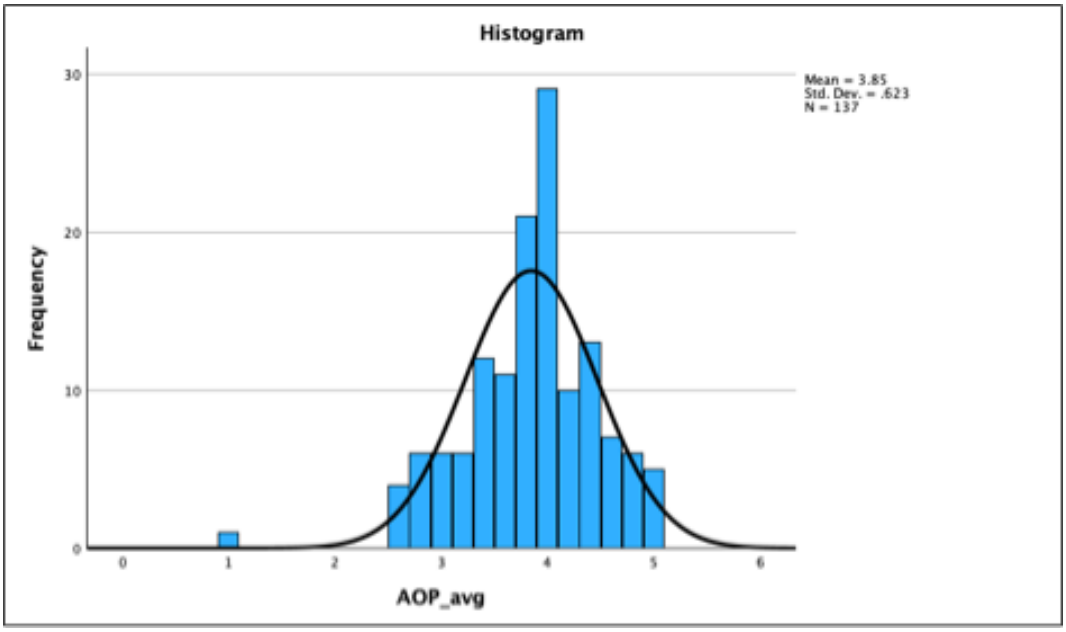


Figure 1.2. Q-Q Plot - AOP

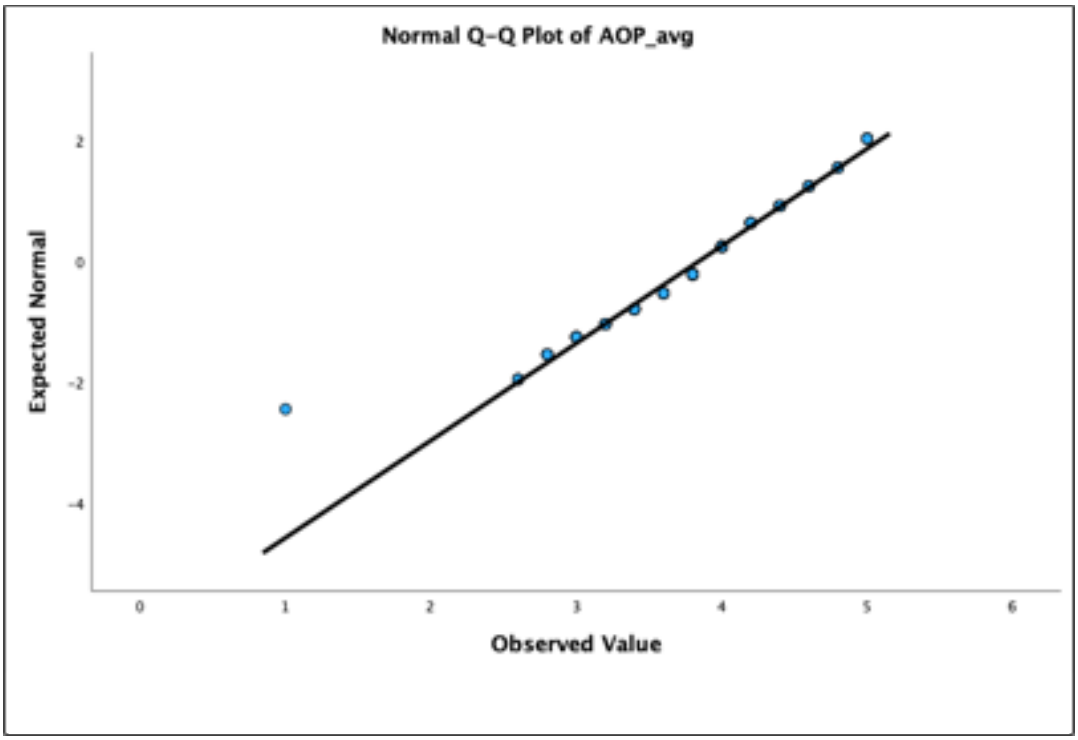
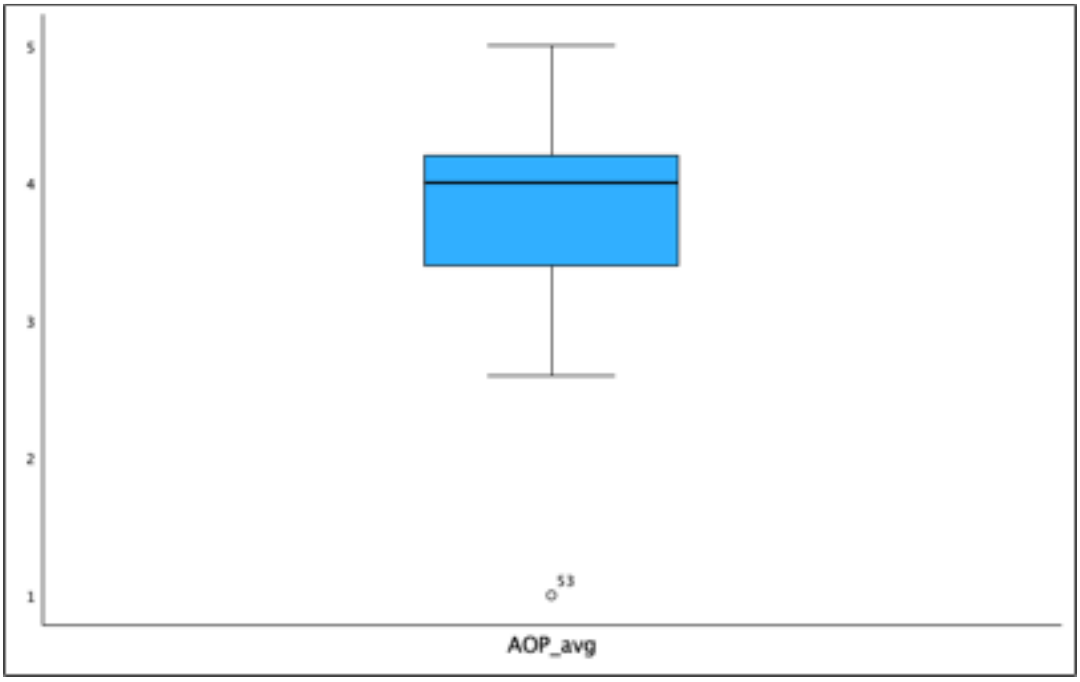


Figure 1.3. Boxplot – AOP



4.2 Rivalry Intensity (RI)

Table 2.1. Descriptives – RI

Descriptives

			Statistic	Std. Error
RI_avg	Mean		3.67	.064
	95% Confidence Interval for Mean	Lower Bound	3.54	
		Upper Bound	3.79	
	5% Trimmed Mean		3.69	
	Median		3.71	
	Variance		.555	
	Std. Deviation		.745	
	Minimum		1	
	Maximum		5	
	Range		4	
	Interquartile Range		1	
	Skewness		-.421	.207
	Kurtosis		.194	.411

Table 2.2. Test of Normality – RI

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
RI_avg	.068	137	.200*	.979	137	.030

*. This is a lower bound of the true significance.
a. Lilliefors Significance Correction

Figure 2.1. Histogram – RI

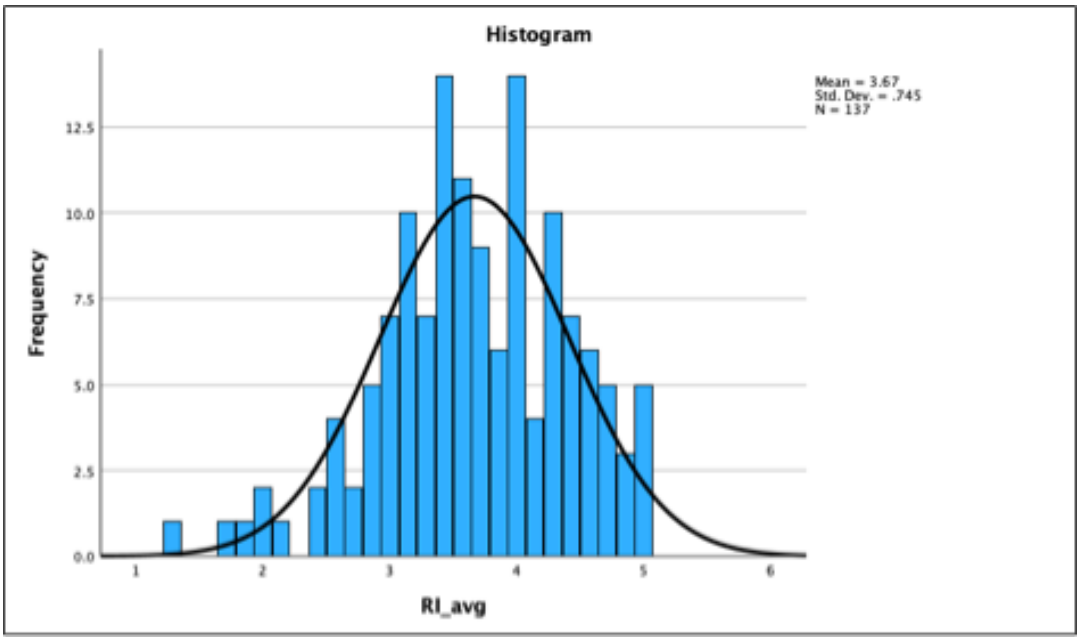


Figure 2.2. Q-Q Plot – RI

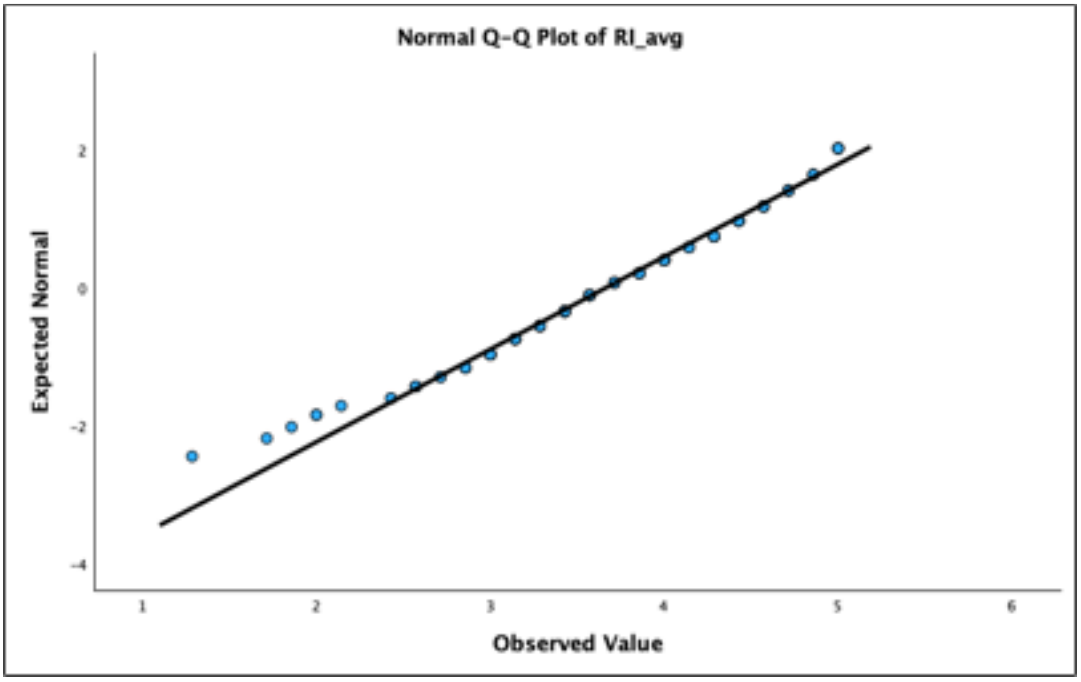
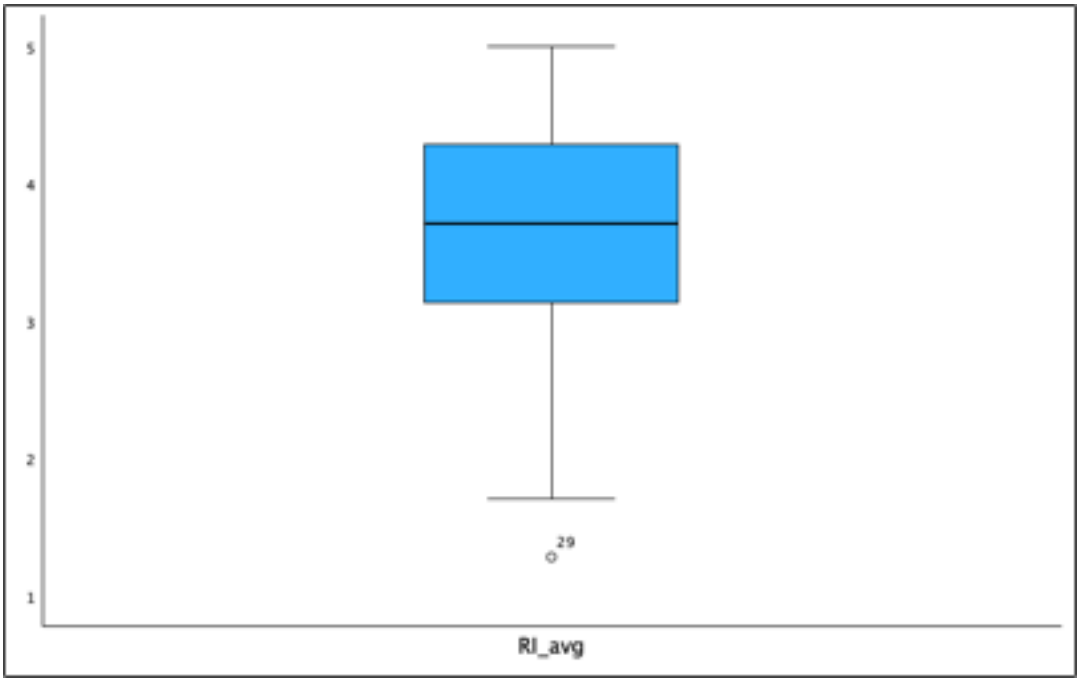


Figure 2.3. Boxplot – RI



4.3 Patient Focus (PF)

Table 3.1. Descriptives – PF

Descriptives

			Statistic	Std. Error
PF_avg	Mean		4.09	.061
	95% Confidence Interval for Mean	Lower Bound	3.97	
		Upper Bound	4.21	
	5% Trimmed Mean		4.14	
	Median		4.20	
	Variance		.511	
	Std. Deviation		.715	
	Minimum		2	
	Maximum		5	
	Range		3	
	Interquartile Range		1	
	Skewness		-.876	.207
	Kurtosis		.659	.411

Table 3.2. Test of Normality – PF

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PF_avg	.117	137	<.001	.929	137	<.001

a. Lilliefors Significance Correction

Figure 3.1. Histogram - PF

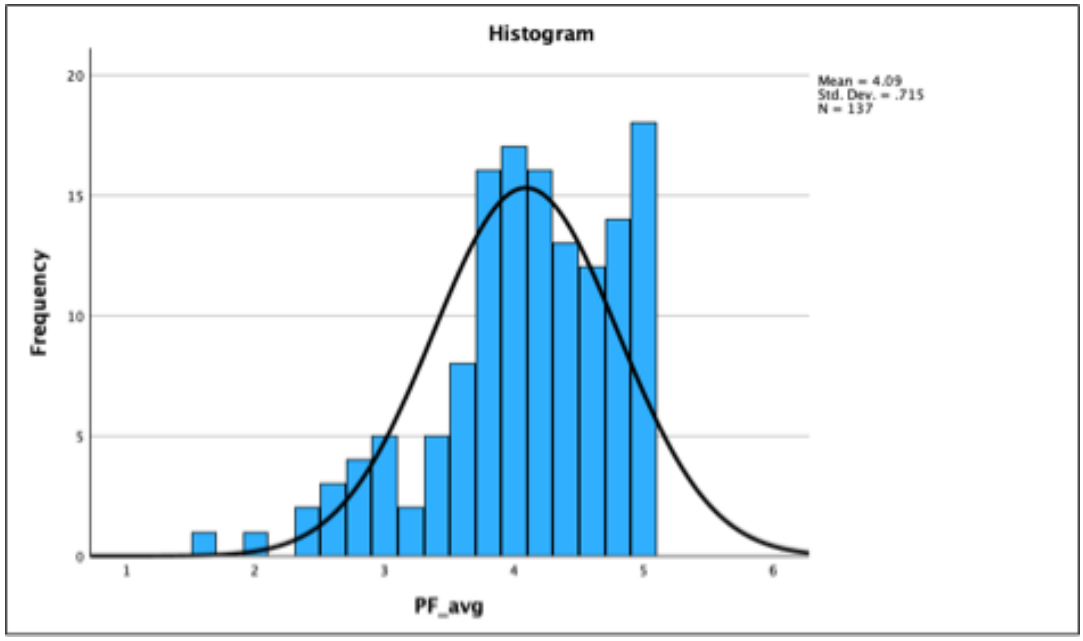


Figure 3.2. Q-Q Plot - PF

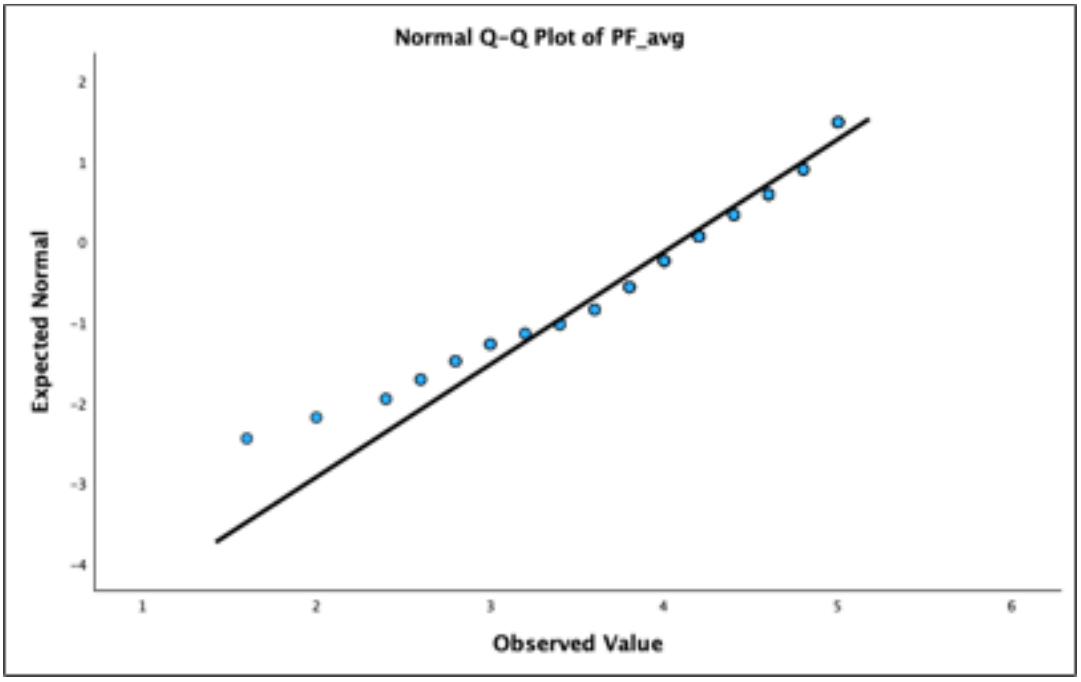
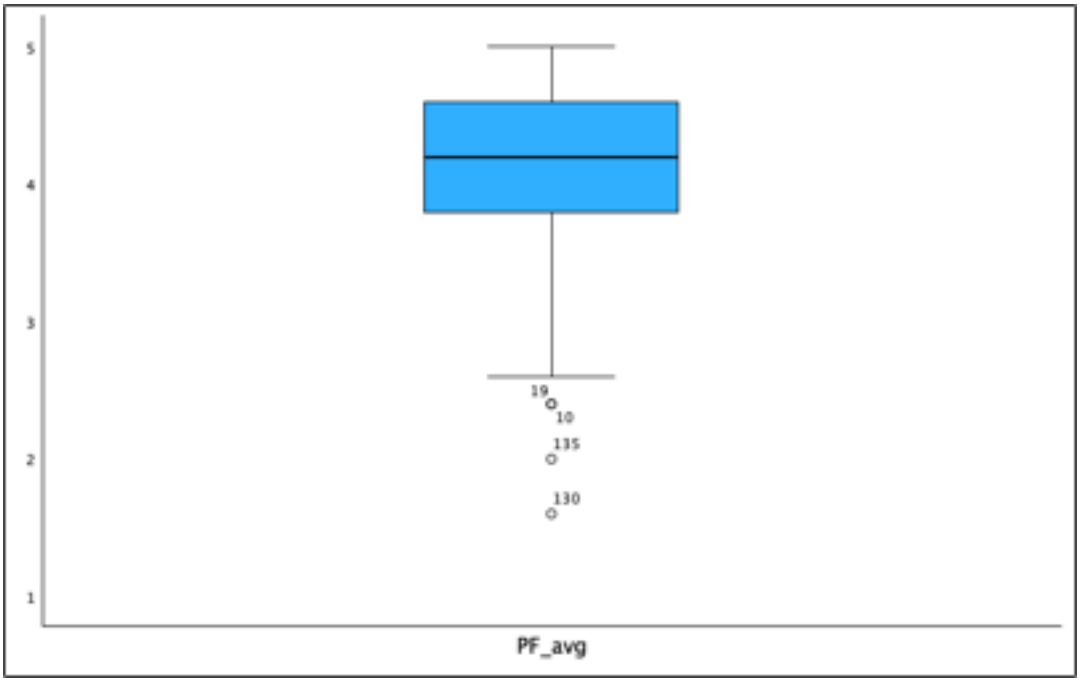


Figure 3.3. Boxplot - PF



4.4 Top Management Support (TMS)

Table 4.1 Descriptives – TMS

Descriptives

			Statistic	Std. Error
TMS_avg	Mean		4.07	.065
	95% Confidence Interval for Mean	Lower Bound	3.95	
		Upper Bound	4.20	
	5% Trimmed Mean		4.14	
	Median		4.20	
	Variance		.577	
	Std. Deviation		.760	
	Minimum		1	
	Maximum		5	
	Range		4	
	Interquartile Range		1	
	Skewness		-1.350	.207
	Kurtosis		2.930	.411

Table 4.2 Test of Normality – TMS

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
TMS_avg	.118	137	<.001	.896	137	<.001

a. Lilliefors Significance Correction

Figure 4.2 Histogram – TMS

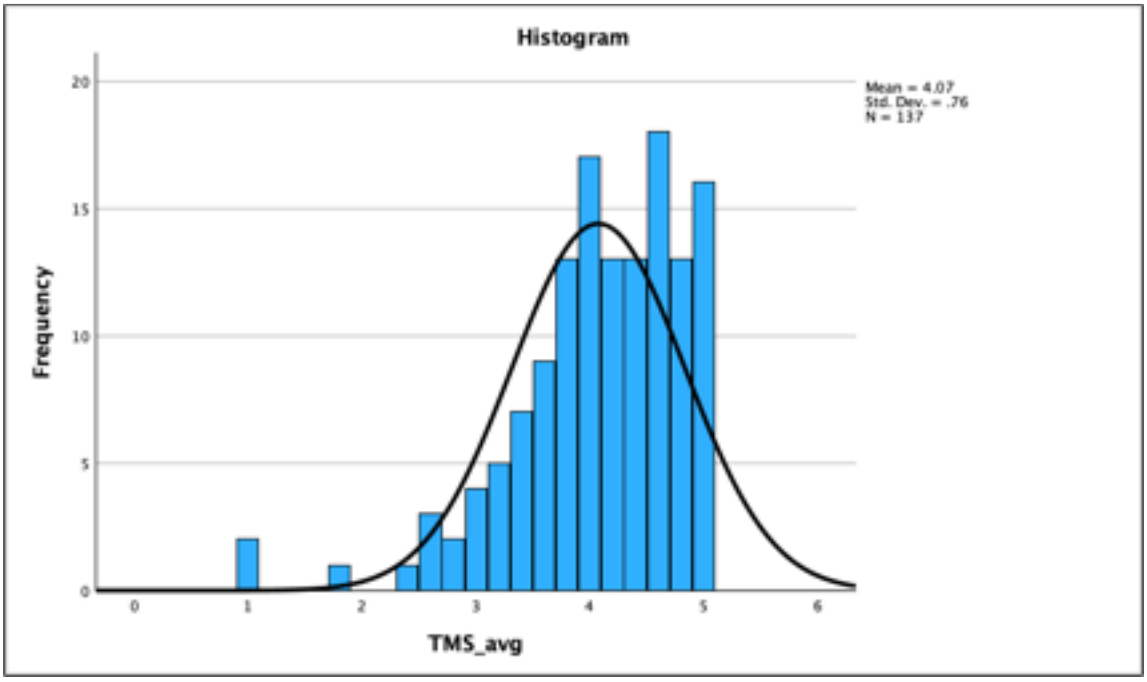


Figure 4.3. Q-Q Plot – TMS

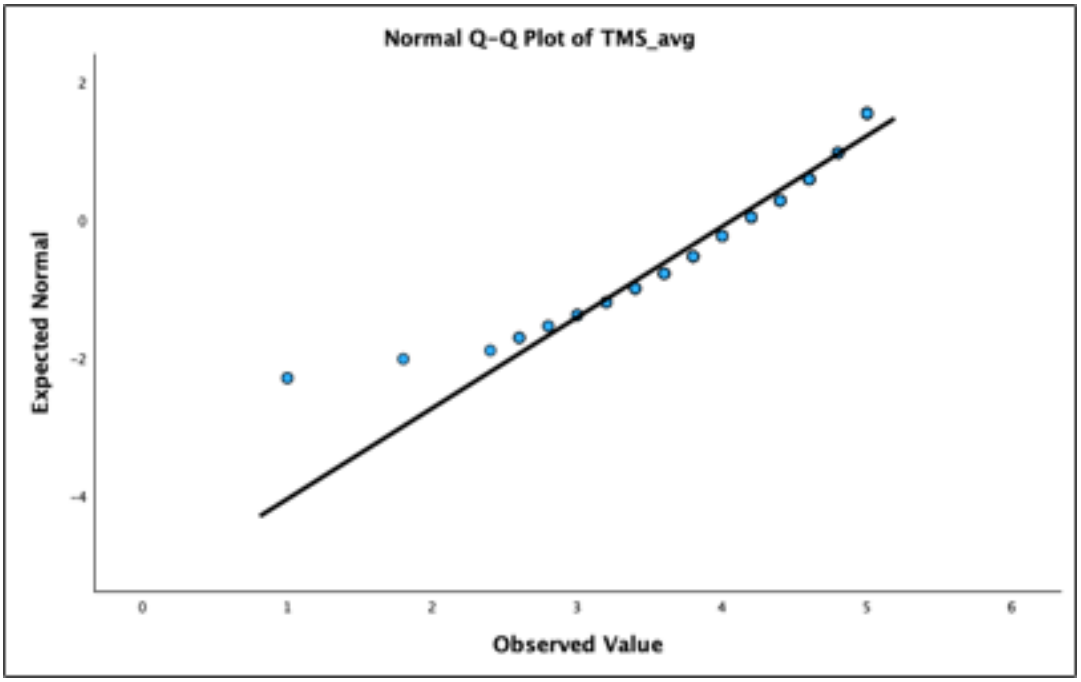
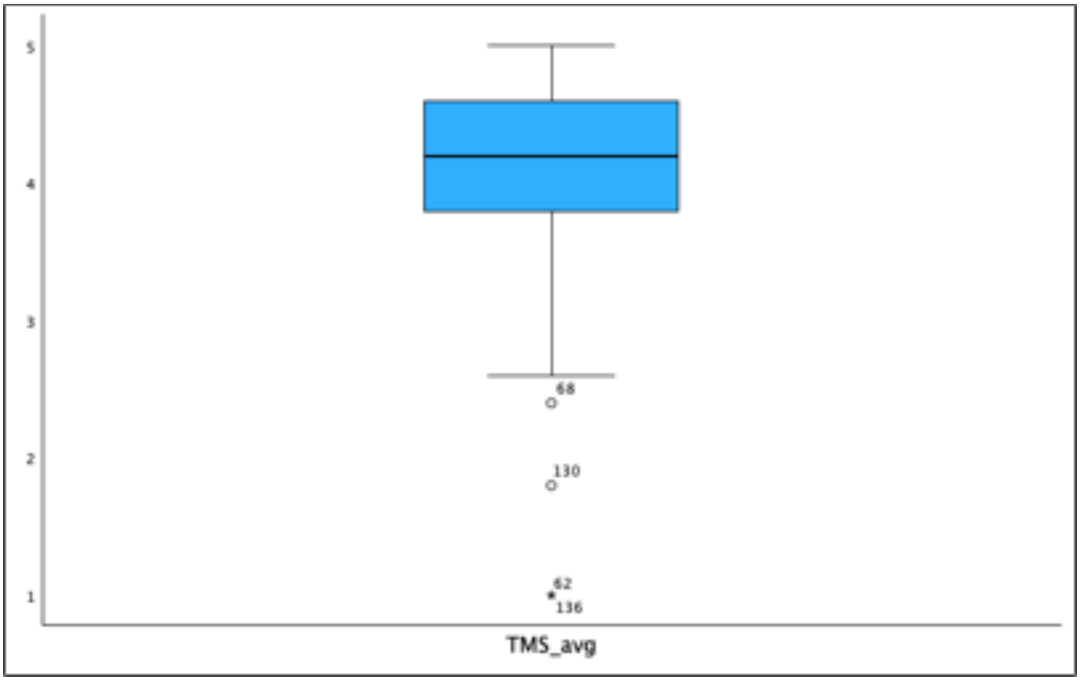


Figure 4.4. Boxplot – TMS



4.5 Process-Oriented Culture (POC)

Table 5.1. Descriptives – POC

Descriptives

			Statistic	Std. Error
POC_avg	Mean		3.80	.053
	95% Confidence Interval for Mean	Lower Bound	3.69	
		Upper Bound	3.90	
	5% Trimmed Mean		3.82	
	Median		3.91	
	Variance		.381	
	Std. Deviation		.618	
	Minimum		2	
	Maximum		5	
	Range		3	
	Interquartile Range		1	
	Skewness		-.631	.207
	Kurtosis		.864	.411

Table 5.2. Test of Normality – POC

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
POC_avg	.076	137	.050	.972	137	.006

a. Lilliefors Significance Correction

Figure 5.1. Histogram – POC

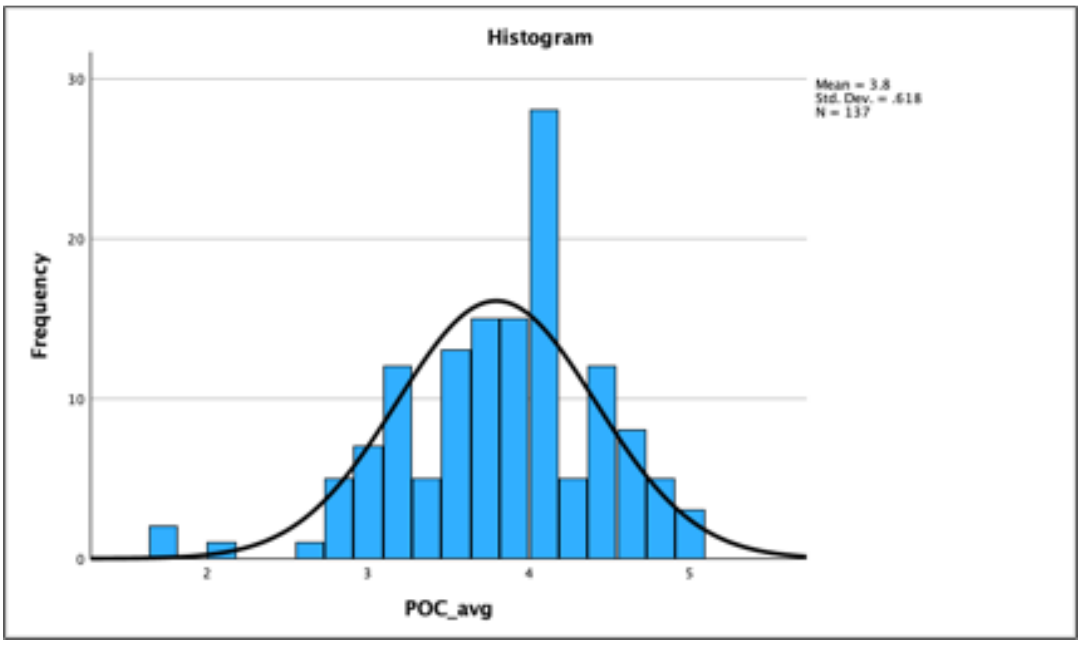


Figure 5.2. Q-Q Plot – POC

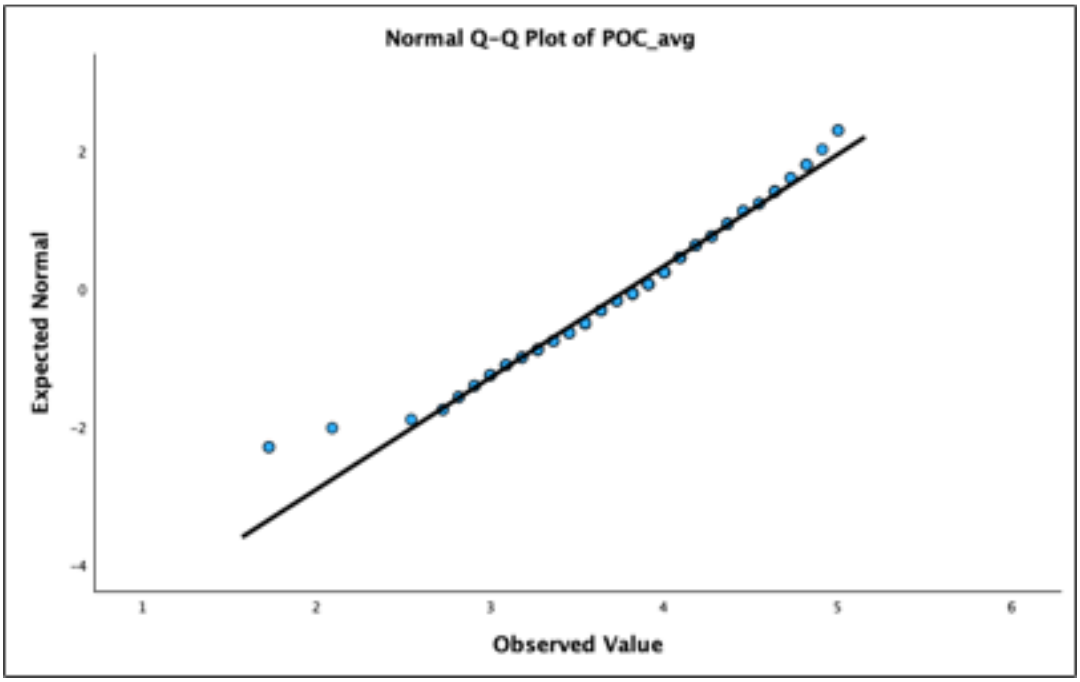
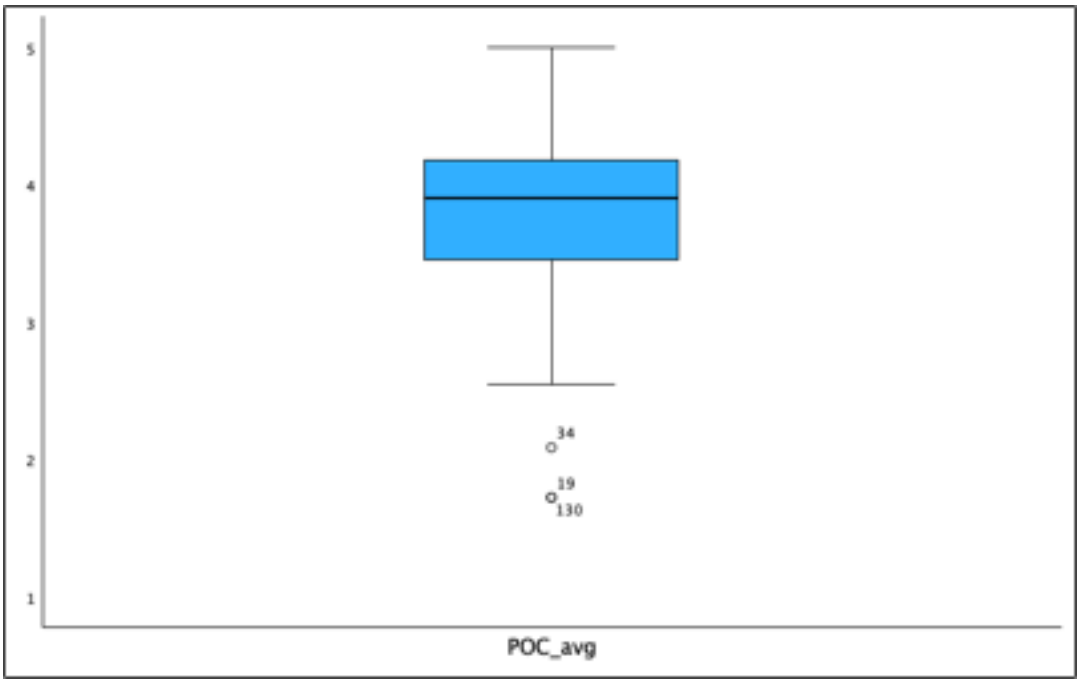


Figure 5.3. Boxplot – POC



4.6 IT Personnel Business Knowledge (ITPBK)

Table 6.1. Descriptives – ITPBK

Descriptives

			Statistic	Std. Error
ITPBK_avg	Mean		4.10	.062
	95% Confidence Interval for Mean	Lower Bound	3.98	
		Upper Bound	4.23	
	5% Trimmed Mean		4.16	
	Median		4.13	
	Variance		.520	
	Std. Deviation		.721	
	Minimum		1	
	Maximum		5	
	Range		4	
	Interquartile Range		1	
	Skewness		-1.028	.207
	Kurtosis		1.435	.411

Table 6.2. Test of Normality – ITPBK

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
ITPBK_avg	.114	137	<.001	.923	137	<.001

a. Lilliefors Significance Correction

Figure 6.1. Histogram – ITPBK

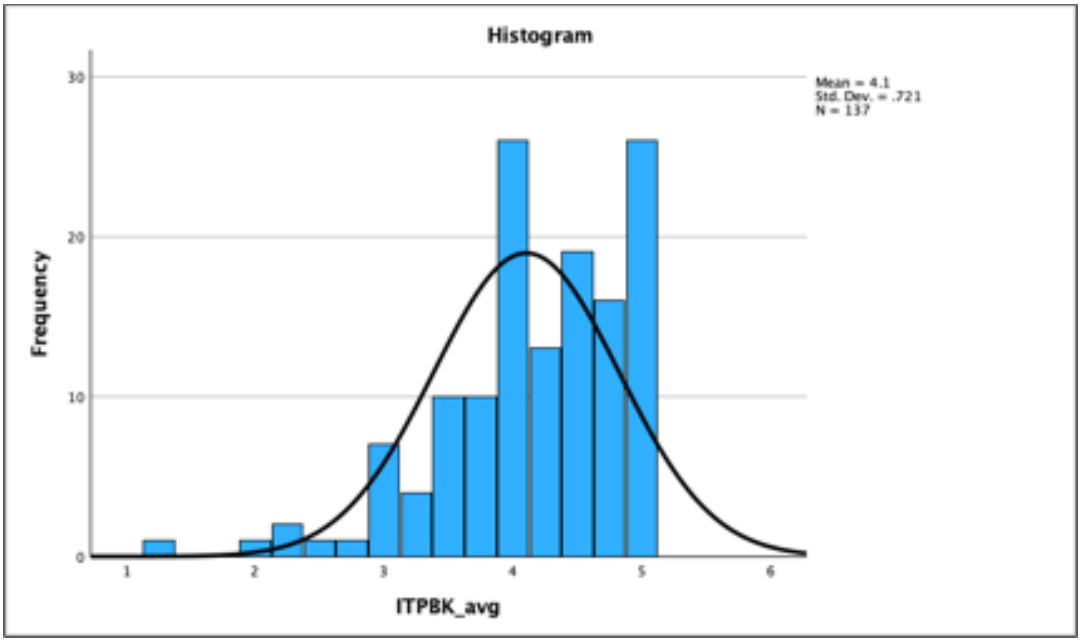


Figure 6.2. Q-Q Plot – ITPBK

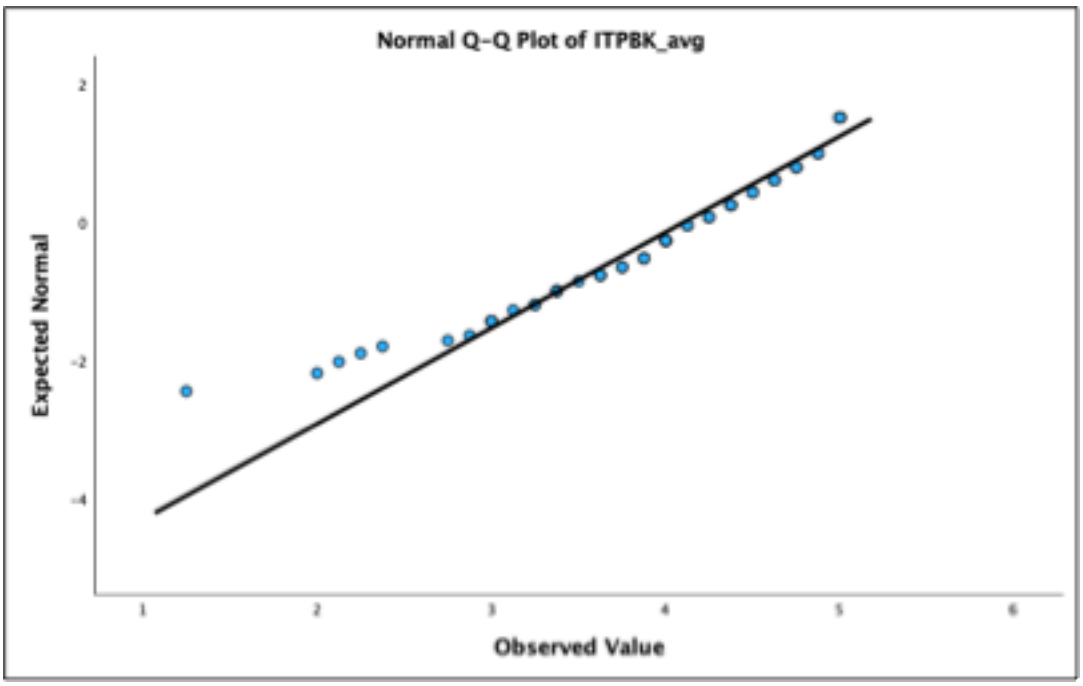
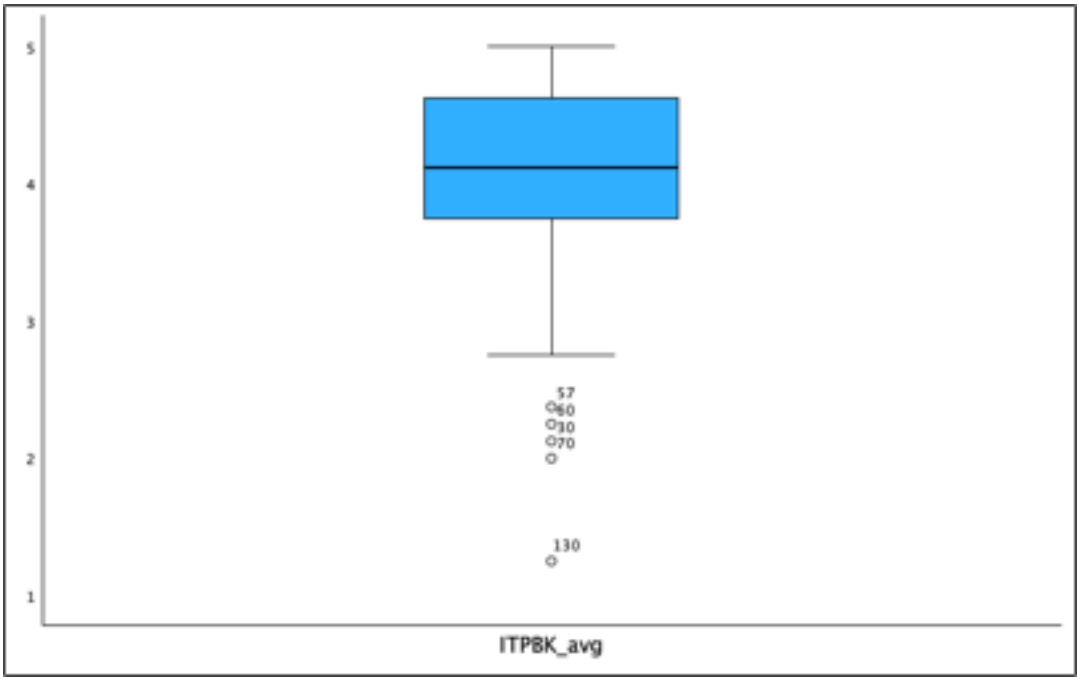


Figure 6.3. Boxplot – ITPBK



4.7 Perception of Readiness (PR)

Table 7.1. Descriptives – PR

Descriptives

			Statistic	Std. Error
PR_avg	Mean		3.51	.036
	95% Confidence Interval for Mean	Lower Bound	3.43	
		Upper Bound	3.58	
	5% Trimmed Mean		3.52	
	Median		3.50	
	Variance		.180	
	Std. Deviation		.425	
	Minimum		2	
	Maximum		5	
	Range		2	
	Interquartile Range		1	
	Skewness		-.550	.207
	Kurtosis		.381	.411

Table 7.2. Test of Normality – PR

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PR_avg	.123	137	<.001	.967	137	.002

a. Lilliefors Significance Correction

Figure 7.1. Histogram – PR

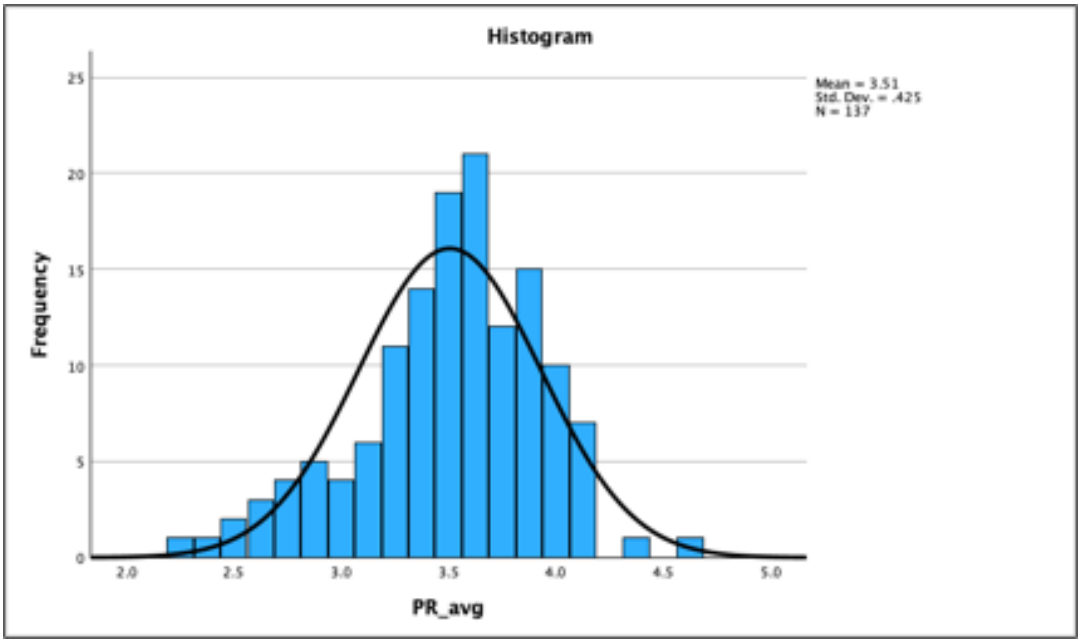


Figure 7.2. Q-Q Plot – PR

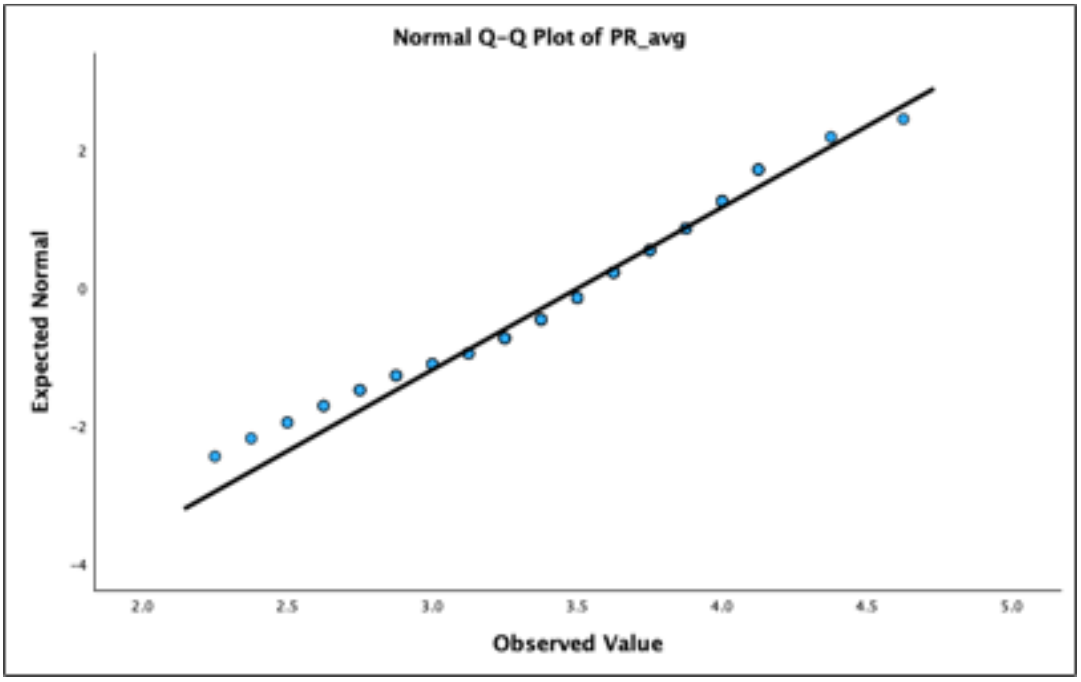
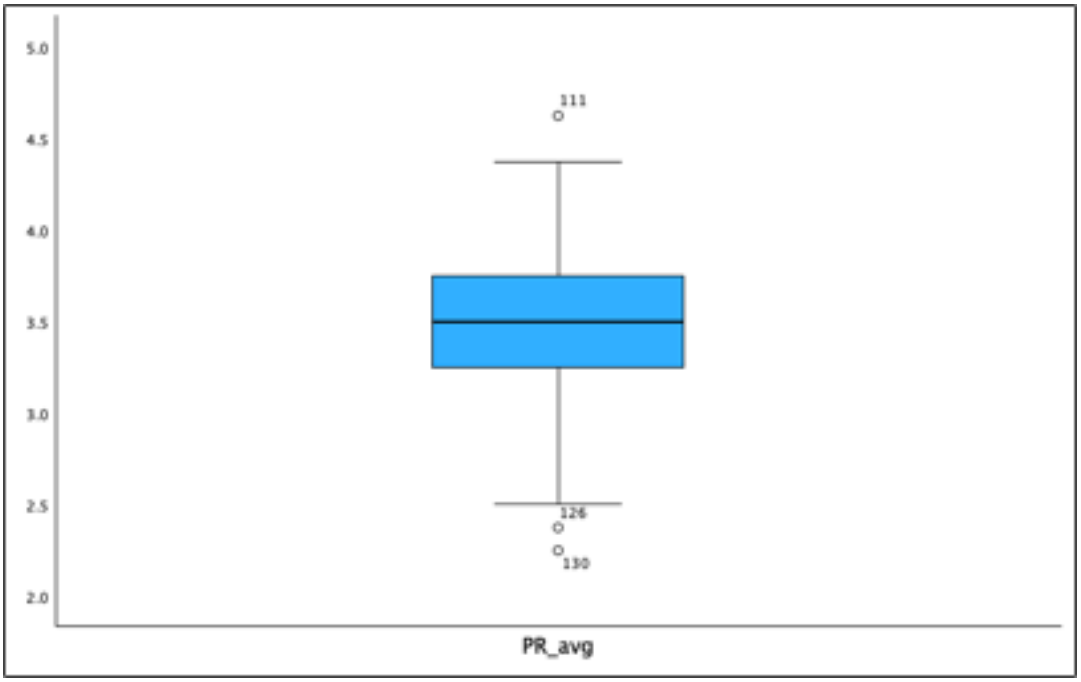


Figure 7.3. Boxplot – PR



4.8 Perception of Need (PN)

Table 8.1 Descriptives – PN

Descriptives

			Statistic	Std. Error
PN_avg	Mean		4.19	.062
	95% Confidence Interval for Mean	Lower Bound	4.07	
		Upper Bound	4.31	
	5% Trimmed Mean		4.22	
	Median		4.25	
	Variance		.521	
	Std. Deviation		.722	
	Minimum		3	
	Maximum		5	
	Range		2	
	Interquartile Range		1	
	Skewness		-.580	.207
	Kurtosis		-.789	.411

Table 8.2. Test of Normality – PN

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PN_avg	.156	137	<.001	.893	137	<.001

a. Lilliefors Significance Correction

Figure 8.1. Histogram – PN

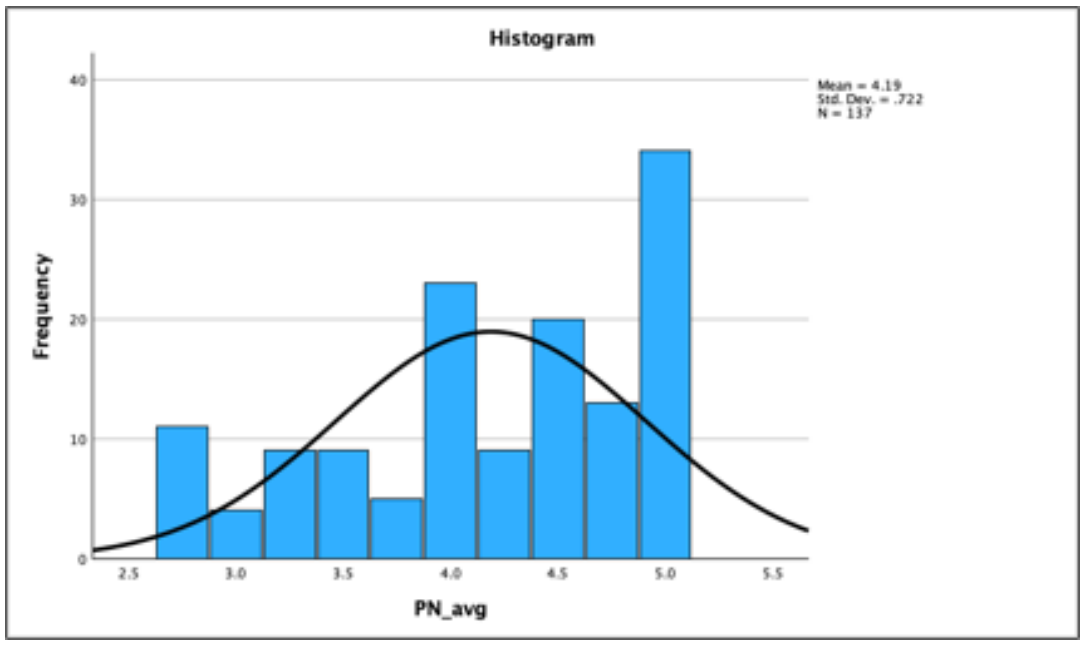


Figure 8.2. Q-Q Plot – PN

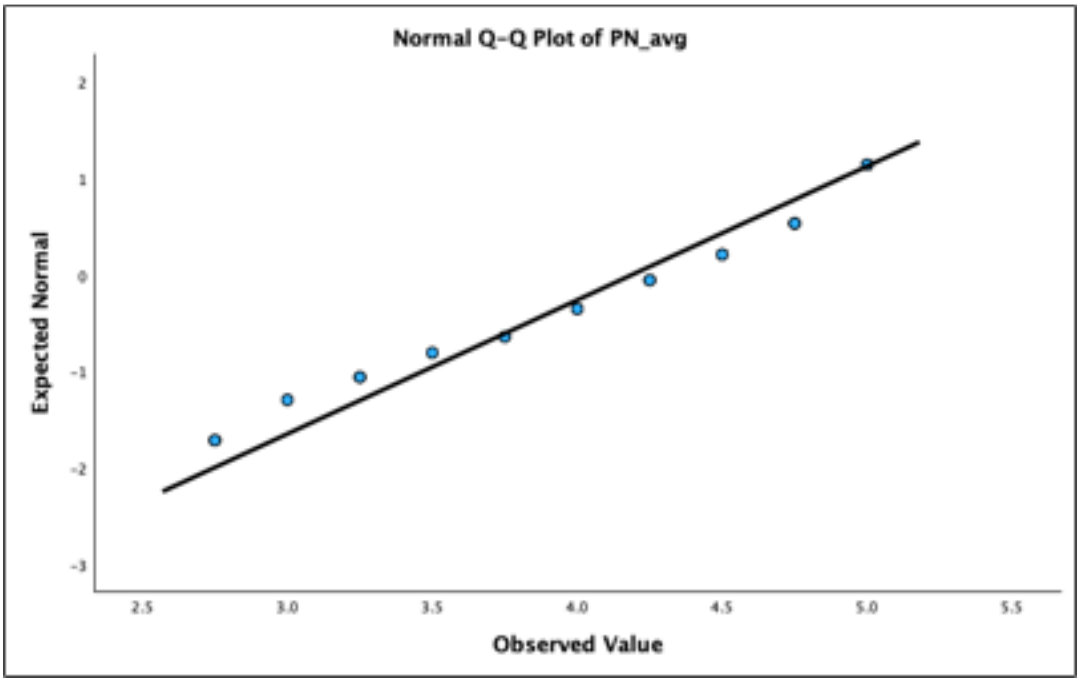
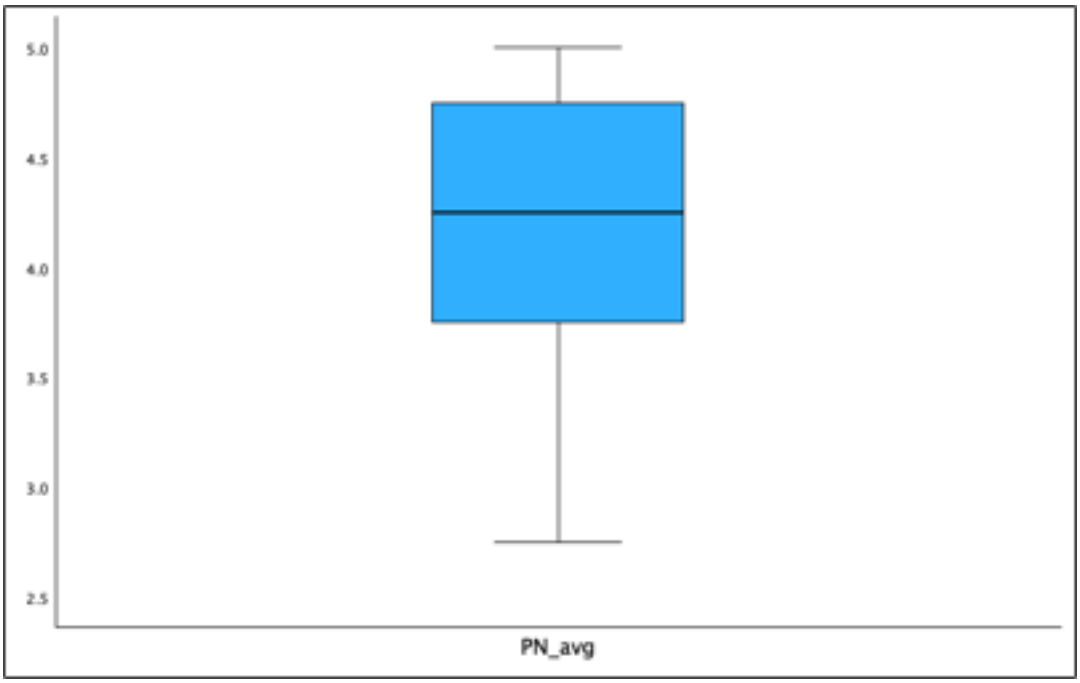


Figure 8.3. Boxplot – PN



4.9 Intention to Adopt Operational Quality Improvement (INT)

Table 9.1. Descriptives – INT

Descriptives

			Statistic	Std. Error
INT_avg	Mean		4.13	.055
	95% Confidence Interval for Mean	Lower Bound	4.02	
		Upper Bound	4.24	
	5% Trimmed Mean		4.16	
	Median		4.14	
	Variance		.414	
	Std. Deviation		.644	
	Minimum		2	
	Maximum		5	
	Range		3	
	Interquartile Range		1	
	Skewness		-.513	.207
	Kurtosis		-.083	.411

Table 9.2. Test of Normality – INT

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
INT_avg	.091	137	.008	.950	137	<.001

a. Lilliefors Significance Correction

Figure 9.1. Histogram – INT

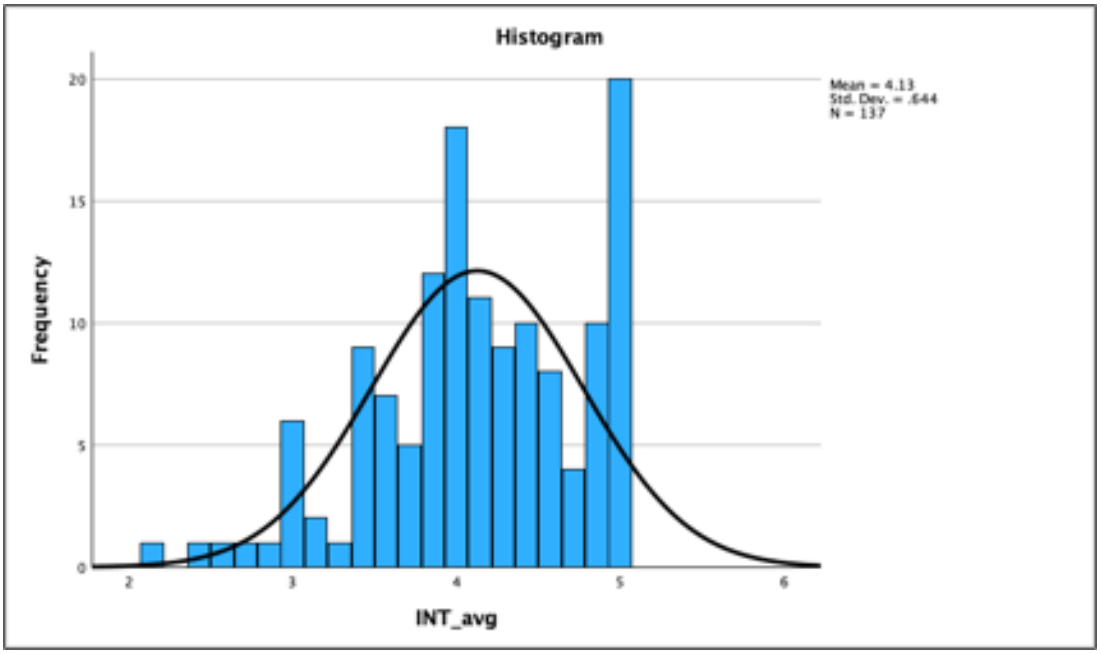


Figure 9.2. Q-Q Plot – INT

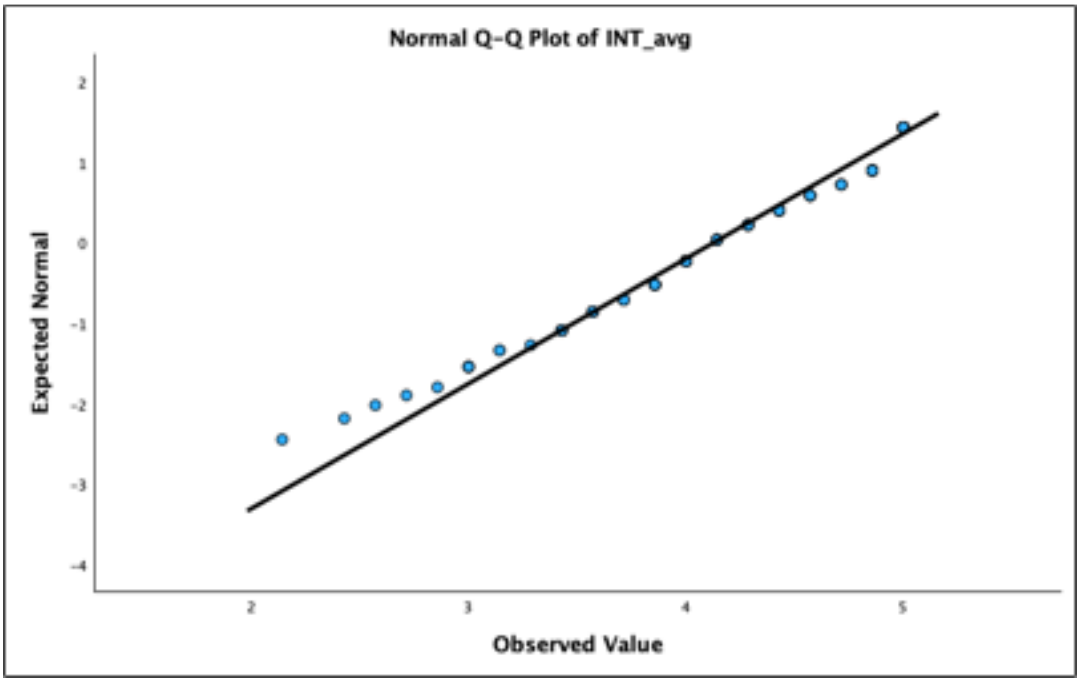
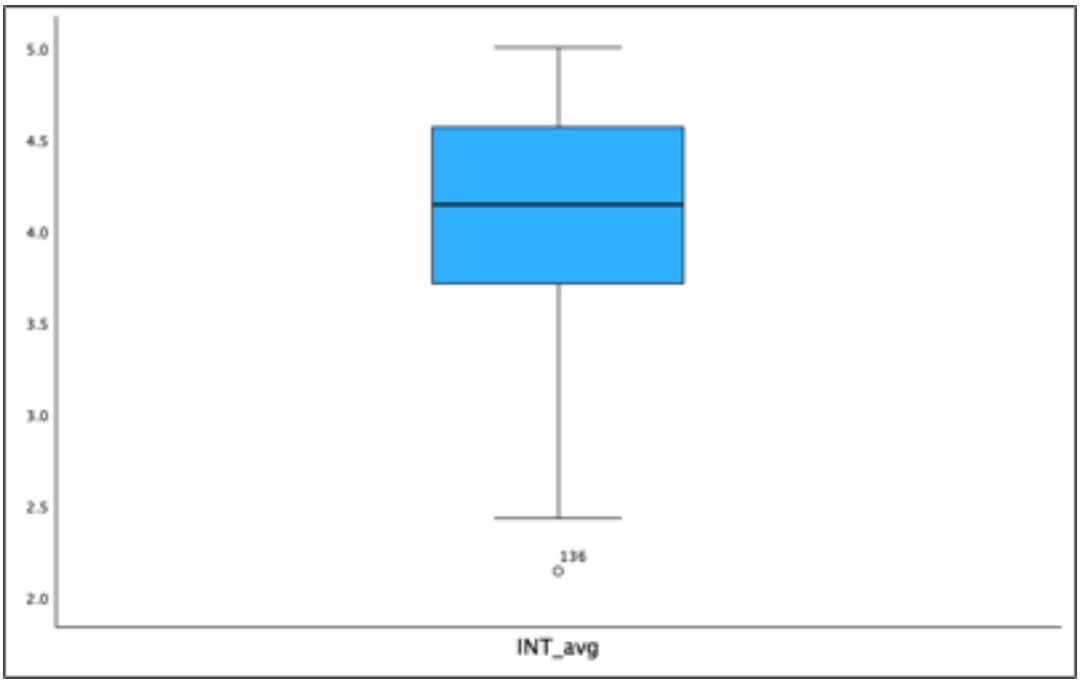


Figure 9.3. Boxplot – INT



5. Explanatory Factor Analysis Outputs

Table 5.1. Anti-Image Matrices

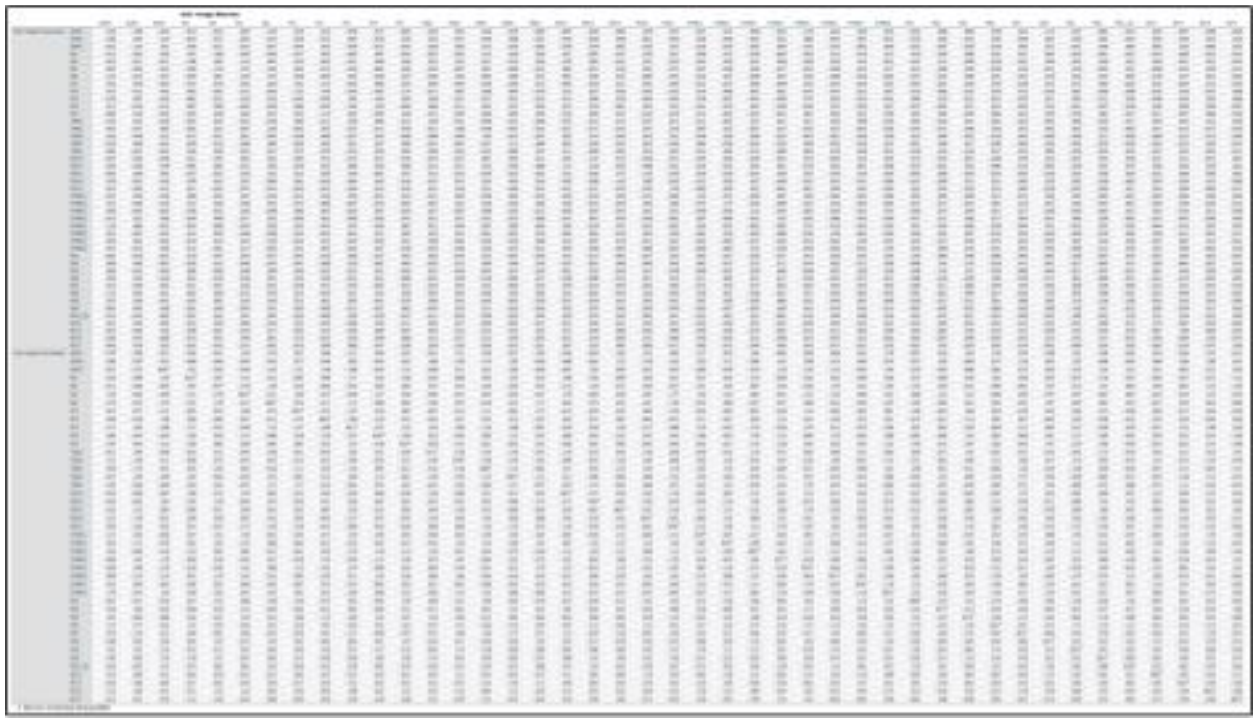
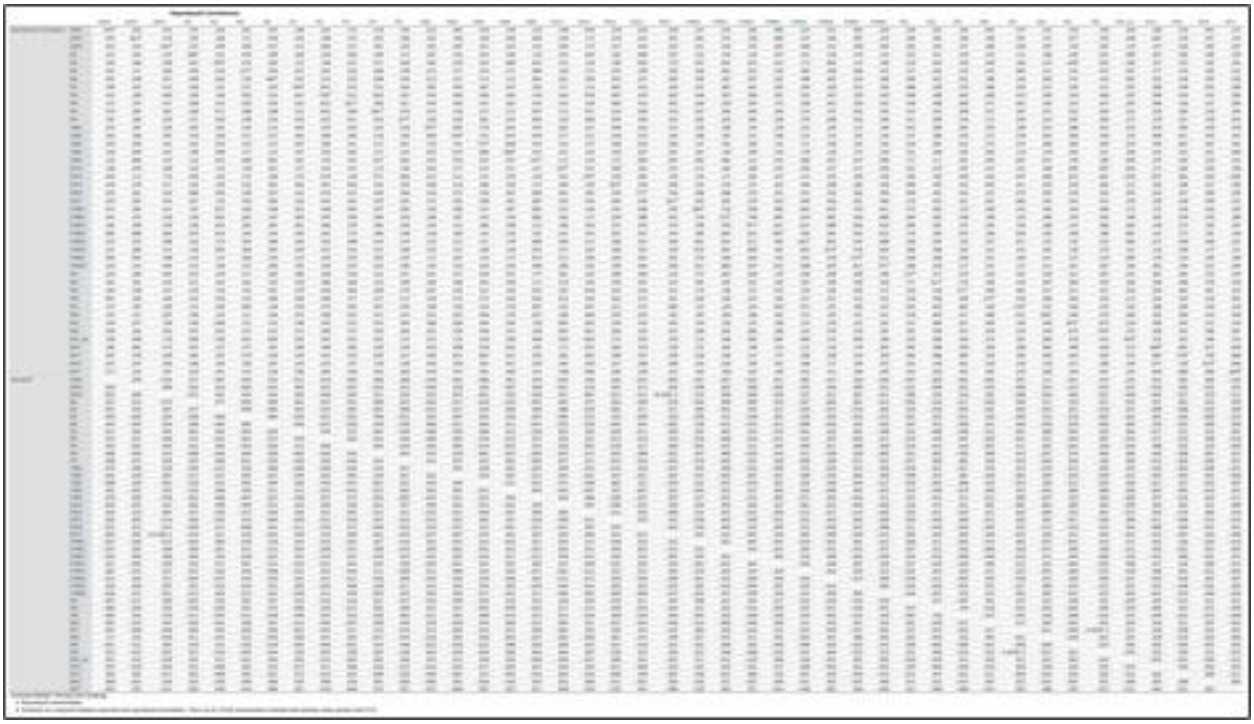


Table 5.2. Reproduced Correlations



6. Reliability Test Results

Table 1. Reliability Statistics – INT

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.901	.901	4

Table 2. Item – Total Statistics – INT

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
INT4	12.34	4.639	.766	.589	.877
INT5	12.24	4.699	.797	.644	.865
INT6	12.39	4.695	.794	.640	.866
INT7	12.17	4.876	.755	.572	.880

Table 3. Reliability Statistics – ITPBK

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.930	.931	8

Table 4. Item – Total Statistics – ITPBK

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
ITPBK1	28.74	25.622	.779	.663	.919
ITPBK2	28.61	25.665	.804	.727	.918
ITPBK3	28.58	25.965	.815	.701	.917
ITPBK4	28.90	25.534	.706	.520	.925
ITPBK5	28.64	26.395	.726	.553	.923
ITPBK6	28.74	25.563	.769	.612	.920
ITPBK7	28.82	26.087	.698	.505	.925
ITPBK8	28.80	25.002	.791	.659	.918

Table 5. Reliability Statistics – TPS

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.880	.882	5

Table 6. Item – Total Statistics – TPS

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
TMS1	16.13	9.424	.774	.658	.841
TMS2	16.28	8.790	.791	.667	.835
TMS3	16.21	9.242	.808	.706	.833
TMS4	16.22	9.599	.741	.555	.848
TMS5	16.65	10.494	.484	.244	.908

Table 7. Reliability Statistics – PN

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.760	.799	3

Table 8. Item – Total Statistics – PN

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
PN1	8.36	2.410	.680	.529	.618
PN2	8.46	2.412	.648	.508	.641
PN3_rec	8.81	1.640	.548	.302	.822

Table 9. Reliability Statistics – PF

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.855	.857	5

Table 10. Item – Total Statistics – PF

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
PF1	16.39	8.651	.672	.543	.824
PF2	16.40	7.786	.792	.656	.790
PF3	16.49	8.105	.659	.482	.828
PF4	16.30	8.902	.686	.489	.822
PF5	16.20	8.884	.553	.376	.854

Table 11. Reliability Statistics – AOP

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.749	.750	3

Table 12. Item – Total Statistics – AOP

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
AOP3	7.76	2.317	.552	.320	.696
AOP4	7.58	2.201	.639	.408	.592
AOP5	7.30	2.432	.542	.309	.704

Table 13. Reliability Statistics – POC

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.756	.769	5

Table 14. Item – Total Statistics – POC

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
POC3	15.53	8.427	.484	.258	.732
POC4	15.73	8.478	.477	.253	.734
POC5	15.39	9.180	.540	.388	.708
POC6	15.28	8.955	.647	.486	.677
POC7	15.12	9.207	.520	.328	.715

Table 15. Reliability Statistics – RI

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.696	.697	3

Table 16. Item – Total Statistics – RI

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
RI2	7.35	3.332	.531	.292	.582
RI4	7.52	3.046	.542	.303	.563
RI5	7.16	3.268	.464	.216	.664

Table 17. Reliability Statistics – PR

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.858	.859	6

Table 18. Item – Total Statistics – PR

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
PR1	19.51	11.663	.717	.574	.822
PR2	19.44	12.410	.658	.547	.834
PR3	19.64	11.658	.672	.542	.830
PR6	19.68	12.558	.628	.399	.839
PR7	19.90	12.210	.589	.420	.846
PR8	19.86	11.797	.635	.435	.838

Appendix D

1. Main Study – Revised Measurement Instrument

Table 1.1. Revised Measurement Instrument

Variable	Variable Type	Definition	Item	Survey Items
Awareness of Organizational Performance	Independent	Respondent's perceptual rating of customer satisfaction of products and services, customer retention rate, sales growth rate, profitability and overall performance of organization.	AOP1	My company's customers receive good value for their money when buying our health services and products.
			AOP2	My company's customer retention rate is as high as or higher than that of our competitors.
			AOP3	My company's sales growth rate is as high as or higher than that of our competitors.
			AOP4	My company's profitability is good compared to the overall performance of our business sector.
			AOP5	My company's overall performance is strong.
Rivalry Intensity	Independent	The extent to which organizations in this industry frequently and vigorously engage in outwardly manifested competitive actions and reactions in their search for competitive advantage in the marketplace.	RI1	In our industry, competition for market share is intense.
			RI2	In our industry, competitive moves by one company noticeably affect other competing companies.
			RI3	In our industry, organizations typically respond aggressively to competitor actions.
			RI4	In our industry, price competition is highly intense.
			RI5	In our industry, there is a wide variety of competitors.
			RI6	In our industry, organizations have the resources to compete effectively.
			RI7	In our industry, organizations continually seek ways to outperform competitors.
Patient Focus	Independent	The organization understands and reacts to their patient/customer, and anticipates their future needs. It reflects the degree to which the organization is driven by a concern to satisfy its patients/customers.	PF1	In my organization, patient comments and/or recommendations often lead to improvements.
			PF2	In my organization, patient input is incorporated into decision-making.
			PF3	In my organization, the patient's interests are always prioritized in decision-making.
			PF4	In my organization, employees have a deep understanding of patient wants and needs.
Top Management Support	Independent	The extent to which organizational members felt senior leaders support the change.	TMS1	My Senior Leaders have encouraged all employees to embrace quality improvement.
			TMS2	My organization's Top Management has put all their support behind quality improvement.
			TMS3	My Senior Leaders have emphasized the significance of quality improvement.
			TMS4	My organization's most Senior Leader is committed to quality improvement.
			TMS5	My Top Management communicated clearly that our organization is going to change.
Process-Oriented Culture	Independent	Values that favor business processes and their translation into attitudes and behaviors. The importance of abstract ideas (i.e. beliefs or principles) within the organization to facilitate the modeling, deployment, optimization, and management of business processes, as well as feelings and activities of organizational members that express process-oriented values beyond the context of individual business processes.	POC1	In my organization, all process documentation is stored in a central location.
			POC2	In my organization, all employees have access to a central location for process documentation.
			POC3	In my organization, employees show a strong commitment to a continuous improvement.
			POC4	In my organization, employees follow processes that support organizational goals.
			POC5	In my organization, the overall process effectiveness is measured.
IT Personnel Business Knowledge	Independent	Business skills relate to the ability of IT personnel to understand the business processes they are to support and to apply the appropriate technical solutions to a given business problem.	ITBK1	My company's Information Technology personnel are knowledgeable about business functions.
			ITBK2	My company's Information Technology personnel understand the organization's objectives.
			ITBK3	My company's Information Technology personnel understand the business environment they support.
			ITBK4	My company's Information Technology personnel understand the organization's environmental constraints (e.g.
			ITBK5	My company's Information Technology personnel are well-informed about the organization's quality improvement
Perception of Readiness	Mediator	The extent to which an individual is cognitively and emotionally inclined to accept, embrace and adopt a particular plan to purposefully alter the status quo.	PR1	I have a good feeling about quality improvements.
			PR2	I see change as a positive process.
			PR3	I think that most changes will have a positive effect on the patients/clients we serve.
			PR4	I think that quality improvements will simplify my work.
			PR5	I want to devote myself to quality improvement.
Perception of Need	Mediator	The extent to which one feels that there are or are not legitimate reasons and needs for the prospective change.	PN1	There are legitimate business reasons for quality improvement initiatives.
			PN2	Quality improvements are necessary to enhance my organization's overall efficiency.
			PN3	It doesn't make sense for my organization to make quality improvements at this time.
			PN4	I understand the reasons for quality improvements.
			PN5	Quality improvements are essentional for my organization to stay competitive.
Intention to Adopt Quality Improvements	Dependent	Individual and organizational readiness and conscious plan to adopt a particular plan.	INT1	My organization intends to use quality improvement in daily operations.
			INT2	My organization plans to use quality improvements more frequently.
			INT3	My organization intends to adopt quality improvement initiatives in the near future.
			INT4	My organization is committed to implementing quality improvement initiatives.
			INT5	My organization is planning to allocate resources to adopt quality improvement initiatives.
			INT6	It is likely that my organization will adopt quality improvement initiatives within the next year.
			INT7	My organization will take the necessary steps to implement quality improvements in the near future.

2. Background and Demographic Questions

    1. Is your organization currently involved in quality improvement initiative/s?
        a. Yes
        b. No
        c. Unsure
    2. What type of quality improvement initiative/s is your organization currently involved in? (Select the option that best fits the main goal of your organization's quality improvement initiative):
        a. Patient care improvement (e.g., clinical protocols, safety)
        b. Organizational process improvement (e.g., workflows, efficiency, automation, optimization)
        c. Patient experience and satisfaction improvement
        d. Other
    3. Does your organization use CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys?

a. Yes
b. No
c. Unsure

4. For what purpose does your organization use CAHPS data? (Select the best option to your knowledge):
    a. Quality Improvement initiatives
    b. Government funding
    c. Public reporting of healthcare quality
    d. Patient experience improvement
    e. Compensation and performance reviews
    f. Accreditation or certification
    g. Other
5. Is your organization currently engaged in any Government-funded (e.g., Medicare, Medicaid) programs?
    a. Yes
    b. No
    c. Unsure
6. What percentage of your organization's operations depend on Government-funded programs?
    a. 0-20%
    b. 21-50%
    c. 51-80%
    d. 81-100%
    e. Unsure
7. Is your organization required to submit quality data or performance metrics for Government-funded programs?
    a. Yes
    b. No
    c. Unsure
8. What employee size is your organization?
    a. Small (1-99)
    b. Medium (100-999)
    c. Large (> 1,000)
9. What type of healthcare organization do you work for?
    a. Hospital
    b. Clinic
    c. Pharmacy
    d. Health Insurance Company
    e. Laboratory
    f. Mental Health Facility
    g. Outpatient Facility
    h. Medical Equipment
    i. Other
10. Which department do you work in? (Select the option that best fits your department):

a. Administrative (e.g., human resources, patient scheduling, records, etc.)
b. Clinical (e.g., nursing, emergency, lab & diagnostics, specialty care, pharmacy, mental health, etc.)
c. Financial & Accounting (e.g., billing, accounts receivable, payroll, etc.)
d. Information Technology (e.g., tech support, implementation, development, data analytics, etc.)
e. Other

11. What is your current title? (Select the option that best fits your role.):
    a. Administrative (e.g., assistant, coordinator, scheduler, secretary, etc.)
    b. Registered Nurse (e.g., LPN, nurse practitioner, case manager, etc.)
    c. Physician (e.g., therapist, primary care, clinical dietitian, chiropractic, etc.)
    d. Financial Specialist (e.g., billing specialist, financial analyst, pricing manager, etc.)
    e. IT Professional (e.g., data analyst, system engineer, quality assurance, etc.)
    f. Manager/Director (e.g., project manager, team lead, supervisor, office manager, research director, etc.)
    g. Medical Technician (e.g., lab, radiology, pharmacy, emergency medical, surgical, medical equipment, etc.)
    h. Other
12. How long have you been working at your current organization?
    a. Less than 1 year
    b. 1-5 years
    c. 5-10 years
    d. More than 10 years

The following demographics were included by default from CloudResearch:

- Age
- Gender
- Education
- Household Income
- Race
- Employment Status

3. Variables

AOP1-5: Items comprising the “Awareness of Organizational Performance” scale.
RI1-7: Items comprising the “Rivalry Intensity” scale.
PF1-5: Items comprising the “Patient Focus” scale.
TMS1-5: Items comprising the “Top Management Support” scale.
POC1-11: Items comprising the “Process-Oriented Culture” scale.
ITBK1-8: Items comprising the “IT Personnel Business Knowledge” scale.
PR1-8: Items comprising the “Perception of Readiness” scale.
PN1-4: Items comprising the “Perception of Need” scale.
INT1-7: Items comprising the “Intention to Adopt Quality Improvements” scale.

4. Normality Tests

4.1. Awareness of Organizational Performance (AOP)

Table 1.1. Descriptives – AOP

Descriptives

			Statistic	Std. Error
AOP_avg	Mean		4.01	.039
	95% Confidence Interval for Mean	Lower Bound	3.93	
		Upper Bound	4.09	
	5% Trimmed Mean		4.04	
	Median		4.00	
	Variance		.404	
	Std. Deviation		.636	
	Minimum		2	
	Maximum		5	
	Range		3	
	Interquartile Range		1	
	Skewness		-.434	.149
	Kurtosis		-.136	.297

Table 1.2. Test of Normality – AOP

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
AOP_avg	.109	268	<.001	.965	268	<.001

a. Lilliefors Significance Correction

Figure 1.1. Histogram – AOP

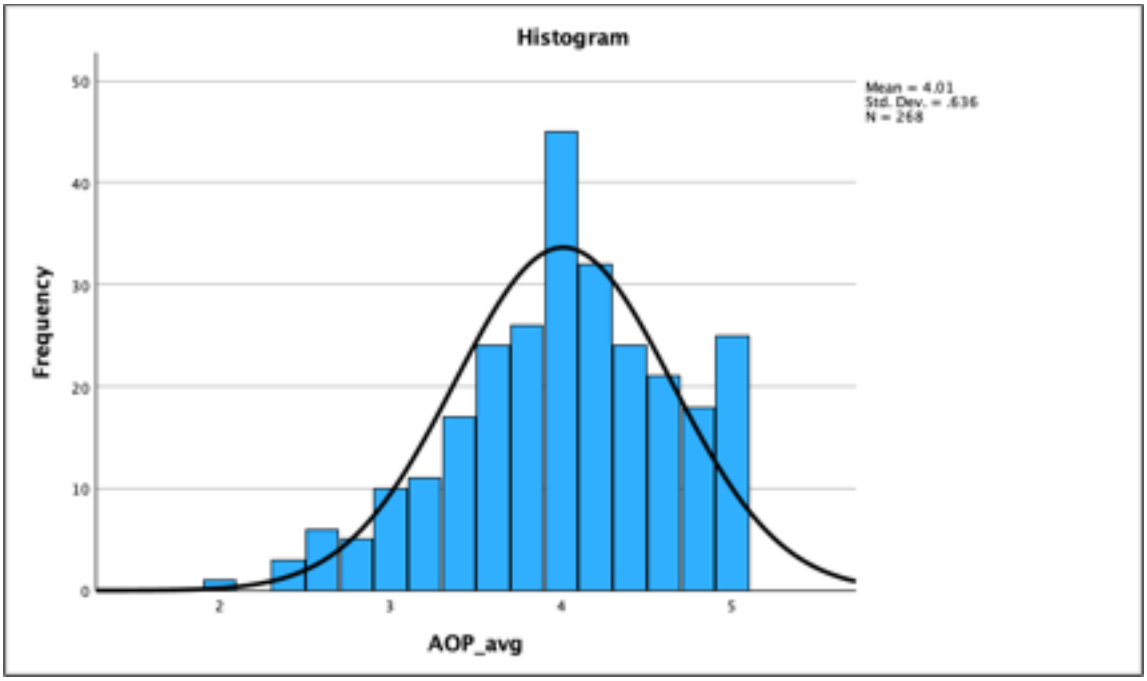


Figure 1.2. Q-Q Plot – AOP

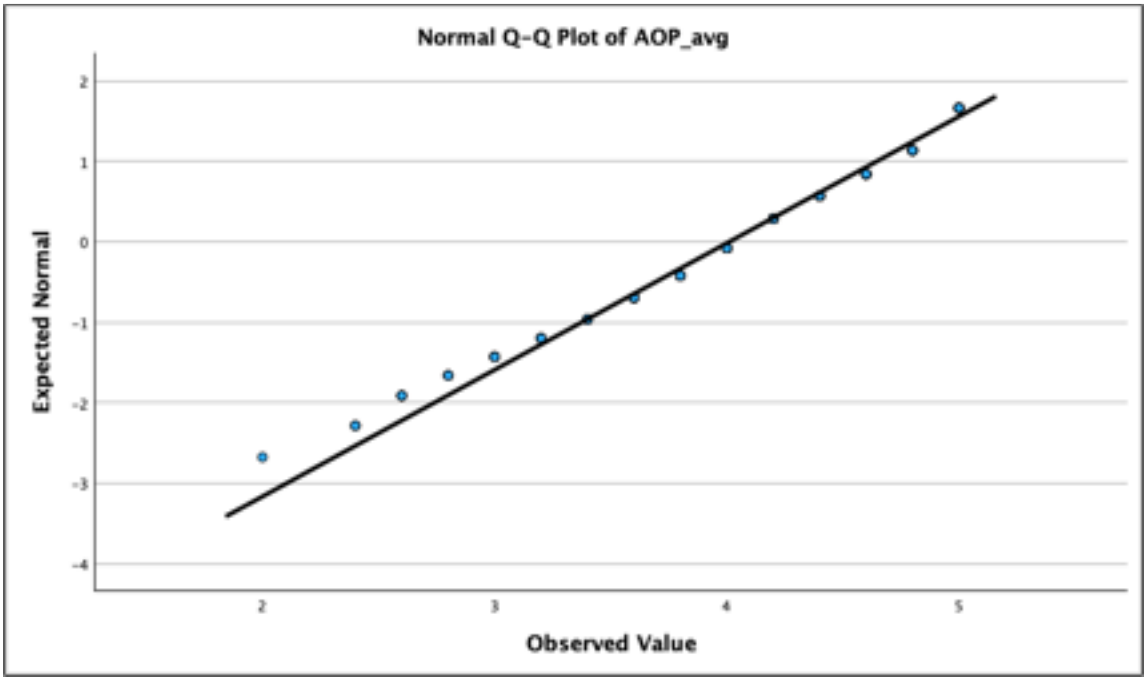
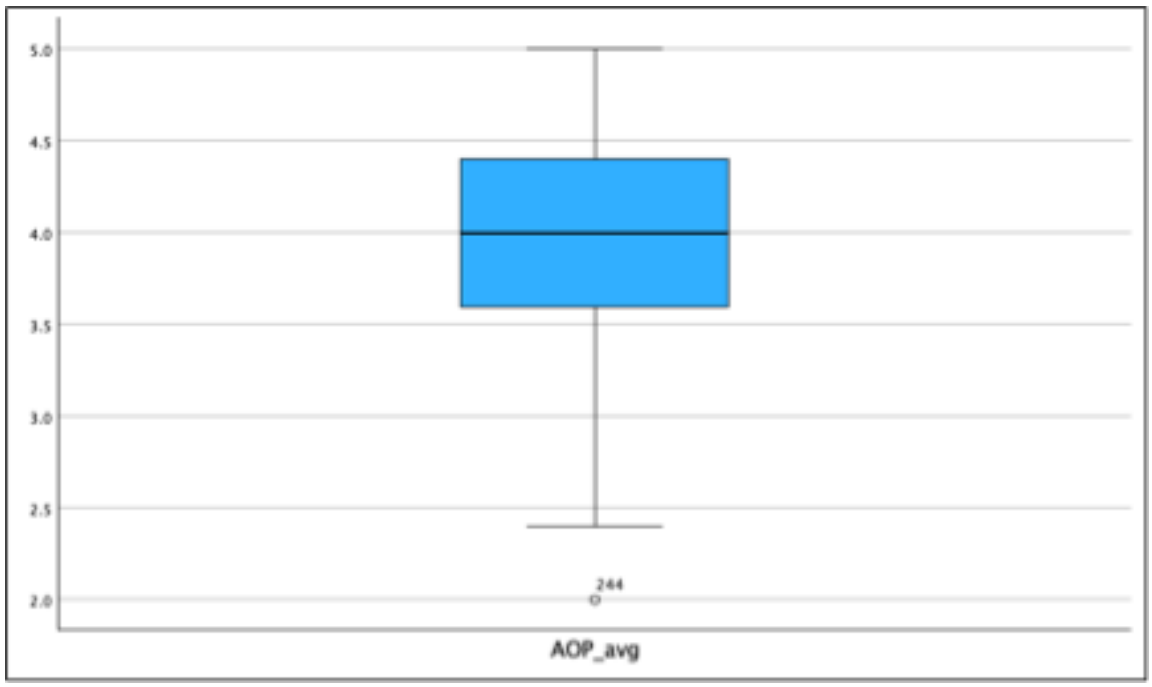


Figure 1.3. Boxplot – AOP



4.2.Rivalry Intensity (RI)

Table 1.1. Descriptives – RI

Descriptives

			Statistic	Std. Error
RI_avg	Mean		3.66	.047
	95% Confidence Interval for Mean	Lower Bound	3.57	
		Upper Bound	3.75	
	5% Trimmed Mean		3.68	
	Median		3.71	
	Variance		.581	
	Std. Deviation		.762	
	Minimum		2	
	Maximum		5	
	Range		3	
	Interquartile Range		1	
	Skewness		-.312	.149
	Kurtosis		-.528	.297

Table 1.2. Test of Normality – RI

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
RI_avg	.104	268	<.001	.976	268	<.001

a. Lilliefors Significance Correction

Figure 1.1. Histogram – RI

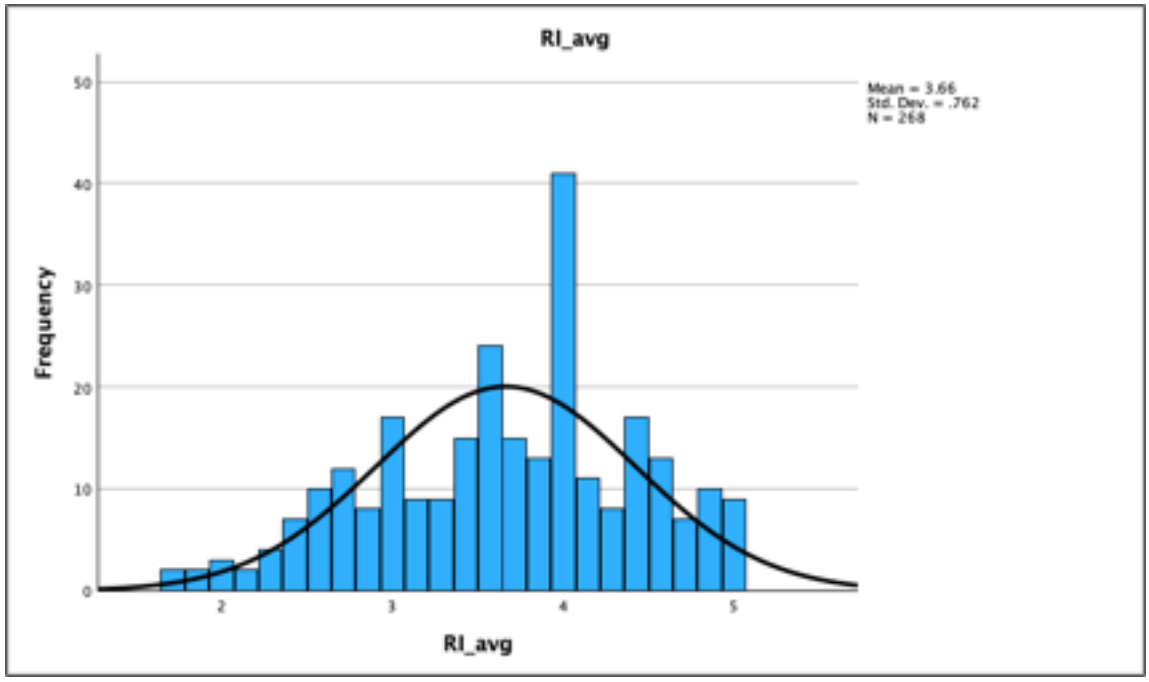


Figure 1.2. Q-Q Plot – RI

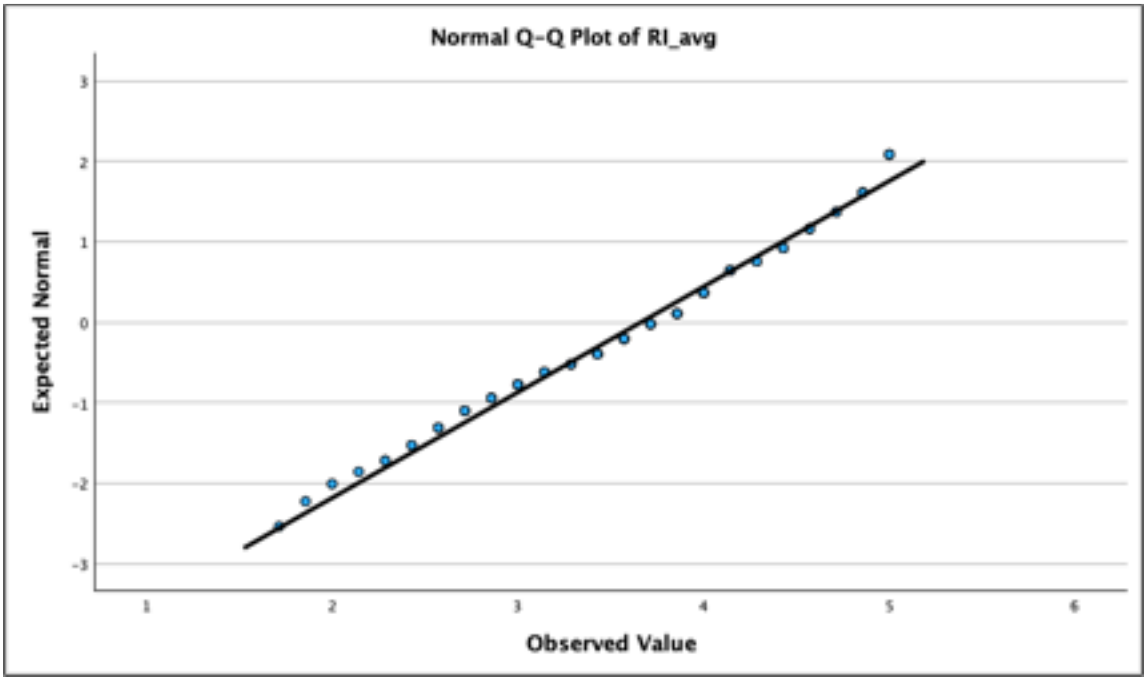
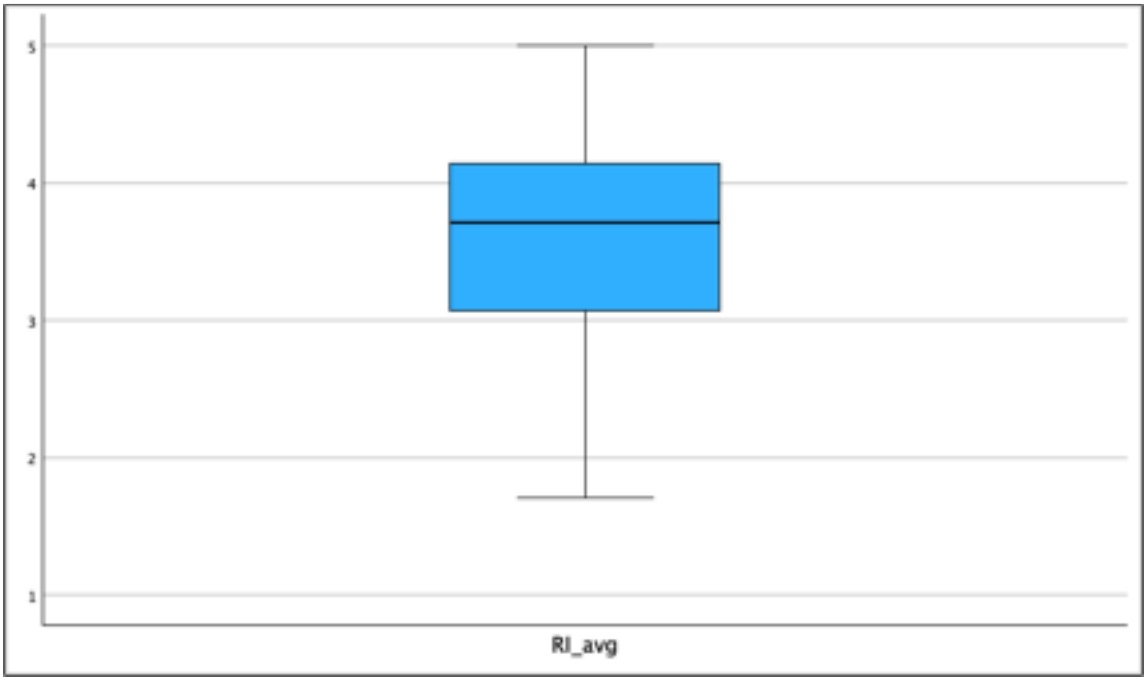


Figure 1.3. Boxplot – RI



4.3 Patient Focus (PF)

Table 1.1. Descriptives – PF

Descriptives

			Statistic	Std. Error
PF_avg	Mean		4.03	.049
	95% Confidence Interval for Mean	Lower Bound	3.93	
		Upper Bound	4.13	
	5% Trimmed Mean		4.09	
	Median		4.00	
	Variance		.650	
	Std. Deviation		.806	
	Minimum		1	
	Maximum		5	
	Range		4	
	Interquartile Range		1	
	Skewness		-.885	.149
	Kurtosis		.546	.297

Table 1.2. Test of Normality – PF

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PF_avg	.154	268	<.001	.918	268	<.001

a. Lilliefors Significance Correction

Figure 1.1. Histogram – PF

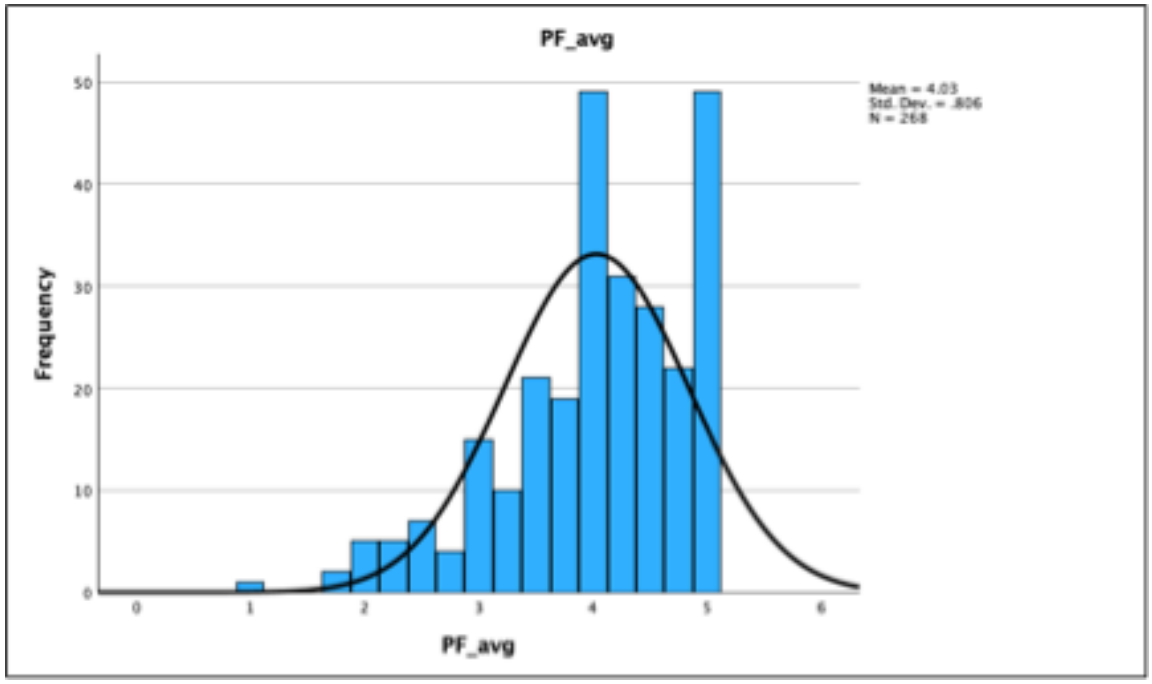


Figure 1.2. Q-Q Plot – PF

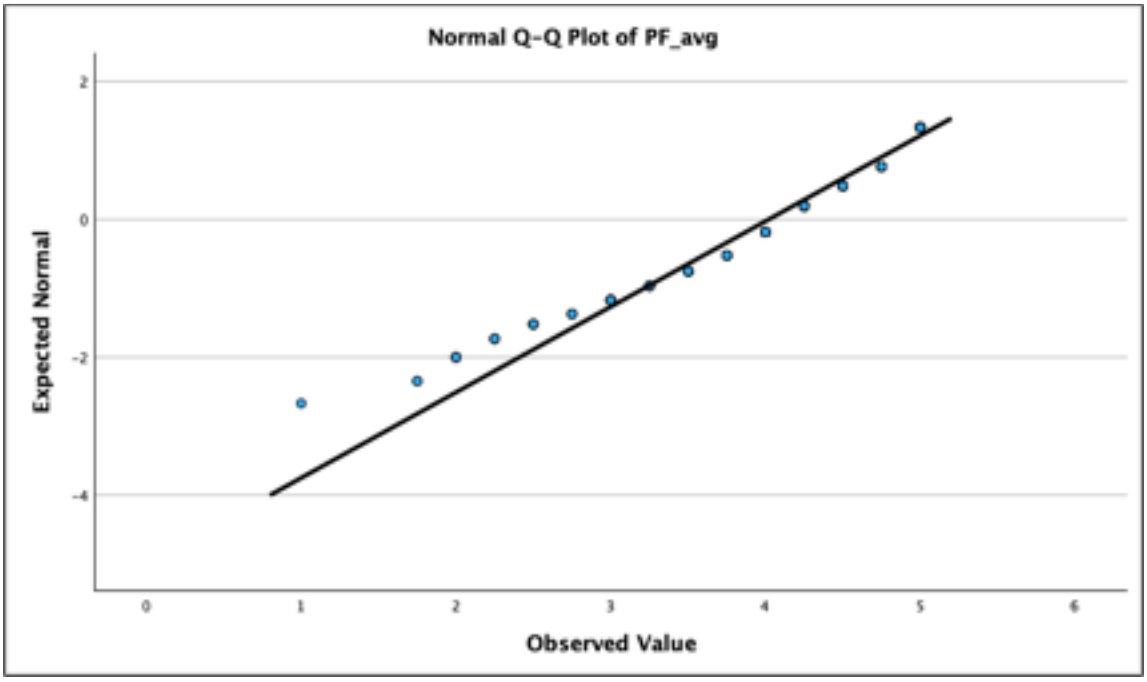
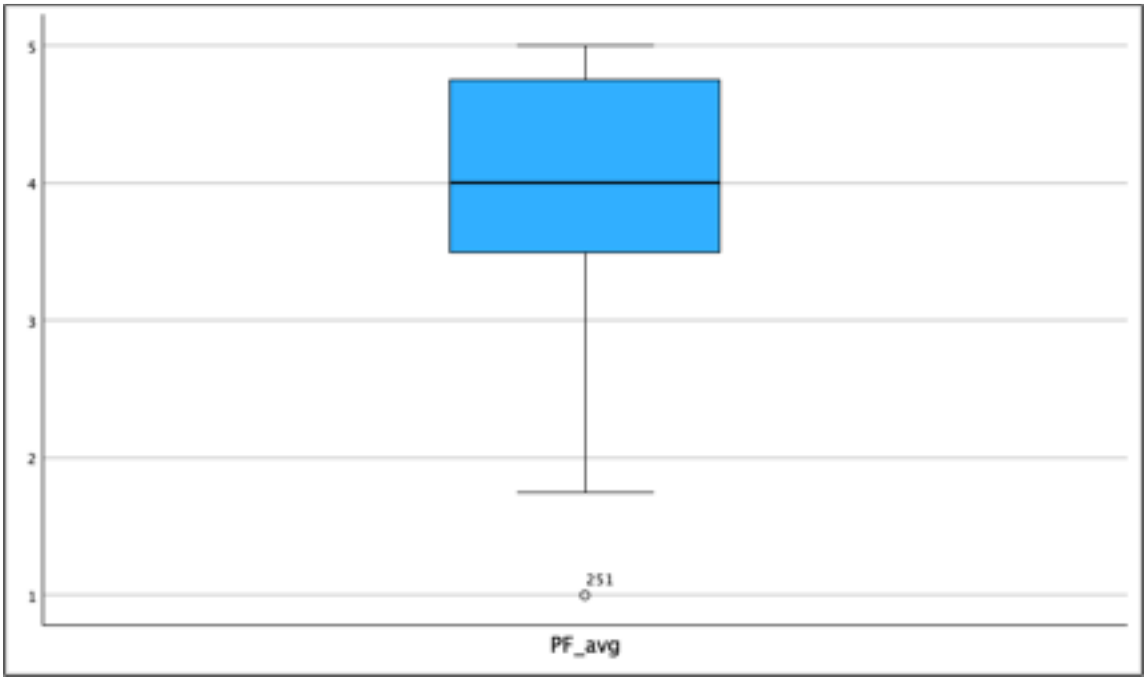


Figure 1.3. Boxplot – PF



4.3. Top Management Support (TMS)

Table 1.1. Descriptives – TMS

Descriptives

			Statistic	Std. Error
TMS_avg	Mean		4.16	.044
	95% Confidence Interval for Mean	Lower Bound	4.08	
		Upper Bound	4.25	
	5% Trimmed Mean		4.22	
	Median		4.20	
	Variance		.513	
	Std. Deviation		.716	
	Minimum		1	
	Maximum		5	
	Range		4	
	Interquartile Range		1	
	Skewness		-1.003	.149
	Kurtosis		1.160	.297

Table 1.2. Test of Normality – TMS

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
TMS_avg	.122	268	<.001	.911	268	<.001

a. Lilliefors Significance Correction

Figure 1.1. Histogram – TMS

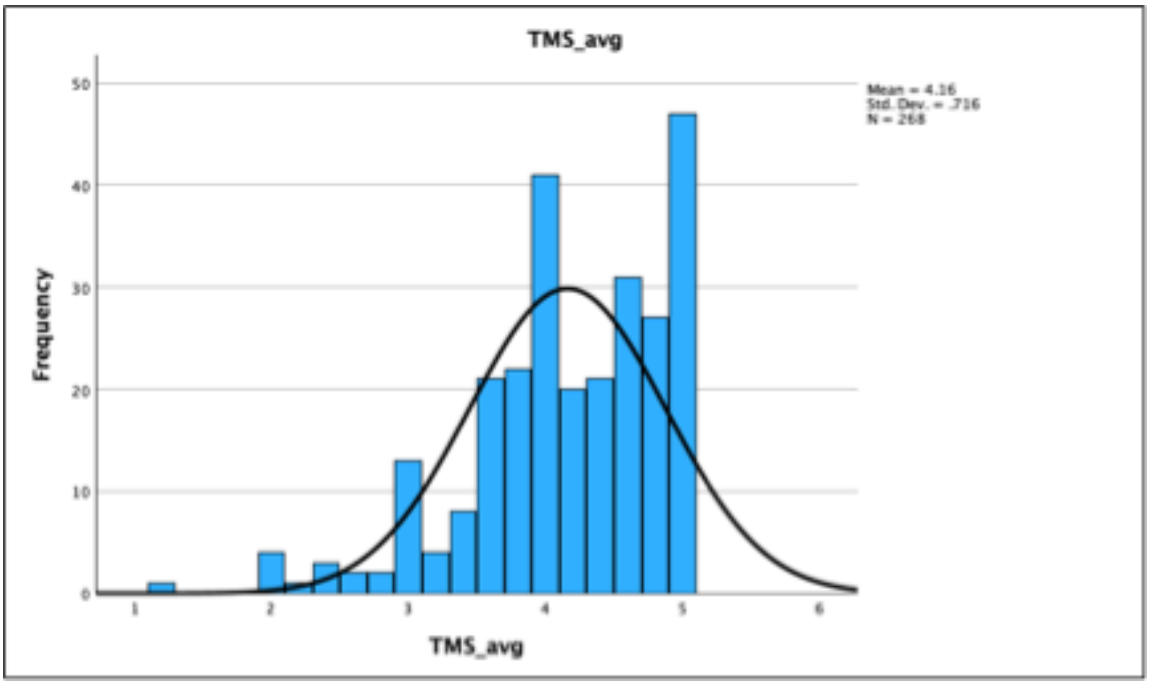


Figure 1.2. Q-Q Plot – TMS

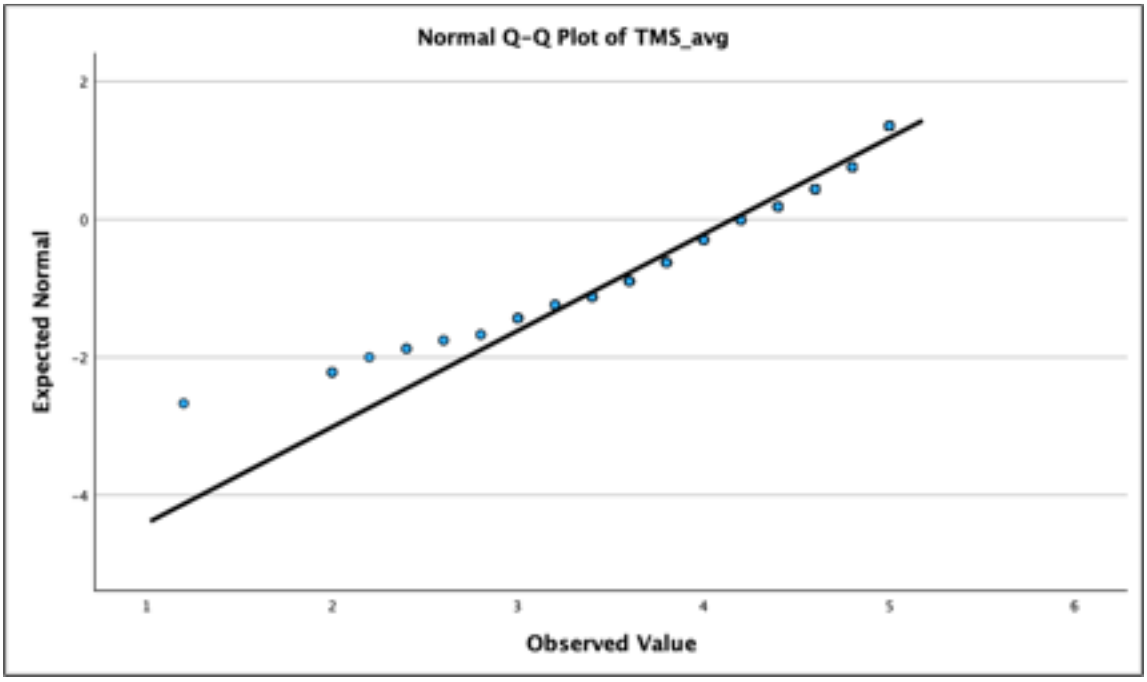
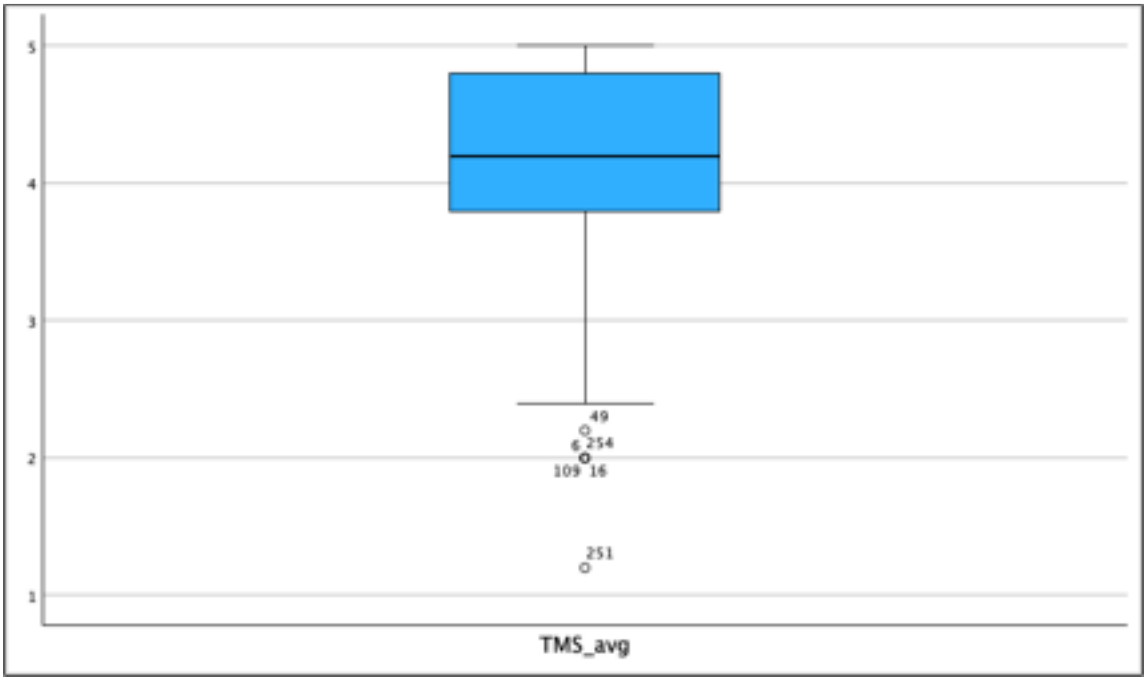


Figure 1.3. Boxplot – TMS



4.4. Patient-Oriented Culture (POC)

Table 1.1. Descriptives – POC

Descriptives

			Statistic	Std. Error
POC_avg	Mean		3.98	.045
	95% Confidence Interval for Mean	Lower Bound	3.89	
		Upper Bound	4.07	
	5% Trimmed Mean		4.02	
	Median		4.00	
	Variance		.546	
	Std. Deviation		.739	
	Minimum		2	
	Maximum		5	
	Range		3	
	Interquartile Range		1	
	Skewness		-.808	.149
	Kurtosis		.373	.297

Table 1.2. Test of Normality – POC

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
POC_avg	.116	268	<.001	.939	268	<.001

a. Lilliefors Significance Correction

Figure 1.1. Histogram – POC

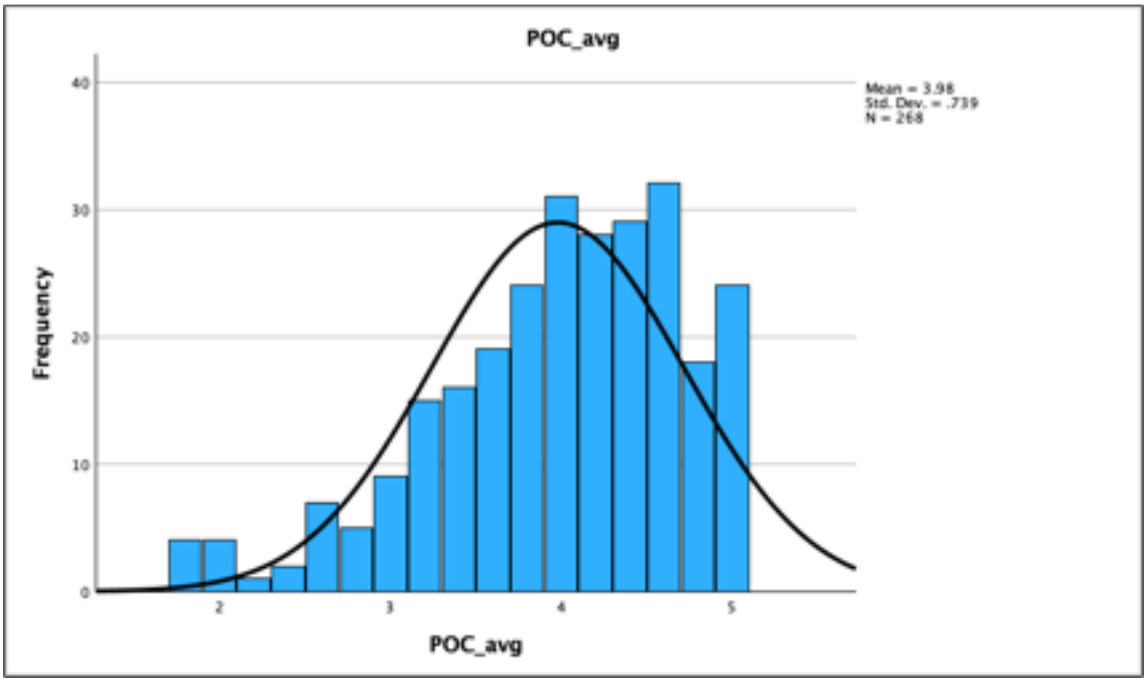


Figure 1.2. Q-Q Plot – POC

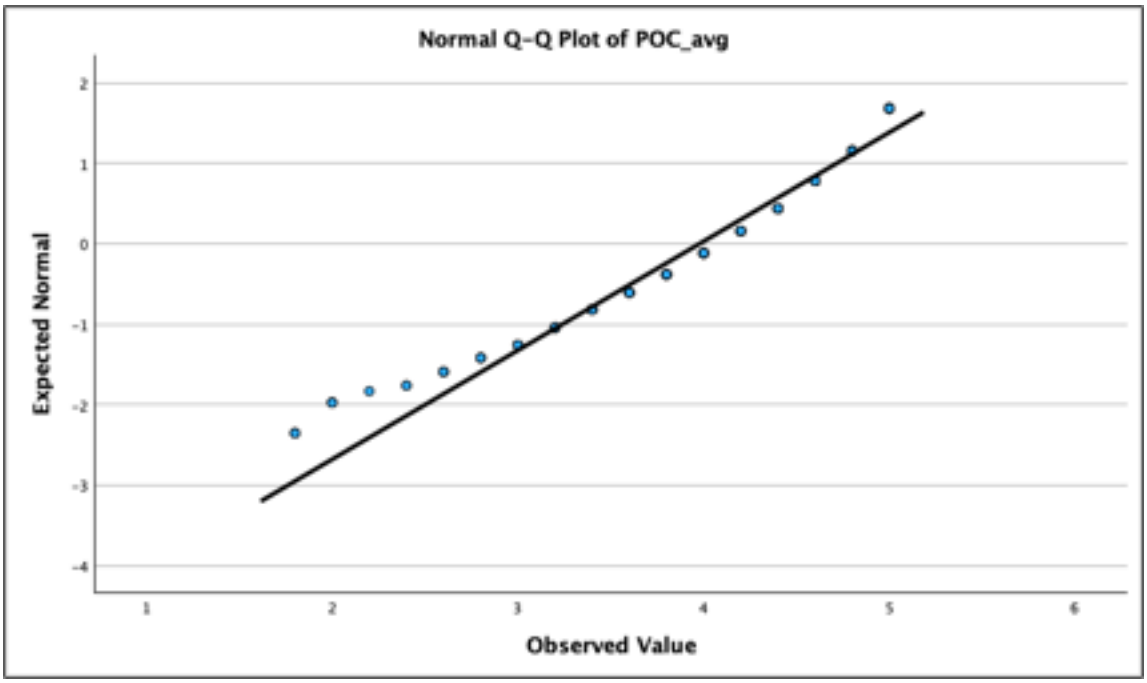
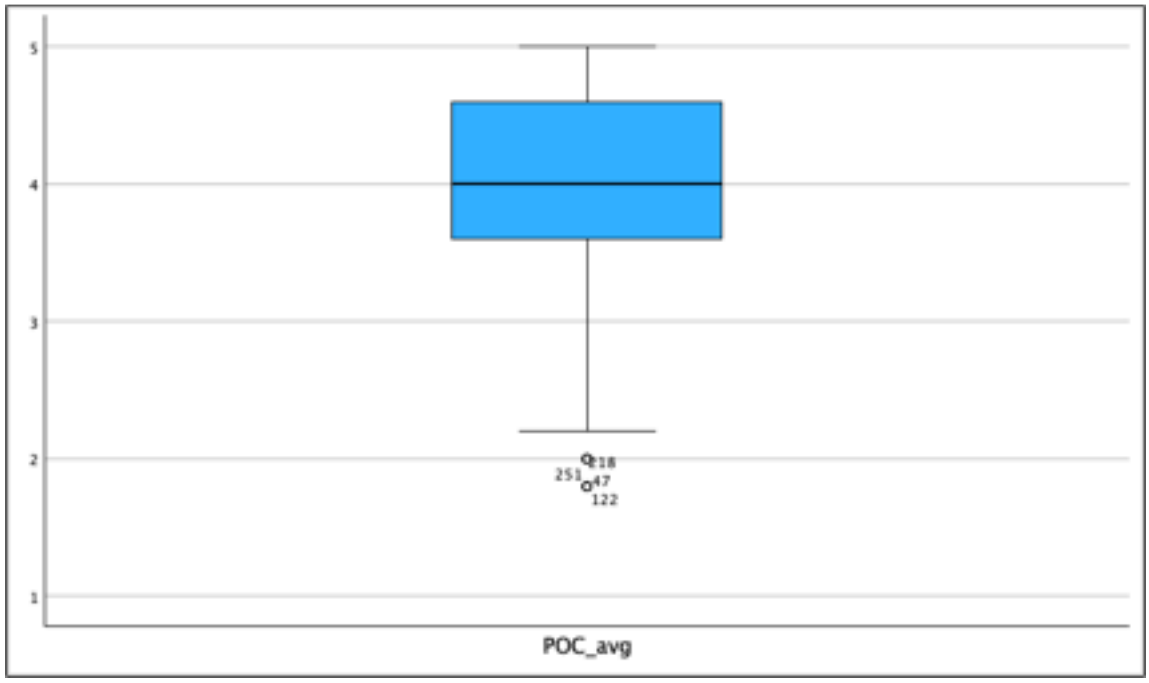


Figure 1.3. Boxplot – POC



4.5. IT Personnel Business Knowledge (ITPBK)

Table 1.1. Descriptives – ITPBK

Descriptives

			Statistic	Std. Error
ITPBK_avg	Mean		4.08	.052
	95% Confidence Interval for Mean	Lower Bound	3.98	
		Upper Bound	4.18	
	5% Trimmed Mean		4.15	
	Median		4.20	
	Variance		.719	
	Std. Deviation		.848	
	Minimum		1	
	Maximum		5	
	Range		4	
	Interquartile Range		1	
	Skewness		-.978	.149
	Kurtosis		.735	.297

Table 1.2. Test of Normality – ITPBK

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
ITPBK_avg	.148	268	<.001	.895	268	<.001

a. Lilliefors Significance Correction

Figure 1.1. Histogram – ITPBK

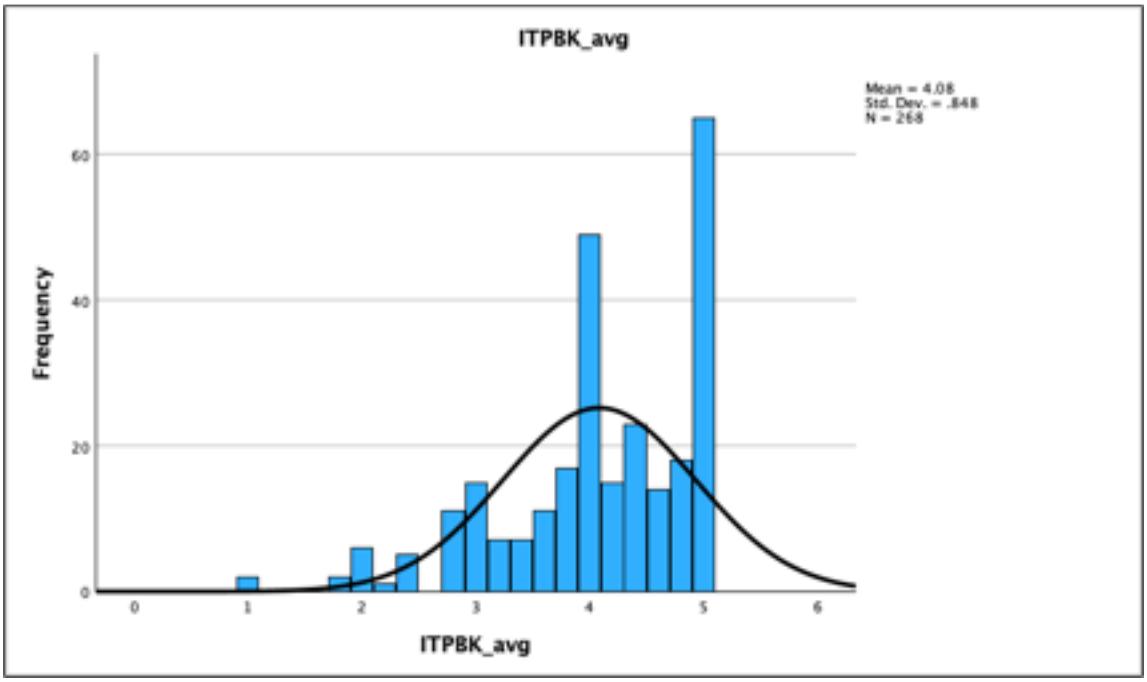


Figure 1.2. Q-Q Plot – ITPBK

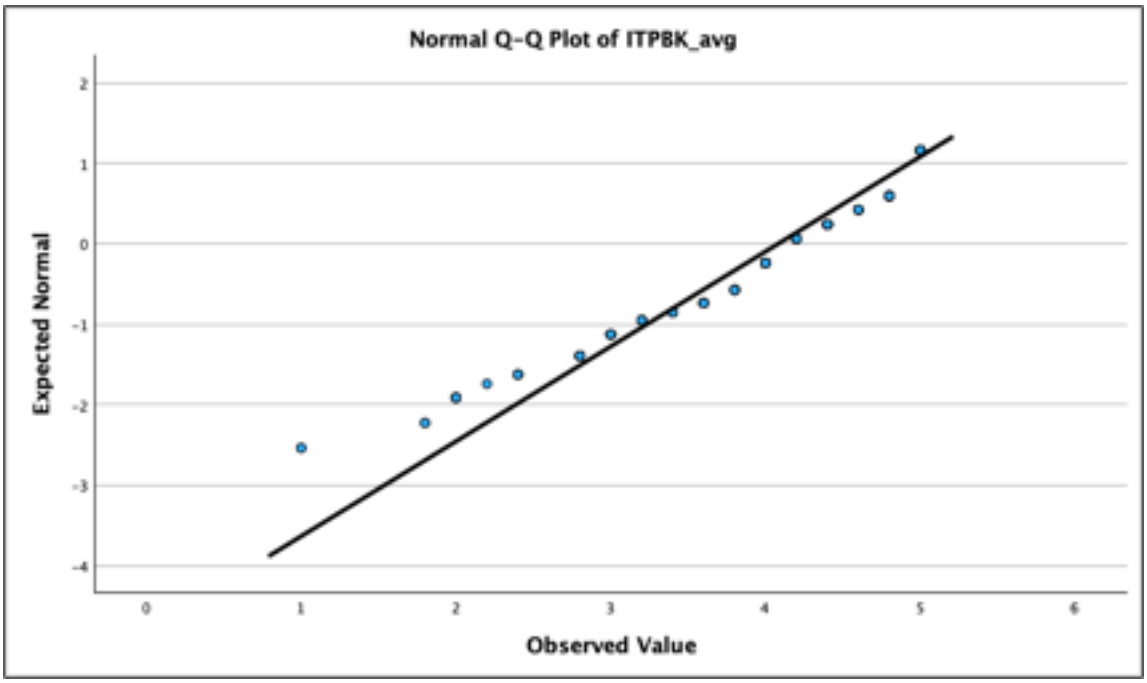
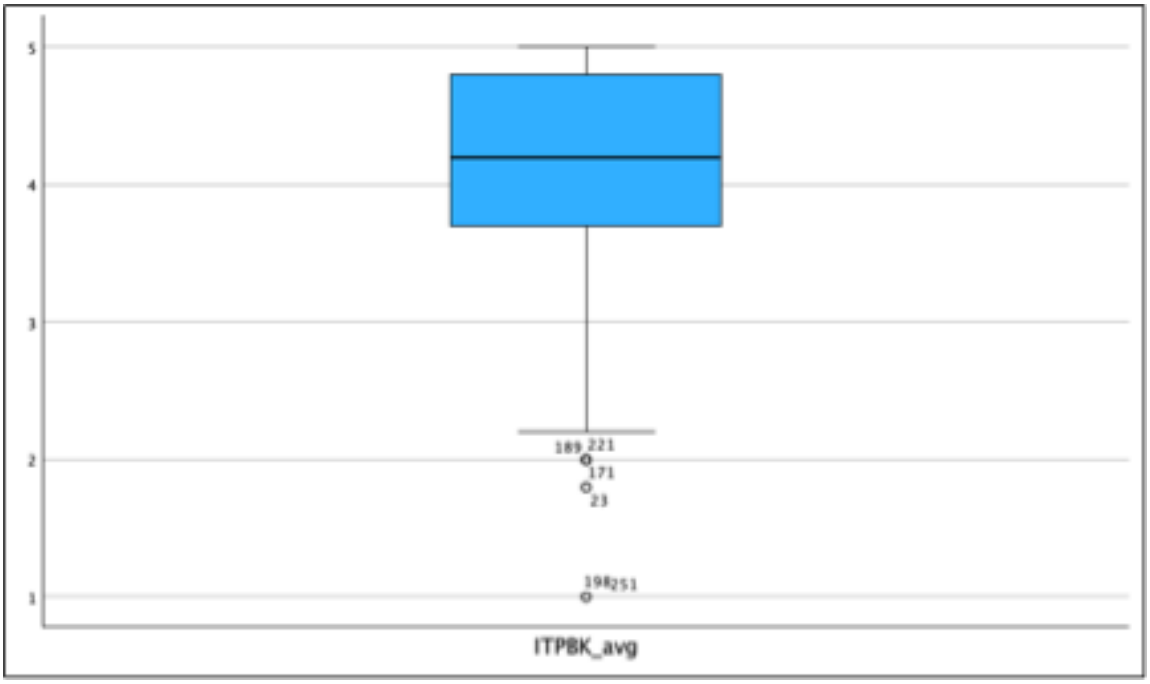


Figure 1.3. Boxplot – ITPBK



4.6. Perception of Readiness (PR)

Table 1.1. Descriptives – PR

Descriptives

			Statistic	Std. Error
PR_avg	Mean		4.14	.039
	95% Confidence Interval for Mean	Lower Bound	4.06	
		Upper Bound	4.22	
	5% Trimmed Mean		4.18	
	Median		4.20	
	Variance		.407	
	Std. Deviation		.638	
	Minimum		2	
	Maximum		5	
	Range		3	
	Interquartile Range		1	
	Skewness		-.712	.149
	Kurtosis		.584	.297

Table 1.2. Test of Normality – PR

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PR_avg	.102	268	<.001	.943	268	<.001

a. Lilliefors Significance Correction

Figure 1.1. Histogram – PR

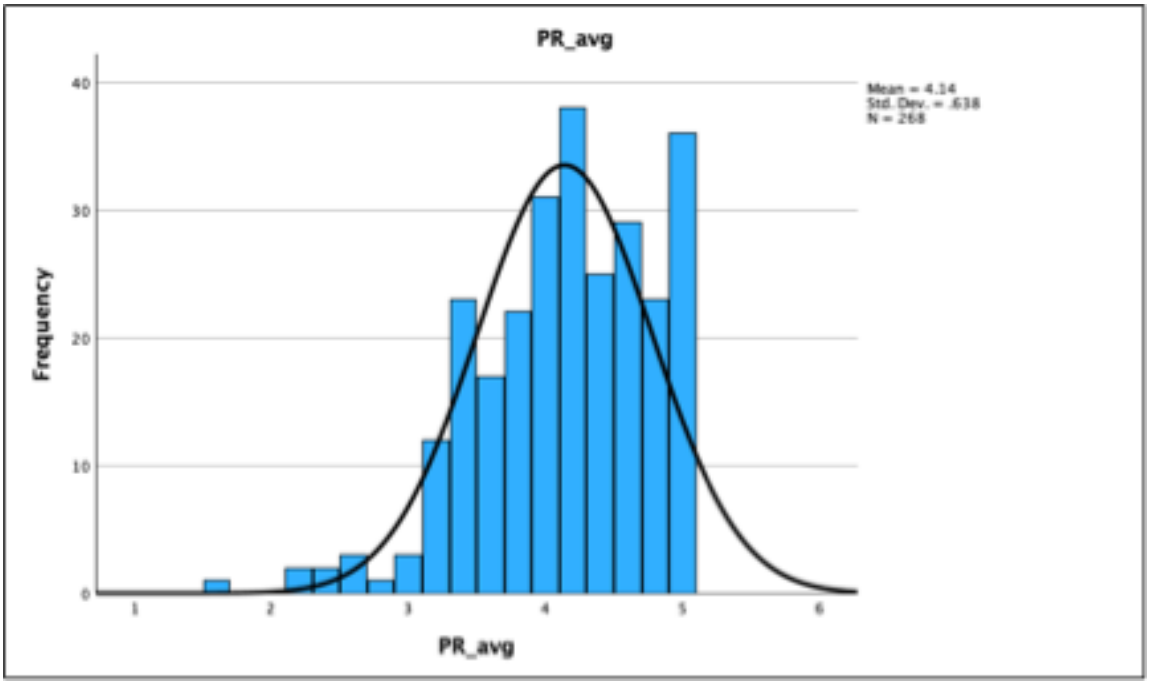


Figure 1.2. Q-Q Plot – PR

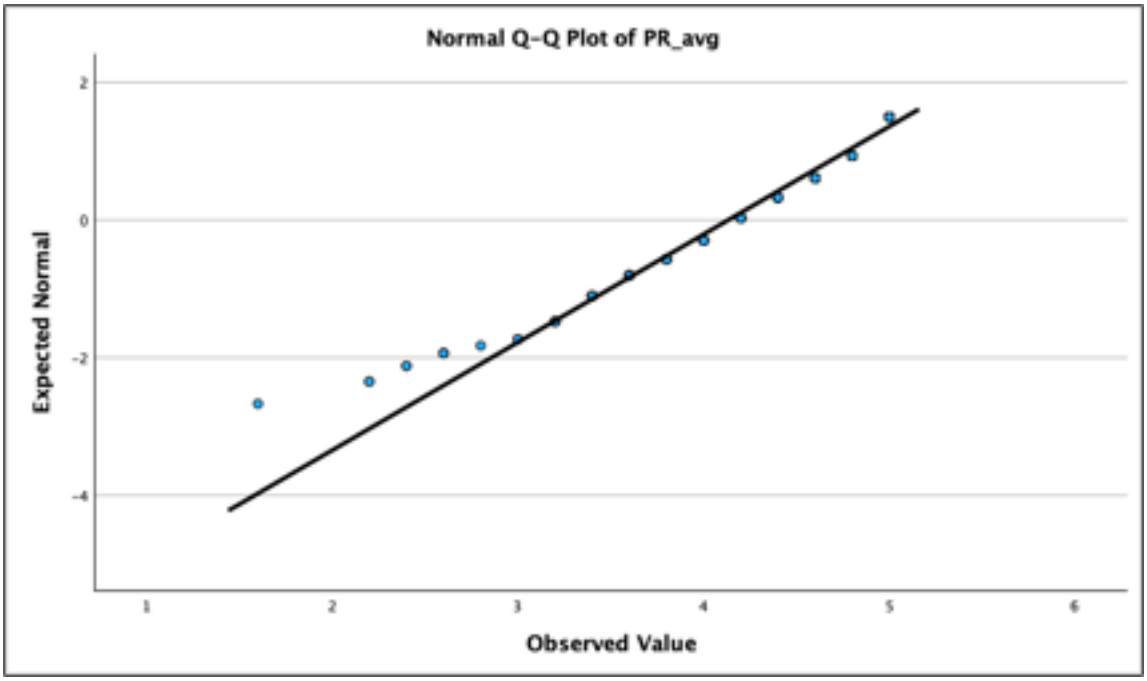
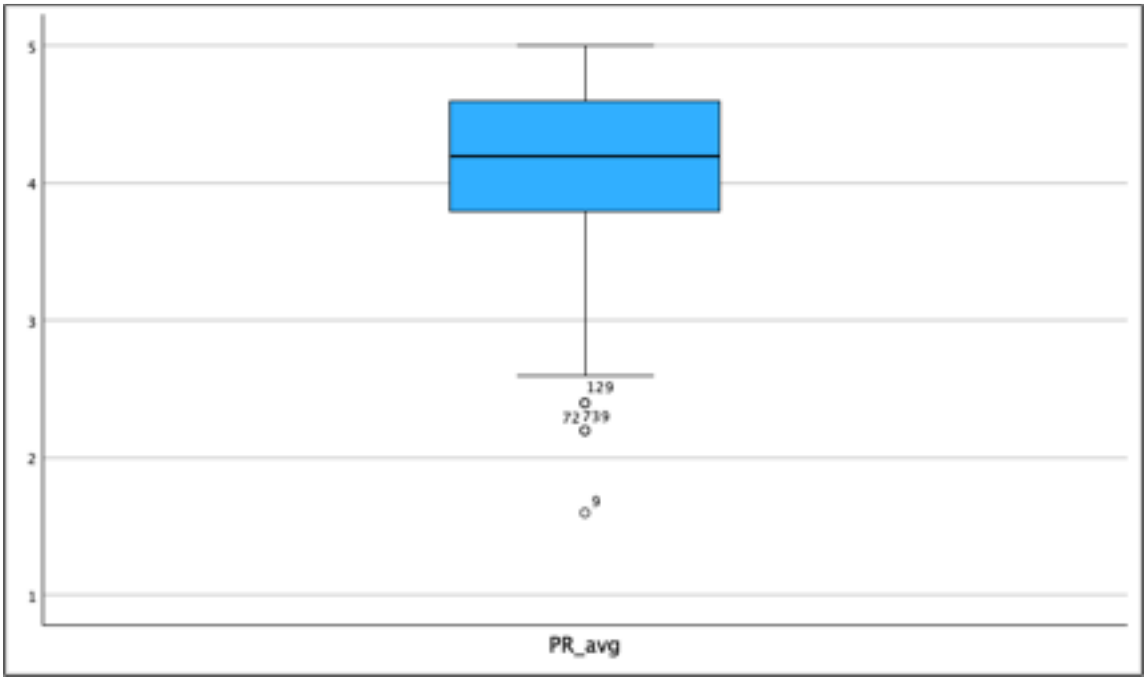


Figure 1.3. Boxplot – PR



4.7. Perception of Need (PN)

Table 1.1. Descriptives – PN

Descriptives

			Statistic	Std. Error
PN_avg	Mean		4.43	.034
	95% Confidence Interval for Mean	Lower Bound	4.37	
		Upper Bound	4.50	
	5% Trimmed Mean		4.47	
	Median		4.60	
	Variance		.304	
	Std. Deviation		.551	
	Minimum		3	
	Maximum		5	
	Range		2	
	Interquartile Range		1	
	Skewness		-.691	.149
	Kurtosis		-.270	.297

Table 1.2. Test of Normality – PN

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PN_avg	.177	268	<.001	.883	268	<.001

a. Lilliefors Significance Correction

Figure 1.1. Histogram – PN

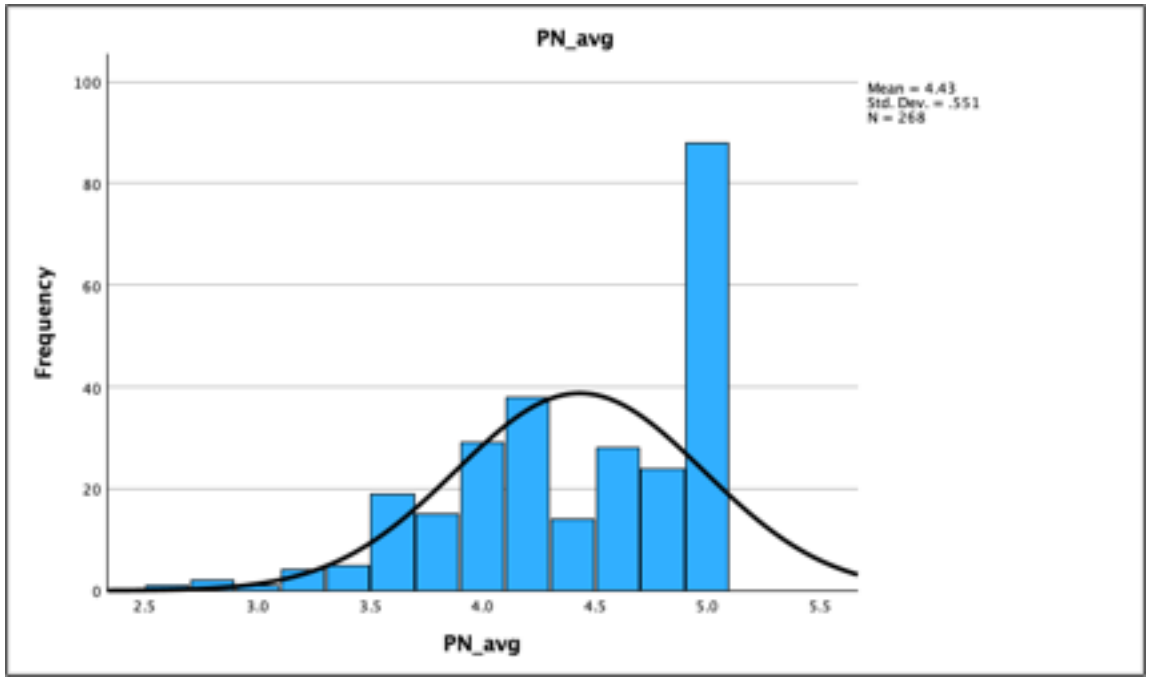


Figure 1.2. Q-Q Plot – PN

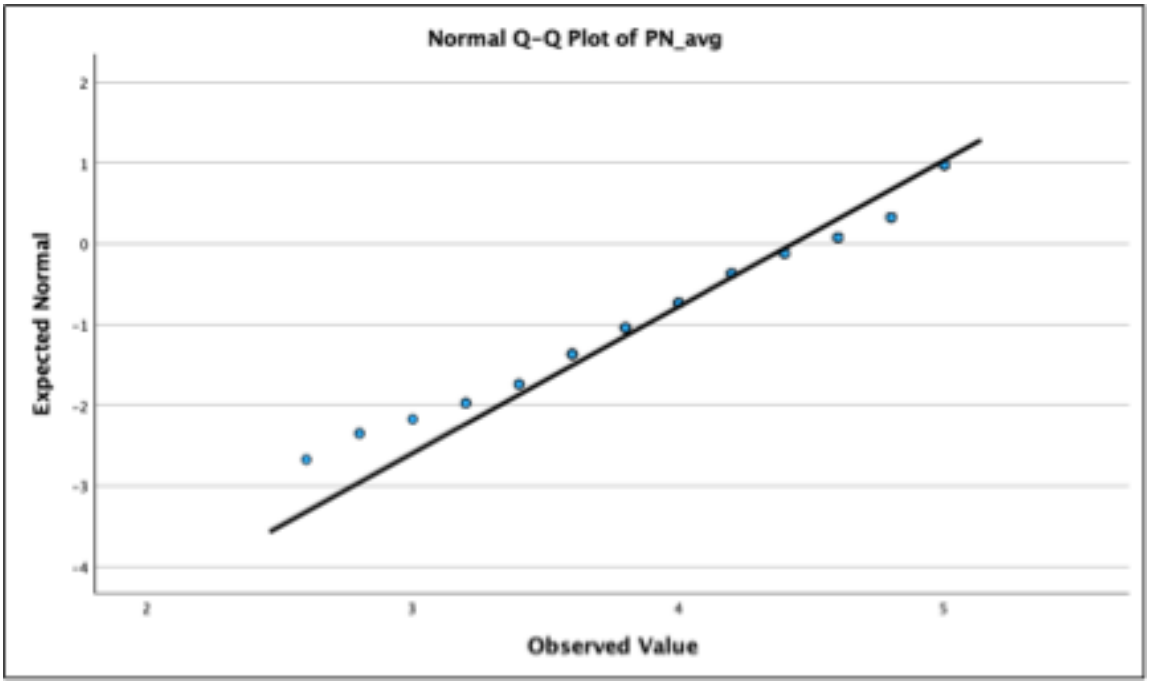
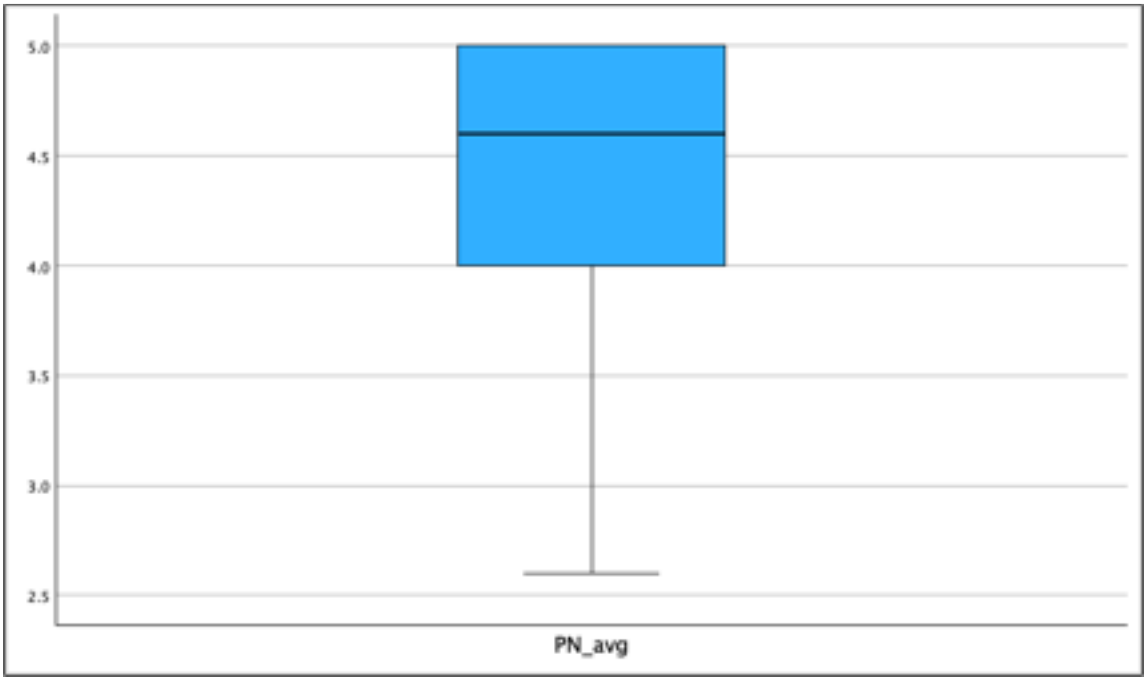


Figure 1.3. Boxplot – PN



4.8.Intention to Adopt Operational Quality Improvement (INT)

Table 1.1. Descriptives – INT

Descriptives

			Statistic	Std. Error
INT_avg	Mean		4.24	.039
	95% Confidence Interval for Mean	Lower Bound	4.16	
		Upper Bound	4.32	
	5% Trimmed Mean		4.28	
	Median		4.29	
	Variance		,413	
	Std. Deviation		.643	
	Minimum		1	
	Maximum		5	
	Range		4	
	Interquartile Range		1	
	Skewness		-,793	.149
	Kurtosis		.866	.297

Table 1.2. Test of Normality – INT

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
INT_avg	.120	268	<.001	.918	268	<.001

a. Lilliefors Significance Correction

Figure 1.1. Histogram – INT

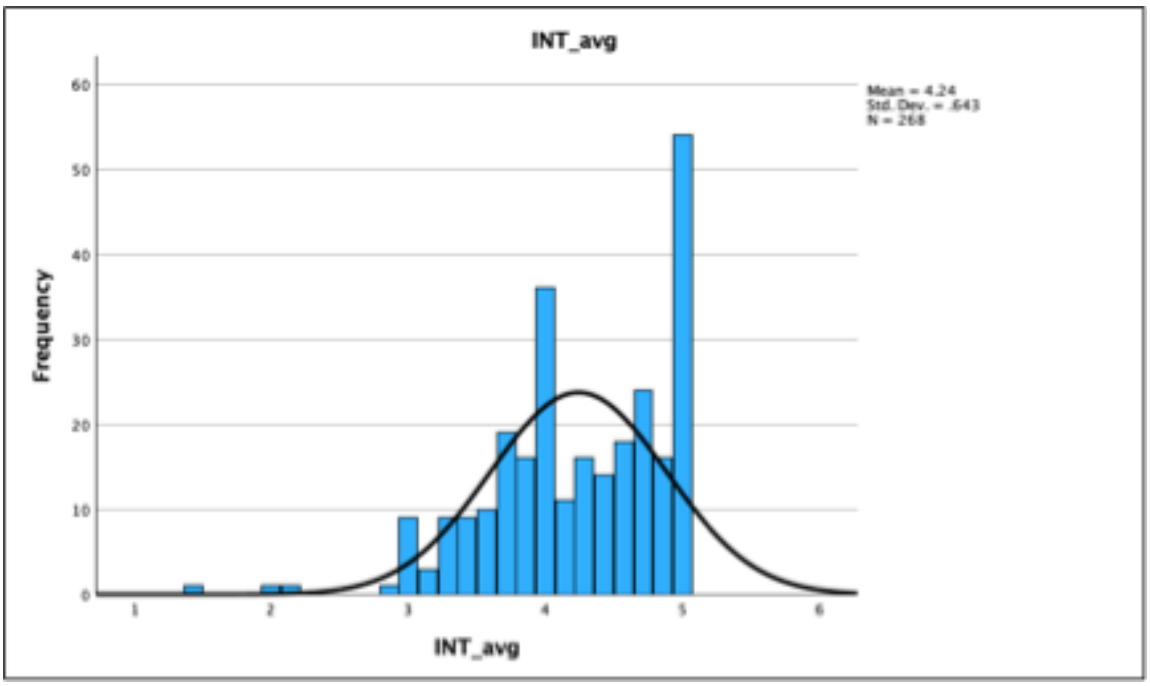


Figure 1.2. Q-Q Plot – INT

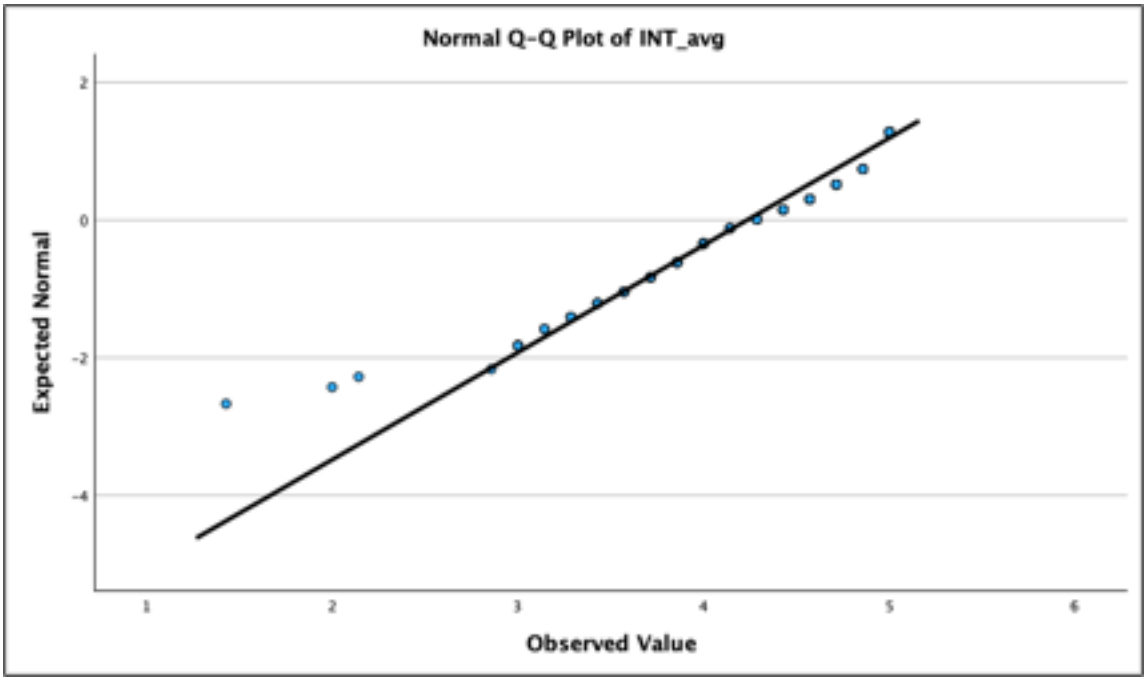
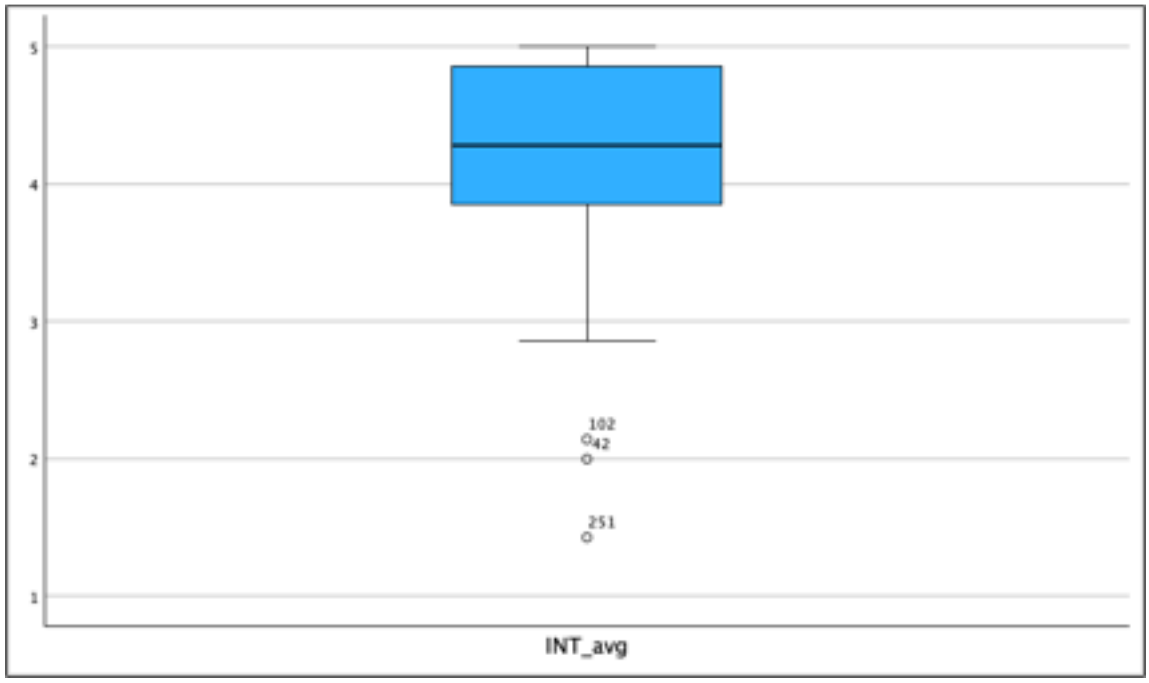


Figure 1.3. Boxplot – INT



VITA

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