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Identifying Factors Associated With Rapid Readmissions in Behavioral Health Organizations

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Abstract

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MS, Capella University, 2015

BS, University of Texas, 2009

Doctoral Study Submitted in Partial Fulfillment

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Abstract

Healthcare reform and changes to traditional reimbursement models have placed increasing pressure on healthcare industry leaders to identify ways of remaining competitive while responding to the challenge of reducing excessive costs. Behavioral health organizations are included in this systemic challenge, and rapid readmissions have been identified as one significant contributor to increasing and unsustainable costs. A qualitative case-study design was used to identify factors associated with rapid readmissions in an inpatient psychiatric hospital. The research problem centered on insufficient information about the rapid readmission population of the inpatient psychiatric hospital involved in the study. Methodological triangulation of data was achieved via semi structured individual interviews with senior leaders, in addition to a retrospective review of administrative and clinical records. The Baldrige Excellence Framework was used to conduct a comprehensive assessment of the organization's effectiveness and strategic context related to providing inpatient psychiatric care. Results indicated opportunities for improvement in using existing patient data to inform treatment decisions and the need for further coordination of care between service providers. Recommendations involved the creation of specific policies and procedures targeted for the readmission population. The results may help behavioral health leaders identify how to improve care while utilizing existing best practices to respond to legislative and reimbursement changes. Reducing readmission rates work toward positive social change as inpatient psychiatric readmission rates have placed an unsustainable financial burden on the national healthcare system.

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Section 1a: The Behavioral Health Organization

Introduction

A privately owned behavioral health organization (BHO) in the southern United States was the subject of this case study and will be referred to as *Organization X* throughout this study. Organization X's mission is to "commit to the care and improvement of human life above all else" (Organization X, 2020). It provides compassionate care and support to adults and seniors with a wide range of behavioral and mental health conditions. Categories of service provision include crisis stabilization, acute inpatient treatment, case management, community outreach, recreational therapy, pharmacological interventions, and psychoeducational services (Organization X, 2020). Services are offered in both individual and group settings, and care plans are determined by patient need, program type, and treatment modality. Organization X is privately owned and has a mixed payor source that includes Medicaid, Medicare, and commercial insurance plans (Organization X, 2020).

Practice Problem

Patients who experience rapid readmission to inpatient psychiatric facilities (IPFs), defined as being readmitted within 30 days of discharge, may suffer from an increase in stigma, disruption of social support networks, and greater dependency on expensive hospital services that are not as cost effective as community-based care (Evans et al., 2017). BHOs would benefit from identifying factors associated with rapid readmissions, both as a financial incentive and to work toward improving patients' quality of life (Akerele et al., 2017). These factors warrant further investigation to help

the organization begin the strategic process of ameliorating risks (Cox et al., 2016). BHO leaders are being held increasingly accountable for patients' post-discharge outcomes, but finding ways to bridge the gap between inpatient and outpatient services can be facilitated only after associated factors for patients at greatest risk for readmission are identified (Boyer et al., 2000).

Identifying factors related to rapid readmissions places an organization in the position to implement strategies aimed at reducing readmission rates by tailoring services for patients at higher risk of readmission (Evans et al., 2017). Additionally, once pertinent client data are extracted and analyzed for commonalities, less common outlying factors can be assessed further with regard to specific diagnoses and treatment modalities. Thus, the following research question guided this case study: What factors are associated with rapid readmissions to IPFs?

Purpose

This study's purpose was to identify factors associated with rapid readmissions to Organization X. The resulting recommendations can be used to expand case-management service offerings, strengthen staff training, and improve operational processes. The study was aimed to provide recommendations on how Organization X can use factors associated with rapid readmissions to tailor services and address unmet patient needs that may contribute to patients overutilizing inpatient care. To achieve this aim, I explored Organization X's existing operational client data to identify factors associated with patients who were rapidly readmitted within a preselected timeframe. These data were combined with individual semi structured interviews with senior organizational leaders to

provide insight into their perceptions of the rapid readmission population. Data sources included existing operational and administrative client data, internal archival data, public resources such as the organization's website, and transcripts from interviews with senior leaders.

This study followed a case-study approach using the Baldrige Excellence Framework (National Institute of Standards & Technology [NIST], 2017). The framework's purpose is to help organizations assess how well they are doing, how they know, and what they can do to improve services (NIST, 2017). This study will help Organization X's leaders gain a better understanding of the factors associated with the organization's rapid readmission population, which may assist them in implementing strategic initiatives to alleviate or minimize rapid readmissions.

Significance

Identifying factors associated with rapid readmissions is of potential value to Organization X because, armed with this information, the organization's leaders can strategically plan how to provide services that effectively ameliorate common impediments that prevent patients from utilizing lower levels of care (Cox et al., 2016). According to Evans et al. (2017), "The identification of the factors associated with rapid readmissions allows servicers to quickly and effectively implement strategies to support those patients most likely to need additional support" (p. 273).

This study is of potential value to BHOs' practices and leadership because rapid readmissions are costly and may be an indication of poor quality of care (Habit et al., 2018). The Centers for Medicare and Medicaid Services (CMS) have designated hospital

readmission rates as a critical healthcare quality metric (Cox et al., 2016), and BHOs are tasked with identifying ways to meet these quality metrics and reduce readmission rates. BHO leaders seeking to understand factors associated with rapid readmission populations may benefit from or increase their effectiveness by accessing this study's results. Behavioral health leaders must also find ways to increase quality of care while cost-effectively meeting legislative standards; this study may be useful in highlighting the importance of understanding BHOs' patient populations (Santosa et al., 2015).

The Institute of Medicine estimated that approximately $765 billion was wasted on excess healthcare costs in 2009 (Ferguson, 2012). Hospital readmissions contribute substantially to this excess cost, and they are a serious public health issue. According to Wani et al. (2019), schizophrenia and psychotic-related disorders demonstrated the highest 7-day readmission rates and second-highest 30-day readmission rates of all hospital admissions in 2014. It is evident that identifying factors associated with rapid readmissions would be valuable to individual BHOs, as well as for society at large. Identifying ways to reduce ever-increasing healthcare costs and providing services to populations at risk of over utilizing expensive treatment could contribute to positive social change. Behavioral health leaders who are successful at reducing readmissions, because they have identified factors associated with populations at risk of readmission, may affect the community positively by establishing effective provider partnerships, implementing services targeted to community needs, and assisting patients at risk of readmission to remain mentally healthy with outpatient care (Evans et al., 2017).

Summary and Transition

The information provided in this section highlights the importance of this study's purpose to identify factors associated with rapid readmissions. This study will allow the leaders of Organization X to gain additional insight into patients who have rapidly readmitted historically and to find commonalities and outlier information that may help them form strategic initiatives aimed at reducing readmissions and overutilization of services. Utilizing the Baldrige framework to analyze practice problem data collected from the organization allowed for a systemic understanding of the organization's overall mission and vision. In the next section, Section 1b, the organizational profile provides an assessment of Organization X's services, leadership, vision, workforce, strategy, and knowledge management. Data collected about the rapid readmission population informed an understanding of the organization's profile, key factors, background, and context.

Section 1b: Organizational Profile

Introduction

Rapid readmissions to IPFs are a growing concern for BHOs as leaders experience increased pressure to identify causes for and reduce the frequency of these readmissions, which represent a substantial cost for healthcare systems; while improving quality of care (Ferguson, 2012). The practice problem identified in this study was Organization X's insufficient information about the rapid readmission population in the organization's inpatient psychiatric and other behavioral health programs. The organization has served its local community for more than a decade, and the facility is part of a larger healthcare network that includes 184 hospitals and 2,000 sites located in 21 states and the United Kingdom (Corporate Profile, Organization X, 2020). This section addresses the organization's profile and key factors, in addition to its background and context.

Organizational Profile and Key Factors

Organization X's profile provides a foundation on which to understand the practice problem and the key factors that I have identified as being strategically important to the BHO's overall purpose. The factors include the organization's structure and consideration of partners, stakeholders, and clients. The practice problem is directly related to the organizational purpose, which is to provide the highest quality of care in the industry. Having insufficient information about the rapid readmission population may hinder the organization's capacity to realize its mission and address issues that may contribute to patients' overutilization of services. I obtained information for this

organizational profile from Organization X's website and from public newsletters, public financial statements, and internal administrative reports, including employee policies and procedures.

Organization X's Profile

As a national leader in healthcare services, Organization X's (2020) parent company proclaims itself to be a learning health system that capitalizes on data collected from approximately 35 million patient encounters a year. It prioritizes data analysis to develop technologies and best practices aimed at improving patient care. Additionally, partnerships with other healthcare systems and government agencies allow the organization to share and coordinate knowledge gains to improve societal care overall. Through employment, investment, and charitable giving, Organization X has maintained a reputation of being engaged with communities and socially responsible. According to the 2019 IBM Watson Health 100 Top Hospitals annual study, cited in Organization X's *2020 Impact Report*, 10 of the nation's best-performing hospitals are part of the research site's larger healthcare system (Organization X, 2020).

Healthcare Service Offerings

The following information, which provides important context for the research site involved in this study, was obtained online (Organization X, 2020). Organization X's stated vision is "to be a world-class hospital," while its mission is to "provide compassionate care and exceptional service to every patient, every day," and "above all else, [to be] committed to the care and improvement of human life." To achieve these goals, the organization seeks to "encompass the ideology of 'the power of one'; values

include teamwork, integrity, communication, ownership, respect and safety." Its mission, vision, and value statements are incorporated into regular meetings and educational materials, ensuring their continued presence in the organizational culture as they are used to remind staff about the importance of collaborative effort.

Organization X offers adult mental health services to diagnose and treat individuals with depression, anxiety, and other psychiatric conditions, including through crisis stabilization, emergency, and inpatient services that utilize a mix of psychotherapeutic, pharmacological, and psychosocial interventions (Organization X, 2020). The facility is part of a larger international healthcare organization, which influences the culture, policies, and procedures of the individual campus involved in this study. The parent company is cited as one of the leading healthcare service companies in the United States, and as of December 2019, it operated 184 hospitals, including 179 general acute-care, three psychiatric, and two rehabilitation hospitals (Organization X, 2020). Inpatient psychiatric services are significant to the organization's success because they make up its primary income source. Organization X receives payment for services from the federal Medicare program, state Medicaid programs, managed-care plans, private insurance, and patients who self-pay (Corporate Profile, Organization X, 2020).

Table 1

Organization X's Vision, Mission, Philosophy, and Values

Element	Content
Vision	To be a world-class hospital.
Mission	Provide compassionate care and exceptional service to every patient, every day.
Goals	To provide exceptional quality and unparalleled service
Values	Encompass the ideology of "the power of one"; values include teamwork, integrity, communication, ownership, respect and safety

Note. Adapted from Organization X's 2020 website.

Key Factors

Organizational Core Competencies

Organization X achieves its commitment to providing high-quality, cost-effective care while growing the business and creating sustainable value for its stakeholders through its core competencies (Corporate Profile, Organization X, 2020). According to its corporate profile, the organization's growth agenda includes several overlapping objectives. Primary objectives include growing the organization's presence in existing markets; achieving industry-leading performance in clinical measures; recruiting, employing, and retaining physicians that meet high quality standards; and maintaining a disciplined developmental strategy (Organization X, 2020). Industry-leading performance in clinical measures was directly associated with the case study's purpose of identifying factors associated with rapid readmissions because readmitting patients within 28 days of discharge is considered a service quality indicator internationally (Duhig et al., 2017).

Organizational Structure

Organization X features the traditional hierarchical structure often found in private for-profit facilities (BH Organizational Chart, Organization X, 2020). Although it is part of a larger healthcare system, the study site is governed by an executive leadership team comprised of executive, medical, and clinical directors who oversee their respective departments. The nursing manager, social work team lead, utilization review (UR) manager, and mental health leads are mid level managers who report to their own directors. While the facility's executive director reports to the division chief executive officer (CEO), there are no corporate leaders or non-psychiatric-focused departments at Organization X's physical location (BH Organizational Chart, Organization X, 2020). Information and systemic changes are communicated from the top down, although frontline employees may choose to participate on several committees, including the Practice Guidance Council, which meets monthly to discuss organizational and/or process-related challenges to obtain employee feedback on ways to improve the organization's effectiveness (BH Organizational Chart, Organization X, 2020).

Clients, Customers, and Stakeholders

Organization X's primary clients are patients who receive inpatient psychiatric care (Corporate Profile, Organization X, 2020). They are segmented into three service groups: adult acute, adult chronic, and geriatric. Patients' families and other support individuals are considered indirect clients and stakeholders who are invested in the care that patients receive. Other customers include community organizations such as nursing homes or outpatient providers who make referrals to the organization when a patient

requires a higher level of care (Corporate Profile, Organization X, 2020). Because Organization X is a privately owned inpatient psychiatric hospital, many overlapping stakeholders must be considered in the decision-making process, including the organization's executive leaders; its workforce, which is comprised of interdisciplinary caregivers; suppliers; patients; and the community. Both customers and stakeholders require that the organization provides safe, effective, timely, and quality healthcare to address its primary patients' needs (Corporate Profile, Organization X, 2020).

Partners

Several suppliers, partners, and collaborators are involved in helping Organization X provide quality care while meeting its customers' and stakeholders' needs (Corporate Profile, Organization X, 2020). Suppliers and vendors include organizations that provide both medical and non medical equipment to the facility, which the director of materials management and plant operations manages, as well as companies that provide basic services to Organization X such as internet, electricity, telecommunication, and maintenance services (Corporate Profile, Organization X, 2020). Partners also include subcontractors who provide security and food services support.

All facility psychiatrists are considered partners because they are licensed independent practitioners who have formal contracts with the organization to deliver direct patient care (Corporate Profile, Organization X, 2020). The facility also partners with local emergency medical service (EMS) agencies and fire departments to improve emergency response systems.

Collaborators are local healthcare organizations such as outpatient providers, therapists, other inpatient facilities, nursing homes, and community outreach programs that refer clients to the facility and work closely with staff to help patients transition to lower levels of care when necessary. Additionally, Organization X collaborates and partners with a local university that provides intermittent support and educational opportunities for students and interns (Corporate Profile, Organization X, 2020).

Organizational Background and Context

Organization X and the healthcare industry as a collective continue to face challenges in providing quality patient care while addressing rising costs and increasing competition for patients (Aagaard et al., 2014; Ko et al., 2015). In its corporate profile, Organization X (2020) acknowledges that admissions, average lengths of stay, and reimbursements are negatively impacted by preadmission authorization requirements, URs, and pressures to maximize lower-cost levels of care such as outpatient services. Additionally, increased competition, admission constraints, changes in legislation that impact healthcare coverage availability, and third-party payer pressures are expected to increase (Corporate Profile, Organization X, 2020). It is strategically prudent for the leaders of Organization X to learn as much as possible about the rapid readmission population so that they may proactively inform decisions to meet these organizational challenges.

Competitive Environment

Organization X operates in a highly competitive marketplace with at least 10 other inpatient psychiatric hospitals within its primary service area, two of which are

identified as primary competitors because of an overlapping geographic service area and the potential for patient migration (Corporate Profile, Organization X, 2020). Relative to the larger geographic market's size and growth, the organization is relatively small in both size and scope of services, as it only offers inpatient services for adults and does not currently offer different levels of care such as outpatient, intensive outpatient, or partial hospitalization (Organization X, 2020). Organization X's leaders expected to address this challenge strategically with the expansion of the organization's behavioral health pavilion, which was anticipated to open on July 8, 2020. This expansion had been completed as of the time of this study, but the new facility had not opened due to organizational constraints resulting from the COVID-19 pandemic. Some competing facilities are owned by physicians or tax-supported government agencies, while many others are owned by not-for-profit entities that may be supported by endowments or charitable contributions and are exempt from sales, property, and income taxes (Corporate Profile, Organization X, 2020). Because such exemptions are not available to Organization X, they may provide not-for-profit entities an advantage in funding capital expenditures. (Corporate Profile, Organization X, 2020)

A fiscally competitive advantage can be found in the facility's designation as a medical-surgical psychiatric hospital rather than a freestanding facility, which is an important distinction when private-paying patients have exceeded their mental health benefits and must receive psychiatric services at a medical-surgical facility that can utilize *medical* benefits (Corporate Profile, Organization X, 2020). Often, competing hospitals refer patients once they can no longer meet criteria for continued stay under

private-payer benefit contracts. Trends toward clinical and pricing transparency may impact Organization X's competitive position in ways that are difficult to predict; for example, hospitals are currently required to publish online a list of standard charges for items and services. In 2019, CMS issued a final rule that, beginning in 2021, requires hospitals to publish additional types of standard charges for items and services, including discounted cash prices and payer-specific de-identified negotiation charges, in a publicly accessible format. Although the 2019 rule is engaged in ongoing court challenges, these trends have the potential to impact organizations' competitiveness (Corporate Profile, Organization X, 2020).

Regulatory Environment

Organization X operates within many local, state, and federal regulatory environments (Corporate Profile, Organization X, 2020. These regulations have an expansive reach and relate to medical care, equipment, operation policies and procedures, maintenance of adequate records, fire prevention, rate-setting, building codes, and environmental protection (Organization X, 2020). The varying requirements are incorporated into the facility's risk-management plan, which requires the risk manager to meet with the CEO and chief operational officer (COO) at least annually to review risk-management issues and provide input on facility, departmental, and medical staff policies that may need updating to ensure continued regulatory and accreditation compliance (Risk Management Plan, Organization X, 2020). The risk-management department helps staff leaders and directors monitor employee compliance and works with the training and

education department to create educational and training materials that address licensure and accreditation processes.

Organization X utilizes an internal education, training, and certification database that assigns all employee trainings, manages individual licensing requirements and expirations, and tracks organizational compliance (Education and Training, Organization X, 2020). Additionally, participation in any federal healthcare programs, including Medicare and Medicaid, is heavily regulated. If Organization X fails to comply with the numerous conditions of participation in these federal programs or performs specifically prohibited acts, participation in these programs may be terminated and civil and/or criminal penalties could be imposed. (Corporate Profile, Organization X, 2020)

Strategic Context

The healthcare industry is changing rapidly, which places many underlying pressures on organizations and their leaders to be mindful of internal and external indications that change may be needed (Soril et al., 2015). Strategic management allows an organization to be proactive while continuously assessing challenges and advantages for opportunities to improve (Johnson, 2009). According to Johnson (2009), strategic management is comprised of the following components: monitoring external environmental elements; evaluating how these elements impact the organization; determining how potential changes align with the organization's mission, resources, and capabilities; and developing an action plan that is specific and adaptive to future considerations. Organization X has capitalized on several areas to maintain its ability to realize its mission and vision (Corporate Profile, Organization X, 2020).

Organization X is in the final stages of a previously announced $52 million behavioral health and rehabilitation services expansion. The organization broke ground in May 2019, with completion targeted for July 2020. The expansion represents a key change that affects the organization's competitive situation because it allows the organization to expand services and opportunities for innovative and creative service delivery (Organization X, 2020). The service line will expand service capacity by doubling the number of inpatient psychiatric beds, while creating an entirely new outpatient service line and providing creative therapy solutions such as an outdoor healing garden (Organization X, 2020). This strategic initiative was implemented in response to changes in the regional marketplace that occurred when two IPFs in the organization's primary service area closed (Corporate Profile, Organization X, 2020).

Strategically, Organization X (2020) anticipates value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to impact a higher percentage of reimbursements (Corporate Profile, Organization X, 2020). This concern further supports the importance of identifying factors associated with the rapid readmission population. If the organization is unable to meet or exceed quality performance standards or fails to coordinate the efficient delivery of quality healthcare services, its reputation may be negatively impacted, it may receive reduced reimbursement amounts, or it could be required to repay payers, all of which may cause a decline in revenue (Corporate Profile, Organization X, 2020).

Performance Improvement System

A performance improvement system describes an organization's plan for continuously improving its service quality (NIST, 2017). Organization X's performance improvement and patient safety plan is located in its internal policies and procedures database. The facility claims the plan was written in accordance with the Joint Commission's performance improvement and leadership standards and is aligned with the organization's vision, mission, and key strategic initiatives (Performance Improvement and Patient Safety, Organization X, 2020). Organization X utilizes multiple ongoing evaluation methods, including in-house patient satisfaction surveys, annual employee engagement surveys, clinical outcomes determined via benchmarking and internal audits, and direct engagement with staff and physicians. Length-of-stay reports, UR denial audits, discharge planning, and physician evaluation audits provide insight into additional service opportunities that may relate to the facility's rapid readmission population (Performance Improvement and Patient Safety, Organization X, 2020). According to Organization X's (2020) performance improvement plan, leadership is responsible for setting expectations, developing strategic plans, and implementing procedures to assess and improve the organization's governance management, clinical, and support processes.

Summary and Transition

This organizational profile, background, and context provided insight into how Organization X operates, governs, and responds to both internal and external challenges. The Baldrige framework was utilized to explore the organization's service offerings,

leadership, workforce, stakeholders, clients, operational strategy, and regulatory environment. Section 2 of this study transitions from a broad overview to an individualized assessment of these previously addressed factors as they relate directly and specifically to the practice problem.

Section 2: Background and Approach – Leadership Strategy and Assessment

Introduction

The study's purpose was to identify factors associated with rapid readmissions at Organization X. The following research question guided this study: What factors are associated with rapid readmission to IPFs? This section of the study reviews previous literature about rapid readmissions and associated topics such as healthcare reform, overutilization of emergency department (ED) services, interventions aimed at reducing readmissions, and patients' views of rapid readmission experiences. Sources of evidence and data-collection methods for the study are identified. A more detailed assessment of Organization X's leadership strategy, governance, and key strategic challenges is also explored in relation to the practice problem.

Supporting Literature

Literature Searches

An exhaustive review of literature is important for conducting case-study research and setting the foundational context from which to understand a practice problem (Simons, 2009). I utilized several sources to identify scholarly literature focused on the topics of rapid readmissions, healthcare reform, organizational contexts influencing BHOs' need to reduce readmission rates, and interventions that BHOs have attempted. I used the Walden University Library's Subject Resources databases, which allowed me to locate databases for further review. Additionally, the Thoreau search tool allowed me to use keywords to search the following databases simultaneously: MEDLINE with Full

Text, PsycINFO, Academic Search Complete, Journals@OVID, and SocINDEX (Walden University, 2017).

I used the following keywords and terms for this study: *rapid readmission, multiple admissions, inpatient, inpatient psychiatric costs, Medicare reimbursement, causes of readmission, reducing costs, healthcare reform, organizational change, behavioral health reform, revolving door admits, behavioral health, strategic initiatives,* and *factors associated with readmits.* Often, I conducted Boolean searches using varying combinations of keywords and terms, and I narrowed down results to include only peer-reviewed journals and articles.

Literature Review

Rapid Readmissions

Rapid readmissions to IPFs can produce detrimental effects for patients, healthcare systems, service providers, patients' families, private and public payers, and communities (Niimura et al., 2016; Santosa et al., 2015; Seow et al., 2018). Although a review of existing literature provided several explanations for the increase in rapid readmissions, the general consensus is that this population is a substantial cost-burden to the healthcare system (Garrido & Saraiva, 2012). Legislative and societal trends toward deinstitutionalization have been prominent in Westernized healthcare systems, resulting in significantly shorter stays in psychiatric hospitals with consistently high occupancy levels (Moss et al., 2014). Evidence related to rapid readmission predictors often varies and is sometimes contradictory, though common factors include patients' previous

admission history; length of stay; medical comorbidities; gender; and marital, housing, employment, and legal statuses (Moss et al., 2014).

Moss et al. (2014) conducted a retrospective review of a standardized data set for mental health patients admitted to General Psychiatric at Sunnybrook Health Sciences Center between April 5, 2006 and October 31, 2008 to determine variables predictive of readmission within 180 days of discharge. Consistent with extant literature, the primary variable associated with subsequent readmission was previous admissions, with patients admitted one or two times in the previous 2 years being 15.6% more likely to be readmitted and those admitted three times or more in the same period being 24.2% more likely to be readmitted (Moss et al., 2014). Contrary to other research, factors such as age at admission, diagnosis, comorbidities, education, marital status, gender, global assessment of functioning, and unemployment were not found to be significant predictors of readmission. According to Moss et al., "The lack of association is consistent with the fact that few factors, with the exception of previous hospital admission, are consistently predictive of readmission" (p. 428).

Identifying factors associated with rapid readmissions helps BHO leaders understand more about a critical population. Equally important is reviewing existing literature that includes experiences of the patients who are identified as being included in this group. Duhig et al. (2017) set out to understand the perspectives and needs of patients who rapidly readmitted to a psychiatric hospital in Australia by facilitating a cross-sectional exploratory qualitative study involving patient interviews. The authors argued that existing literature often did not include service users' perspectives, making it

difficult to assess their satisfaction with admission processes and outcomes (Duhig et al., 2017). The researchers conducted the study at a public mental health organization providing psychiatric treatment to a geographically defined area in Australia serving approximately 330,000 residents. Analysis of the participants' accounts revealed themes, including their perception of admission as a sanctuary, dissatisfaction with the discharge timing and/or process, and disappointment at being discharged with insufficient resources to manage interpersonal and socioeconomic challenges (Duhig et al., 2017). Findings supported previous literature defining readmission as a complex process with overlapping influences and associated factors: "Readmission can be seen as related to sub-optimal environmental and social circumstances highlighting the need for a comprehensive societal response" (Duhig et al., 2017 p. 79).

Readmission and Recurring Emergency Department Admissions

Literature indicates that rapid readmissions are associated with increases in patients' utilization of ED services (Li et al., 2018). Aagaard et al. (2014) set out to identify predictors for frequent visits to a Danish psychiatric emergency room over a 12-year period (1995-2007) while speculating how these predictors may have been influenced by changes in mental healthcare services over time. The authors were interested in incidents of both recidivism (e.g., recurring visitations) and overuse of services (e.g., frequent visits), citing both as being under researched. Aagaard et al. (2014) completed a large-scale registry-based logistic regression analysis combined with a small-scale explorative, interpretive interview study, and they drew research data from the Danish Central Psychiatric Research Register. Most significantly, long-term effects of

deinstitutionalization had increased the burden on emergency psychiatric services, making it more difficult for staff members to provide necessary resources and strategically identify ways to change trends that indicated a continuous increase in service use (Aagaard et al., 2014). According to the authors, there was a 151% increase in individuals with at least one psychiatric emergency visit from 1995 to 2004.

Studies involving recidivism have identified several factors predictive of rapid readmissions, including being male, being younger, having a schizophrenic or other psychotic-related diagnosis, being unemployed, having prior psychiatric admissions, being enrolled in a mental health plan, and self-referring (Aagaard et al., 2014; Santosa et al., 2015; Sori et al., 2015; Wani et al., 2019). Studies of frequent visits to psychiatric emergency services have included the same predicting factors and added patients' homelessness status, unreliable support systems, uncooperativeness, developmental disabilities, and pharmaceutical drug use histories (Aagaard et al., 2014; Roick et al., 2004; Santosa et al., 2015; Seow et al., 2018).

Per Li et al. (2018), "the development of a clear understanding of the drivers of ED use and psychiatric readmission for those with mental illness is of potential benefit to mental health consumers, service providers and health service administrators" (p. 4). These researchers used four datasets including population health administrative records in Australia in coordination with new deidentified information provided to them to gain insight into factors associated with mental health service use. This study was unique because it reviewed readmissions after indexing admission in three different time intervals: 0-1 month, 2-5 months, and 6-24 months. Sociodemographic factors, length of

stay at index admission, comorbidities, psychiatric diagnosis at index admission, and non psychiatric inpatient admissions were all significantly associated with ED presentation and psychiatric readmission across all time intervals (Li et al., 2018). Findings indicate a need for greater emphasis on providing tailored and individualized services in both mental health and primary healthcare environments, a point that has been asserted in previous literature (Li et al., 2018).

Interventions to Reduce Frequent Emergency Department Visits

As previously indicated, rapid readmissions to IPFs contribute to patients' frequent utilization of ED services. Per Ostermeyer et al. (2018), case management has been found to be the most successful intervention to reduce frequent ED visits; however, the authors recognized that more research is needed to determine the influence of other interventions such as patient navigators, internet-based multidisciplinary interventions, ED decision-support programs, and individual patient care plans. According to Soril et al. (2015), between 1% and 5% of the entire patient population seen in the ED accounts for approximately 12%-18% of all annual ED visits in the United States This point directly illustrates how a small population of service users can disproportionately impact the overall healthcare system by incurring excessive costs. Soril et al. (2015) completed a systematic review of published literature that reported interventions aimed at reducing the number of ED visits by frequent users. Three types of interventions were identified: case or care management, individualized care plans, and information sharing (Soril et al., 2015). Case or care management is considered an all-inclusive interdisciplinary approach

to assess, personalize, and inform a patient's healthcare services, with the goal of improving patient outcomes.

Typically, there is a single point of contact assigned to the frequent ED user who coordinates their care. Case-management services vary but typically include referrals to primary-care and other service providers, individual therapy, crisis management, referrals to substance abuse services, coordination of care among ED staff, and assistance with social needs such as stable housing and employment (Soril et al., 2015). Individualized care plans are similar to case-management interventions in that they also involve interdisciplinary staff and strategies such as cross-departmental care meetings, but they often do not involve a designated case manager and are considered less comprehensive (Soril et al., 2015).

Regardless of the differences between them, both case-management and individualized care plans were consistently reported to reduce hospital charges, but with conflicting results regarding subsequent ED utilization reduction. It is important to note that findings have varied with regard to the extent of reductions in charges, with limited evidence to demonstrate whether intervention costs were offset by these reductions. Information sharing was used to describe intervention approaches where patient information was shared among healthcare providers, usually via electronic databases. However, the limited evidence did not result in a significant difference in the number of ED visits between treatment groups, and the researchers were unable to find literature about the potential relationship between information sharing and cost-related outcomes (Soril et al., 2015). In consideration of the data's variability, the authors contended that it

remains unclear which interventions should be considered the most clinically beneficial and cost-effective to decrease frequent ED use, recommending further research. This report indicates the complexity of both understanding the implications of rapid readmissions related to ED utilization and identifying interventions and strategies to reduce service use.

Behavioral Health Reform

According to the literature, behavioral healthcare reform holds significant implications for IPFs such as Organization X and warrants consideration of how it relates to strategic initiatives aimed at reducing healthcare costs (Organization X, 2020). According to Rochefort (2020), single-payer health plan legislation is being considered in 20 U.S. states. Although it is difficult to predict future healthcare reforms, it is prudent for BHO leaders to incorporate these potential implications into business plans and strategic initiatives. Single-payer reform has the potential to improve behavioral health care by reducing out-of-pocket spending, improving access to services, expanding professional autonomy, and supporting the concept of healthcare as a right (Rochefort, 2020).

Bao et al. (2013) reviewed literature on the Affordable Care Act (ACA) healthcare reform models of patient-centered medical homes, health homes, and accountable care organizations. The researchers selected these models for review due to their potential to expand behavioral health services, citing the ACA as adding approximately 3.7 million individuals with serious mental health issues to the health insurance system (Bao et al., 2013). Bao et al. (2013) considered patients' insurance type

when assessing which reform model would best provide necessary behavioral health services, as there are key differences between Medicaid, Medicare, and private-payer plans. According to the authors, Medicaid recipients with behavioral health problems often have a greater need for social and human services than Medicare recipients (Bao et al., 2013).

Sources of Evidence

A case study allows for a comprehensive exploration of a specific project, policy, program, phenomenon, or system in a real-life context (Simons, 2009). The current study aimed to identify factors associated with rapid readmissions in an inpatient psychiatric facility. I conducted individual semi structured interviews with senior organizational leaders to explore their perceptions of factors associated with the rapid readmitting population. I supplemented these interviews with a retrospective records review in which I analyzed the organization's tracked rapid readmissions, thus incorporating existing operational data into the study. Data related to the records review were considered secondary because these data were already available, although not specifically for this study's purposes. Approximately 20% of all Walden doctoral studies are based on analysis of secondary data that were collected originally for non-research purposes (Walden University, 2014). Because this study's purpose was to identify factors associated with rapid readmissions and not to establish causal relationships or test a specific hypothesis, its design was considered exploratory.

I obtained the necessary data by submitting an internal records request to Organization X's information technology (IT) department for clinical information on

patients identified as being rapidly readmitted to the facility within 30 days. In July 2019, Organization X's leaders introduced a strategic initiative within the clinical services and admissions department whereby case managers were instructed to complete short clinical questionnaires about rapid readmissions. Items collected patients' demographic information, legal status at the time of readmit, history of treatment compliance, assertive community treatment (ACT) team assignment, outpatient follow-up, long-acting injectable (LAI) offering, access to transportation, and support systems. I combined this information with currently available rapid readmission reports, which specified payor sources, previous discharge and subsequent admit data, previous admission lengths of stay, and discharge dispositions. Organization X provided me with de-identified information to maintain patients' confidentiality (Patanwala, 2017). I presented descriptive statistics to address the research question and provided a comprehensive overview of the factors associated with the organization's rapid readmission population. According to Patanwala (2017), "Records review studies can be particularly useful in some fields of research involving high-acuity patient populations, where substantial barriers to conducting prospective studies exist" (p. 1859).

Leadership Strategy and Assessment

Responsible Governance

Organization X (2020) provides information on its leadership and governance structure in its corporate governance guidelines, nominating corporate governance committee charter, and code of conduct. The governance guidelines reflect the board of directors' commitment to a system of governance that enhances corporate responsibility

and accountability; and that meets the requirements of the Sarbanes-Oxley Act of 2002, which mandates that the organization disclose whether it has adopted a written code of ethics for its senior financial officers and CEO (Organization X, 2020).

Legal, Regulatory, and Community Concerns

The board meets several times each fiscal year and devotes at least one of these meetings to reviewing long-term strategic plans, including principle issues or potential risks that may impact the organization in the future. This strategy relates to inpatient rapid readmissions because while there is pressure to reduce readmission rates, pending litigation and healthcare reform efforts, including challenges to the ACA, may impact these operations directly in currently unknown ways. However, the board remains responsible for considering possible changes and how they may affect the organization's governance and societal responsibility. According to Organization X's (2020) corporate profile, "Changes by Congress or government agencies could eliminate or alter provisions beneficial to us, while leaving in place provisions reducing our reimbursement or otherwise negatively impacting our business" (p. 33).

Societal Responsibility

Based on its commitment to support the communities served, Organization X leaders initiated an enterprise-wide community engagement pilot in 2019 focused on prioritizing strategies like partnering with community and national organizations to address societal concerns. Some of the organization's national partners include the March of Dimes, American Red Cross, Habitat for Humanity, and the Jason Foundation (Organization X, 2020). These partnerships directly align with the case study's purpose

of identifying factors associated with rapid readmissions, as my goal is to utilize information obtained from Organization X to assess further how this population may benefit from additional services or partnerships with key community providers. Identifying associated factors may provide me with additional insights into community engagement gaps that influence patients' risk of readmission within 30 days of discharge.

Clients/Population Served

Organization X's behavioral health services are separated into categories for adults aged 18 to 55, seniors aged 55 and older, and adults needing dual-diagnosis programming, including those with chemical dependency issues (Organization X, 2020). Currently, the facility offers only inpatient mental health services, but the recent completion of a new behavioral health pavilion will allow it to offer outpatient services as soon as November 2020 (Organization X, 2020). The new behavioral health pavilion is approximately 100,000 square feet and includes a pond with a walking path, an interior meditation courtyard, and an increase from 48 to 80 inpatient beds (Organization X, 2020). Organization X (2020) offers behavioral health services for a variety of mental health diagnoses, including mood disorders, anxiety or panic attacks, suicidal thoughts or feelings, psychosis, trauma, and dementia and/or Alzheimer's disease.

Organization X staff obtain client data throughout the service-delivery process, beginning with preadmission, and they utilize a multidisciplinary approach to documenting, managing, and coordinating information to ensure quality of care (Information Management, Organization X, 2020). The clinical services team is primarily responsible for maintaining processes for collecting data from patients, families,

physicians, and other consumers as necessary. Within 24 hours of a patient's admission to the facility, a treatment manager attempts to contact outside family members or support systems to gather pertinent information, as long as the patient grants their consent to do so. Pertinent treatment information may include psychosocial stressors identified as influential to the current admission, treatment and diagnostic history, family medical and/or psychiatric history, history of treatment compliance or lack thereof, identification of outpatient providers, past medication trials, available support systems, and information critical to establishing a safe discharge plan, such as whether the patient has a safe residence (Organization X, 2020).

Workforce and Operations

According to a document Organization X's chief medical officer (CMO, personal communication, November 3, 2019) sent me titled "Patient Engagement, Experience, and the Price of Quality Care," the client experience is important because it matters to clients and their families, care experience is linked to clinical quality, and client experience is good for business. Clients are engaged throughout service delivery in an effort to build relationships and positively impact the overall care experience. Creating a positive client experience does more than increase satisfaction, however; it also increases capacity, drives down operating costs, improves employee satisfaction, and builds the brand and reputation with consumers (CMO, personal communication, 2019). Therefore, staff are encouraged to talk with patients, families, physicians, and other consumers on a regular basis to elicit questions, concerns, or general comments regarding the quality of services they receive.

Per the resource, effective communication is required to meet the organization's core values of providing quality care, minimizing redundancy, and incorporating client preferences into treatment decisions (CMO, personal communication, 2019). Specifically, effective and meaningful bidirectional client-physician communication is foundational and considered the key component to best-practice care. The resource identifies the following best practices as necessary to engage clients and establish relationships: adjusting vocabulary and use of medical terms to the client's level of understanding, acknowledging and apologizing for delays in service, performing continuous check-ins via rounding, including clients in treatment decisions, taking sufficient time to explain diagnoses, and proactively seeking feedback about patients' perceptions of care throughout their inpatient stay (CMO, personal communication, 2019).

Additionally, all registered nurses (RNs) are expected to perform purposeful hourly rounding, and assigned facility leaders conduct daily rounding, entering the unit to meet with patients, receive feedback, and address unmet needs (BH Best Practices, Organization X, 2020). According to Mahoney (2016), hourly rounding is a patient-centered best practice that involves nursing staff checking on patients at regularly scheduled intervals to address needs intentionally and proactively. All Organization X's units are locked, and mental health technicians, nurses, or treatment managers conduct safety checks at least every 15 minutes, in which they account for each client and document their status. In addition to these safety checks, nurses are required to complete hourly rounding with designated clients for more thorough assessments. Per Meade et al. (2006), purposeful hourly rounding produces positive effects, like increases in patient

satisfaction scores, reductions in patient falls, reductions in call-light usage, and reductions in the distance staff members walk each day. Undeniably, staff being readily available to address client needs and proactively inquiring about services' sufficiency influences client experiences and the organization's ability to build relationships positively.

Analytical Strategy

The study's purpose was to describe and identify factors associated with rapid readmissions to an inpatient psychiatric facility. Qualitative research allowed me to understand the complex phenomenon of rapid readmissions while retrieving data directly from professionals who provide care and from administrative records containing pertinent data. Collecting data from multiple sources was important because it allowed for a complex and multidimensional data-analysis process. According to Morse (2009), mixing qualitative methods allows the researcher to gain different perspectives that might be overlooked otherwise. A qualitative research design aligned with this study's goal to understand further rapid readmissions while acknowledging each patient's individual characteristics.

I conducted an exploratory case study with semi structured interviews of senior leaders to gather their perspectives and input related to rapid readmissions. These interviews were supplemented with a review of existing administrative and clinical records. Using both semi structured interviews and a records review ensured the study had sufficient depth to answer the research question confidently via methodological triangulation (Carter et al., 2014; Ravitch & Carl, 2016). Qualitative research denies the

concept of a universal truth and instead acknowledges and seeks to interpret a phenomenon from multiple perspectives (Ravitch & Carl, 2016). The study was exploratory in nature because it sought to clarify ambiguities, discover multiple realities, and provide ideas for later research (Fusch et al., 2018).

Role of the Researcher

An understanding and incorporation of the researcher's role in the research process is critical to any qualitative study. Researchers must accept that they cannot entirely remove themselves from the research and instead acknowledge how their personal experiences, values, and perspectives can result in biases (Fusch et al., 2018). Qualitative research is an iterative process that demands transparency as it relates to mitigating researcher bias (Megan et al., 2015). Understanding my influence in the research process starts with acknowledging my potential conflicts as a scholar-researcher completing a case study at my current place of employment. In my current professional role at Organization X, I do not provide direct patient care and I am not involved in documenting or tracking any of the information I examined in my records review. Additionally, there was limited risk related to conducting individual semi structured interviews because I am not a member of the target population of senior leaders. I took additional precautions to mitigate researcher bias, including using an interview protocol, maintaining a qualitative reflective journal, and achieving data saturation through triangulation (Fusch et al., 2018; Jonsen & Jehn, 2009).

Participants

I asked Organization X's senior leadership team to participate voluntarily in semi structured interviews that explored their perceptions of factors associated with rapid readmissions. All leaders invited to participate were employed in Organization X's inpatient psychiatric facility and were directly involved in making organizational decisions and designing strategic plans. The following four leaders were invited to participate: the clinical director, executive director, nursing director, and medical director. Although there were additional senior leaders at the organization's corporate level, only those who worked directly in inpatient psychiatric care were considered for this study. This purposeful sampling method included a complete target-population strategy because all the facility's senior leaders were invited to participate in individual interviews (Ravitch & Carl, 2016). Determining an appropriate sample size in qualitative research requires considering the study's nature, access, feasibility, and data saturation (Megan et al., 2015). During the data-collection process, saturation is considered the point at which additional data does not provide new information (Megan, 2015). Since all Organization X's senior leaders were invited to participate in semi structured interviews, there were no additional leadership perspectives to consider.

Procedures

I obtained primary data via semi structured individual interviews with Organization X's senior leaders and secondary data through a review of existing administrative and clinical data. I completed the semi structured interviews and records review independent of each other, I used pattern matching to analyze the semi structured

interviews, and I obtained descriptive statistics from the records review using Excel and second-checking with the Statistical Package for Social Sciences (SPSS). Once I completed these procedures, I used triangulation to bring the data together for comprehensive analysis. This application of triangulation enhanced the study's reliability and enabled me to reach saturation (Fusch et al., 2018). I utilized a qualitative journal for ongoing notetaking and to contribute to the study's iterative process. I revisited and reviewed these notes throughout the research process to monitor study progress and idea development. Preliminary findings and questions from the literature review, challenges in locating organizational data, and insights or ideas that arose from my review of existing patient data were tracked and maintained throughout the research process. Qualitative studies require the researcher to spend significant effort creating a systematic, well-developed data-collection protocol (Megan et al., 2015). See Appendix A for this study's interview questions, which were incorporated into an interview guide aimed at creating a natural flow in the interview process. I utilized a new interview guide for each interview and took notes during these interactions to track questions, observations, and/or clarifying statements.

Semi Structured Interviews

Semi structured interview questions and the process for reviewing existing organizational data were presented in this study's prospectus and approved by Walden University's Institutional Review Board (IRB). I created an interview guide informed by the literature review, and this study's goals resulted in edits to the questions. The guide began with a spoken introduction, review of the study's purpose and interview rules, and

included a confidentiality statement. Although I used the guide as a reference point to keep the questions on track with the study's focus, there was room for improvisation as the need to ask new questions or seek clarification arose. An ideal qualitative interview should feel like an extended conversation, focused but natural, while yielding sufficient insight into the research phenomenon (Megan et al., 2015). Thus, I conducted interviews on-site in a previously identified private conference room that could be scheduled in 30-minute increments. I interviewed each leader for approximately 30-45 minutes, and each interview was recorded, transcribed verbatim, and uploaded electronically for analysis. Transcription was completed within 24 hours of the interview. I purchased a digital recorder prior to the interviews and tested it to ensure clarity of tone and voice, as well as effective playback. In addition to the recorder, I took notes using the interview guide to add pertinent insights. I practiced using the interview guide and recording several times prior to the interviews to build confidence in the interview flow and adjust as needed.

According to Frey (2000; in Carter et al., 2014), the individual interview is one of the most powerful tools for gaining insight into human beings and exploring ambiguous topics in depth. Although this study's focus was on identifying factors related to rapid readmissions, senior leaders were in a unique position to contribute to this research problem because they were directly involved in organizational decisions related to providing a high quality of care while decreasing excessive healthcare spending. Senior leaders are tasked with managing organizational factors while responding to external challenges such as behavioral healthcare reform and adjustments to payor reimbursements. Leaders provided insight into their impressions of factors associated

with rapid readmissions and spoke to how Organization X may utilize the results of this study to influence future decisions. In qualitative research, the intent of individual interviews is not to theorize findings or prove a hypothesis, but rather to explore the intrinsic value participants contribute to understanding research phenomenon from their unique experiences (Saldaña, 2016).

Archival and Operational Data

This study used secondary analysis of existing administrative and clinical hospital data to supplement the semi structured leadership interviews. To address the study questions, I computed descriptive statistics (counts, percentages, means, and standard deviations) using SPSS to identify factors associated with Organization X's rapid readmission population in 2019. I retrieved the study variables for the rapid readmission population from the facility's administrative and clinical databases. I requested permission to gain access to operational data from the facility's clinical director, and I made a specific request to the IT department to compile administrative and clinical data for the previously identified rapid readmission population for 2019. This information was de-identified to protect patients' confidentiality.

Organization X currently documents and manages pertinent administrative data in the intake department and includes the initial flag of rapid readmission status using an automated systemic review of previous discharge dates in comparison to current admissions. Once a rapid readmission is flagged, this information is communicated to the clinical services department and clinicians complete an additional assessment to gather information about the circumstances surrounding the rapid readmit.

Data Analysis

I began the data-analysis process by transcribing the individual semi structured interview responses and entering them into an online secure document with participants' identifying information removed. Each participant was assigned a random number based on the number of interviews conducted and these identifiers were kept in both a qualitative journal and a coding manual that was only be accessible to me. After transcription, I initiated an interpretive process of coding and thematic analysis. In qualitative research, coding supports analysis because it allows the researcher to identify patterns across data sources, relationships within or between data sources, and common themes (Ravitch & Carl, 2016). I read the transcripts initially to organize the data and created preliminary codes that were transferred to a researcher-created codebook.

Coding involves the intentional process of reviewing interview transcriptions and looking for reoccurring phrases, terms, sentiments, or experiences (Ravitch & Carl, 2016). Novice researchers are encouraged to create a codebook because it allows them to track the progression of codes into categories and themes (Ravitch & Carl, 2016). Since coding is considered an iterative process, I read the transcriptions multiple times on different days to ensure I agreed with previously defined codes upon later review. I tracked changes in coding and definitions of themes in the codebook. The final codebook included an organized list of codes, their definitions, and examples of them in the transcripts.

After sufficient coding was completed, I analyzed the data in consideration of existing literature and generated overarching themes. As creating codes and generating

themes is not a precise science, it is critical to check and recheck interpretations against the data to identify possible alternative explanations for or misinterpretations of data (Ravitch & Carl, 2016). I considered themes based on the information explicitly retrieved from the transcriptions and other sources such as previous literature reviews. According to Megan et al. (2015), theme development entails finding common threads between the data that have been previously divided and categorized by codes.

Triangulation

Qualitative data analysis should facilitate an understanding of the research phenomenon within its specific context (Megan et al., 2015). As previously mentioned, methodological triangulation assists qualitative researchers in gathering data from multiple sources to ensure quality and depth of information is available to answer research questions (Ravitch & Carl, 2016). Thus, I reviewed and analyzed the semi structured interviews and retrospective records as complementary sources to gain insight into factors associated with rapid readmissions. I conducted the initial analysis of each data-collection method independently. I gathered the descriptive statistics via Excel and double-checked manual equations via SPSS from the retrospective records review and identified themes via analysis of the semi structured individual interviews with senior leaders. Once combined via triangulation, the overall data analysis incorporated findings from existing patient data and senior leaders' impressions to provide a comprehensive understanding and response to the practice problem.

Reliability and Validity

According to Fusch et al. (2018), "The importance of triangulation cannot be underestimated to ensure reliability and validity of the data and results" (p. 23). Triangulation adds depth to data analysis, which is especially important in qualitative research that uses multiple data-collection techniques to further understand ambiguous and multifaceted phenomenon (Fusch et al., 2018). Triangulation aligned with the study's goal to clarify and further understand rapid readmissions by gathering multiple perspectives. Therefore, the data retrieved from the records review was supplemented with senior leaders' individual perspectives and experiences in providing healthcare services to the rapid readmission population. Although the data were analyzed separately initially, I synthesized them to identify similarities or differences and to direct future research endeavors. Purposeful sampling also improved validity because it incorporated measures to ensure that only senior leaders who work directly with the rapid readmission population were invited to complete the semi structured individual interviews.

Summary and Transition

This section has described supporting literature that illustrated the relevance of the study's practice problem and the potential benefit of behavioral health leaders proactively and strategically learning more about their rapid readmission population. It provided information about the sources of evidence and analytical strategies, as well as how Organization X's current leadership priorities align with the study's purpose of identifying factors associated with rapid readmissions. I facilitated methodological triangulation by combining semi structured interview responses with a retrospective

records review to better understand the research problem. Organization X's culture encourages innovation and being proactive in recognizing and preparing for situational contexts that may influence the organization's capacity to fulfill its mission. I have also provided literature involving behavioral health reform as an example of this situational context. Section 3 will provide further detail into the case study, including analysis of the organization and knowledge management.

Section 3: Measurement, Analysis, and Knowledge-Management Components of the Organization

Introduction

Along with other BHOs, Organization X is challenged with having insufficient information surrounding its rapid readmission population while acknowledging existing legislative, political, and societal pressures to reduce healthcare costs without sacrificing quality (Rochefort, 2020). This study's purpose was to identify factors associated with rapid readmissions, and to achieve it, I conducted individual semi structured interviews with senior leaders, as a well as a retrospective records review. The records review sample included previously identified patients who rapidly readmitted to the inpatient psychiatric facility from January 2019 to December 2019.

In Sections 1a, 1b, and 2, I introduced the study's practice problem, provided an initial assessment of the BHO involved in the study, and explained the study's analytical strategy. Section 3 expands on the organizational assessment with a comprehensive analysis of Organization X's workforce operations and knowledge management. Evidence for this section was collected from secondary sources, including existing operational and administrative data, archival documents, and public sources. In this section, I will analyze further how Organization X is positioned to address the practice problem of having insufficient information about its rapid readmission population by considering its current workforce environment, operations management, and organizational performance measures.

Analysis of the Organization

Internal processes for continuously assessing its current operating environment via audits and using comparative data help Organization X build and maintain an effective workforce environment. In relation to rapid readmissions, leadership communicates the organization's successes and identifies challenges from comparative data to engage staff in maintaining high performance levels. Additionally, leaders perform internal chart audits and incorporate feedback into monthly rounding sessions with direct reports.

Providing real-time data to employees and being transparent about areas that need further development create a workforce culture that places emphasis on collective learning and accountability (Northouse, 2018). One such resource that Organization X's leaders use to assess daily operations and evaluate the need to improve key services and work processes is the Program for Evaluating Payment Patterns Electronic Report (PEPPER; Potter, 2018). PEPPER provides a summary of provider-specific Medicare data for targeted areas often associated with improper Medicare payments. CMS determines these target areas and includes 3- to 5-day readmissions and 30-day readmissions for IPFs. The 30-day readmission target area is directly related to this case study's definition of rapid readmissions.

Effective Management of Operations

The U.S. Office of Inspector General encourages hospitals to use PEPPER to monitor readmission rates and identify opportunities for workforce improvements related to case management, discharge planning, quality of care, and medical record

documentation (Potter, 2018). It is considered an educational tool that should be used to raise providers' awareness of areas of risk for improper Medicare payments and as an assessment tool to improve key services and work processes. In addition to internal auditing, Organization X uses comparative data such as PEPPER to identify and communicate necessary improvements in key services and work processes (Potter, 2018).

Pre-2019 PEPPERs have been cited as influencing senior management's decision to incorporate the rapid readmission template in July 2019 to create a strategic way of gathering and storing pertinent client data (BH Strategic Initiatives, Organization X, 2020). Utilizing comparative data and internal audits as a means for providing feedback to staff ensures effective operations management. Not only does PEPPER model transparency related to how leaders determine the need for organizational changes, but it also engages staff to think of how their daily practices contribute to the larger workforce environment (BH Strategic Initiatives, Organization X, 2020).

Knowledge Management

Organization X measures, analyzes, and attempts to improve organizational performance through the Professional Practice Evaluation Committee (PPEC), the membership of which includes multidisciplinary senior leaders (Corporate Profile, Organization X, 2020). It is tasked with providing secondary audits and peer reviews for potential quality-related issues identified by the quality/risk management department, which identifies potential performance issues prompted by quality-of-care incidents such as mortality, deviations from standards of care, unexpected or adverse patient outcomes, breaches of medical bylaws, complaints, identified adverse trends, or reviews required by

the Joint Commission and federal or state regulations (Strategy Implementation, Organization X, 2020). Once the quality/risk management department initiates a review, initial clinical information including a brief summary of pertinent data and the reason for review is forwarded to the PPEC and assigned to the senior leader of the respective discipline (i.e., nursing, case management, rehab). After the case is assigned, the PPEC representative completes a comprehensive analysis of all available data, and findings are reported back to Organization X's quality/risk management department and chief of staff (Strategy Implementation, Organization X, 2020). Then, review findings and performance-improvement recommendations are communicated to involved staff. Recommendations may vary from taking no action to modifying current procedures to recommending termination to the executive committee (Strategy Implementation, Organization X, 2020).

Organizational Knowledge Assets

Organization X's management of knowledge assets, information, and IT structure is defined within the internal "Information Management Plan," which describes the processes that staff utilize to obtain, manage, and use information to enhance and improve organizational performance in patient care, governance, management, and support processes (Organization X, 2020). Organization X utilizes an automated information management system that enables data to be combined, allows information to be transferred across different systems, produces reports, and assists in interpreting data over time. Utilizing its electronic health records (EHR) asset, Organization X has already facilitated data sharing between the intake and clinical services departments and updated

processes to identify patients who have been rapidly readmitted as requiring additional assessment. Evidence shows that the EHR's major benefits include increased guideline-based care, enhanced patient monitoring, improved communication, and increase coordination of care (Pantanwala, 2017).

Summary

Section 3 has provided a review of how Organization X tracks data and information on daily operations to assess overall organizational performance. In addition to government resources such as PEPPER, internal audits provide information relating to the rapid readmission population, although it is considered general and high-level. Feedback regarding best practices resulted in leadership implementing a rapid readmission assessment within the clinical services processes in July 2019; however, this information has not been analyzed further. Analysis of the existing archival and operational data served to shed additional insight into specific factors associated with Organization X's rapid readmission population. These data can be used in combination with existing efforts to improve organizational performance based on feedback from existing knowledge assets.

Section 4: Results–Analysis, Implications, and Preparation of Findings

Introduction

This case study involving Organization X, an IPF, was intended to identify factors associated with the organization's rapid readmission population. Being aware of the factors associated with rapid readmissions allows for an organizational assessment to determine service effectiveness related to reducing recidivism (Aagaard et al., 2014). The following research question guided this case study: What factors are associated with rapid readmissions to inpatient psychiatric facilities?

Primary data were obtained via semi structured individual interviews with the organization's four senior leaders, and secondary data were retrieved via a retrospective records review of existing administrative and clinical data. Additionally, I analyzed existing data such as the organization's corporate profile, internal policies and procedures database, senior leader announcements, website, employee engagement surveys, and other relevant internal sources to further understand implications of rapid readmissions as they relate to organizational effectiveness. The records review data were deidentified and spanned the entire 2019 fiscal year. Yin suggested that researchers make use of multiple sources of evidence that converge around the same set of facts or findings for the purpose of triangulation; this is important when using case study as a research methodology as it is still evolving with a paucity of well-defined strategies and techniques (Yazan, 2015).

First, descriptive statistics resulting from the records review will be presented, then a thematic analysis of the semi structured leader interviews will be followed by a review of organizational documents. Finally, the results will be triangulated and analyzed

to identify implications and future recommendations. Qualitative insights gained from both the records review and semi structured interviews are included in the triangulation section. “When research methods are purposely designed to collect some overlapping data, the possibility for triangulation certainly exists and, if the results are convergent, greater confidence may be placed in the study’s overall findings” (Yin, 2013, p. 323). An analysis of case study methods found that those using multiple sources of evidence were rated more highly, in terms of overall quality, than those that used one source only (Yin, 2018).

Analysis, Results, and Implications

Organization X currently documents pertinent administrative and clinical data for admissions the intake department has flagged as rapid readmissions. Case managers must ask specific questions included in a rapid readmission template that focuses on information related to why a patient is readmitted within 30 days of discharge (Clinical Director, personal communication, July 2019). This template was used to identify variables for analysis in the retrospective records review.

Records data were retrieved from all inpatient admissions previously identified as rapid readmissions from January 1, 2019 to December 31, 2019. The template used by case managers was embedded with required fields that needed to be completed before it could be saved; therefore, there were no missing data in the sample obtained from the organization. The sample included 103 adult psychiatric admissions flagged as readmitting within 30 days of discharge. Descriptive statistics were initially computed manually via Excel and the Statistical Package for Social Sciences (SPSS) was used

solely for computational verification as this program is often used for quantitative research (Frankfort-Nachmias & Leon-Guerrero, 2018). Data print outs from SPSS can be located in Appendix B. The following variables were taken directly from the rapid readmission template used by Organization X's case management staff:

- legal status at subsequent readmission (i.e., voluntary, or involuntary)
- whether the patient was offered a long-acting injectable (LAI) at initial admission
- whether the patient was assigned or referred to assertive community treatment (the ACT team) upon discharge from the previous admission,
- whether the patient was compliant with their aftercare appointment from initial admission
- did the patient have a support system involved during initial inpatient admission?

Additional demographic information including age and gender was also included for the analyses. The content included in the rapid readmission template was determined by the clinical team; it reflects items aligned with current measures tracked by CMS in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program and other items deemed important by the team. The IPFQR program is cited as being a quality reporting mandate intended to provide consumers with transparent information related to inpatient psychiatric facilities (CMS, 2020). As CMS (2020) explained,

> "It is also intended to encourage hospitals and clinicians to improve the quality of inpatient care provided to beneficiaries, by first, ensuring that providers are aware

of and reporting on best practices for their respective facilities and type of care" (para. 2).

Records Review Analysis

Of the 103 readmissions, 74% were male and 26% were female (see Table 2), with a majority being between the ages of 46 and 55 (see Table 3). A visual representation of each of the five categorical variables and their associated percentage differences can be found in Table 4.

Table 2
Patient Gender

	Frequency	Percent
Male	76	73.8
Female	27	26.2
Total	103	100.0

Table 3
Patient Age

	Frequency	Percent
18 to 25	5	4.9
26 to 35	21	20.4
36 to 45	21	20.4
46 to 55	30	29.1
Over 56	26	25.2

Table 4
Categorical Variables and Percentage Differences

	Percentage	Percentage	Percentage difference
Legal status (i.e., voluntary vs. involuntary)	57% voluntary (n = 59)	43% involuntary (n = 44)	15%
ACT team designation*	18% assigned (n = 18)	82% unassigned (n = 85)	64%
LAI administration*	26% given LAI (n = 27)	74% not given (n = 76)	48%
After-care compliance*	37% compliant (n = 38)	63% non-compliant (n = 65)	26%
Support system	55% yes (n = 57)	45% no (n = 46)	10%

**indicates review of patient status at initial admission*

Of the variables analyzed, three were highlighted as having the largest percentage difference between each categorical group: (a) after care compliance, (b) ACT team designation, and (c) whether the patient was given or offered a LAI. Visual analysis of the two remaining variables (i.e., support system, legal status) suggested no substantial differences based on categorical percentages. For example, for the support system variable, 57 patients who readmitted reported having a support system, while 46 reported no support system; this reflects an 10% difference. Similarly, 44 of the readmitted patients reported legal involvement, while 59 did not; representing a 15% difference. As can be seen in Table 3, 63% of patients in the rapid readmission population were unable to follow up with their aftercare appointments prior to being rapidly readmitted (N = 65).

There was a small number of rapid readmission patients who were offered and provided a LAI during initial admission. Per Table 3, 74% (*N* = 76) of patients were not provided a LAI during the initial admission, while 26% (*N* = 27) were. Lastly, the number of patients assigned to the ACT team with an outpatient provider was low. Of the 103 rapid readmissions, 82% (*N* = 85) did not have ACT team designations at initial admission, compared to 18% (*N* = 18) of those who did (see Table 3). As can be seen, these three variables represent the larger percentage difference between groups for each category.

Records review data served as an additional source from which to draw information about the rapid readmission population of Organization X. Drawing data from multiple sources allows a researcher to capture case study phenomenon in its complexity and entirety (Yin, 2013). The variables with the largest percentage differences were further analyzed for potential qualitative insights and convergence with data retrieved from the semi structured leader interviews; the exploration of said analysis will be included in the *Triangulation of Results and Interpretation* section. Although the records review and interviews were conducted at separate times, the data collected from both were reviewed as complimentary so as to gain as thorough of an understanding of factors associated with rapid readmissions as possible. The multiple sources of data essentially worked to provide multiple measures and impressions of the same research phenomenon (Yin, 2018).

Semi Structured Leader Interviews

I completed four semi structured, individual interviews in September 2020 with Organization X's leadership team: executive director, nursing director, clinical director, and medical director. The collective tenure of the leadership team with the organization was approximately 32 years, though these leaders' collective experience in the mental health field exceeded 65 years. I conducted interviews in a private conference room after agreeing on convenient times with each interviewee outside my designated working hours. I sent the initial invitation to participate in the semi structured interview with Walden University's IRB-approved consent form. Explicit consent to record the interviews was discussed before starting the interview, with an explanation that recordings would be transcribed. I created an interview guide based on existing literature and the study's research question, allowing room for content improvisation or clarifying questions based on responses obtained during the interview. The interview was semi structured in that it allowed interviewees to expand on topics as they deemed fit with the guide used to redirect to pre determined interview questions as deemed necessary. Member checking, a process of ensuring validity in qualitative research, was completed by providing each interviewee a copy of their transcribed interview to check for accuracy and to clarify points that were not appropriately represented. I completed the initial transcriptions within 24 hours of each interview and there were no requests for changes or edits made by any of the participants. Member checking works toward validity by allowing the feedback from interviewees to ensure that data collection was accurate and reflected their intended messages (Posavac, 2011).

Qualitative research methodologies are still evolving and can be characterized as having varying, and sometimes opposing, protocols for best practices. Yazan (2015) compared the major views of three prominent methodologists: Robert Yin, Sharan Merriam, and Robert Stake; while identifying that epistemological beliefs can influence a researcher's conceptualizations and operations of qualitative studies. Data analysis begins with "playing around" with data while searching for patterns, insights, or concepts (Yin, 2018). In this sense, and taking on a constructivist view more aligned with Merriam and Stake (Yazan, 2015), the qualitative data were analyzed by interpreting the words, meanings, and impressions of participants. I applied a step-by-step process of inductive thematic analysis by familiarizing myself with the data via transcription, coding each individual transcript by grouping statements reflecting similar sentiments, generating categories from said codes, and assigning themes while re-reading transcripts to ensure that they closely reflected participants' actual words.

Specifically, each transcript was printed out and reviewed for general comprehension. I highlighted words, phrases and sentences and added notes reflecting initial impressions and thoughts. This review process served to summarize responses to interview questions, with attention paid to words that were repeated throughout the transcript. After the initial review, a second line-by-line review was completed to consolidate comprehension of content and identify codes (Seet Table 5, Initial Codes column). based on word frequency and content interpretation in notes taken during first review.

Table 5

Excerpt of coded transcript (Participant 3)

Transcript	Initial Codes
Of course, it's important, the issue may not get as much *attention* as it deserves but that's not to say it isn't on our *radar*.	Radar Awareness Priority
Priorities are often reactionary in healthcare, so reducing readmissions are *important*, but they may not be an *immediate priority* because something else potentially has *more immediate consequences* on the organization. It's about *balancing all of these things at the same time*.	Importance Priority Consequences Balancing multiple objectives
At this point I think anyone who has been in this field for any amount of time knows that *readmissions are costly* and facilities are afraid of being *penalized* for behaviors that *may not be under their control*. What can you do? That's what we are in the beginning stages of looking into…. it's on the *radar*…. even if it isn't brought up at every meeting.	Expensive Penalties Negative consequences Radar Awareness
I know we've been using the *rapid readmission template*, that was something we decided was *important to add in response* to the information that is required for reporting to Medicare. The goal was to be *proactive* in trying to *capture some of that data* about our readmission population. *I can't quite say* what is being done with the information in real time, but I know it's available.	Using patient data Proactive vs. reactive Priority Uncertainty Tracking information Rapid readmission template

When line-by-line coding was completed for each transcript, a subsequent analysis compared the designated codes from each interview to identify categories of codes based on similarities across all transcripts. Codes that were not represented in all or a majority of transcripts were eliminated. The resulting codes were sorted into categories based on similarity of content represented. Themes were determined based on review of categories, with more attention paid to the presence of reoccurring categories, and

deductive analysis from the literature review, which had influenced the selection of interview questions. The connection between initial and second level coding to categories and ultimately to themes was documented within the code book and an excerpt can be found in Appendix C. Table 6 provides an example of the relationship between themes, categories, and transcript data.

Table 6

Linkages between themes, categories, and interview data (direct quotes)

Theme	Organizational use of existing patient data	Coordination of care between providers	Challenges to treatment initiatives	Discrepancies between informal and formal organizational priorities
Categories	tracking, rapid readmission template, patient records, screening, monitoring	access to records, continuation of care, maintaining treatment following treatment plans, cooperation, collaboration	non-compliance, support system, housing, follow-up, lack of information	policies and procedures, official changes, discussions amongst smaller teams, relocation, expanding services
Interview Excerpts	"*….the rapid readmission template which is included in the patient record…*" (Participant 2) "*Tracking and keeping up patients at high risk of readmission is the goal*" (Participant 4)	"*hurdles faced by an inpatient facility*" (Participant 3) "*Collaboration with outpatient providers is necessary*" (Participant 2)	"*…can be hard to make decisions without seeing the whole picture*" (Participant 1) "*Issues such as a history of non-compliance and lack of housing...*" (Participant 4)	"*…policy specific to rapid readmissions…can't confidently say one exists yet*" (Participant 1) "*Official changes take time, we are aware of the need though and that's a good thing*" (Participant 2)

According to Saldaña (2016), "In qualitative data analysis, a code is a researcher-generated construct that symbolizes or translates and thus attributes interpreted meaning to each individual datum for later purposes of pattern detection, categorization, and other

analytic process" (p. 11). After initial analysis was complete, I solicited the assistance of an unaffiliated doctoral student from a separate university and who had experience with case studies and qualitative research methods. The de-identified interview transcripts were provided and feedback regarding the codes and subsequent themes was discussed and incorporated; the goal was to address any issues of researcher bias and to validate that selected themes represented participant interview data. Guidance and recommendations from the capstone committee were also incorporated to inform the analysis. Thematic analysis of the interview data revealed the following themes:

- organizational use of existing patient data
- coordination between service providers
- challenges to treatment initiatives
- discrepancies between informal and formal organizational priorities

Organizational Use of Existing Patient Data.

Interview transcript analysis consisted of coding content related to the organization's current utilization of existing patient data. The following keywords were included in this theme: tracking, patient records, monitoring, rapid readmission template, and screening. When asked how Organization X currently retrieves necessary information about its rapid readmission population, leaders were familiar with efforts to collect data on potential factors affecting rapid readmission, but were less clear on when and how that data were currently being used to inform interventions. For example, three participants referenced the recently implemented rapid readmission template used by case

managers but were unable to explain how that information was currently being used. Participant 1 stated,

> Well, I know that leaders have identified the need to find out more about rapid readmissions. If you recall, we created a template specific to rapid readmissions for treatment managers to use when doing initial assessments. We wanted to identify some commonalities between these experiences and track the information for future use. I'm not quite sure if we've gotten to the point of doing anything with the data, but that is the goal.

Participant 2 added, "Anytime something new is introduced, like the rapid readmission template, it takes time to incorporate that into daily practices…. It takes time to go to from monitoring and tracking to actually using the information in a productive way." Another participant further asserted, "The first step was finding out how to get information about patients who rapidly readmit. Now we are in the process of finding out what to do with the information."

Coordination Between Service Providers

Each participant identified challenges associated with coordinating care between different providers, such as inpatient versus outpatient. Codes identified within the theme of coordination between service providers included access to records, continuation of care, maintaining treatment plans, and transparency. Participant 3 shared,

> A major hurdle that we face as an inpatient facility is not having access to outpatient records or knowledge of decisions that impacted the patient's treatment plan. If the doctors aren't aware of what has been done in the outpatient setting, it

> is unlikely they can continue care in a way that doesn't compete with services given in the community. It defeats the purpose.

When asked about the impression that rapid readmissions have on the overall healthcare system, Participant 1 stated,

> I think it's apparent that rapid readmissions affect the overall health system, and not in a good way. This is especially the case when there is lack of coordination between outpatient and inpatient. It can feel like swimming upstream when providers don't respond or provide med records or critical information that can be used to make treatment decisions. Without collaboration and coordination, each rapid readmission is like starting all over in the treatment continuum.

Challenges to Treatment Decisions

Participants made connections between rapid readmissions and challenges that providers face when making treatment decisions. Although challenges to treatment decisions were often discussed as an expansion of the previous themes, coordination of care between service providers and the use of existing patient data, the amount of information related specifically to treatment challenges warranted a unique and separate theme. Codes included in this theme were non compliance, support systems, housing, LAI, follow-up, and length of stay. Participant 4 reported,

> All of these topics are intertwined and play off of one another. If I don't have all the necessary information I need about a patient, like for instance, whether or not they had any recent med changes in an outpatient setting, or even if they were compliant with aftercare appointments, then I'm going to be more hesitant to start

> a new med or offer a LAI. Having a comprehensive picture is critical to the decisions we make. Not to mention, there are only a few days to make these decisions. Length of stay is always on the radar of management, so it's a challenge to determine what is best for the patient but also what is going to be the easiest to maintain when they are discharged.

Participant 2 stated,

> Too often we as providers are held accountable for circumstances that are outside of our control. We are expected to stabilize and get patients back into the community, but it can be difficult to determine how this can best be achieved without having all parts of the puzzle. For example, on most peer reviews, payors are asking if long acting injectables are being offered. Of course, we want to offer meds that can potentially improve compliance, but there is rarely a look back to determine whether a LAI was offered at last admission and the patient failed to stay compliant at the outpatient level. Do we continue to initiate the med over and over again? Each case is different, and there cannot be a one-size-fits-all attitude towards inpatient psych.

Discrepancy of Formal and Informal Organizational Priorities

Codes identified included policies and procedures, official changes, casual communication, and relocation. Each leader participant was able to articulate their understanding that rapid readmissions are important to understand further and should be an organizational priority. However, when asked specifically about their understanding of the organization's priority related to identifying factors associated with rapid

readmissions, there appeared to be ambiguity related to formal organizational priorities. Participant 2 replied, “Of course reducing rapid readmissions [is] important; no one would argue that. However, with the recent expansion and relocation, it may not be considered a priority at this very moment.”

Participant 3 also stated, “I know that we’ve discussed rapid readmissions in huddles and meetings; it has been a hot topic, but a current policy specific to this population…. I can’t confidently say that one exists yet.” Further, Participant 1 responded,

> Change sometimes happens slowly, especially in a large organization where there are competing priorities and areas that may demand immediate attention. Updating procedures and making official changes is the natural next step after identifying something can be improved. So, there may not be anything in the policy and procedure database, but the first step was creating the rapid readmission template and communicating to staff the importance of getting additional information about these patients. The end goal is to further identify how we can do better. That won’t happen overnight; it will take time.

Organizational Documents

Review of the organization’s internal policies and procedures database, 2019 Annual Report, company website, and financial statements revealed a lack of documentation specifically related to rapid readmissions. The internal policies and procedures database was analyzed by entering in key words associated with rapid readmissions; the same database was then utilized to identify references to the organization’s strategic plans and department meetings. The company website was

thoroughly searched for content related to policies, strategy, and risk management, resulting in the extraction of the organization's *Code of Conduct, 2019 Annual Report, and Letter to Stakeholders* (Organization X, 2020). These documents were analyzed by reading them in their entirety and looking specifically for references to rapid readmissions. Analysis reflecting a lack of inclusion of rapid readmissions in any of the organization's formal documentation aligned with feedback received from the semi structured leader interviews. Although leaders referred to the rapid readmission template, no formal documentation surrounded this process. Instead, informal emails were sent regarding the expectation that case managers begin using the rapid readmission template to gather pertinent client data and leaders recognized the opportunity to create official policy surrounding the process.

In October 2020, Organization X leaders were notified of recent legislative changes aimed at reducing rates of individuals cycling in and out of hospitals while utilizing expensive healthcare services (Court Liaison, personal communication, October 2020). This notice was specific to court-ordered mental health services as updated legislature modified various mental health codes to address perceived shortfalls in the healthcare delivery system prompting BH leaders to identify how said changes could directly impact Organization X's service provisions. The updated legislation mandates that all patients who are admitted for inpatient mental health services be assessed by a facility administrator to determine if a lower level of care, such as outpatient services, is appropriate. If this determination is made, the facility is required to notify the court and transfer the patient to an outpatient commitment rather than discharge them back into the

community (Court Liaison, personal communication, October 2020). The correspondence prompted Organization X leadership to review the recent changes and identify compliance status.

After review of this internal communication, I inquired about compliance status with the clinical director. I was informed that the issue was being actively reviewed by senior leadership and risk management to determine how to incorporate the new provisions into daily practices (Clinical Director, personal communication, October 2020). The notice and subsequent review were being prioritized due to the potential of an injunction for violations and civil penalties under the state's Health and Safety Code. The ongoing action plan would utilize help from the state's Behavioral Health Authority to create an assessment plan for determining whether a patient who was previously committed for inpatient services would be appropriate for transition to an outpatient commitment. As of the time of this study, said organization plan was in process and not yet completed.

Triangulation of Results and Interpretation

The current study's purpose was to identify factors related to rapid readmissions at Organization X. Data were retrieved via a retrospective records review, semi structured leader interviews, and analysis of internal organizational documents. Utilizing multiple forms of data collection, and incorporating feedback from an unaffiliated researcher to validate themes from the transcript analysis served as methodological and investigator triangulation. Combing a records review with individual interviews served to provide a thorough understanding of factors associated with rapid readmissions; results and

associated implications reflect an analysis that considered all available data. Analysis of existing organizational documents also informed interpretation by highlighting the existing strengths and available opportunities that Organization X can utilize to further quality of care. Triangulation aims to use different research methods and multiple data sources to provide a holistic understanding (Yin, 2013). Triangulation of data resulted in the following themes: LAI administration, ACT referrals, coordination of care between providers and the creation of policies and procedures specific to rapid readmissions. Table 4 illustrates a visual comparison of data sources across main study themes.

Table 7

Comparison of Data Sources Across Main Study Themes

	Client programs & services (ACT team and LAI)	**Leadership & governance**
Records review	24% of rapid readmissions offered LAI at initial admission 85% of rapid readmissions not assigned to ACT team	Variables indirectly related to leadership and governance (i.e. treatment decisions of MDs)
Leader interviews	Themes included lack of coordination of care between inpatient and outpatient providers Challenges to Tx decisions (i.e. whether to offer LAI) include insufficient patient and/or treatment information	Discrepancy between formal and informal strategic prioritization of rapid readmissions at the executive level
Organization documentation	No specific policies or procedures located related to LAI or ACT referrals	Updated legislation aimed at reducing over-utilization of inpatient care and tasking BH organizations to initiate outpatient commitments

Long-Acting Injectable Administration

Descriptive data indicate that the majority of patients (76%) who rapidly readmitted to Organization X in 2019 were not administered a LAI during their initial admission. Although Organization X offers a range of services on the treatment spectrum, further review of current practices related to LAI offerings is warranted. Upon completing an internal policy and procedure search, as well as thoroughly reviewing the

internal employee intranet and public organizational websites, I was unable to find specific documentation related to LAI use. Thus, the organization's current expectations and barriers related to discussing LAI and medication alternatives with patients are unclear. As previously noted, Participant 4 expressed challenges to treatment decisions including having pertinent treatment information to inform decisions to offer LAIs. Long-acting medications have the potential to support treatment and medication compliance but continue to be underutilized (Robinson et al., 2020). Variances in rates of use of LAIs can be found across countries with the United States reflected as having lower utilization than comparable nations (Robinson et al., 2020). A focused ethnographic study of psychiatrists' and patients' experiences with LAIs found that barriers include providers not discussing medication alternatives with patients, patients being unaware of LAIs as a treatment option, concerns about LAI formulations and effectiveness, and providers' pre-existing perceptions about the likelihood that a patient might reject a new medication (Robinson et al., 2020).

Organization X would benefit from further exploration of current perceptions related to LAIs, as well as industry standards associated with utilization; this is discussed further in Section 5. This may assist Organization X leaders in determining if optimal utilization of LAIs is occurring as only 24% of rapid readmission patients were administered LAIs during initial admission. If protocols, recommendations, and procedures related to a specific service offering are not established, it can be difficult to determine their effectiveness (Northouse, 2018). Gathering feedback from current staff can bring insight into potential breakdowns in treatment. Are patients included in

conversations regarding medication considerations? Do providers feel educated and adequately trained to understand the implications of LAI use? According to Robinson et al. (2020), patients reported feeling a lack of support when making decisions about starting new medications. Additional barriers to LAI administration have been identified within the literature that could serve as areas of further review for leadership, including insufficient provider/patient time to discuss medication options, lack of education and training for support staff such as social workers to support patients in decision making, and uncertainty surrounding payment and reimbursement for LAIs (Agency for Healthcare Research and Quality [AHRQ], 2015; Bauer, 2001; Correll et al., 2016; Robinson et al., 2020).

Assertive Community Treatment Team

Results indicate that 83% of patients who rapidly readmitted to Organization X were not assigned to the ACT team at initial admission. ACT is an evidence-based intervention targeted toward individuals with severe and persistent mental illness. It utilizes an interdisciplinary, comprehensive, and assertive case management model that provides 24/7 access to care and frequent community contacts (AHRQ, 2015; Bromley et al., 2015). ACT's purpose is to provide wraparound services that fully support patients so they do not have to work with multiple providers, which could create a break in care, while managing most psychiatric crises without the need for inpatient hospitalization (AHRQ, 2015). It is important to identify potential reasons for why there is such a small representation of ACT assignments in the rapid readmission population of Organization X. Case managers and discharge planners are primarily responsible for transitioning

patients to lower levels of care and providing aftercare appointments and ACT referrals. I could not locate any established policies in my review of organizational documentation specific to ACT referrals. Therefore, it is unclear what expectations leaders have about referring and determining which patients are appropriate for such services. How should staff determine whether an ACT referral should be made? What is the process once a referral has been sent? Are there follow-up procedures to determine if a patient identified as being high risk for readmission and referred for ACT services was successfully added to the program? These areas warrant further exploration so Organization X's leaders can better understand why there is such low representation of ACT within the rapid readmission population according to the data.

Advantages of ACT have been identified as its consistent ability to decrease hospital admissions and length of stay, ability to keep providers in contact with historically hard-to-engage patients, and positive effect on areas such as patient satisfaction and social functioning (AHRQ, 2015; Bauer, 2001). It is evident that ACT has the potential to reduce rapid readmissions, so identifying specific contextual factors related to the availability of ACT within the community Organization X serves would be prudent.

Leadership and Governance Results

I used semi structured leader interviews and internal documentation specific to leadership and governance to analyze the organization's results. One theme I identified in the leader interviews was a discrepancy between formal and informal organizational priorities. All leaders were able to articulate their understanding and perceptions

regarding the importance of rapid readmissions, but they had difficulty specifying how that importance was represented in official organizational policies and procedures. Data indicates that the organization is in the process of strategically incorporating existing patient data into change initiatives, but this has not yet been achieved. Organization X recently received correspondence from a local mental health authority regarding recent legislative changes associated with rapid readmissions and decreasing recidivism. After speaking with leadership, it became apparent that the organization was not in compliance with the requirements of the legislative changes and leaders found themselves needing to identify and implement new processes. This retroactive response may place the organization at risk for civil penalties and injunctive actions for violations. According to Galli (2018), "Poor delivered organizational policies and a misalignment between top-down and bottom-up philosophies will doom change management attempts" (p. 127).

The evidence I analyzed from semi structured interviews and internal organizational correspondence converges with literature indicating how critical it is for BH leaders to be proactive and committed to compliance with regulatory, legal, and ethical standards (Northouse, 2018). The specific legislation referred to in the correspondence is found in Section 574.061 of the Texas Mental Health Code:

> The facility administrator of a facility to which a patient is committed for inpatient mental health services, not later than the 30th day after the date the patient is committed to the facility, shall assess the appropriateness of transferring the patient to outpatient mental health services. If after the assessment is done and the Facility Administrator believes that outpatient services are appropriate for the

patient, then the Facility Administrator may recommend that the committing court modify the inpatient commitment order to an outpatient commitment order.

The language in the updated legislation refers to involuntary outpatient commitments or OPCs. OPCs are legal orders that compel an individual with mental illness to engage in outpatient treatment to avoid future hospitalization (AHRQ, 2015). It is critical that Organization X immediately identify how to become compliant with current legislation, not only to avoid penalty, but also to realize the vision of being a world-class hospital (Organization X, 2020). Several factors influenced the creation of OPCs, including the deinstitutionalization of individuals with serious mental illness starting in the 1950s, rising hospital readmission rates, and public concern over non-compliance in individuals who are mentally ill (AHRQ, 2015).

Interview data revealed several themes, including a lack of coordination between providers and ambiguity around the official prioritization of rapid readmissions as a strategic priority at the executive level. These themes suggest an opportunity for improved alignment between strategy and operations and proactive internal assessment when state regulations are revised. Leaders are tasked with being proactive and advocating for community and organizational issues that impede the ability to provide quality healthcare. Another theme identified within the semi structured interviews was difficulty accessing pertinent patient data that could inform treatment decisions, an example previously provided by Participant 4 included having insufficient knowledge of recent med changes in the outpatient setting or being unaware of a patient's compliance history. According to the Statewide Behavioral Health Strategic Plan (Statewide

Behavioral Health Coordinating Council [SBHCC], 2019), there exists a current gap within the state healthcare system related to the utilization and sharing of existing patient data:

> Rich data sets exists throughout the behavioral health and other systems, but much is yet to be done toward developing efficient technical and administrative processes to link this information and make it available in useful forms for timely decision making. (p. 38)

BH organization leaders, specifically those employed at Organization X, would benefit from identifying how to address existing gaps and the role they can play in furthering the provision of care within the larger healthcare system. As seen in the data from the semi structured interviews, there exists a current opportunity to further utilize existing patient data in ways that can improve overall care. This feedback converges with the Statewide Behavioral Health Strategic Plan that calls for further utilization and sharing of existing patient data (SBHCC, 2019).

Individuals, Organizations, Communities, and/or Systems

Organization X values its commitment to the larger community it serves and hosts several outreach and community advocacy programs. Programs include a collaboration with EVERFI to provide an interactive mental health and wellness digital education course for middle- and high-school students, annual “Crush the Crisis” events to raise awareness about the dangers of opioid misuse, and charity care for patients who are identified as living at 200-400% of the federal poverty level (Corporate Profile, Organization X, 2020). However, societal responsibility is an ongoing obligation that

requires BH leaders to be aware of how to improve, support, advocate, and partner with its key partners. Integrated behavioral health has been identified as a best practice and developing the capacity to share clinical data in "real time" is associated with organizations' ability to collaborate and coordinate services for patients (SBHCC, 2019). As identified in senior-level interviews, having necessary information at the beginning of treatment has been identified as a challenge. One example is having access to data on specific medications that a patient has tried or is currently prescribed while in the ER and prior to transfer to psychiatric facilities so medication reconciliation can begin at Day 1.

From 2010 to 2017, the state's population increased by 12.6% and it is expected to double by 2050; the population is becoming younger and more diverse, and is increasing at a rate more rapidly than it is for the entire nation (SBHCC, 2019). Therefore, it is necessary for organizational leaders to specifically identify and plan to adapt services to meet its changing patient population's needs. Participating in community conversations with other leaders, attending and educating policymakers on current community gaps, and empowering staff to get involved in volunteer opportunities are all incorporated into Organization X's current model for social well-being.

Potential Implications for Positive Social Change

Identifying factors associated with rapid readmissions has the potential to provide benefits directly to Organization X while contributing to larger positive social change. Patients who suffer from severe mental illness need tailored and specific care that responds to the unique challenges they face. According to Bauer (2001), improving the mental healthcare system is a multifaceted challenge that requires the involvement of

providers from all levels of care. Greater efficiencies in outpatient and community services have the potential to reduce strain on the overall health system as care is provided on a continuum (Bauer, 2001). Consideration of the current study's results and analysis places Organization X in a position to improve effectiveness and accountability for its role in the overall patient experience. How does the lack of referrals for ACT or low administration of LAIs impact patients at the outpatient level? How can the organization become more impactful and assistive in bridging the gap between different levels of care? Although these are organizational questions, the impact of solutions identified to answer these questions have implications beyond the individual facility.

Understanding factors associated with rapid readmissions also places the organization in a position to challenge preconceived notions that readmissions should be considered a negative consequence with financial risk. Criteria for discharge have become overly reliant on legal and insurance systems rather than a patient's actual readiness and/or likeliness of being successful in the community (Bauer, 2001). Identifying factors associated with rapid readmissions can empower organizations to advocate for incidents where rapid readmissions were warranted based on clinical presentation. According to Bauer (2001), "A key consideration for reimbursement systems and for good quality of care delivery is to able to account for when readmission is the correct outcome, one that should not be penalized" (p. 239).

Strengths and Limitations of the Study

Strengths

Qualitative research includes varying data-collection methods that can be customized to fit the needs and address the goals of multiple research questions (Fontana & Frey, 2000). Qualitative data-collection methods include interviews, focus groups, review of documents, questionnaires, observation and field notes, and others (Ravitch & Carl, 2016). Utilizing multiple forms of data collection, including semi structured leader interviews, a review of existing patient records, and a review of organizational documentation, strengthened this study's ability to fully explore factors associated with rapid readmissions. Individual participant interviews are commonly found in qualitative research because they allow the researcher to gather specific information about the subjective experiences, beliefs, values, and meaning-making processes of those directly involved in the phenomenon of interest (Ravitch & Carl, 2016). Utilizing multiple data-collection methods allowed for methodological triangulation, which has also been determined to help achieve data saturation and enhance a study's reliability (Fusch et al., 2018; Jonsen & Jehn, 2009).

Limitations

There are several limitations associated with qualitative research worth noting and that are applicable to the current case study. Primarily, qualitative research can be difficult to replicate due to the unique nature of the specific phenomenon being studied. Factors that influence the rapid readmission population of Organization X may not be generalizable to other inpatient psychiatric facilities. Additionally, I worked as the sole

researcher/student scholar and therefore did not have the opportunity to utilize another researcher for data analysis to ensure objectivity of results and interpretation. Rapid readmissions are influenced by various factors that were outside the scope of this study, such as quality of outpatient treatment, homelessness, transportation availability, psychiatric bed availability, and utilization review policies related to admissions (AHRQ, 2015; Bromley et al., 2015; Correll et al., 2015). It must also be noted that the information obtained via the records review was limited to what was already available based on existing organizational documentation parameters and, therefore, limited what could be fully explored. Limitations also include having a small sample size and no follow-up period regarding ongoing issues related to legislative compliance (Bauer, 2001).

Summary and Transition

Section 4 provided a comprehensive analysis of results from data collection and the organization's service offerings, leadership and governance, and potential implications for positive social change. Other areas were also included, such as the study's strengths and limitations, unanticipated outcomes, and areas for further exploration. Utilizing multiple data-collection methods provided an abundance of data to analyze and places the organization in a good position to address the practice problem of having insufficient information about its rapid readmission population. In the next section, Section 5, I will further the conversation by discussing the impact of findings and subsequent recommendations for Organization X.

Section 5: Recommendations and Conclusions

Identifying factors associated with the rapid readmission population of Organization X, an IPF, was the purpose of this study. Identifying these factors is beneficial in that they may provide insight into how the organization can strategically tailor services so as to effectively address common issues that influence a patient's likeliness to readmit. Primary sources of data were retrieved from individual senior leader interviews which were supplemented with secondary data from records review. The individual interviews and records review were analyzed along with existing organizational data including internal policies and procedures, the corporate profile, the organization's website, Code of Conduct, 2019 Annual Report, and internal communications from leadership. Thematic analysis of the interview transcripts and descriptive statistics of the records review were triangulated with analysis of existing organizational data to identify study themes and findings. The study's results were discussed and analyzed through the lens of the Baldrige Excellence Framework (NIST, 2017). The Baldrige framework can be utilized to help organizations determine how well they are accomplishing their mission and vision while identifying areas of opportunity to further develop in addressing organizational needs (NIST, 2017). This framework is used to facilitate discussion of recommendations for Organization X.

BHOs are tasked with responding to both internal and external challenges that require organizational learning, agility, and flexibility. Rapid readmissions are a relatively new quality metric receiving increasing attention from legislators and payors (Zayas et al., 2013). According to the IPFQR program, managed by CMS, Organization

X's 30-day readmission rate is worse than the national rate (Hospital Compare, CMS.gov, 2020). It is evident that the organization would benefit from addressing the existing problem of having insufficient information about patients who readmit within 30 days. Therefore, the following recommendations are offered based on insights from this case study related to factors associated with the organization's rapid readmission population.

Study Themes and Organization Recommendations

Recommendation 1: Formal inclusion of LAI and ACT considerations into Policy

As evidenced from analysis of the individual leader interviews and review of organizational documents, rapid readmissions are currently not specifically represented in policies and procedures of Organization X. Although organizational leaders recognize the importance of further understanding factors associated with rapid readmissions, as noted during study interviews, this is not currently reflected in the organization's documented strategic initiatives. It is recommended that the leaders of the organization create official policies and procedures based on findings of factors associated with the rapid readmission population. Records review data indicated an opportunity to further evaluate current service provisions related to both ACT team referrals and LAI offerings. New policies might involve expectations surrounding ACT referrals within the clinical department or considerations for LAI administration by medical staff. The ultimate goal would be to eventually incorporate rapid readmissions into the larger organizational strategic plan. An effective strategic plan includes action items that delegate responsibility, a timeline for completion of goals, and a list of resources needed to

implement identified strategies (McNamara, 2006). Incorporating LAI and ACT team considerations into official policy emphasizes the importance of utilizing patient data to further develop services and work towards improving quality of care. It would be the first step in incorporating the reduction of rapid readmissions into strategic initiatives.

Leaders within the organization have previously created and implemented a rapid readmission template aimed at providing additional information about patients identified as having rapidly readmitted. Although this is a positive step towards learning about and addressing the causes of readmissions, a comprehensive action plan targeting reduction of readmissions is needed to address this complex problem (Hadley et al., 2011). Strategic planning helps the organization to focus attention and resources towards goals and strategies that will help the organization grow, progress, and adapt successfully in the constantly changing national and global environments. (Zomorrodian, 2017). It is recommended that initiatives be developed to ensure that each strategic objective is translated from paper to action. Hadley et al. (2011) noted that such implementation efforts should include action plans that define the initiative in terms of deliverables, project team, key activities, resource requirements, performance metrics, and a timeline of key milestones. The authors also suggested that, when possible, the activities of the initiative should be integrated into existing processes and procedures.

Recommendation 2: Utilize best practices to address challenges to treatment initiatives

A comprehensive theme identified within Section 4 was challenges to treatment decisions; study participants relayed a significant amount of information related to

treatment challenges including history of noncompliance, support systems, length of stay, and coordination of care between providers. Treatment challenges that impact a patient's risk for readmission are undoubtedly complex and multi layered; however, organizational leaders would benefit from understanding how comparable facilities address some of the same issues. This can be achieved by utilizing literature that reflects best practices. In order to gain a better understanding regarding best practices, organizational learning needs to be embedded within the IPF. This translates to learning being a regular part of daily work, that results in solving problems at the root cause, that focuses on building and sharing information throughout the entire organization, and that is driven by opportunities to implement impactful change resulting from innovation (NIST, 2017).

As previously indicated, assigning patients to ACT teams is an evidence-based practice for the treatment of individuals with severe and persistent mental illness (AHRQ, 2015). Therefore, BH leaders would benefit from further researching best practices and incorporating these into daily practices. Additionally, according to the *Inpatient Psychiatric Facility All-Cause Unplanned Readmission Measure*, created by the Health Services Advisory Group (HSAG) for CMS, transitional interventions including patient education, transition managers, medication reconciliation, and ACT team assignments have been effective in reducing early psychiatric readmissions (HSAG, 2016). Therefore, utilizing current literature and standards associated with best practices for inpatient psychiatric facilities, specifically those targeted towards rapid readmissions, is recommended to inform organization attempts to reduce readmission rates. "Successful

healthcare organizations are continually monitoring the external environment in an effort to anticipate and predict forces of uncontrollable change" (Johnson, 2009, p. 298).

Recommendation 3: Improve Use of Existing Patient Data

The semi structured individual leader interviews provided helpful insight into perceptions regarding Organization X's current efforts to address rapid readmissions. Discussion of the rapid readmission template during the interviews highlighted opportunities for improving how data from this process can be maximized. Although the creation of the template is a good starting place, there is currently no official incorporation of the information obtained within the template to inform treatment decisions. Therefore, it is recommended that the rapid readmission template, and the specific insights gained from its use, be incorporated into individual patient treatment teams. According to Organization X's Interdisciplinary Treatment Plan policy (Organization X, 2020), a comprehensive, individualized treatment plan will be developed for each patient admitted to the unit. This plan should include input from the entire treatment team and will be based on the patient's strengths, abilities, needs, preferences and barriers to progress (Interdisciplinary Treatment Plan, Organization X, 2020). Treatment team meetings at Organization X are held every Monday, Wednesday, and Friday and include the treatment manager, attending psychiatrist, assigned nurse, and mental health technician. Information obtained by case managers, which is included within the rapid readmission template, can be useful within the treatment team to identify specific barriers that prevented a patient from utilizing a lower level of care and led to the patient ultimately readmitting within 30 days. By incorporating the readmission into

individual patient treatment teams, the organization is improving its use of existing data to influence decisions in real time.

Leadership Recommendations

Recommendation 4: Coordination Between Service Providers

Challenges associated with coordinating care between service providers, along the entire continuum of inpatient and outpatient care, were identified as a theme from interviews with Organization X's leaders. Specifically, it was noted that these coordination challenges are believed to be a factor affecting high readmission rates. Strategic partnerships and alliances with other health care organizations can facilitate organizational learning and agility (NIST, 2017). As indicated in the leadership and governance results section, legislative changes related to recidivism and rapid readmissions have recently been put into effect, requiring that BHOs in Organization X's region re-assess current compliance. Cross-agency coordination is also cited in the Statewide Behavioral Health Strategic Plan (SBHCC, 2019) as being critical to improving healthcare. Therefore, it is recommended that the leaders of Organization X collaborate with external stakeholders and other health care organizations, such as regulating agencies, to analyze current processes and identify needed change initiatives to ensure compliance with existing regulatory requirements. Partnerships could also be pursued with local outpatient providers to ensure continuity of care and improvements in provider communication. This may address themes identified within the individual leadership interviews of having insufficient information available to inform treatment decisions such as information indicating whether a patient has had recent medication

changes. External partnerships have the potential to address sector wide issues and can provide comparative performance data (NIST, 2017). The SBHCC (2019) argues for increased coordination of services between behavioral health providers across the continuum of care with the goal of eliminating redundancy and improving the patient experience. Partnering with external organizations to learn more about reducing rapid readmissions could potentially benefit Organization X, but may also have a positive impact at the community and state levels by reducing overall recidivism and associated healthcare costs.

Recommendation 5: Assess Workforce Engagement to Reduce Rapid Readmissions

If the organization is to be successful at utilizing existing patient information to inform treatment decisions with the overall goal of reducing rapid readmissions rates, it will need the buy-in of the entire workforce. Employees are considered internal stakeholders and can be critical in realizing organizational goals and implementing strategic initiatives (Bryson, 2018). Employee buy-in is gained through clear and consistent communication from leaders that explains the logic and benefits of change initiatives (Zomorrodian, 2017). A first step that the organization could take toward improving workforce engagement for reducing readmissions is to assess employee awareness of the organization's goals and priorities related to this population. Group meetings and surveys could be utilized to assess employees' current knowledge regarding readmissions and invite feedback / thoughts on associated factors and potential service improvements.

To understand current workforce awareness and engagement, I recommend utilizing two questionnaires: a) Are We Making Progress? and b) Are We Making Progress as Leaders? (NIST, 2017). Both questionnaires are included within the Baldrige framework and are described as being helpful in checking progress on achieving organizational excellence and improving communication (NIST, 2017). Both tools can be adapted and edited to ask questions specific to readmissions to assess perceptions of leaders and employees regarding the seven Baldrige Criteria for Performance Excellence categories: leadership, strategy, customers, measurement, workforce, operations, and results (NIST, 2017). Analysis of responses can provide insight into areas that need further development and assist in recognizing opportunities for innovation. Data obtained from the assessments could serve as a starting point for developing a plan to improve or sustain employee engagement in reducing readmissions.

Future Studies Recommendations

Organization X's challenge of responding to external pressures related to reducing rapid readmission rates is not unique. BHOs across the nation have similar pressures as legislative and payor requirements related to utilization of care continue to change (Aagaard et al., 2014; Duhig et al., 2017; Niimura et al., 2016). The practice problem that created the need for this study was Organization X having insufficient information related to its rapid readmission population. As this was a single case study, future research should incorporate larger multi case studies to determine if the issue of having insufficient patient data to inform treatment decisions is a broader concern among BHOs. Additionally, although there is an abundance of research that accounts for the immense

cost associated with rapid readmissions (Akerele et al., 2017; Blonigen et al., 2018; Bao et al., 2013; Cox et al, 2016), less is known regarding the impact of payor incentives for reimbursement and financial penalties associated with IPF's efforts to reduce readmission rates. As legislation continues to evolve, it is recommended that future research evaluate whether financial incentives and disincentives faced by IPFs have a significant impact on national readmission rates.

Dissemination of Findings

Findings and associated recommendations will be presented to the leadership team of Organization X via an executive summary and associated PowerPoint presentation. The initial presentation will be completed with the clinical director and assigned committee chair; after this is achieved, I will discuss with the clinical director the best time and opportunity to present findings to the rest of the leadership team. Although the presentation to the organization will include major highlights of the capstone study, the majority of time and focus will be placed on findings and recommendations. Consulting and organizational development presentations should be tailored to the specific audience and provide data that are both understandable and specific (McNamara, 2005).

Summary

This study's purpose was to identify factors associated with rapid readmissions at Organization X, an IPF. Rapid readmission was defined as any readmission within 30 days of a previous discharge. Data were collected via semi structured, individual leader interviews, a retrospective records review, and analysis of secondary organizational data.

Results, findings, and themes were reached via methodological triangulation of these data sources, which also worked to achieve data saturation (Jonsen & Jehn, 2009). Results indicate the need for further coordination of care between providers, improved utilization of existing patient data to identify areas in which to improve services, further research to identify best practices related to LAI administration and ACT team referrals, and formalization rapid readmissions as an organizational priority. Recommendations are provided for Organization X, future research, and for other BHOs. It is hoped that the results of this study can be used by Organization X to improve existing processes and tailor services to address the unique needs of the rapid readmission population.

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Appendix A: Interview Protocol

Interviewer: Hello (senior leader's name/title), thank you for taking the time out of your day to meet with me, it is appreciated. As you are aware, I am meeting with you today as a student/ researcher of Walden University and not as an employee of Organization X. Our interview today will be utilized for my graduate capstone study, but it is important for you to know that any identifying information will be kept confidential and your identify will not be disclosed in the actual study. Your participation is completely voluntary and if at any time you'd like to end the interview, you have the right to do. For data collection and transcription purposes, I will be taking notes throughout the interview but would also like to record the interview. Is that okay with you?

Leader Response:

Interviewer: I will eventually transcribe this interview electronically so that it can be analyzed for recurring themes so I may ask clarifying questions or ask for additional details from your responses as it is important for me to understand what you are communicating. As I previously mentioned, once the interview is transcribed, all of your identifying information will be removed and kept confidential. There is a chance that the redacted transcripts will be shared with my professors or staff with the university however no one from this organization will have access to information that can tie you to the study. Only you have the right to request a copy of your transcript. The interview transcripts will be stored in a safe and secure place for at least 5 years per my university's requirements. Any questions so far?

Leader Response:

Interviewer: The purpose of this interview is to explore your impressions of factors associated with rapid readmissions. As you know, we define rapid readmissions as patients who have readmitted to the inpatient psychiatric facility within 30 days of a previous discharge. As a senior behavioral health leader, your perspective can help shed insight into this population and also into how healthcare organizations are attempting to reconcile providing quality services with minimizing excessive costs associated with rapid readmits. I expect the interview to take approximately 20 or 30 minutes and should not go over 45, are you okay with this?

Leader Response:

Interviewer: We will start with a few background questions to understand your current role and then jump into questions related to the research topic. You can stop and ask for clarification if necessary and provide as little or as much information in response to a question as you deem fit. Any questions?

Leader Response:

Interviewer: Can you start by telling me your title and how long you've worked at Organization X?

Leader Response:

Interviewer: Okay let's move straight into rapid readmissions. As a senior leader, what is your understanding of the organization's priority as it relates to reducing rapid readmissions?

Leader Response:

Interviewer: How do you feel rapid readmissions impact the overall healthcare system?

Leader Response:

Interviewer: From your experience, how does the organization go about getting necessary information about its rapid readmission population?

Leader Response:

Interviewer: In your experience, what are some of the factors you consider being associated with rapid readmissions?

Leader Response:

****clarify information provided thus far and ask questions as necessary.*

Interviewer: What sources of data or feedback does the organization use to determine how well or unwell it is doing in reducing rapid readmission rates? How does it rate performance?

Leader Response:

Interviewer: Is there any other information you'd like to provide regarding rapid readmissions? It can be additional factors that you believe are associated or how the population influences strategic initiatives of the organization. Anything you would like to share.

Leader Response:

Appendix B: SPSS Output

B1 Involuntary or Voluntary Legal Status at Admission

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Voluntary	59	57.3	57.3	57.3
	Involuntary	44	42.7	42.7	100.0
	Total	103	100.0	100.0	

B2 Compliance in Treatment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Compliant	67	65.0	65.0	65.0
	Noncompliant	36	35.0	35.0	100.0
	Total	103	100.0	100.0	

B3 Act Team Assignment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	18	17.5	17.5	17.5
	No	85	82.5	82.5	100.0
	Total	103	100.0	100.0	

B4 After-care follow-up

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	38	36.9	36.9	36.9
	No	65	63.1	63.1	100.0
	Total	103	100.0	100.0	

B5 LAI

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	27	26.2	26.2	26.2
	No	76	73.8	73.8	100.0
	Total	103	100.0	100.0	

B6 Male or Female

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	76	73.8	73.8	73.8
	Female	27	26.2	26.2	100.0
	Total	103	100.0	100.0	

B7 Age Group

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Under 25	5	4.9	4.9	4.9
	26 to 35	21	20.4	20.4	25.2
	36 to 45	21	20.4	20.4	45.6
	46 to 55	30	29.1	29.1	74.8
	Over 56	26	25.2	25.2	100.0
	Total	103	100.0	100.0	

B8 Support System Involved in Treatment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	57	55.3	55.3	55.3
	No	46	44.7	44.7	100.0
	Total	103	100.0	100.0	

Appendix C: Codebook Excerpt

Theme: Organizational use of existing patient data	
Codes	**Tracking / Screening / Monitoring**
Definition	Gathering information from a previously identified population (rapid readmissions) to be used to inform organizational decisions
When to Use	Applies to leadership responses to interview question about getting necessary information about rapid readmissions.
When not to use	Any references not directly associated with using information within the organization such as keeping up with patient's treatment once they are no longer inpatient (see Coordination of Care theme)
Transcript example	"…the goal is to find a way to use the information we have available and somehow incorporate it into current and future treatment decisions" (Participant 2). "..we wanted to find some commonalities between these experiences and track for future use" (Participant 1)
Code	**Rapid Readmission template**
Definition	Referring to the template utilized by Organization X to gather information at initial assessment for patients identified as having rapidly readmitted
When to Use	When identified specifically by a leader within the interview transcript
When not to use	When not identifying current ways the organization gathers data specific to rapid readmission or not identified by name
Transcript example	"…we created a template specific to rapid readmissions for treatment managers…" (Participant 1)
Code	**Patient Records**
Definition	Data available to the organization that identifies and provides pertinent information specific to a patient
When to Use	language assigned to accessing information available to the organization within clinical and administrative records
When not to use	When referring to information available that would not be located within patient records such as public resources
transcript example	"Patient records already provide so much information that can help figure out why a patient may be coming back to the hospital often"