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Hospital Administrators' Strategies for Reducing Delayed Hospital Discharges and Improving Profitability

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This is to certify that the doctoral study by

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Abstract

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MBA, Olivet Nazarene University, 2006

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Doctoral Study Submitted in Partial Fulfillment

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Abstract

Inefficiencies in leadership and limited leadership strategies in hospitals contribute to delayed hospital discharges and an increased financial burden on a hospital. Three administrators from 2 hospitals who are part of a hospital conglomerate in Chicago, Illinois were selected for interview in this qualitative multiple case study to explore how hospital discharge strategies reduce delayed hospital discharges and improve profitability. Contingency was the primary theoretical theory for this study. The purposive sampling consisted of the selections of individual who were knowledgeable and had experience to organize, manage, and implement processes in an organization. Data collection occurred using face-to-face semistructured interviews, direct observation, and a review of discharge documents. Data analysis took place using the modified van Kaam method. Two emergent themes were identified relating to strategies for efficient communications and facilitating effective leadership. Implications for positive social change include the potential to improve health services within the community where access to health care is limited or the need exists for additional hospital beds. Positive leadership strategies in hospitals tend to contribute to the success and wellbeing of employees, patients, communities, and the economy.

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Dedication

I would like to dedicate this dissertation to my daughter, Mackenzie Boyd. I want you to always push yourself to be the best at everything you set your mind to do. It takes much hard work and determination to get through adversity, and as long as you strive for excellence, you can achieve any and all goals you set forth.

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I thank the hospital administration for allowing me to have the opportunity to utilize the facilities for data collection and for understanding the importance of social change. I also thank all others who participated and who were giving of their time. I am grateful for their input, as it served as a basis for the study results. Finally, I thank my family and friends for giving me the encouragement to complete this work.

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Section 1: Foundation of the Study

Delayed discharges cause loss of hospital profitability (Swain, 2014). Delayed hospital discharges increase the length of the waiting list for hospital beds, undermine the efficient delivery of appropriate care, and are not efficient (Harrison et al., 2016; Majeed et al., 2012). Delayed discharge occurs during a hospital episode in which a patient who has been determined to be clinically ready for discharge continues to occupy a bed beyond the ready-for-discharge date (Costa, Poss, Peirce, & Hirdes, 2012). Majeed et al. (2012) defined delayed discharge as the inappropriate occupancy of hospital beds. A patient is clinically ready for discharge when a reliable clinician (in consultation with other agencies) clears the patient to leave the hospital (Costa et al., 2012). In the service function chain, an effective discharge process is essential for smooth operational activity (Koskinen, 2013). Appropriate care and streamlining of processes can create an early discharge and allow a new patient to occupy a recently vacant bed.

Hospital readmissions are costly, and hospital administrators strive to balance deferring discharge with discharging patients prematurely (Suñol, 2014; Swain, 2014). Refining the hospital discharge process has become a primary objective for hospital administrators who seek to identify and implement efficient processes for making the correct assessments and using appropriate leadership strategies to limit unnecessary expenditures (Greysen, Schiliro, Horwitz, Curry, & Bradley, 2012). Timely identification of barriers to efficient discharge can help to reduce a patient's length of stay (LOS), which increases hospital profitability (Hurwitz et al., 2014). The purpose of my study was

to explore leadership strategies that hospital business administrators use to increase profitability by decreasing delayed discharges and LOS.

Background of the Problem

Prolonged patient LOS in hospitals is a major concern for healthcare business leaders because delayed of releases: (a) increase business costs, (b) reduce profitability, and (c) lead to the increases in waiting lists for patient beds (Swain, 2014). Delayed discharges are common; they affect patient flow and increase the costs incurred by the hospital (Costa et al., 2012; Hendy, Patel, Kordbacheh, Laskar, & Harbord, 2012). Patients who remain in the hospital beyond their appropriate discharge date increase the financial burden on hospitals, which results in loss of profit (Majeed et al., 2012). The increasing number of discharge delays has an adverse impact on the overall system, resulting in loss of income (Costa et al., 2012).

Hendy et al. (2012) analyzed delayed patient discharge and discovered that waiting lists for additional inpatient hospital services caused a backup regarding available beds. The backup ultimately resulted in discharge delays. One of the concerns for determining the date of discharge is the exchange of information between hospital staff and physicians (Dobrzykowski & Tarafdar, 2015). A lack of communication leads to poor patient outcomes and the possibility of a prolonged LOS (Dobrzykowski & Tarafdar, 2015). When inefficiencies in leadership cause patients to overstay their time in the hospital, and delays the effective use of hospital beds, this decreases hospital profitability (Shepperd et al., 2013). In contrast, efficient leadership surrounding the discharge planning processes reduces both LOS and unplanned readmissions by

improving coordination of services following discharge from the hospital (Tak, Kulkarni, & More, 2013).

Problem Statement

Hospitals across the United States are experiencing a loss of revenue due to resource mismanagement, most notably regarding unwarranted lengths of stays (Weiss & Elixhauser, 2014). Holland, Pacyna, Gillard, and Carter (2016) reported that hospital discharge delays averaged 23.6 days for hospital patients. Holland et al. found that 61.4% of these patients, determined able to care for themselves at home, experienced discharge delays. The general business problem is that inefficiencies in leadership, which result in patients remaining in the hospital longer than necessary, are a financial burden on a hospital and decrease hospital profitability. The specific business problem is that some hospital business administrators have limited leadership strategies to reduce delayed hospital discharges and improve profitability.

Purpose Statement

The purpose of the qualitative multiple case study was to explore leadership strategies hospital business administrators use to reduce delayed hospital discharges and improve profitability. The target population was hospital business administrators from two hospitals that are part of a hospital conglomerate in Chicago, IL. The hospital business administrators had strategies to reduce delayed hospital discharges and improve profitability. Findings of the study might help hospital business administrators to improve profitability by identifying leadership strategies to reduce delayed discharges. Results

from the study may also contribute to improved patient care, fulfillment of organizational goals through effective leadership, and promote the health of the community.

Nature of the Study

Conducting a qualitative multiple case study allowed for a detailed exploration of the phenomenon of hospitalized patient LOS and the leadership strategies hospital administrators use to minimize inefficiencies in the discharge process and increase business profitability. Qualitative research methods are appropriate for use in studies that benefit from the collection of information from multiple sources (Ulin, Robinson, & Tolley, 2012). Therefore, using the qualitative method in this study was beneficial for collecting rich data. Quantitative or mixed method approaches were not appropriate for this study; quantitative researchers test hypotheses, and qualitative researchers explore textural material for themes (Wisdom, Cavaleri, Onwuegbuzie, & Green, 2012). The objective of a quantitative approach is to examine the relationship between dependent and independent variables to test a hypothesis with statistical assumptions (LoBiondo-Wood & Haber, 2014). A mixed-method approach combines qualitative and quantitative techniques in a single study (Stake, 2013). However, a more data-rich method will provide more in-depth responses to address the research problem. Therefore, neither quantitative nor mixed methods approaches were appropriate for this study.

Case studies, which allow for gathering abundant data in answer to questions of *how* and *why*, are designs used in many studies (Yin, 2015). In this study, I asked both questions of how and why, justifying the multiple case study approach. I considered other research methods such as phenomenology and ethnography. Phenomenology is useful for

exploring participants' lived experiences (Bevan, 2014). However, the goal of this study was not to understand participants' experiences. Ethnographers explore the customs, beliefs, behaviors, or other social traditions of a population (Keutel, Michalik, & Richter, 2014). Because the purpose of the study includes neither understanding participants' lived experiences nor the customs or behaviors of a population, neither phenomenology nor ethnography was an appropriate approach to use in the study.

Research Question

The following research question guided the study: What leadership strategies do hospital business administrators use to reduce delayed hospital discharges and improve profitability?

Interview Questions

Participants responded to the following interview questions to address the study research question:

1. What is your main leadership strategy for making the discharge process timely?
2. How would you describe the discharge process in relation to leadership strategies employed to reduce discharge time?
3. What leadership strategies have you put in place within your organization to reduce incidents of delayed discharges?
4. What type of leadership strategies used in the discharge process can you see as being most effective?

5. What different types of leadership strategies seem to work best in a given situation? Please give examples.
6. How do the current leadership strategies reduce discharge inefficiencies?
7. What aspects of leadership have you changed to better facilitate the discharge process in your hospital?
8. Is there anything you would like to add regarding leadership strategies you use in your hospital to decrease delayed hospital discharges and ultimately improve profitability?

Conceptual Framework

Contingency theory served as the conceptual framework for the study. Researchers posited that contingency theory can explain how organizational structures differ according to the strategic choices made by leaders of unique organizations (Battilana & Casciaro, 2012; Moon, 2016). Contingency theory dates back to 1967 when researchers Lawrence and Lorsch discovered the importance of environmental certainty after reviewing prior literature (Lawrence & Lorsch, 1967). Building on the work of Lawrence and Lorsch, Fiedler (1964) used contingency theory for addressing businesses as an organizational structure.

Contingency theory holds four main tenets (Fiedler, 1964). First, contingency theorists hold that there is no universal method of management. Second, organization design and all subsystems must be appropriate for the environment. Third, all subsystems must function together, and fourth, meeting organizational needs occurs when both the

organizational design and the appropriate management style fit the tasks to be accomplished (Fiedler, 1964).

Battilana and Casciaro (2012) argued that organic organizational approaches by management achieve the best results in dynamic environments, while more structured approaches work best in stable environments. Contingency theory relates to situational and behavioral theories, which postulate that there is no single best method to organize, manage, and implement processes in an organization (Wadongo & Abdel-Kader, 2014). Instead of a single best method, optimal solutions are contingent on the circumstances, such as technology, environment, and products associated with the organization. Because patient discharge from a hospital stay is a complex process, contingency theory was useful for analyzing the process (Senot, Chandrasekaran, & Ward, 2015). Each hospitalized patient requires a customized discharge plan. Contingency theory allows for flexibility and analysis of the hospital discharge phenomenon (Senot et al., 2015).

Operational Definitions

The definitions of the terms used in this study are as follows.

Bed blocking: The condition resulting from patients remaining in the hospital or medical unit for longer than necessary because a place (a bed) in another setting (e.g., a long-term care facility or another unit) is not available (Gaughan, Gravelle, & Siciliani, 2015).

Delayed discharge: The result of hospital staff delaying the length of patient stay deemed medically necessary (Costa et al., 2012).

Handover: Handover is the transfer of essential information and responsibility for the care of the patient to another party (van Sluisveld et al., 2015).

Healthcare landscape: The healthcare system and approaches to the provision of care (Brooks, Polis, & Phillips, 2014).

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions are factors in a study that are out of the researcher's control (Marshall & Rossman, 2015). For this study, I assumed participants had knowledge about the topic and were willing to honestly, truthfully, and fully share their experiences. I assumed I correctly interpreted the subjective verbal expressions of meaning provided by the participants. The categories of meaning and themes expected to emerge from the interview data did so and assisted me in answering the research question. Finally, I constructed reliable meaning from the data collected, and analyzed the data in a manner that readers could easily access and understand, as was suggested by LoBiondo-Wood, Haber, Berry, and Yost (2013) in their work.

Limitations

Limitations are weaknesses related to decisions the researcher makes in conducting a study that are difficult to control (Marshall & Rossman, 2015). The participants' ability to understand the purpose of the study and identify with the interview questions could have limited their ability to speak about the topic succinctly. Nevertheless, their knowledge and their ability to articulate their knowledge did not seem limited. The level of the participants' honesty and thoroughness did not limit the findings

of the study. My ability to interpret the subjective verbal expressions of meaning provided by the participants correctly did not limit the generalizability of the results.

Delimitations

Delimitations are features of a study that researchers can control (Marshall & Rossman, 2015). The sample included three administrators from two hospitals who are part of a hospital conglomerate in Chicago, IL. The selection criteria for the administrators required them to have been employed in a leadership position by a hospital for at least 2 years at the time of the study and to have played a role in the discharge process and in the handling of strategies to improve profitability by reducing delayed hospital discharges. I collected data using face-to-face semistructured interviews, direct observation, and a review of discharge documents.

Significance of the Study

The results of the study can be of value to businesses because the findings can provide guidelines to hospital administrators in streamlining the discharge process, thereby creating a reduction of waste and increasing revenue. Giving hospital administrators an effective tool for making the discharge process more efficient can improve hospital earnings (Hesselink, Zegers et al., 2013). Insights identified from participants' experiences implementing effective leadership strategies can encourage other leaders to adopt identified leadership strategies, which could enable hospital leaders to improve profitability by leveraging change. Knowing how other hospital administrators have addressed the challenge of delayed discharges and improved hospital profitability can prompt hospital administrators to consider different leadership strategies,

and how various strategies within leadership have an impact on hospital processes. Ultimately, this study was significant because it identified effective leadership strategies hospital administrators could implement to reduce LOS and improve hospital efficiency.

Contribution to Business Practice

This study contributes to business practices by identifying strategies hospital administrators use to reduce delayed hospital discharges and improve profitability. Understanding and eliminating inefficiencies in leadership that result in patients remaining in the hospital longer than necessary can add value to businesses and business practices. Delayed discharges can lead to increased costs and reduced income for the hospital, as well as increased costs to the patient (Hesselink, Zegers et al., 2013). Hospitals lose revenue because of high LOS (Majeed et al., 2012; Skurka, 2017). Findings from this study offer hospital administrators leadership strategies that the participants have found effective for reducing LOS and thereby increasing hospital profits. The findings, conclusions, and recommendations from this study contribute to making hospital discharge processes more effective, thereby adding value to hospital business practices.

Implications for Social Change

Hospital care for admitted patients accounts for the largest proportion of healthcare spending in the United States (Dobrzykowski & Tarafdar, 2015). In acute care hospitals, the standard model for a hospital, prolonged LOS not only increases costs but also increases the rates of patient complications, leading to further increases in cost (Holland et al., 2016; Majeed et al., 2012). The results of this research can contribute to

positive social change by demonstrating how effective organizational strategies reduce delayed hospital discharges. The findings from this study can help hospital administrators implement improved discharge processes that can contribute to positive social change within communities, both local and national, by promoting care that is more efficient.

A Review of the Professional and Academic Literature

The purpose of the qualitative multiple case study was to explore leadership strategies hospital business administrators use to reduce delayed hospital discharges and improve profitability. The target population was hospital business administrators from two hospitals that are part of a hospital conglomerate in Chicago, IL. The hospital business administrators had strategies to reduce delayed hospital discharges and improve profitability. Findings of the study can help hospital business administrators to improve profitability by identifying leadership strategies to reduce delayed discharges. Results from the study can also contribute to improved patient care, fulfillment of organizational goals through effective leadership, and promote the health of the community.

To explore the leadership strategies that business administrators at a hospital use to reduce delayed hospital discharges and improve profitability, a review of the literature was imperative. Exploration of leadership strategies used to reduce delayed discharges in previous research roots this study and allowed for discussion on what types of leadership strategies were best suited for addressing costly discharge delays in a hospital environment.

Search Strategy

A review of journal articles, dissertations, and other reference materials obtained from the Walden University library were the foundation for the study. Health sciences, nursing, management, and business database categories were searched to identify applicable source materials. Specific databases included SAGE Publications, MEDLINE, EBSCOhost, CINAHL Plus with Full Text, and ABI/INFORM Complete. Search limits include the following words and terms: *bed blockers*, *behavioral theories*, *contingency theory, delayed hospital discharges, discharge cost*, *discharge and coordination of care*, *emergency care*, *financial inefficiencies and profitability, improving profitability, inefficiency in the discharge process*, *inpatient days*, *leadership strategies, length of stay*, *patient discharge*, *pay for performance*, *profitability,* and *situational leadership*. The overall document consists of 111 sources, and the literature review incorporates 84 references. Out of the 111 sources, 101 were peer-reviewed references at 90.99% and 95 were published within the last 5 years at 85.58%.

Organization of the Literature Review

One component of the literature review serves as an introduction to contingency theory and some of the concepts of leadership and organizational culture as they apply to hospitals and their discharge policies. Given the focus of exploring leadership strategies used to reduce hospital discharges and reduce LOS, an overview of the available and current leadership approaches extends knowledge on the subject. Included in this section is information on the history and development of three leadership theories—transactional, transformational, and situational—and the relationship between contingency theory and

situational leadership. An exploration of organizational culture is key as hospital culture and efficiency is largely a reflection of leadership strategies. Finally, I explored recent literature on hospital discharge and leadership strategies to reinforce the need for the study.

The following topics related to the study problem statement were addressed in this review: (a) contingency theory, (b) leadership theories (transactional, transformational, and situational), (c) organizational culture and change, (d) hospitals as businesses, (e) inefficiencies in the discharge process, (f) lack of standardization in discharge timing and procedures, (g) customization in patient discharge plans, (h) inadequate coordination and communication between multidisciplinary discharge teams, and (i) emergency room issues.

Contingency Theory

Contingency theory, a combination of more than one theory, relates to behavioral and situational leadership strategies (Dinh et al., 2014). Along these lines, a leader's capacity for leadership rests on several situational factors, which sometimes vary widely. Some of the specific factors include (a) a leader's approach to leadership, (b) the skills and behaviors of employees, and (c) any other situationally dependent factors (Dinh et al., 2014). Primarily, contingency theory asserts that there is no one best way to lead and that an array of leadership strategies must be assessed to see which will work most effectively in a given area or situation (Dinh et al., 2014). One effect of this type of approach is that a leader may be very successful at one place and at one time, but may not continue to perform in the same manner given changing environments or factors.

Consistent with House, Dorfman, Javidan, Hanges, and de Luque (2013), there are also four leadership strategies in contingency theory. The four leadership strategies consist of asking for participation, being supportive, giving directives, and being an achievement-oriented leader (House et al., 2013). In the case of participatory leadership, a leader will encourage employees to participate in decision-making processes. A supportive leader exhibits emotional support for employees as individuals, and the directive leader provides detailed guidance and clear guidance to employees (House et al., 2013). Finally, the achievement-oriented leader expects employees to follow through on well-established goals and to perform efficiently (House et al., 2013). Using any of these contingency theory leadership strategies, motivating employees is central to this approach (Dinh et al., 2014).

Leadership Theories

There were multiple leadership theories available for use and all address understanding behavior. Leadership as a concept ties the individual to the organization and affects the methods used by management in relating to both the employee and the wider organization (McCleskey, 2014). Avolio and Yammarino (2013) defined leadership as a set of behaviors leaders use to guide a group of individuals toward a shared objective. Effective managers use leadership to ensure that employees carry out all aspects of organizational performance and that the system operates efficiently (Avolio & Yammarino, 2013).

Leadership is an important concept in relationship to evaluating behavior. It represents the link between the individual and the organization. Leadership is an indicator

of the manner in which management relates to the organization and collaborates with staff to lead and manage the organization effectively. A definition of leadership is behavior that guides a team to achieve a common goal (Boonstra, 2012). Organizational performance is the ability of a group to achieve set objectives and is an indication of the productivity level of those within the organization (Rowitz, 2013). An understanding of leadership strategies can provide insight into the relationship between the behavior of hospital administrators and organizational performance. Within a hospital context, given the size of most hospitals, exploring effective leadership theories is important.

An understanding of the effects of leadership style on LOS within a hospital environment allows for a comprehensive view of the relationship between leadership strategies and performance in a healthcare setting. Leadership is more complex than in the past due to numerous changes in technology and environmental factors (Chemers, 2014). Greater accessibility to information, newer technologies, variability, and variety in the talent available, as well as shifting politics, affect the way leadership functions within a hospital setting (Stoller, 2013). Leadership in a hospital setting connects the individual to the organization and influences the approaches used by hospital management in linking the employee and the wider organization (McCleskey, 2014).

Stoller (2013) categorized hospital leadership as a more bureaucratic and transactional leadership style, potentially indicating a need for change. Transactional leaders evaluate and quantify employee and organizational performance through analysis, supervision, and control (McCleskey, 2014). However, there is a need for hospital leaders and managers to redefine traditional policies and strategies in response to the changing

nature of the hospital environment (Chemers, 2014). As change takes place, new challenges arise, forcing the use of leadership strategies that will influence increased communication and variable approaches for the benefit of hospital productivity (Stoller, 2013). However, hospital systems frequently use a system in which change is difficult to implement due to staid bureaucratic styles of functioning (McCleskey, 2014). The three primary forms of leadership addressed here are transactional, transformational, and situational. Ultimately, I used the situational theory of leadership, in partnership with contingency theory, as the theoretical framework for this study.

Transactional leadership. At the onset, Burns (1978) associated transactional leadership with political leadership. Chemers (2014) described transactional leadership as a type of active leadership in which there is a strong managerial component. Leaders of large corporations or organizations frequently take this approach to leadership. The transactional nature of the hospital system exemplifies transactional leadership (Chemers, 2014). Transactional leadership typically occurs when a leader interacts with employees strictly as a means to facilitate exchange (Boonstra, 2012). Transactional leadership aligns with employees gaining rewards for their efforts via money or prestige (McCleskey, 2014). Transactional leadership is not an approach that fosters independent or creative thinking; transactional leadership relates to doing the work as efficiently as possible and negative consequences could occur when followers do not produce the desired results (McCleskey, 2014).

Out of the different theories of leadership, many incorporate transactional features, yet some approaches are much less bureaucratic (Avolio & Yammarino, 2013).

Although transactional leadership can be effective, due to its highly structured goals and driven nature, this type of leadership is weak in facilitating change (Avolio & Yammarino, 2013). As in many bureaucratic environments, leaders in hospital settings are frequently willing to implement diverse leadership approaches when there are breakdowns in the system (Avolio & Yammarino, 2013). Due to the hospital breakdown regarding LOS, this study needed new approaches in leadership within hospital settings.

Transformational leadership. Transformational leadership is an approach that is rapidly gaining worth as a means to understand and explore leadership within many disciplines and fields (McCleskey, 2014). Employees and others follow transactional leaders based on their value systems, and transactional leaders tend to be innovative and tolerant of others (McCleskey, 2014). Transactional leadership is a method where leaders inspire trust in employees, and followers of this model approach work achievement as a means to achieve higher personal and organizational objectives (Menegazzo, Cruz-Ortiz, Ortega-Maldonado, & Salanova, 2015). Transformational leaders encourage creativity, motivation, and innovation, and demonstrate a commitment to their employees. Transformational leadership is frequently associated with higher returns and greater satisfaction for all who participate in the approach (Menegazzo et al., 2015).

In describing transformational leadership, Dinh et al. (2014) pointed out four different behavior types: intellectual stimulation, charisma, inspirational motivation, and individual consideration (Dinh et al., 2014). For intellectual stimulation, employees can create new ideas and think creatively. Leaders encourage reasonableness, diversity, and a problem-solving intellect as the best way to approach an issue (Avolio & Yammarino,

2013). Charismatic leadership is the ability to engage employees in trusting in a meaningful vision (Menegazzo et al., 2015). Employees can benefit from taking pride in their work and achievements with a charismatic leader. Leaders often garner considerable respect and trust from followers through charisma, and there is a promotion of an end goal that emphasizes great benefit to individuals and the organization as a whole (Avolio & Yammarino, 2013). The third form, inspirational motivation, is the process whereby a leader exemplifies operating at a high standard of optimism and vision, and this sets the standard for the behavior of the followers (Dinh et al., 2014). Employees tend to look up to and respect the inspirational leader (Avolio & Yammarino, 2013). Inspirational motivation differs from charismatic leadership in that leaders instill a sense of higher purpose in the followers, and the communication of clear expectations and objectives is meant to encourage followers to perform at their best (Avolio & Yammarino, 2013).

The fourth aspect, or behavior, within transformational leadership, is that of individual consideration. In this instance, leadership is concerned with the skilled individual and the personal development of employees (Avolio & Yammarino, 2013). Managers often use basic forms of leadership style to encourage employee development by coaching and mentoring, while simultaneously remaining aware of individual styles and preferences (Avolio & Yammarino, 2013). While all four of these transformational leadership approaches have merit, the exploration of a variety of leadership approaches offered a comprehensive assessment of which theories can best initiate change in a hospital setting.

Situational leadership theory. Situational theory addresses leadership in relationship to the particular personalities and traits of varying leaders. Here, the principle idea is that leaders are unique and tend to exhibit different levels of performance and ways of responding to a given situation (Lynch, Alba, Krishna, Morwitz, & Gürhan-Canli, 2012). The primary aspect of this theory is that leadership achievement occurs through the actions of employees (Dinh et al., 2014). Being able to measure the skills and willingness of employees is not as common in other leadership theories, making this a unique approach (Hutchinson & Jackson, 2013; Moon, 2016).

As noted by Lynch et al. (2012), there are also four leadership types. The first of these is the high task—high relationship model. In this model, leaders offer a supportive culture with ample direction. In the low task—high relationship model, making decisions is a joint effort shared by both leaders and employees. Here, the principle role of the leader is to guide through communication (Lynch et al., 2012). In relationship to the low task—low relationship model, delegation is the primary purpose, and the leader grants employees little support and direction. In the last leadership style, within situational leadership, the high task—low category is the most regulated in that the leader informs employees of their roles very specifically (Dinh et al., 2014).

Within these four categories, promotion of one kind over another is dependent on both the employee's level of willingness and aptitude as well as the work situation environment as a whole (Cherlin et al., 2013). Situational leadership holds components of all the leadership theories discussed so far, and while it may not work perfectly in every

category in which to measure output, it is a very useful theory for creating change in particular hospital settings, especially when combined with contingency theory.

The areas in which contingency theory and situational theory connect are that both agree there is no one, simple, right way to lead to ensure the best results (Dinh et al., 2014). The principle difference between the two is that situational theory focuses primarily on behaviors that leaders should adopt, given any number of varying situational factors used to facilitate positive responses in employee behavior (Dinh et al., 2014). Contingency theory, however, is broader in its approach in that it takes into account any contingent factors about a leader's capacity to create change while considering all other variables within the situation (Hutchinson & Jackson, 2013).

Using both situational and contingency theories provided a dynamic framework for this study. Because individual hospital leaders are unique, and because hospital culture is dependent on a variety of different conditions (both internal and external), contingency theory may be best facilitated when paired with the situational leadership style to honor the differences found in hospitals and situations within hospitals (Moon, 2016). Senot et al. (2015) echoed using contingency theory in this way given that discharging a patient from the hospital can be complex. Both situational theory and contingency theory were useful for analyzing the discharge process.

Organizational Culture and Change

Understanding organizational culture and change is one of the key challenges that leaders have to manage. During periods of change, such as financial crises, mergers, or other important events, effective strategic leadership is critical to successful outcomes

(Boonstra, 2012). However, Battilana and Casciaro (2012) asserted that it is essential that leaders have the necessary foundational skills and tools available to implement and manage change effectively in any given situation where there is a need for change.

Using certain tools, leaders guide an organization in adopting new policies when needed. Boonstra (2012) provided a framework for managing change that focuses on cultural factors. Certain conditions, such as a willingness to communicate and remain flexible in response to changing circumstances, are useful within an organization to achieve positive cultural and strategic transformation, and this transformation is critically dependent on leadership (Battilana & Casciaro, 2012). Effective strategic changes should create synergy within an organization. Creating change requires a form of leadership that goes beyond transactional roles to leverage the diverse factors that influence culture and employee performance (Battilana & Casciaro, 2012).

Bolman and Deal (2014) discussed four contextual frameworks for looking at organizations as a means to move them forward. The four frameworks represent different perspectives: (a) structural, (b) human resource, (c) political, and (d) symbolic interactions (Bolman & Deal, 2014). Bolman and Deal assessed organizational structure and how managers and leaders could improve the structure of teams and groups to achieve the best results. The framework looks at the political dynamics within the organization, how managers and leaders can learn to address power and conflict, improve political skills, build coalitions, as well as engage effectively with both internal and external forces (Bolman & Deal, 2014).

The human resource framework looks at those within the organization with the goal of building positive group dynamics, satisfying human needs, and enhancing human resource management (Bolman & Deal, 2014). Lastly, the symbolic framework looks at meaning and culture within organizations in relationship to how leaders and managers can shape the work environment and culture for their internal and external audiences (Bolman & Deal, 2014). Using this material provided a supportive framework from which the researcher could examine organizational dynamics, in the hospital setting, and thereby strengthened the relevance of this study.

Managing organizational culture is important for managing organizational change (Jacobs et al., 2013). Therefore, the effective management of organizational culture is necessary for the effective management of performance (Jacobs et al., 2013). Organizational culture as a concept has some degree of ambiguity. Recent research has viewed the concept as the practices organizations develop around their handling of people or the climate that arises from the values and beliefs of the organization (Jacobs et al., 2013). In this view, culture is something that cannot be cultivated.

There is a strong relationship between organizational culture and the leadership structures in an organization, and the management of organizational culture constitutes a very important leadership function (Jacobs et al., 2013; Skurka, 2017). Culture conveys a sense of identity in organizations through the practices, norms, and values that determine the way employees and leaders conduct business in an organization (Hesselink, Vernooij-Dassen et al., 2013). Culture also defines what the organization is good at, and what its past successes are.

An organization develops established norms, with time, that guide expected behavior patterns (Jacobs et al., 2013). Established norms may be formal or informal, and create acceptance for behaviors that employees and leaders consider normal within the organization. People who have worked within the organization for a long while typically accept these organizational practices without question (Hesselink, Vernooij-Dassen et al., 2013).

Culture has an invisible dimension (Hesselink, Vernooij-Dassen et al., 2013). Although this dimension is below the surface, it is just as powerful as anything that is readily apparent. Forces that constrain a group's behavior drive culture and these forces manifest as shared norms (Hesselink, Vernooij-Dassen et al., 2013). Visible levels, or surface manifestations of corporate culture, include observable symbols, slogans, behaviors, stories, dress, and settings. Invisible levels of culture include attitudes, beliefs, feelings, assumptions, underlying values, and attitudes (Jacobs et al., 2013). Change strategies often focus on the visible level of culture. However, it is important to address the invisible level of culture as it can impede or promote change. There can also be more than one culture active within an organization (Hesselink, Vernooij-Dassen et al., 2013).

Organizational culture plays a role in patient discharge in a hospital setting. In one study, researchers used focus group interviews to determine the relationship between culture and discharge (Cherlin et al., 2013). Hesselink, Zegers et al. (2013) focused on organizational culture, noting that the extent to which care providers value processes within the organization is critical to effective hospital discharge. Hesselink, Zegers et al. (2013) found three themes that represented the different aspects of organizational culture

and how they affected hospital discharge: (a) the undervaluing of administrative tasks, (b) a divided hospital surrounding the primary care interface, and (c) a failure to reflect on discharge process improvements. The implication drawn from the study was that the level to which care providers value processes within the system is critical to implementing effective hospital discharges (Hesselink, Zegers et al., 2013). Hospital culture is important in improving the hospital discharge process, and further exploration of the strategies hospital administrators use to improve profitability by reducing delayed discharges can contribute to Hesselink, Zegers et al.'s findings. As noted by Jacobs et al. (2013) and Cherlin et al. (2013), organizational culture plays a principle role in the discharging of patients in a hospital setting, and this can take place at both the visible and invisible level.

Hospitals as Businesses

Hospitals, whether for-profit or not-for-profit, are all businesses with a bottom line and a need to sustain operations. The best way in which to ensure a business succeeds is to be flexible and be able to adapt to changing circumstances as they become apparent (Boonstra, 2012). By using statistics from the healthcare cost report information system, maintained by the Centers for Medicare and Medicaid Services, significant findings were revealed for the years between 1996 and 2004 (Das, 2013). Das (2013) found that although revenue fell notably, resulting in reduced profits, hospital administrators did not shift their funding structures or use of capital. An important implication of Das' findings is an elevated level of borrowing for hospitals, which can alternately affect the future growth and long-term viability of hospitals. In addition,

Medicare patients are the largest segment of a hospital's revenue source, and this system is experiencing shifts as well (Das, 2013). Understanding how fluctuations and variability in Medicare reimbursement for hospitals is useful in exploring the potential effects of future shifts in Medicare payments (Das, 2013).

White and Wu (2014) conducted a study to determine the effect of changes in Medicare inpatient hospitals prices on the overall revenues, profits, and operating expenses of hospitals. White and Wu (2014) discovered that Medicare price cuts resulted in significant revenue reduction. In their study, White and Wu (2014) also noted that ownership of the hospitals played an influential role in the variations of revenue reduction. Not-for-profit hospitals, compared to for-profit hospitals, were less likely to minimize operating costs. The expectation may be that for-profit hospitals would experience profit reduction, but not necessarily other healthcare institutions (Medicare Payment Advisory Commission, 2013). In either case, the inability to make changes when shifts occur in payment systems necessitates action on the part of hospital administrators.

Per-case hospital payment systems influence the manner in which hospitals operate (Landman, 2013). Landman (2013) explained that the number of states employing per case hospital payment systems has been increasing recently. Nevertheless, the debate about the results for equity of access to services continues. Hospital cost concerns related to the failure of classifications for diagnosing to take into consideration patients' care requirements accurately. Such failures create a likely loss of profit from the inefficient handling of the hospital discharge process (Garrity & Fiedler, 2016).

Joynt, Orav, and Jha (2014) observed hospitals shifting to for-profit status. A shift toward earning a profit often leads to profit-seeking hospitals lowering their overall quality of care, which often creates the need for patient readmission and reduced hospital profitability. Joynt et al. (2014) also found that the need to make a profit drives hospital administrators to reduce the number of staff, resulting in poor service delivery. Reduced staffing makes discharge a less efficient and costly process. In contrast, Garrity and Fiedler (2016) noted that profits provide much greater incentives for hospitals to provide affordable services that are efficient. Therefore, if hospitals retain quality outcome of care, and eliminate delays in discharge, a profit-seeking motive may help hospitals to be more stable financially and more conscious of costs.

Another issue, medical spending, is the leading component associated with the rocketing healthcare expenditures (Kwon, 2014). Kwon (2014) noted that the competition among hospitals and other health institutions leaves hospitals at risk for shutdown or debt accumulation because they are limited in funds. As a result, this motivates for-profit hospital administrators to make profits through the shifting of their care to avoid losses. In one study exploring state benchmarks for hospital performance, the scorecard results for Illinois (the setting of this study) on health systems, revealed that performance was not sufficient (Landman, 2013). Landman's study revealed that Illinois placed 44 out of 50, with an increase in patient readmissions to the hospital within 30 days.

Robust interest in decreasing readmissions has led to a unique, statewide collaboration among BlueCross BlueShield of Illinois, the Illinois Hospital Association (IHA), and the Society of Hospital Medicine to join efforts in decreasing the state's

readmission rate (Landman, 2013). The goal of this initiative was to increase the state's performance on readmissions so that the state's healthcare performance could move from the bottom to the top of the Commonwealth Fund's measure by 2014. Eighty-nine percent of IHA supporters have used this strategy, with many experiencing surges in follow-up care appointments. Utilizing this strategy contributed to significant reductions in readmission rates and costs (Landman, 2013). The joint initiative introduced in the collaboration between the BlueCross BlueShield of Illinois, the Illinois Hospital Association (IHA), and the Society of Hospital Medicine has the potential to counteract detrimental Medicare price cuts, which result in significant revenue reduction for hospitals (Das, 2013; White & Wu, 2014). Furthermore, the shift in hospitals to for-profit ventures (Joynt et al., 2014), and an increase in medical spending (Kwon, 2014) make apparent the need for more initiatives to decrease the loss of revenue at hospitals.

Inefficiencies in the discharge process. In the United States, hospital spending was $882.3 million in 2012, with a recorded growth of 4.9% (National Center for Health Statistics, 2013). Despite the high expenditures and steady growth, the advent of non-hospital providers, such as specialized physicians, commercial clinics, and emergency care facilities, has led to increased competition (Kwon, 2014). Competition drives hospitals to perform to stay in business. Rising costs and waste within the system have led hospital management to demand improvements to the value and quality of healthcare by eliminating inefficiencies (Pfuntner, Wier, & Steiner, 2013). To remain competitive, hospitals can benefit from streamlining the discharge process (El-Banna, 2013).

An efficient discharge process starts as soon as the patient enters the hospital (Shepperd et al., 2013). In line with Shepperd et al. (2013), understanding the patient's condition, anticipated length of stay, and necessary care, and creating a post-discharge plan should take priority in an acute care facility as a way to guarantee efficiency. A patient's improved health and the completion of inpatient care should immediately shift the managers' focus to the discharge process. In the service function chain, the discharge process is fundamental and essential in the operational area for both institutional and non-institutional activity (Koskinen, 2013). Appropriate care and streamlining of processes has the added benefit of creating an early discharge and allowing a new patient to occupy a recently vacant bed.

Discharge Delays

Discharge delays were one of the primary focuses of this study because of the cost they incur for hospitals (Venkatasalu, Clarke, & Atkinson, 2015). As an example, Weiss and Elixhauser (2014) reported that in 2012, the average hospital stay was 4.5 days, for 36.5 million patients, at an average cost of $10,400 per stay. Greysen et al. (2012) also identified five unified themes that limit the quality of discharge care: (a) competing levels of importance in the discharge process, (b) inadequate coordination within multidisciplinary discharge teams, (c) lack of standardization in discharge procedures, (d) poor patient and family communication, and (e) lack of post-discharge feedback and clinical responsibility. Establishing clear strategies for discharge procedures, such as interdisciplinary teamwork, patient communication, and post-discharge continuity of care

may contribute to improving the quality of discharge processes (Hesselink, Zegers et al., 2013).

When patients remain in the hospital beyond their appropriate discharge date, the result is an increase in the financial burden on hospitals, creating a loss of profit (Majeed et al., 2012). The increasing number of discharge delays has an adverse impact on the overall system, resulting in loss of income (Costa et al., 2012). Weinberger, Johnson, and Ness (2014) noted three factors that delayed hospital discharges: (a) an improper patient evaluation by physicians, (b) the socioeconomics of patient backgrounds, (c) an unorganized discharge team, and (d) inefficient communication between inpatient and outpatient providers. When any of these factors are present, bottlenecks occur; reducing bottlenecking is a crucial means of improving hospital profitability (Weinberger et al., 2014; Weiss et al., 2015).

El-Eid, Kaddoum, Tamim, and Hitti, (2015) also confirmed that when patients are not cared for appropriately, delays in the discharge of inpatients leads to bottlenecks in hospital activities. For example, the longer a patient is in a bed, the fewer number of patients a hospital can admit. The financial consideration behind bed capacity, along with the care needed to balance against avoidable admissions, has economic implications (Majeed et al., 2012, Harrison et al., 2016). Abo-Hamad, Rashwan, and Arisha (2015) explored ways to effectively address the delayed discharges of elderly patients, while at the same time responding flexibly to the expanding services for this portion of the population. Their study results indicated approximately 600 delayed discharges occurred monthly, with 80% arising from long-term care. Abo-Hamad et al. (2015) also reported

that the average cost of running a bed was $935 per day. For 600 delayed patients, this equated to about $510,000 per day.

In 2016, Holland et al. noted that hospital discharge delays averaged 23.6 days for hospital patients and that 61.4% of all patients who were able to care for themselves at home experienced discharge delays. Hartman, Martin, Lassman, and Catlin (2015) also found that the cost of running inpatient care is approximately one-third of the U.S. total healthcare expenditures. Hospitals across the United States are experiencing a loss of revenue due to resource mismanagement, most notably regarding unwarranted lengths of stays (Hwabejire et al., 2013).

A primary form of discharge delay is bed-blocking. Gaughan et al. (2015) used this term to denote a patient who has completed treatment in one part of the treatment chain but is still awaiting treatment in the next part of the chain. Bed-blocking problems result from insufficient capacity in the patient's next medical facility, floor, or department. Therefore, patients occupy a bed for significantly longer than necessary, blocking new patients from getting the care they need. Costa et al. (2012) argued that bed blocking leads to increased healthcare costs because hospital beds are more expensive than home beds. When patients are encouraged to stay in hospital beds longer, either as a result their own or the hospital staff’s decision, the hospital absorbs the cost. In this manner, bed blocking directly reduces hospital revenue (Abo-Hamad et al., 2015). For hospitals to increase their revenue, patients admitted to the hospital should adhere to a more rigorous discharge schedule, as should the medical teams (Majeed et al., 2012).

Majeed et al. (2012) studied the sources of delayed hospital discharges and their effect on unnecessary bed blocking in acute care facilities. The study concluded that prolonged patient length of stay (LOS) stems, in part, from the lack of adequate outside support for patients after they leave the healthcare facility (Majeed et al., 2012). As maintained by Abo-Hamad et al. (2015), the shortage of available community care beds has contributed to delayed discharges from acute care hospitals. Acute beds are one of the most expensive resources within the healthcare system and delayed discharges from acute care result in fewer vacated beds that can accommodate new patients. Therefore, new admissions into hospitals are often restricted. The hospitals must shoulder unjustified costs, which increases the cost of running each acute bed (El-Eid et al., 2015). The financial implications behind bed blocking, both in primary and secondary and care situations, need to be balanced against the associated negative economic implications of patients overstaying their acute care stays (Majeed et al., 2012; Moon, 2016).

Lack of standardization in discharge timing and procedures. Inefficiencies in the hospital discharge process links to delays in discharging patients for various reasons. Streamlining the discharge process can decrease the discharge time and reduce the costs associated with patient care (El-Banna, 2013; Pfuntner et al., 2013). Improved patient flow can reduce wait times for care, ease emergency department overcrowding, and increase profitability due to enhanced process efficiency. Hendy et al. (2012) found that 65% of patients waiting for ancillary services (e.g., lab and x-ray services) experienced more than usual wait times, and 48% of patients experienced lengthy delays for these types of ancillary services, which ultimately extended their hospital discharge date. The

ability of hospital staff to transport patients appropriately, either to another area of the hospital or to home care, is also crucial to bed availability (Hendy et al., 2012).

To ascertain the effects of earlier patient discharge on emergency department patient stays, Beck, Okerblom, Kumar, Bandyopadhyay, and Scalzi (2016) made use of a cross-sectional computer modeling analysis of data obtained from the Feinberg School of Medicine. Beck et al. (2016) found that discharging 75% of patients by noon, or by discharging all the patients by 4 p.m., reduced the emergency department boarding time from 77 hours to as little as 3 hours. Bed occupancy is an important variable in the LOS issue associated with hospital discharges and relates to what occurs in the Intensive Care Unit (Beck et al., 2016). In a retrospective qualitative analysis, Wong, Chau, So, Tam, and McGhee (2012) also provided data that determined the most common indicators of delayed discharge and bed occupancy issues were the day of the week and holidays, followed by group planning, and (poor) scheduling.

In line with Wong et al. (2012), Wertheimer et al., (2014) identified the effects of hospital admissions and discharge timing on bed availability concerning peak times for daily admissions and discharges. Wertheimer et al. divided patient admission data from a public hospital into groups based on appropriate scheduling of daily admission and discharge curves. They found that choke points could be alleviated based on hospital administrators' willingness to adjust the timing of patient discharge (Wertheimer et al., 2014). Hospitals should adopt clear policy guidelines for reducing a patient’s duration of stay to improve hospital throughput (Mathews & Long, 2015).

The need to reduce expenses has led healthcare organizations to adopt formulated strategies to decrease patient LOS at acute care hospitals. An efficient discharge process benefits both hospitals and patients, as it increases profitability and reduces the cost of returning patient care (Hurwitz et al., 2014). In the early decades of the 21st century, there has been an increase in hospital throughput (El-Eid et al., 2015). However, it is possible to improve hospital throughput. Hospital administrators need to work on refining patient flow throughout the hospital, which includes shortening the phases involved in the discharge process to make the entire process more effective and less time-consuming (Tak et al., 2013). Increasing the efficiency of the patient discharge process can lead to cost savings related to medical practitioners' overtime and improved overall hospital profitability.

In line with Hurwitz et al. (2014), nurses can play an important part in improving effective discharge planning by diminishing their role in the process (Hurwitz et al., 2014). With such a heavy workload, the discharge process is often considered less important than other tasks nurses are charged within a hospital setting. As a result, Koskinen (2013) determined that nurses do not have enough time to discuss discharge issues with their patients, especially patients who are aging. Nurses regard this as a lack of recognition of the role of the nurse in the decision-making process, which speaks to the profession's lack of leadership and multidisciplinary teamwork within hospital hierarchies (Hurwitz et al., 2014). Doctor dominance tends to overshadow the functionality of nurses in acute care hospital discharge, which speaks to a degraded holistic approach to effective discharge planning (Koskinen, 2013).

Customization in Patient Discharge Plans

To evaluate the viability of outpatient treatment, Farach, Danielson, Walford, Harmel, and Chandler (2015) produced an evidence-based protocol to enable the discharge of appendectomy patients on the same day as the appendectomy surgery. The system resulted in cost savings and improved efficiency in the hospital's operations (Farach et al., 2015). The protocol was used on all appendectomy patients, 206 in total, who were present between July 2012 and June 2013. The length of stay was approximately 3.1 ± 1.4 hours, and inappropriate discharge made up only 10%. The results indicated that the implementation of the discharge protocol led to an inpatient reduction from 99% to 53% (Farach et al., 2015).

In an attempt to facilitate discharges, Holland, Knafl, and Bowles (2016) asserted that discharge planning should include the creation of a customized plan for the patient prior to discharge from the health organization. Proper discharge planning should assure that patients leave the hospital in a timely and efficient manner (Holland et al., 2016; Moon, 2016). The researchers also agreed that an appropriate discharge document could decrease readmission rates. Therefore, the effects of discharge planning have a direct correlation with patient health effects and hospital expenses (El-Banna, 2013).

Holland et al.'s (2016) objective was to reduce the inpatient LOS, decrease the total number of chronic care patient admissions, and help patients transition back into the community while controlling expenses. A customized discharge plan will help patients achieve their personal health goals, keep costs down for both patients and the hospital, and make beds available for new admissions.

Inadequate communication between discharge teams. One of the primary issues leading to discharge inefficiencies is a breakdown in communication among members of the hospital staff. The length of stay and successful discharge are dependent on the quality, efficiency, and success of communication from one department to another, as well as from the hospital administration to the patient (Joynt et al., 2014). It is paramount that the discharge process is coordinated smoothly to eliminate inefficiencies within the system.

The organizational challenges faced by medical practitioners involved in the discharge process occasionally culminate in adverse influences on their roles, which affect their ability to communicate discharge instructions efficiently. As determined by Soong, High, Morgan, and Ovens (2013), one way to improve patient flow is to eliminate variations in the process along the care pathway that can prevent or impede movement. Samuels-Kalow, Stack, and Porter (2012) analyzed effective discharge communication in the emergency department. Samuels-Kalowet et al. (2012) found that successful transmission of discharge information is critical to ensuring an efficient discharge process. Koskinen (2013) found that planning for discharge starts at hospital admittance. When the discharge fails in some way, patients experience discharge without full assessment for readiness (Koskinen, 2013). Communication problems of this nature can lead to readmission, incurring a greater cost for the hospital.

Samuels-Kalow et al. (2012) also argued that the medical practitioners conducting patient discharges from acute care facilities face organizational challenges in their roles. In addition, limitations such as fatigue, inexperience, and language fluency affect health

care professionals' ability to communicate discharge instructions succinctly (Joynt et al., 2014). Samuels-Kalow et al. (2012) further argued that the discharging provider must make decisions about the content of the discharge instructions, the method of delivery, and whether to verify if patients understand the information after they received the instructions. Patients can only understand the discharge instructions well if the instructions contain all the relevant information in a format that is easily understood. Patient comprehension requires a high level of organization and patient communication by the employee providing the instructions (Tortorella, Ukanowicz, Douglas, Ray, & Triller, 2013). Ridding waste from the process allows for cost savings by improving communication between all parties involved in a patient's care (Tortorella et al., 2013).

Chan et al. (2014) concluded that managers could reduce overtime costs by focusing on improvements to the discharge summary completion. Bertsch (2014) suggested focusing solely on the day-of-discharge process for a patient who is ready to leave the inpatient unit. On the discharge day, it is important that multi-disciplinary discharge teams, comprised of nurses, managers, physicians, and social workers, should all work toward facilitating the patient’s discharge (Bertsch, 2014). The day of discharge carries more importance than other days during the hospital stay as it determines whether the discharge of a patient will open a space for another patient while preventing readmission (Landman, 2013).

Another method to improve discharge efficiency is by linking patient discharge summaries (DS) with previous patient data. The DS incorporates complications, diagnosis, comorbidities, and anticipated future treatment(s). Patients receive this

summary upon their discharge from an inpatient stay. The DS function contains information that is available in many of the hospital's systems, such as the *electronic patient journey board*. Automatically linking the DS within the hospital's systems would allow an immediate transfer of the required information (Chan et al., 2014). Facilitating discharges in this manner would save the time required for unneeded discharge tasks by junior doctors and other hospitals employees, which previously required the payment of overtime (Shepperd et al., 2013). Not only would the hospital staff work with efficiently with other patients, but this simple discharge plan would also result in cost savings, leading to higher hospital profitability.

Upsurge in readmission. Prolonged hospital inpatient stays relate to increased readmission rates and costs due to inefficiencies that arise in the provision of quality healthcare (Pfuntner et al., 2013). Increased readmissions lead to inpatient congestion, producing poor patient health outcomes (Suñol, 2014). The subsequent increase of inpatient days is also responsible for greater costs incurred to the hospital (Waring, Marshall, & Bishop, 2015). Timely discharge can help reduce congestion and the related stress on the hospital system, which improves the care facility's revenue collection.

To deal with some of the increases in cost that hospitals must absorb, regulations put forth by the federal government aimed at preventing hospital readmissions have become a top priority for healthcare organizations across the United States (van Sluisveld et al., 2015). The federal government has negatively incentivized readmissions by reducing Medicare payments to hospitals that demonstrate an increasing number of readmissions for an accurate diagnosis. The hospital readmissions reduction program, as

part of the Affordable Care Act, went into effect on October 1, 2012, and organizations with high 30-day readmission rates for diagnoses have experienced annual hospital Medicare payment reduction by up to 1% (White & Wu, 2014). Medicare spending for readmissions within only 30 days after discharge cost approximately $15 billion for Medicare patients. Reforming patient care during the discharge process will prevent additional hospital expenditures (White & Wu, 2014).

Chan et al. (2014) also studied the effect of various discharge decisions in the ICU on patient readmissions. Chan et al. (2014) noted that ICU patient admission delays had a significant effect on the length of stay and overall patient outcomes, at times leading to the need to readmit a patient at an additional cost to the hospital. In an attempt to mitigate waste in this area, Chan et al. (2014) created a discharge decision-making support tool to help decide when to discharge a patient, wholly dependent on readmission risk. What they concluded was that implementing the discharge decision-making support tool would reduce the number of patients readmitted to hospitals (Chan et al., 2014).

Emergency Room Issues

When the discharge process does not function effectively, delays in patient throughput negatively affect the transfer of newly admitted patients from the emergency department, a growing entry point into hospitals (East et al., 2013). An inpatient bed request from an upstream unit means that the patient has to wait at a particular location until an inpatient bed becomes available (Bertsch, 2014). Johnson et al. (2013) used the number of critical care bed numbers in the United States, payer mix, occupancy rates, and costs to carry out a study of cost analysis. Johnson et al. (2013) concluded that delays in

ICU transfer to standard beds, and subsequent delays in discharge from the hospital, placed a significant financial burden on the hospital. Johnson et al. (2013) also noted that the time spent in the ICU cost more than time spent on a regular hospital floor; therefore, delays in transfers resulted in increases in the overall cost of care. However, Johnson et al. (2013) also noted that the cost difference between patient floor days and ICU days related to the difference in patient-to-staff ratio.

Another issue, perhaps counterintuitive, is that inpatient days in the hospital have declined by a third since the 1980s. The days of inpatient decline are a seemingly positive trend; nevertheless, it has put pressure on healthcare providers to focus more on emergency care, rather than routine admission care (Kwon, 2014). Emergency care demands more sophisticated and specialized treatment and diagnosis methods than what exists in a typical inpatient setting, and there is a growing need to care for increasing numbers of emergency patients in this second decade of the 21st century (Kwon, 2014). As a result, more patients are using beds that may otherwise be empty, and at a higher cost.

While examining the effect of discharge delays on business profitability, Hurwitz et al. (2014) assessed the cost of emergency department crowding needs and recommended further study to bring about the necessary changes. Hurwitz et al. documented that although patient mortality and morbidity are high in crowded emergency departments, these findings have yet to trigger the implementation of solutions in acute care settings. Hurwitz et al. stated the financial drain that accompanies emergency department crowding might provide the needed stimulus.

In their study aimed at examining financial costs related to delay discharges, Hurwitz et al. (2014) also discovered that increasing the patient duration of stay in emergency departments lead to direct additional costs to the hospital Hurwitz et al. noted a significant loss of revenue due to increased LOS in patients admitted to the emergency department and concluded that transferring admitted patients from the emergency department to an inpatient unit within 120 minutes would increase the functional treatment capacity of the emergency department, thus boosting hospital profits Hurwitz et al. further noted that an additional 3,175 patients experienced timely treatment through the 12-month study period when the admission process was improved. Contrary to the expectation of generating more revenue from these patients, however, the hospital did not realize the same profits. Effective patient flow procedures are necessary to curb costs and prevent readmissions.

Hurwitz et al. (2014) found solely decreasing the patient length of stay will not necessarily result in marked hospital savings. Hospitals may need to readmit patients if they are not cared for adequately from the onset (Majeed et al., 2012). Such readmissions can lead not only to poor patient outcomes but also to a decrease in Medicare payments from the Federal Government. Effective strategies aimed at increasing profitability and reducing costs should recommend improved care and discharge procedures on the first day, as opposed to just focusing on reducing the length of stay (Kwon, 2014). A holistic, streamlined approach to patient care, from examination to discharge, can help hospital staff perform their duties more efficiently, release patients more effectively, and improve profits exponentially for acute care facilities.

In summary, to effectively explore leadership strategies hospital business administrators use to reduce delayed hospital discharges and improve profitability, a review of the pertinent literature was warranted. A review of leadership and organizational culture, as they apply to hospitals and their discharge policies, incorporated a review of transactional, transformational, and situational theories. Primary emphasis was placed on the relationship between contingency theory and situational leadership given that the focus of exploring leadership strategies used to reduce hospital discharges and reduce LOS are highly dependent upon the individual circumstances that take place in a hospital setting.

Transition

Although there are gaps in understanding how hospital administrators can introduce leadership strategies to achieve profitability through reducing discharge inefficiencies or readmission to the hospital, some options are available (Dobrzykowski & Tarafdar, 2015). Delayed discharge results from multiple factors, including (a) the organizational structure of most hospitals; (b) federal mandates; (c) poor communication between the hospital management, physicians, and nurses; (d) an upsurge in readmissions; and (e) emergency room functions (Shirley & Sanders, 2013). Administrators could reduce business losses incurred by implementing strategies to increase profits through improving discharge efficiency. Hospital administrators can implement leadership strategies to increase profitability and reduce delayed hospital discharge, as demonstrated in some of the studies presented in this review of the literature.

The primary aim of this study was to explore the leadership strategies hospital business administrators use to improve profitability by decreasing delayed hospital discharges. I conducted the study in hospitals that are part of a hospital conglomerate in Chicago, IL. The major focus was on the leadership strategies hospital administrators use to reduce discharges inefficiencies. In the following section, Section 2, there is a description of the qualitative method research approach used in this study. Section 2 includes presenting the population and sampling, data collection, data analysis, and reliability and validity. All portions of the following blueprint for conducting this study kept in mind reducing researcher bias. The material presented in Section 3 consists of the doctoral study findings—including applications to professional practice, implications for social change, and recommendations for future study.

Section 2: The Project

As discussed in Section 1, and as presented by Steiner, Andrews, Barrett, and Weiss (2013), prolonged patient LOS results in excess hospital costs across all levels. Average costs exceed projected costs when patients exceed their necessary LOS. In contrast, patients discharged in less time than the average stay reduce hospital costs, yet employees must follow the process correctly to mitigate costly readmissions (El-Banna, 2013). In this study, I explored leadership strategies hospital business administrators use to reduce delayed hospital discharges and improve profitability. The following section provides the details of the project. Section 2 features a comprehensive discussion of the research methods, research design, and the role of the researcher. There is a discussion of participant information, population and sampling, data collection instruments and techniques, data organization, data analysis, and reliability and validity. A transition and summary statement ends this section.

Purpose Statement

The purpose of the qualitative multiple case study was to explore leadership strategies hospital business administrators use to reduce delayed hospital discharges and improve profitability. The target population was hospital business administrators from two hospitals that are part of a hospital conglomerate in Chicago, IL. The hospital business administrators have strategies to reduce delayed hospital discharges and improve profitability. Findings of the study can help hospital business administrators to improve profitability by identifying leadership strategies to reduce delayed discharges. Results from the study also contribute to improved patient care, fulfill organizational goals

through effective leadership, and promote the health of the community by reducing the additional time and cost accrued by remaining in the hospital.

Role of the Researcher

Stake (2013) noted researchers assume a variety of roles in qualitative studies. As an administrator working in an associated setting, I am an insider as opposed to an outsider. I currently work and reside in the geographic area of the study, Chicago, IL. I have personally experienced instances of delayed patient discharges. I have seen how communication between nurse practitioners and physicians affects the flow of the discharge process, and I am privy to information that depicts a bottleneck for patient discharge.

In this qualitative multiple case study, I gathered detailed information to help understand the various strategies hospital administrators employ to reduce discharge delays. I conducted semistructured interviews with open-ended questions to collect data from hospital business administrators. An interview protocol that reassures participants that (a) all material they share is confidential and (b) they can elect not to participate at any time will ensure that each participant can share fully in a consistent and inclusive manner (Yin, 2015). The interview protocol for participants is both thorough and informative (see Appendix A).

Researchers must follow all required procedures and maintain ethical principles when conducting research as well (Yin, 2015). I followed all moral principles stipulated in the Belmont Report. Information provided by individuals participating in this study are considered confidential and only confined to research purposes.

Additionally, I (a) made every effort to treat the study, and any information learned, objectively, and (b) minimized researcher bias by remaining objective and neutral when interviewing the participants and analyzing the data. I deliberately gathered, analyzed, and interpreted information only through means consistent with an earnest attempt to understand and compare accurately the relevant beliefs, actions, and perspectives of the participants in this study. There were many features of the research design of this study that aim to maximize validity while minimizing researcher bias. For example, the member-checking processes helped ensure that the results presented were objective, and the study design remained valid throughout the research process (Yin, 2015).

As my primary roles in this study were as the observer, data collector, and data analyzer, I attempted to remain objective throughout both the data collection and analyses phases of the study. Although there is no cohort to verify data with, I recorded and analyzed the data accurately, and coded the information relevantly and without bias. Method triangulation aided in verifying the accuracy of results obtained from this study.

Participants

For this study, I selected three hospital administrators from two hospitals in a hospital conglomerate operating in Chicago, IL. The selection criteria for the administrators required them to be in a leadership position, at a hospital for at least 2years at the time of the study, and taken part in the discharge process, and to have been responsible for the strategies implemented to improve profitability by reducing delayed hospital discharges. In line with LoBiondo-Wood et al. (2013), and in consideration for

the study, participants in a study must meet with a certain number of qualifications an authority in a particular area. In recruiting hospital administrators, it was imperative that they spent significant time in a leadership position as well as having had direct experience with the phenomenon (Yin, 2015).

After verifying the administrators' credentials, and I received approval from the Walden University Institutional Review Board (IRB), the recruitment process took place by email. To acquire study participants, I requested email addresses from the human resources departments, whose administrator gave the consent to email administrators. Using purposive sampling (Yin, 2015), I solicited participation from eligible participants. Researchers use purposive sampling in qualitative research for the selection of a representative population (Palinkas et al., 2015). The purposive method focuses on the selection of individuals, or groups of individuals, who are knowledgeable about a particular phenomenon and is appropriate for qualitative analysis (Ritchie, Lewis, Nicholls, & Ormston, 2013). Palinkas et al. (2015) noted that unlike purposive sampling, random sampling is appropriate for quantitative studies was therefore not used in this study.

After obtaining email addresses, I sent an email (see Appendix B) to all eligible hospital administrators introducing myself as a fellow administrator and doctoral student intending to make the discharge process more effective. The email message I sent to participants (a) explained the purpose of the study, (b) asked participants if they meet the criteria to participate in the study, and (c) asked participants if they would meet with me privately in a face-to-face interview, as recommended in a cohort study by LoBiondo-

Wood et al. (2013). After exhibiting an interest in participating, and in meeting the criteria, the participants received an email in which they had the ability to sign the consent form by replying to the email with the words "I consent." In accepting the request, I also followed up with a phone call to each participant to set up a prearranged meeting time. The participants received an informed consent document that detailed the expectations of their role during the time of the study (Ritchie et al., 2013).

I was prepared to conduct a second interview with hospital administrators, either face-to-face or over the phone, to follow-up on themes that emerged from the coding and analysis of the interview data. Although unnecessary to use, the second interviews would have followed a less structured approach, based on the interviewees' previous and current responses, as recommended by Palinkas et al. (2015).

Research Method and Design

Research Method

A qualitative methodology was appropriate to explore the various leadership strategies that hospital business administrators in a Chicago, IL hospital used to reduce delayed patient discharges. A qualitative methodology was useful for establishing the foundation of the entire study and identified the best approach for framing and communicating the outcomes (Yin, 2015). The core of a qualitative study comprises semistructured participant interviews, through which the researcher obtains both retrospective and real-time explanations from those people experiencing the phenomenon of theoretical interest (Gioia, Corley, & Hamilton, 2013).

The questions posed during the interviews remained completely open-ended to avoid rehearsed or yes/no answers while encouraging respondents to communicate their attitudes and experiences tied to the topic. I conducted the questioning in an iterative style, and had little cause to adjust follow-up questions based on the answers provided to previous questions. The data collection process was very flexible and useful in the study.

Qualitative research is exploratory in nature. Qualitative research is appropriate when the researcher hopes to gain insight into the underlying opinions, reasons, and motivations associated with behavior (Yilmaz, 2013). One advantage of using a qualitative multiple case study method for this endeavor was the collaboration between the researcher and the interviewees, which allowed participants to share their experiences more fully (Adams, Wong, & Wijeysundera, 2015). Qualitative research is subjective; the researcher makes inferences from information that participants provide (Yilmaz, 2013). Adams et al. (2015) suggested that researchers use a qualitative approach to allow the reader to understand the data and interpret the meaning through the participants' understandings. In this manner, researchers might utilize qualitative research strategies to decrease ethical inferences, avoid possible bias, and increase the reliability of the data gathered (Greene, 2014).

A quantitative approach, alternately, was inappropriate for this study. The objective of a quantitative approach is to examine the relationship between dependent and independent variables in a given population (Stake, 2013). Quantitative and qualitative researchers use distinct processes, different types of research strategies, and different methods of inquiry (Wisdom et al., 2012). In explaining quantitative studies in greater

depth, Stake (2013) asserted that researchers use randomization in quantitative designs to ensure internal validity. However, such randomization is not always feasible or warranted. In this study, which addressed leadership strategies and inefficiencies in the hospital discharge process, it was not possible to randomly assign administrators into groups of those who lead in a particular manner—or who consistently obtain certain outcomes. In this regard, a design that omits randomization, based on securing large numbers of participants, was more useful. Choosing a qualitative method of research instead of quantitative method allowed for a deeper understanding of the phenomenon.

Ganong and Coleman (2014) also noted that qualitative research methods tend to produce rich data that surpass quantitative approaches for reaching qualitative goals. Another reason for selecting a qualitative research method, rather than a quantitative one, was that the qualitative method represented a logical and unbiased means of describing and measuring the results (Elo et al., 2014). Finally, a mixed-method approach combines qualitative and quantitative techniques in a single study (Stake, 2013). However, my study benefited from a more direct, data-rich method that indicated the need to focus on one method only—the qualitative. Choosing a qualitative research method over a quantitative or a mixed research method allowed for a deeper understanding of the phenomena.

Research Design

Yin (2015) stated a multiple case study involves research questions that ask how and why, which was consistent with the research questions in this study. Analyzing multiple questions and collecting perceptual data was also consistent with involving

hospital administrators as participants (Stake, 2013). The multiple case study design was suitable to explore the patient discharge process of hospitals in Chicago, IL, as related to LOS and decreased profitability tied to inefficient discharging (van Sluisveld et al., 2015). The multiple case study method helps a researcher focus on the descriptions of individuals' experiences and their perceptions (Bevan, 2014).

Furthermore, the multiple case study design allowed me to collect fine-grained qualitative data related to the causes of inefficient discharge processes at the different hospitals (Wong et al., 2012). In choosing the research design for this study, the multiple case study design was preferred to ethnography, phenomenology, and narrative in terms of the purpose of the study and the type of data required to conduct the study appropriately. For instance, phenomenology is useful for exploring participants' lived experiences (Bevan, 2014). However, the goal of this study was not to understand participants' experiences. Ethnographers explore the customs, beliefs, behaviors, or other social traditions of a population (Keutel et al., 2014). Because the purpose of the study included neither understanding participants' lived experiences nor the customs or behaviors of a population, neither phenomenology nor ethnography was appropriate approaches to use in the study. The multiple case study design allowed for an in-depth study of the phenomenon from a wider sphere, albeit bounded by time, events, activities, and individuals.

The multiple case study design allowed for richness in context, drew data from several sources, and was also appropriate given the number of perspectives present (Stake, 2013). Multiple sources help construct a comprehensive picture of the subject

under study (Yin, 2015). Participants responded to face-to-face interviews and provided relevant documentation to support their responses. Data saturation occurs when nothing new emerges from interviewing participants (Marshall, Cardon, Poddar, & Fontenot, 2013). During the interviews, I asked the participants to provide answers to the interview questions until there was nothing new to add. After reviewing the data and interpreting the interview transcripts, I provided a simplified version of the material to the participants to see if the information I had was correct, and if anything new needed additional consideration. When nothing more was needed, I assumed data saturation took place. In line with the purpose and research question explored in this study, a multiple case study research design was the most appropriate as it incorporated the use of data saturation and triangulation techniques. I achieved data saturation as the responses provided thick, rich descriptions and no new themes emerged. As the materials were compared and corroborated method triangulation of data occurred as data from the interviews, observations, and documents. Finally, accurate coding of the data occurred, and data analysis took place to reveal emerging themes (Ulin et al., 2012).

Population and Sampling

To facilitate this multiple case study, I used purposive sampling. Purposive sampling is widely used in qualitative research for the selection of a representative population (Palinkas et al., 2015). The purposive method centers on the selection of individuals, or groups of individuals, who are knowledgeable about, and have experience with, a particular topic of interest (Ritchie et al., 2013). Palinkas et al. (2015) noted that unlike purposive sampling, random sampling applies to situations in which the

generalizability of data is of concern. Because the study did not focus on generalizability specifically, purposive sampling was the preferred sampling method. For this study, I selected three hospital administrators from two hospitals in a hospital conglomerate operating in Chicago, IL.

The selection criteria for the administrators required them to have been (a) in a leadership position, (b) employed by a hospital for at least 2 years at the time of the study, and (c) have taken part in the discharge process. The participants had to be responsible for the implementing discharge processes. To acquire study participants, I requested email addresses from the Human Resources department, whose administrator gave me consent to email administrators. I asked participants to take part in the study after looking through multiple years of assessment data to identify the appropriate subjects. Furthermore, I requested recommendations from hospital administrators who I also asked to identify leaders who were eligible to participate in the study.

The justification for the number of interviewees asked to participate was evident in the assertion by Yin (2015), who suggested that a study could offer valid data for analysis given the depth of information gathered from participants. Ultimately, I did not consider the study valid until data saturation took place and none of the participants had anything new to offer for analysis, as recommended by Stake (2013). There was a possibility that the number chosen to participate would need an amendment; yet, this was not necessary. Finally, conducting research in the location of the phenomenon under study helped facilitate greater understanding of the leadership roles involved in the hospital discharge process, especially in relationship to the observation portion of the

study LoBiondo-Wood et al. (2013). In line with this reasoning, the observation portion of this study was conducted at the hospitals used in this study.

Ethical Research

To conduct ethical research, I sought and obtained approval (number 01-27-17-0368136) for this study from the Walden University IRB before beginning data gathering. I used ethical research protocols put forth by National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1978). The IRB certified that this study is in accordance with ethical standards for protecting participants in this study. The rights and welfare protection of those voluntarily participating in a study are a fundamental principle of ethical research (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978). Consequently, I ensured that (a) the participants were protected, (b) their rights were respected, (c) the recruitment strategy was adhered to, (d) the informed consent process was followed, and (e) the research participants' privacy was protected.

Participants who agreed to the interview signed the informed consent form. The consent agreement, combined with personally ethical behavior, helped me protect participants' rights throughout the study. To ensure privacy and confidentiality, the identities of the participants and their organization remained confidential. Only the researcher knows the identity of the hospitals and participants.

In addition, participants had the opportunity to choose a meeting place that was comfortable, safe, and convenient for them. The hospital administrators were able to withdraw from the study at any time without penalty, and they had the option of not

responding to all interview questions. I informed participants of their right not to participate at the beginning of the interview, as is recommended by Yin (2015). I assured the interviewees that they only needed to verbally express this at any time during the interview to be relieved of participating. In their work, Manning and Kunkel (2014) posited that interview participants must feel they are in a safe environment. In the event that they did not, any participant in this study would have been encouraged to discontinue the process. The data collected for the study will remain in a locked cabinet to which only the researcher will have a key, and I will destroy the data after 5 years.

Psychologically, administrators might have believed that I was critiquing their leadership roles and that I would share any negative judgments with their supervisors, despite the assurances of confidentiality. Administrators may also have experienced trepidation or discomfort when they reflected on their perceptions about their daily discharge practices and procedures. Socially, administrators might have felt that they were in competition with other leaders, which might have caused social anxiety and discomfort. To minimize an administrator's discomfort, I never revealed other research participants, or an administrator's leadership strategies to another, and assured the participants that the study was for informational gathering purposes only, not as a means to negatively judge administrators or their leadership strategies.

There were no perceived legal, physical, or economic risks for participants or any direct incentives for participating in the study. Participants did not receive financial compensation for their participation. Nevertheless, one incentive to participate was that administrators may receive future opportunities to enhance their knowledge and skills

based on the results of the study. Participants may also have the opportunity to shape future leadership policies regarding discharge procedures. In line with Battilana and Casciaro (2012) and Dinh et al. (2014), participants in studies often experience non-monetary incentives for participating.

Data Collection Instruments

In addition to identifying the student as the primary instrument, Yin (2015) identified six sources of data: (a) documentation, (b) archival records, (c) interviews, (d) direct observation, (e) participant observation, and (f) physical artifacts, while noting that not all sources are essential in any one study. Houghton, Casey, Shaw, and Murphy (2013) also noted that the inclusiveness of data is concerned mainly with gathering numerous perspectives from multiple resources so that a complete picture of the phenomenon is available. In this study, I made use of three of these sources of data. The first was a set of written interview questions, were asked throughout the one-on-one, semistructured interview process.

I used the interview protocol closely to ensure consistent results. When beginning the interviewing process, I made the participants aware of the nature and intent of the study. I assured the administrators that the information they shared will remain confidential and that they were free to discontinue the interview at any time. The interview questions were open-ended and as such, could not be answered simply with a yes or no or one-word answer. Although not needed, I was willing to utilize prompts to encourage the administrators to answer questions more thoroughly.

The second instrument was the observation protocol checklist for the discharge process (see Appendix C), and the third was the hospital documentation on discharges. For the discharge process, I primarily observed for behaviors and strategies that included how and when orders for discharge took place and whether the streamlining of orders was taking place. I explored the documentation on discharges to gain an understanding of the flow of patients through the discharge process, and how efficiently and timely the process was for the majority of the patient records assessed. A fellow administrator at one of the hospitals as well as a university cohort reviewed the three instruments (interview questions, observational data gathering methods, and hospital documentation on discharges) for content validity. I checked the instruments for clarity of language, the appropriate number of questions, and to ensure the projected time for interview and observation processes was suitable. Gioia et al. (2013) recommended these methods to guarantee the use of valid procedures.

Data Collection Technique

I collected data using face-to-face semistructured interviews, direct observation, and a review of discharge documents. Although I may have used telephone interviews, it was only if necessary, as Jubelt, Volpp, Gatto, Friedman, and Shea (2015) concluded they would have been an effective research tool for qualitative research. Nevertheless, I would only have conducted telephone interviews if I had been unable to meet with the participants in person.

To ensure the validity of collected data and data analysis, I deliberately gathered, analyzed, and interpreted information only through means consistent with an earnest

attempt to understand and compare accurately the relevant beliefs, actions, and perspectives of the administrators used in this study. There were many features of the research design of this study that aimed to maximize validity while minimizing researcher bias. For example, the member-checking processes helped ensure that the results presented were objective and the study design remained valid throughout the research process (Yin, 2015).

Semistructured Interviews

According to Irvine, Drew, and Sainsbury (2013), there were advantages to conducting interviews face-to-face including (a) the ability to gain trust, (b) politeness, (c) nonverbal communication, and (d) the ability for the participant to express themselves. Consequently, I used face-to-face interviews in a hospital setting. Manning and Kunkel (2014) stated that conducting participant interviews allows for a sense of sentiment, feelings, and understanding of participants' experiences. Other methods of data collection may not have had the same effect. Distinctive ways of posing questions with the use of prompting and probing helped mine more information and steer the interview to more comprehensive and exhaustive levels (Klenke, 2016). I asked open-ended, semistructured questions during the interviews to obtain rich data and achieve a greater understanding of the participants' experiences.

The interviews were semistructured and occurred at the onset of the research, prior to the observations. Each interview lasted for approximately an hour; although the actual time will vary depending on the detail included in the participants' experiences and shared responses. The interviews took place at the administrator's work site, thus

eliminating the need for them to travel to another location and minimized time, cost, and potential discomfort. I conducted interviews individually and privately, in a location of the administrator's choosing, with only the researcher and respective administrator present.

The instruments used to conduct interviews consisted of a tool for keeping notes organized. Additionally, I used an audio recorder to capture the interviews verbatim for transcription. Interviewees had the opportunity to review their interview transcripts for accuracy and representative responses. Additionally, an outside administrator from one of the hospitals in the study reviewed the interview questions for content validity. I made changes based on her feedback.

I conducted the questioning in an iterative style, and although it was not necessary, I would have altered follow-up questions based on the answers provided to previous questions. The process used to collect data was very flexible (Lynch et al., 2012). Finally, I used member checking and strove to capture rich, thick descriptive data from study participants, to ensure reliability and validity, until data saturation took place. Member checking was completed after the interviews took place by asking the participants to review the transcript of what they shared as member checking ensures that participants shared what they intended to share by having them go over their responses (Yin, 2015). In having participants go through their responses after the interview concluded, I was able to check to ensure they said what they intended to say and they had nothing new to include. Through member checking, full exploration of the themes and

the literature, data saturation occurred. In other words, no new patterns emerged from the data collection and analysis (O'Reilly & Parker, 2013).

Direct Observation

The key role of a researcher during an observation process is to collect crucial data related to factors affecting the patient discharge process. The process should not merely support inferences or judgments during the observation; the researcher must also be able to analyze and synthesize the evidence (Yin, 2015). As part of the observation process, I sought an introduction to the patient discharge team by the hospital administrator. The administrator informed the discharge team that, as a researcher, I had permission to observe the discharge process to acquire crucial data and information for educational purposes. In addition, the hospital administrator requested cooperation from the discharge team in providing all information that affected the patient discharge process.

At times, there are disadvantages to direct observation (Stake, 2013). One concern in this study was that administrators may have thought that their leadership roles were being criticized and that any negative judgments would be shared with their superiors despite assurances of confidentiality. Administrators may have felt that they comparisons to other leaders were being made, which might have caused discomfort. Nevertheless, the advantages to direct observation are more numerous than the disadvantages, and these dangers seemed to be of little importance to the participants. Researchers have the opportunity to understand a phenomenon as it takes place, providing rich detail for the study, as well as potentially granting participants an outside perspective (Yin, 2015).

In observation of the discharge process in this study, I arrived early and remained as unobtrusive as possible to allow administrators the ability to conduct their work without concern about potential interference. The instrument used to collect data during the observations of the administrators was the observation protocol checklist (see Appendix C). I used field notes to collect data during the observations through jotting down thoughts and insights on the observation protocol checklist to corroborate that discharge processes were taking place in the most effective manner.

Document Analysis

To analyze documentation, I obtained permission from the hospital administration to have access the anonymous discharge information for use in the study. Document analysis allows for broad coverage of the study topic through a collection of exact facts about the topic, and repeated reviews, as long as the documents are available, which they were in this case (Rowley, 2012). Careful validation of the documents ensured inclusion of correct data from the hospital's database regarding discharge figures.

Participants also had the opportunity to member check the information gleaned from the documents to ensure accuracy. Member checking can serve to verify that what historically took place did, in fact, occur. I completed member checking after the interviews by asking the participants to review the transcript of what they shared. In reviewing what they said, all the participants noted they had nothing more to share and no need to correct their original statements. Document analysis allowed for extensive data comparison (primarily acquired from the interviews), which increased the credibility of interpretation (Birt, Scott, Cavers, Campbell, & Walter, 2016). As qualitative research is

exploratory in nature, helps researchers to gain insight into the underlying opinions, reasons, and motivations associated with behavior. One advantage of using a qualitative multiple case study method to analyze documents was the ability to explore and compare data over time (Adams et al., 2015).

Data Organization Technique

I organized the data into research categories (e.g., notes, recordings, participants' responses, and so on) for easy identification of the data. Using a small tape recorder, I audio-recorded the interviews and transcribed each interview. Houghton et al., (2013) noted a primary objective of proper data organization is to produce self-describing data sets for easy use in the research process. Birt et al. (2016) stated that to attain accuracy, and to avoid inadvertently omitting relevant information, narratives warrant immediate recording. The data organization method allowed for flexibility and yet required the use of accurate organizing (Lynch et al., 2012). Yin (2014) noted member checking is a practice used by member checking is a practice used by researchers to improve the accuracy, credibility, validity, and transferability of the findings from a study. Member checking, or ensuring that participants were sharing exactly what they intended to share, took place during the interview process and also occurred during an informal follow-up with the participants to ensure their intent and to allow for any additional clarification if needed. Throughout this process, I endeavored to build a comfortable rapport with the participants so that they felt comfortable sharing their experiences, insights, and leadership strategies.

To gather the most accurate and rich information, I used memoing. Memoing is open-ended and has been compared to free writing or stream-of-consciousness writing (Rowley, 2012). Memoing was an effective means for writing down thoughts, questions, and reflections for later reference and analysis (Birks & Mills, 2015). Birks and Mills further assert that, in qualitative research, a researcher should never throw away any notes taken, no matter how brief or seemingly insignificant. All data collected in a study has the potential to reveal vital information that may add to important patterns of thought that may emerge (Birks & Mills, 2015).

Lastly, made an audio recording of each interview and then transcribed each recording; I then provided the transcripts to the respective participants to ensure the credibility and completeness of the participants' responses. Use of this method was considered appropriate for ensuring the accuracy and intended meaning of the data collected and can serve as a design that can be replicated by future researchers (Houghton et al., 2013; Yin, 2015). I saved interview transcripts in a Microsoft Word document and on a thumb drive. The thumb drive, transcripts, and consent forms will be stored in a locked location for 5 years. After 5 years, I will destroy the data. Use of this methodology was a recommendation of qualitative research experts such as Yin (2015) and Stake (2013).

Data Analysis

The key elements of qualitative data analysis via the modified van Kaam method (Moustakas, 1994) included (a) organizing the data, (b) becoming familiar with the data, (c) classifying, (d) coding, (e) triangulating, (f) interpreting, and (g) presenting and

writing up the data (Rowley, 2012). For interviews, I first transcribed the recordings by closely listening to the recorded audios. Second, I holistically reviewed the transcripts and related memoing notes. Next, I conducted open coding of the data by hand, using a codebook, to identify the categories of information shared by the respondents. Rowley (2012) has recommended coding data in this way. Coding the data also helped identify possible themes that emerged in the responses. I used memoing notes to support the coding. I invited two experienced coders to code transcripts as well. I then compared my coding results with the other coders' results and determined outcomes.

Given the dynamic nature of qualitative studies, data analysis is an ongoing process. Rowley (2012) explained that continuous coding is vital to recognizing emerging themes in the data and identifying when data saturation occurs. Open coding is the first step in analyzing any data. Open coding consists of the researcher reviewing the transcribed interviews and notes taken via memoing, identifying categories of information shared by the respondents, and then organizing the information (Urquhart, 2013). I did the coding by hand with the minimal use of NVivo 10 software. Accurate coding of the data occurred as the process was conducted to reveal emerging themes, as noted as highly effective by Ulin et al. (2012). I then analyzed all themes to identify possible subthemes.

A second method for analyzing data is thematic analysis (Vaismoradi, Turunen, & Bondas, 2013), which can be useful for collecting data by using the modified van Kaam method (Moustakas, 1994). Therefore, I analyzed the recorded interviews conducted as part of this qualitative multiple case study using Moustakas's (1994) seven steps:

1. Listing and preliminary grouping of textual data: I listed every expression applicable to the topic under study.
2. Reduction and elimination of the invariant themes: All expressions that did not meet the stipulated requirements, together with repetitive, vague, and overlapping expressions were excluded from the study or revised for a more precise descriptive form.
3. Clustering and thematizing invariant themes: I clustered the invariant themes that related to the study.
4. Final identification of the invariant themes by application validation: I identified the common factors of the study.
5. Construction of an individual textural description of the experience: I used the applicable validated invariant themes to create a single description of the experience.
6. Construction of an individual structural description of the experience: I based this description on the individual textural description.
7. Construction of a textural-structural description of the meanings and essences of the experiences of each participant, taking into consideration the invariant themes.

Steps 1 to 4 of Moustakas's (1994) modified van Kaam method helped to code the data and create categories based on theme. The term "invariant theme" (p. 143) refers to any applicable expression, comment, or component found in the participant interview responses (Birt et al., 2016).

I also used NVivo 10 software to analyze and organize the data collected from the interviewees, as well as to identify themes and organize unstructured data, as was necessary (Richard, 2014). Bazeley and Jackson (2013) reported NVivo 10 software is effective for conducting qualitative data analysis. Sotiriadou, Brouwers, and Le (2014) stated NVivo 10 software allows the researcher to engage in meaningful analysis. I used the NVivo10 software to analyze the interview data while backing up the data using paper format. I used NVivo software, primarily as a backup tool for analyzing and coding data by hand. NVivo 10 software only assisted with coding themes that emerged from the qualitative data and helped determine trends in other interview responses.

Triangulation. My use of method triangulation helped to integrate all types of data collected for this study. Denzin and Giardina (2016) identified and grouped the triangulation of data into four types: (a) data source triangulation, when the investigator seeks identical data in different scenarios; (b) methodological triangulation, when multiple approaches to data collection are used to increase confidence in data interpretation; (c) theory triangulation, whereby different investigators with different thinking interpret the same results; and (d) investigator triangulation, where several investigators participate in the same research study.

In this study, I carried out methodological triangulation by conducting interviews, direct observation, and document analysis of the discharge process. The purpose of using methodological triangulation was to confirm that the data collected were complete (Denzin & Giardina, 2016). The information obtained from these methods helped establish a comprehensive data set to allow for interpretation of the topic under study.

Comparisons from my observation of the discharge process to the experiences of hospital business administrators, as described during the semistructured interview, helped add validity to the research findings.

Finally, accurate coding of the data allowed themes to emerge. The data obtained from discharge observation notes added information gathered during the interview process. A deeper level of investigation into the data permitted multifaceted analysis surrounding LOS and discharge. The resulting effect allowed leadership commonalities to emerge from the responses of the business administrators regarding discharge rates at their hospital, and the potential for hospital time and cost savings.

Reliability and Validity

Moustakas (1994) explained that validity refers to the accuracy of the research results. Reliability and validity are essential to guaranteeing the value of the results of any study. According to Waring et al. (2015), reliability means that other researchers that duplicate the research should obtain similar results. Waring et al. (2015) stated that a truthful understanding of data leads to valid and reliable results.

Houghton, Casey, Shaw, and Murphy (2013) noted to certify the validity and reliability of data; the researcher must confirm the objectivity and credibility of the data. Waring et al. (2015) also indicated researchers confirm the validity of the data collected by comparing those data with data collected from individuals with similar experiences. As I interviewed hospital business administrators, who were involved in the patient discharge process, I confirmed consistency of the data through interviews with administrators from the two different hospitals (Houghton et al., 2013).

Reliability

Determining reliability is most often contingent upon the dependability and credibility of a study (Stake, 2013). Strategies to ensure dependability include peer participation in the analysis by conducting member checking and providing detailed descriptions of the research methods (Houghton et al., 2013). To evaluate the dependability of the study, it was essential to examine the process that made the product achievable by conducting an audit trail, an approach recommended by Houghton et al. (2013). I created an audit trail by outlining the process by which the methodological decisions occurred. Researchers create an audit trail by (a) explaining the particular purpose of the study to participants, (b) explaining the reasons for choosing the participants in the study, (c) explaining the data collection process, (d) explaining the transformation of data during the analysis, (e) explaining the research findings, and (f) explaining the exact techniques used to determine the credibility of the data (Houghton et al., 2013).

Validity

Granting validity of a study frequently consists of transferability, confirmability, and credibility. Confirmability occurs when the researchers have achieved credibility, transferability, and dependability (Houghton et al., 2013). The qualitative research must be reflective, keeping a sense of awareness and honesty to the study that contains telling results. The intrinsic guideline is preferable because it is a way of increasing the credibility of the qualitative research (Sousa, 2014). Through rich, thick descriptions, I provided detailed information to contribute to confirmability of the study.

To further achieve confirmability, I utilized member checking. Member checking is a practice used by researchers to improve the accuracy, credibility, validity, and transferability of a study (Yin, 2015). Member checking, or ensuring that participants were sharing exactly what they intend to share, took place during the interview process. Throughout this process, I endeavored to build a comfortable rapport with the participants so that they felt comfortable sharing their experiences, insights, and leadership strategies.

For credibility, I used method triangulation to achieve the accuracy of the data collected. Researchers engage in triangulation by using responses to semistructured interview questions as sources of data for contrasting and verification purposes. Triangulation helps document variations, or lack thereof, in a study (Venkatesh, Brown, & Bala, 2013). Waring et al. (2015) noted that any method of review has its pros and cons, and the investigator must validate his or her findings by way of triangulation. I integrated method triangulation into the data analysis process to make use of preexisting data and previous research to analyze methods, investigations, and theories, and to provide corroborating evidence for this study.

Finally, I used member checking and strove to capture rich, thick descriptive data from study participants to ensure reliability and validity until data saturation took place. Data saturation occurred when no new patterns emerged from the data collection process. To ensure data saturation, I continued to collect data until no new themes emerged and there were no new emerging patterns in the data. Data collection continued until I found nothing to add and there were no new emerging patterns in the data.

Transition and Summary

The purpose of this qualitative multiple case study was to explore the leadership strategies hospital business administrators used to improve profitability by reducing delayed hospital discharges. Conducting face-to-face or telephonic semistructured interviews with hospital administrators, who play a leadership role in the discharge process, provided a deeper understanding of this phenomenon. A criteria-based sample of those involved in the discharge process included a minimum of three administrators practicing in one of two Chicago, IL hospitals. Additional participants would have been engaged, if necessary, to achieve data saturation (Ando, Cousins, & Young, 2014). After obtaining approval of the research study from the Walden University IRB, I obtained email contact information for participants from the hospital Human Resources (HR) department and sent participants email invitations, which outlined the purpose of the study and the guidelines that I followed throughout the process. In the email, I asked participants if they were willing to participate in a 30 to 60 minute interview. I ensured their confidentiality. In agreeing, I contacted the individuals to set up the interview and take them through the interview protocol (see Appendix A).

I made an audio recording of each interview and then transcribed each recording; I then asked the participants to check their answers to ensure the credibility and completeness of the participants' responses. Use of this method was considered appropriate for ensuring the accuracy and intended meaning of the data collected and serves as a design that can be replicated by future researchers (Houghton et al., 2013; Yin, 2015). Using a purposive participant selection method improved the odds that the

data collected allowed the objective of the study to be achieved (Stake, 2013). With semistructured interviews, thematic analysis, and coding, and with the potential support of NVivo 10 software, I interpreted the data to answer the research question that drove this study. In Section 3, I present the findings, applicability of the study to professional practice, implications for change, recommendations for action, and suggestions for future research.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The purpose of this qualitative multiple case study was to explore leadership strategies hospital business administrators use to reduce delayed hospital discharges and improve profitability. In an analysis of the findings, the most overt themes were those of efficient communication and management strategies to facilitate the discharge process. I used contingency theory and situational theory as a lens to explore the discharge process, contributed to framing the findings, and aided in analysis of the data collected.

Presentation of the Findings

The following research question guided the study: What leadership strategies do hospital business administrators use to reduce delayed hospital discharges and improve profitability? The three administrators who participated in this study shared their thoughts and responses related to the research question through answering the interview questions used in the study. While not all answers to each interview question are presented, those that shed light on the findings and themes are included. To remain compliant with ethical and legal standards, the interviewees were coded Participant 1, Participant 2, and Participant 3, to maintain confidentiality. With the aid of NVivo software, a presentation of the findings is below. The findings are based on the found themes from the interviews, the observations, and through hospital discharge documentation. A description of what ways the findings confirm and extend knowledge in the discipline compared with the literature related to this field. The conceptual framework tied to the findings as well to

confirm the conclusions in relation to the existing literature on effective business practice. Applications to professional practice, implications for social change, recommendations for action, and further research come before any additional reflections and the conclusion.

Main Theme 1: Strategies for Efficient Communication

One of the primary issues leading to discharge inefficiencies is a breakdown in communication among members of the hospital staff. The length of stay and successful discharge of a patient is dependent on the quality, efficiency, and success of communication from one department to another, as well as from the hospital administration to the patient (Joynt et al., 2014). Through an analysis of the findings, one of the most apparent themes was the need for efficient communication. I explored the main theme of efficient communication first, followed by a more detailed account of the subthemes: (a) communication between doctors and nurses, (b) communication between nurses and other staff, and (c) communication between hospital staff and families of patients were addressed.

Specific to improving communication between discharge teams, Joynt et al. (2014) demonstrated the length of stay and successful discharges are dependent on the quality, efficiency, and success of communication from one department to another as well as from the hospital administration to the patient. In discussing the theme of the need for efficient communication between discharge teams, all three participants related their experiences with communication throughout the entire discharge process. Two of the three participants, Participants 1 and 2, characterized communication as "challenging"

and "difficult." Participants 1 and 2 worked at Hospital 1, the larger of the two hospitals, which may have influenced the ease of the discharge process. Nevertheless, all three participants related experiences in which they saw effective and efficient communication benefitting the discharge process.

Joynt et al. (2014) found that communication is essential to the efficient discharge of patients. Joynt et al.'s findings connect well to the findings of this study, most notably in relation to the need for effectual communication between responsible parties. For Hospital 2, Participant 3 stated that communications were "pretty good." Participants 1 and 2 both spoke about the relationship between the size of the hospital and the level of (nature of) communication between staff members. Participants 1 and 2 shared their beliefs that the larger the facility, the more cumbersome the lines of communication and the greater potential for communication problems. In terms of the participants having the opportunity share additional information, all three participants cited the need for better communication overall. However, Participant 3 noted that most discharge processes ran smoothly at Hospital 2, given the overall good communication between leaders and staff.

In summary, communication among members of the hospital staff is vital to creating effective and timely discharges (Joynt et al., 2014). All study participants agreed that effective communication aids in timely discharges as noted in Table 1. There was evidence suggesting that participants believed that the smaller the hospital, the easier it was to have efficient communication. Overall, the support for effective communication from the participants and through the literature is compelling, and the use of strategies

such as streamlining the discharge process and facilitating communication could facilitate effective leadership.

Table 1. Frequency of Response for Main Theme 1

Efficient Communication	Frequency of Response
Participant 1 (Hospital 1)	10
Participant 2 (Hospital 1)	8
Participant 3 (Hospital 2)	7

Subtheme 1a: Communication between doctors and nurses. One of the primary concerns for determining effective discharges is the exchange of information between hospital staff and physicians (Dobrzykowski & Tarafdar, 2015). Participant 3 supported this idea when she stated, "better communication with both nurses and physicians would improve the discharge process." Participant 3 spoke about the importance of the primary nurse who "knows the ins and outs of everything that is going on with that patient" and who "communicates with the physician." Participant 3 finished the interview by saying that "all of the many layers make it difficult" which is why "communication is key." Despite the existence of discharge delays, even in Hospital 2, Participant 3 appeared qualified to critique the effects of communication on the discharge process given the success of timely discharges at Hospital 2.

In responding to Interview Question 3, which asked what leadership strategies were put in place within the participants' organization to reduce incidents of delayed discharges, Participant 1 responded about the importance of physician-nurse communication. The following example, given by Participant 1, was a typical dialogue between a doctor and a nurse regarding the discharge of a patient:

> We call them, we call them, even when they know. "Oh, ok, I know we already talked to them yesterday to remind them, but we need you to go ahead and do this so that we can do what we need to do." So, the biggest thing is the communication level.

As discussed by Dobrzykowski and Tarafdar (2015), efficient discharge of a patient is contingent on the communication between staff members and doctors. From the information gathered from the interviews, observations, and documentation used in this study, smooth and effective doctor and nurse communication is frequently lacking in the hospitals used in the study. However, strategies such as increased coordination and communication, especially in the morning, could lead to an increase in discharge efficiency. Eliminating variation related to effective and clear communication between discharge members and reducing off-set of shift telemetry, situations in which nurses do 12-hour shifts, could be shifted to encourage more communication between nurses and other staff.

Another communication issue, which is specific to improving inadequate communication between discharge teams, is the dominance of doctors over the role nurses play in promoting the efficiency of discharges (Koskinen, 2013). Participant 1 confirmed this by saying "Nurses, even head nurses, are dependent on the doctors okay for discharge, even if we know someone can go home." To further triangulate the findings, Koskinen (2013) found that if nurses had the ability to facilitate the discharge process without doctors having the primary authority, discharge planning could be more effective.

Lack of communication and coordination tends to delay the discharge process (Greysen et al., 201; Tortorella et al., 2013). Participant 2 shared that a lack of both coordination and communication between physicians and other staff members ultimately leads to discharge delays. Participant 2 added that increased coordination and communication, especially in the morning hours, would lead to an increase in discharge efficiency. Participant 1 addressed ineffective communication "trickle-down effects," the benefits of a "Morning Discharge Meeting" which used to be in place, and the need to shift the current meeting/conversation "huddles" to an earlier time. Participant 3 also explained that as opposed to operations at Hospital 2, where things run more smoothly, problems such as nurses not knowing when patients are going home occur regularly at Hospital 1. Furthermore, and despite adequate documentation given to patients at discharge instructions are not always gone over with patients due to nurse overwork, fatigue, and potential inexperience. Increased communication and collaboration work in tandem to support the discharge process, and both are critical to a timely discharge (Boonstra, 2012; Harrison et al., 2016).

Concerning order validations and doctor/nurse communication, I observed Participant 2 reviewing an order created at 7a.m. upon shift change. Participant 2 reviewed the order to validate the order's authenticity (that it had been written by the primary care provider) and to verify that it contained a typical physician statement, declaring that the "Patient is stable for discharge." Participant 2 was observed verifying the completion of the physician's medication reconciliation which was preceded by the

Order for Discharge which been done the evening before. In this instance, communication worked efficiently.

To summarize, physician-nurse communication is critical to efficient discharges, as displayed in Table 2. Although there was a desire for all participants to have more effective communication between doctors and nurses, it was noted that doctors tend to dominate over the role nurses play in promoting the efficiency of discharges, at times impeding the process (Koskinen, 2013). Nevertheless, Participant 2 stressed that increased coordination and communication, especially in the morning hours, would lead to an increase in discharge efficiency, and there is a willingness to shift the current meeting/conversation huddles to an earlier time to create more effective communication between doctors and nurses.

Table 2. Frequency of Response for Subtheme 1a

Communication between Doctors and Nurses	Number of Responses
Participant 1 (Hospital 1)	8
Participant 2 (Hospital 1)	11
Participant 3 (Hospital 2)	10

Subtheme 1b: Communication between nurses and other staff. Although many of the interview questions focused on the use of leadership strategies, effective communication is critical and is inseparable from leadership. Soong et al. (2013) found that one way to improve patient flow would be to eliminate variations in the process along the care pathway that can prevent or impede movement. Soong et al. (2013) noted that eliminating variation relates to the need for more effective and clear communication between discharge members, which the participants shared was lacking or appeared to be

lacking given the information made available to patients at discharge. Participant 1 reiterated this idea when noting the importance of effective communication between physicians, nurses, case managers, social workers, and specialized therapists.

Participant 1 also added how the "off-set of shift telemetry, (where) we do 12-hour shifts and the majority of everybody else in hospital does 8-hour shifts." significantly challenges effective communication. Supported by the work of Soong et al. (2013), the findings from the study were found that the best way to create a well-organized discharge process was to eliminate variations, which serve to impede the successful discharging of patients. Variations, such as the off-set nurse schedule telemetry found in Hospital 2, impeded effective patient discharge. Participant 1's statements about ineffective communication "trickle-down effects," and the benefits of a "Morning Discharge Meeting" were noted as evidence of the communication lacking between nurses and other staff, and illuminated the need to correct and eliminate unnecessary actions, activities, and communications.

In reference to the role of case managers and social workers, one of the causes for the unproductive discharging of patients is inefficient communication between inpatient and outpatient providers (Weinberger et al., 2014). Thorough communication with case managers and social workers is an essential component to providing an efficient discharge. According to Participant 1, the day before discharge, "We need to start these things (the discharge proceedings), get case management involved, get social worker involved, get the respiratory therapist involved; it's complicated." Found both in the literature from authors such as Weinberger et al. (2014), and through the perceptions and

observations of the participants in this study and documentation used in this study, communication between nurses, case managers, and social workers is important to a create a smooth discharge of patients.

Participant 2 shared another perception related to communication between nurses and other staff. Initially, the interviewee stated that one problem area involved case managers and social worker's failure to do their part in the discharge process. Participant 2 shared that case managers and social workers "leave a lot to nursing," which creates "nurse delays" the following day. The interviewee added that such situations often create the impression that nurses "didn't follow through" when the delays were not actually of their doing. When Participant 2 was asked to clarify how case managers and social workers contribute to discharge delays, Participant 2 rephrased her previous statement with the following omission:

> They didn't call me. "I'm waiting for this one here" or "Can you please fax all us the paperwork if they ask for it?" They usually leave a note about what exactly needs to be done, but it's just getting to it, being able to follow through.

Participant 2 acquiesced that not all the case managers' and social workers' failure to do their part was their fault, as often they were impeded by other conditions beyond their control, a circumstance noted by Tak et al. (2013). In either case, I saw the need for enhanced communication between nurses and other staff.

In summary, eliminating variations related to the need for more effective and clear communication between discharge members as exemplified in Table 3. In reducing off-set of shift telemetry, where nurses do 12-hour shifts can be shifted to encourage

more communication between nurses and other staff. (Weinberger et al., 2014). The role of case managers and social workers was also assessed and ineffective communication between inpatient and outpatient providers was noted. Comprehensive communication with case managers and social workers is an indispensable element in providing an efficient discharge. Although the findings related that not all communication between nurses and other staff is operating smoothly, I could see some evidence of success from interviewing the participants.

Table 3. Frequency of Response for Subtheme 1b

Communication between Nurses and Other Staff	Frequency of Response
Participant 1 (Hospital 1)	11
Participant 2 (Hospital 1)	8
Participant 3 (Hospital 2)	5

Subtheme 1c: Communication between hospital staff, patients, and families of patients. Communication between hospital staff, patients, and families is essential to a smooth and effective patient discharge (Tortorella et al., 2013). Interview Question 4 asked the participants about which type of leadership strategies used in the discharge process they saw as being most the effective. In response, Participant 2 highlighted the importance of "good communication with patients." The interviewee further shared that a lack of communication between patients and hospital staff members ultimately led to discharge delays in Hospital 1 despite using a hospital discharge form (see Appendix E) and a complete set of discharge instructions.

Based on the study by Tortorella et al. (2013), patients need to have discharge instructions explained simply and professionally to keep the discharge process

progressing in a timely manner. Providing good service requires a high level of organization and patient communication (Tortorella et al., 2013). The discharge document used by the hospitals in the study provides ample review of the patient's hospital stay and instructions post hospitalization. Although the appropriate information is given to patients when leaving the hospital, patients may need to ask additional questions, or may be at risk for not following the correct procedures and create the potential need to be readmitted for further care (Chan et al., 2014). Confirming that the patient understands all portions of the discharge documentation is critical in creating efficient discharges. Noted by the participants interviewed for the study, observations, and in the literature, clear communication with patients is essential to ensuring the patient understands the discharge instructions, avoids additional readmissions, and moves the discharge process to it its conclusion successfully.

Concerning communication with families, clear dialogues between hospital staff and the family members or caretaker of a patient facilitates the discharge process, especially in the event of ensuring the patient has somewhere to go and a means to get there (Ganong & Coleman, 2014). Participant 1's response to Interview Question 6, which asked participants what current leadership strategies reduce discharge inefficiencies, was that working closely with family members contributes to the timely discharge of the patient. Hospital administrators and discharge nurses give patients, their family members, and care providers information and instructions when a patient experiences discharge. Nevertheless, Participant 1 commented that sometimes the information is misunderstood, or not read upon discharge, and nurses do not always take

the time to ensure that all documentation is read and understood completely (Tortorella et al., 2013).

In other circumstances where difficulties arise due to problems with a patient's family member, Participant 2 shared how she worked with a family member who had difficulty procuring transportation. She stated that her experience "showed her that staff members need to find out what their (family members') concerns are and (then) see what we can do to facilitate them (in order to discharge the patient)." Based on one of the five themes identified by Greysen et al. (2012), poor patient and family communication arose as a primary issue in successfully discharging patients.

Neither Participant 1 nor 3 shared much about communication with patients or their families, and Participant 1 only spoke about confusing communications received by patients from their care providers and even with family members. Joynt et al. (2014) argued that at times issues such as being busy, fatigued, or inexperienced, or lacking language fluency affect the health care professionals' ability to communicate discharge instructions comprehensively.

Samuels-Kalow et al. (2012) further argued that decisions are critical when addressing the content of the discharge instructions, the method of delivery, and whether to verify if patients understand the information after they have received the instructions. In presenting discharge instructions well, and in a format that is understandable, patients, their family members, and or caregivers can understand best. Given the participant responses, or lack thereof, and literature surrounding effective communication between hospital staff members and patients' family members, and the provision of discharge

documentation to patients, family members, and or care providers this issue warrants more attention to create a successful discharge process. These findings are confirmed below by the variation displayed in Table 4.

Table 4. Frequency of Response for Subtheme 1c

Communication between Hospital Staff, Patients, and Families of Patients	Frequency of Response
Participant 1 (Hospital 1)	9
Participant 2 (Hospital 1)	9
Participant 3 (Hospital 2)	3

Main Theme 2: Facilitating Effective Leadership

The conceptual framework for the study related to leadership theories and ways in which to approach organizational structure. Leadership is an important concept when evaluating behavior and it represents the link between the individual and the organization (Boonstra, 2012; Rowitz, 2013). As leadership is an indicator of the manner in which management relates to the organization and collaborates with staff to lead and manage the organization effectively, using this framework for evaluating the hospital discharge process was useful. Gaining an understanding of the effects of leadership style on LOS within a hospital environment allowed for a review of the leadership strategies used in the hospitals in the study. Contingency theory and situational leadership theory are apparent in this study.

Contingency theorists look at an organization from a broad perspective, which accounts for larger organizational influences (both internal and external). Contingency theory help researchers relay that there is no single best method to organize, manage, and

implement processes in an organization (Wadongo & Abdel-Kader, 2014). Instead of one best method, optimal solutions are contingent on varying circumstances, such as technology, the environment, and the products associated with the organization. Because patient discharge from a hospital stay is a complex process, contingency theory was useful for analyzing the process as it allows for flexibility within the hospital discharge process (Senot et al., 2015). Similarly, yet not the same, situational theory focuses on behaviors that leaders should adopt, given any number of varying situational factors, which can be used to facilitate positive responses in employee behavior and shift organizational processes at the micro level (Dinh et al., 2014).

The use of both of these theories was useful in assessing the facilitation of effective leadership at the hospital given the need to be able to respond to each unique situation as it arises effectively (Senot et al., 2015). Interview Question 4 asked if there are different leadership strategies that work better in a given situation. Participant 1 shared that varying strategies are utilized between three different staff positions and are based on the specific situation:

> Our Night Assistant Patient Care Manager (who has) been here for almost 18 years, is in process of training another young lady who has been here only for about 4 or 5 years. She provides a great leadership role; was actually was a supervisor at one point. She (the Night Assistant Patient Care Manager) knows all the different things we need to do, she knows all the protocols, she knows all the policies, and she knows all the procedures. So we kind of utilize that.

The Night Assistant Patient Care Manager at Hospital 1 has a reputation of giving nurses prompt attention when addressing a discharge, and spoke about her "flexible approach" that creates effective discharges. However, the Night Assistant Patient Care Manager at Hospital 1 is only one manager out of many, and not all managers function with the same level of expertise and efficiency. When asked Interview Question 3, which related to what leadership strategies, Participant 2 put in place within her organization to reduce incidents of delayed discharges, she shared about situations in which case managers have difficulties with particular nurses:

> Well if I know there's a problem going on, some of the case managers may come to me and say, "Hey Mindy, you know how this nurse is, you know we're telling her to do this, and she's not really doing it." So then I'll go talk to the staff and see what they need help with.

As reiterated throughout the study, it is important that multi-disciplinary discharge teams all work together toward facilitating the patient's discharge (Bertsch, 2014; Skurka, 2017). Shirley and Sanders (2013) found that discharge delays are a result of poor collaboration between the hospital management, physicians, and nurses. Solid leadership strategies such as streamlining the discharge process and facilitating communication could be used to facilitate effective leadership.. Interview Question 6 asked how current leadership strategies reduce discharge inefficiencies. Participant 2 again referenced the utility of doing rounds three times a week in her hospital:

> Like I said, the rounds really do make a difference. If it is expected that a patient will be in the hospital for 3 or 4 days, we start asking if they are going to need oxygen at home, (and if there is any doubt about the need), we test for that.

Majeed et al. (2012) supported the need for efficient, yet flexible, leadership strategies by acknowledging that admitting patients to the hospital should adhere to a more rigorous and adaptable discharge schedule.

Having a clear understanding of the patients' needs from the onset aids the smooth functioning of the discharge process (Holland et al., 2016). Participant 2 explained that "beginning the discharge process the moment the patient is admitted" is paramount to a smooth and effective process. In their work, both Bertsch (2014) and Shepperd et al. (2013) stressed the importance of focusing on the discharge of the patient from the first moment of arrival to ensure a timely process. Holland et al. (2016) asserted that discharge planning should also include the creation of a customized plan for the patient prior to discharge from the health organization.

The discharge instructions used at both hospitals affirmed that a customized discharge plan was used for each patient leaving the hospital, yet the use of the documentation does not guarantee that patients, their family members, or their care givers always have the information explained to them in a clear and understandable manner. Whether this is due to limitations such as overwork, fatigue, inexperience, language fluency, or any combination of these factors, they affect health care professionals' abilities to coordinate effective leadership practices and discharge patients efficiently (Joynt et al., 2014).

The results from interviews, observations, and documentation review as well as the extant the literature, illustrated the need for flexibility and organization to create an effective discharge process. Proficient leadership includes understanding the patients; needs, a focus on the final discharge, and the appropriate support. The use of leadership strategies that include streamlining the discharge process, facilitating communication to facilitate discharges, and creating a discharge process guide, standardizing orders and protocols, and possibly even mapping the discharge process could be useful to ensure an efficient discharge process. A willingness to work within the parameters set in certain situations and using a contingency theory approach to leadership will aid in motivating employees (Dinh et al., 2014). Implementing these changes will ensure patients can leave the hospital in a timely, efficient, and cost-effective way (Holland et al., 2016).

Regarding complex and not always efficient leadership, hospital managers are typically more bureaucratic and transactional in leadership style (McCleskey, 2014). Hospitals frequently use a system in which change is difficult to implement due to staid bureaucratic styles of functioning, and this presents problems (McCleskey, 2014). Yet, as change takes place and new challenges arise, such as breakdowns in the discharge process, it forces the use of leadership strategies that can influence increased communication and variable approaches for the benefit of hospital productivity (Stoller, 2013).

Varied leadership styles work effectively (Battilana & Casciaro, 2012). Participant 3, shared that a somewhat flexible discharge process **“**works better at [Hospital 2] because with the Residents and the Fellows, there are a lot of (helping) hands

in the cookie jar." The implication is that having more help available allows the staff to make the needed changes and adapt more efficiently based on a given situation. In support of this, Participant 1 elaborated on the varying strategies between three different staff positions at the hospital (Hospital 1) and are based on the specific situation. In their work, Battilana and Casciaro (2012) asserted that it is essential that leaders have the necessary foundational skills and tools available to implement and manage change effectively in any given situation where there is a need for change. The findings from the study support their research, based on what Participant 1 and 3 shared in relationship to having enough support to facilitate the discharge process.

When all parties within the discharge process are using strategies that include all other members, discharge is more effective (Weinberger et al., 2014). Participant 1 spoke about the challenges inherent in-patient care systems that encompass multiple staff members; such challenges are often overcome by "keep(ing) each other in the loop" and through "small huddle(s) in the morning," which involved charge nurses, primary nurses, and physicians. Participant 1 provided a detailed example of one type of conversation that takes place during the huddles:

> So, we get together and say, "Hey these are the people that will potentially get discharged today, these are the people that are going home, these are the people that we need to get an ambulance for (those who are going to nursing home), and these are people we need to contact the family for." So, there's a process which starts as soon as we get here. It starts with the charge nurse and the primary nurse communicating with one another.

When questioned further, Participant 1 responded by explaining how the use of a monitoring tool helps with the quality of care provided to patients. Participant 1 also stated that in addition to the monitoring too, a staff member whose sole purpose is to "come in strictly for quality control (as they are currently carrying out this responsibility)" is required. Furthermore, Participant 1 explained how a new procedure, aimed at assisting patients during their stays and discharges, involving "behavioral consultants," "cardiac rehab consultants," and "Congestive Heart Failure (CHF) Champions," is proving to be somewhat effective.

Lastly, Participant 1 referred to a final process known as "teach-back (which means we are educating the patients) the entire time that they are here," and stated that the initial results of the implementation of this process are promising. Tak et al. (2013) reinforced the thinking that effective leadership surrounding the discharge planning processes reduces both LOS and unplanned readmissions, and the new tools at Hospital 1 are promising. Nevertheless, the discharge process is more complex given that it frequently involves a primary care physician and three or more consulting physicians, not to mention all other members of the discharge team, and the need to fully understand the discharge documentation.

Participant 1 stated that coordinating the input and evaluation of all providers is "one of the main areas we have the biggest problem with" because it involves a high level of communication not only from each of the physicians, but also from nurses that work on different shifts as well as other care providers that may be needed to complete the discharge process. The findings from this study tie into Weinberger et al. (2014) third

factor which promotes ineffective discharges; an unorganized discharge team. The implications drawn from Hesselink, Zegers et al.'s (2013) study further addressed the level to which care providers value processes within the system. Despite costly expenditures and steady growth, the introduction of non-hospital providers, such as specialized physicians, commercial clinics, and emergency care facilities, has led to even more complexity and mires the discharge process even further (Kwon, 2014). The results suggested that the needed flexibility associated with contingency theory and situational leadership theories are not fully in evidence in Hospital 1 to create an organized, team-level discharge event.

The negative results of complexity were most apparent in the materials gathered from the interviews, discharge documents, and observation checklist data for Participants 1 and 2, who work within the same hospital, as well as between all three participants. For example, all three participants cited different methods and strategies used in their hospital discharge processes, and at times the discharge process itself what referred to as a "theory." In terms of the descriptions of the discharge process, and strategies used to reduce time, Participants 2 and 3 frequently used the same answers as they did for Interview Question 1, related to the main leadership method used for making the discharge process timely. It should be noted that both of these participants also answered the question in dissimilar manners. The third participant also stated that the process for discharge was "complex," but failed to mention any specific strategies used. All three participants stated there is a large amount of variability in the discharge process, despite the use of the discharge form and the discharge instructions given to each patient.

When answering questions directly related to different strategies working better in different situations, there was a further lack of consistency between the three participants, and one of the participants stated that no one strategy was better, and that it depended on the situation. Concerning the ways in which current leadership strategies reduced discharge inefficiencies, the three participants cited three different strategies. Regarding aspects of leadership that the participants would change, three different sets of solutions were provided, and all appeared to have very little continuity between the sets of proposed solutions. Little discussion emerged to address that patients, family members, or caregivers understood all the discharge instructions when leaving the hospital, potentially adding to complexity and readmission.

In discussing the most effective leadership strategies used to reduce hospital discharge delays, two of the three participants cited different processes, and Participant 3 stated that the current process "is the best." The third participant, interviewed working at Hospital 2, seemed to view the process at Hospital 2 differently than the other two participants experienced the discharge process at Hospital 1. Nevertheless, there was a lack of information pertaining to what the primary difference was and overall there was little consistency between the three participant's responses.

The conclusions found in the literature, and in the interviews, give credibility to the findings in this study that if not all members of a team are working together under effective leadership, discharge delays and LOS will occur. The findings are in evidence in Table 5, especially given the high response rates, most obvious from Participant 1's responses. Aligning leadership strategies with contingency theory and situational

leadership theory would be extremely effective in ensuring that all needs involving a timely and efficient discharge process could take place, even in situations where spontaneity and creativity do not exist.

Table 5. Frequency of Response for Main Theme 2

Facilitating Effective Leadership	Frequency of Response
Participant 1 (Hospital 1)	18
Participant 2 (Hospital 1)	9
Participant 3 (Hospital 2)	8

Subtheme 2a: Head nurse's role. In this section, the designation head nurse is interchangeably referred to as the throughput nurse, the charge nurse, or the discharge nurse. Whichever term is used by the participants and in the literature, this nurse is responsible for the discharge process and has the ability to enhance the discharge process (Wong et al., 2012). Frequently, those in this position play a critical role in facilitating an efficient discharge process (Wertheimer et al., 2014). To lend further clarity to this nurse's role in discharging patients, Participant 1 shared about the recent approval at her hospital to alleviate the charge nurse's responsibility of having to care for her own patients, as well as oversee other nursing activities during a shift.

Participant 1 stated the positive impact this change has made on the discharge process. Participant 1 shared that the charge nurse "can be an extra set of hands. She is a resource to the floor and she can be working on all the discharges while everyone is getting the (new) admissions settled in and calmed down." Participant 1 added that in having upwards of 14 admissions and 12 discharges for each 12-hour shift, the (new)

availability of the charge nurse prevents the "facility from going into a bypass status" and is "the biggest tool that we use."

In responding to Interview Question 1, which asked about the participants' main leadership method for making the discharge process timely, Participant 3 referenced the importance the admission discharge nurse (throughput nurse) had in ensuring discharge efficiency. Concerning some of the specific processes, the interviewee referred to the need for "medical requests (to be) completed" and stated that working on such requests is "the hardest part of the discharge."

Furthermore, Participant 3 explained how the admission discharge nurse monitors the overall process and "starts communications with those nurses (who have completed the medical requests), to see if there are any loose ends. Admission discharge nurses often question their nurses using statements such as: "Did you do the discharge order (done after the medical request has been completed)?" "Do we need consults?" and "Do we need social services involved?" In the service function chain, an effective discharge process is essential for smooth operational activity, and the discharge charge nurse plays a significant role in this process (Koskinen, 2013; Moon, 2016).

Interview Question 2 asked participants how they would describe the discharge process in relation to leadership strategies employed to reduce discharge time. In response, the role of the discharge nurse was once again mentioned by Participant 3, who explained that through the use of discharge nurse, discharge has become more efficient, especially in relation to timing the discharges:

> So, we had audited originally when we started this process over on 5 South. That's where the original process came from, and at that time, I did a lot of tracking of data as far as when transfers occurred, and when discharges occurred. We had a high volume of discharges at that time happening after the 7 to 11 shift, so within that time, we were seeing a lot of discharges happening. So, we put this position [discharge nurse] in place to see if we could actually drive those times to occur earlier, to avoid having a crunch of throughput. (This was our goal because) we know that ER starts unloading patients anywhere between 3 to 7. That's the busy time, so our goal was to make the discharges happen before 3 o'clock. We saw a lot of changes; many more discharges were (now) happening from 1 to 3 or 1 to 4, versus what we had before. So, we did track that for an extended period of time and we did prove the theory.

To summarize, Participant 3 was part of an initiative to drive discharge times to an earlier hour of the day. After experimenting with different scenarios, the discharge time moved to earlier in the day at Hospital 2, eliminating the discharge bottlenecking that was occurring later in the day. Appropriate care and streamlining of processes can lead to early discharges. In reference to the charge nurse shifting the time of discharge to alleviate potential bottlenecks, Wong et al. (2012) and Wertheimer et al. (2014) identified the effects of hospital admissions and discharge timing concerning peak times for everyday admissions and discharges. In their work, Wertheimer et al. (2014) divided patient admission data from one hospital into groups based on the common scheduling of

daily admission and discharges. They found that bottlenecks could be reducedbased on a willingness to adjust the timing of patient discharge (Wertheimer et al., 2014).

Wong et al. (2012) also contributed to this discussion through their analysis, which provided data related to discharge issues occurring based on day of the week and holidays. In Hospital 2, the role played by the discharge nurse in implementing an earlier discharge time showed positive results, indicating that the literature and the work conducted in the study are valid for addressing a more efficient discharge process via the role of an effective discharge nurse.

When questioned with Interview Question 4, which asked what type of leadership strategies used in the discharge process the participant understood as being most effective, Participant 3 explained that "the process we currently have (is the most effective), because the focus is on the actual needs at hand." Interview Question 5 asked what different types of leadership strategies seem to work best in a given situation. Participant 3 explained that through the use of discharge nurse, the discharge process has become more efficient. Further related to the role of the discharge nurse, and in answering Interview Question 3, which inquired about what leadership strategies were in place within the participant's organization to reduce incidents of delayed discharges, Participant 3 referred to the role of the discharge nurse, as being an invaluable part of the patient care "team."

The role of the discharge nurse should be that of providing consistency to the rest of the discharge team (Hesselink, Zegers et al., 2013). Interview Question 1 asked about the main leadership method for making the discharge process timely. In response,

Participant 2 explained how, as a manager, she conducted her rounds "3 times a week" and "follow up with staff, if I hear that someone is going home to make sure they are keeping up with it (the discharge process)." Participant 2 also stated that, "On a day to day basis, if the staff has a problem with a patient being discharged, they tell me." Concerning Interview Question 2, which related to participants' describing the discharge process in relation to leadership strategies employed to reduce discharge time, Participant 2 continued discussing the nature of their routine stating that the rounds "facilitate us with (the discharge process) because before, we just kind of went back and forth with to the case manager (which wasn't always enough)."

While Participant 2 stated that positive changes have taken place in Hospital 1, it was also noted that there was a lack of any specific leadership strategy, which seemed to work best, and that one problem area involved case managers and social workers' failure to do their part of the discharge process. In contrast to the reality at Hospital 1, Participant 3 shared the following dynamics, which are central to her current place of employment:

> You think the patient is going home, but when you talk to the nurses, and you're looking in the computer, you realize that you don't really know if the patient is definitively going home. You have to wait for the Blue Team, the Gold Team, and Attending Nurse to come and make that decision. It's a lot of fluff.

In this situation, the discharge nurse is not playing an effective role in promoting a more efficient discharge process. However, some of the experience at Hospital 2 may have been beyond the control of the discharge nurse. Tak et al. (2013) supported the finding

that all situations are unique, and it is important to note that not all members of the discharge team can influence the behaviors of the other team members.

Regardless of positive changes made in creating an effective discharge process in Hospital 1, the findings point to the importance of the situational leadership theory in that while flexibility is needed, situational leadership holds components of all the leadership theories discussed, allowing for some structure (Dinh et al., 2014). Overall, there appears a need for implementation of contingency and situational approaches to better facilitate the discharge process (Moon, 2016).

As an additional response to how leadership could be better, Participant 3 explained that they "probably would put one charge nurse in, and change the time of the evening shift from 7a-7p to 10a-10p." The interviewee added that making such changes would require the collaboration of many staff members and could not be "simply initiated." The finding suggested that even in a setting where the participant felt the hospital's leadership strategies were generally effective, there was always room to improve the process. Without question, the three participants cited different leadership methods and styles between the two hospitals, and even more noticeable were the differences in the perceptions between Participant 1 and Participant 2, both of whom work at Hospital 1. Nevertheless, concerning the most effective leadership strategies used, two of the three participants cited different processes and the third participant stated that the current process "is the best."

Reiterated throughout the study, the effective management of organizational culture and change is necessary for the operative management of performance (Jacobs et

al., 2013). In reference to a hospital culture surrounding discharging patients, all three hospitals showed evidence of a divided, and somewhat messy and misunderstood process for discharge. The findings included Hospital 2, although to a lesser extent. Hesselink, Zeger et al.'s (2013) work tied to these findings in that there appeared to be a failure to reflect on discharge process improvements, an important component to creating an efficient hospital discharge culture. For example, all three participants seemed to lack the ability to fully reflect on the discharge process with clarity, including Participant 3 to some extent, and one participant even described the discharge process as a "theory." Given the findings in the study and in the literature, hospital culture is important in improving the hospital discharge process (Jacobs et al., 2013). Further exploration of the strategies hospital administrators use to improve profitability by reducing delayed discharges can contribute to all the findings in this study. There is a strong relationship between organizational culture, the leadership structures in an organization, and the importance of the head nurse as noted in Table 6. The management of organizational culture constitutes a very important leadership function (Jacobs et al., 2013). Matching the appropriate leadership style to distinct organizations is paramount in achieving effective business practices. As seen from the data gathered in the interviews, observations, in the literature, and in hospital documentation of the discharge process, organizational culture, and the roles played by head nurses, strongly relate to how patients experience discharge in a hospital setting.

Table 6. Frequency of Response for Subtheme 2a

Head Nurse's Role	Frequency of Response

Participant 1	(Hospital 1)	12
Participant 2	(Hospital 1)	9
Participant 3	(Hospital 2)	13

Themes Revisited

Through close analysis of the findings, the most apparent themes were those of inefficiencies in the discharge process and inadequate communication between discharge teams. Based on the participants' responses to the interview questions, the observations, and through the literature, ample information gleaned from the findings is revealing. It is obvious that there was quite a bit of variability between the answers given by each participant, some of which depended upon the hospital in which they work. However, enough gathered information warranted saturation as noted in Tables 7 and 8.

While Participants 1 and 2 work at the same hospital (1), some of their answers differed from one another. Participant 3 works in a separate hospital (2) entirely. Although there were distinct findings in relationship to Participant 3's experience at her hospital, there were, nonetheless, common themes revealed for all three hospitals. Through member checking and method triangulation, the main themes primarily consisted of inadequate communication, especially in communications between doctors and nurses, between nurses and other staff, and between hospital staff, patients, and families of patients.

Table 7. Frequency of Total Responses for Themes and Subthemes Related to Communication

Overall Need for Efficient Communication		Frequency of Response
Participant 1	(Hospital 1)	38

Participant 2	(Hospital 1)	36
Participant 3	(Hospital 2)	25

The second main theme, the need to facilitate effective leadership, was explored through the subtheme of the head nurse's role. The implications drawn from the study were that the level to which care providers value processes within the system is critical to implementing effective hospital discharges (Hesselink, Zegers et al., 2013). Given the findings on the participants, all three of these components were applicable. Hospital 1 participants appeared to have greater difficulty in achieving efficient discharges, yet Hospital 2's participant had more success overall. The findings are significant because the undervaluing of administrative tasks interferes with good business practices, and Hospital 2, the hospital that had the most success in efficiently conducting the discharge process, adapted best when presented to a variety of situations or contingencies. These findings are below in Table 8.

Table 8. Frequency of Total Responses for Themes and Subthemes Related Effective Leadership

Facilitating Effective Leadership		Frequency of Response
Participant 1	(Hospital 1)	30
Participant 2	(Hospital 1)	18
Participant 3	(Hospital 2)	21

In relationship to the conceptual framework of contingency theory and situational leadership theory, inadequate communication between discharge teams was obviously problematic and lacking a more dynamic and fluid approach to the discharge process. Some of that which appeared to operate at both hospitals was the older, more

staidhospital systems frequently used in bureaucratic settings (McCleskey, 2014). Transactional leadership systems are inefficient and indicate the need for newer approaches to managing hospital systems Stoller (2013). In both hospitals there appeared to be an awareness for the need to redefine policies and strategies in response to the changing nature of the hospital discharge environment (Chemers, 2014).

Based on the participants' responses to the interview questions, the observations, and through the literature, sufficient information from the findings suggests that the use contingency theory and situational leadership theory would be beneficial in facilitating effective leadership. Hospital 1's participants appeared to have greater difficulty in achieving efficient discharges, and Hospital 2's participant had more success overall. These findings are notable because Hospital 2 appears to have had more success in implementing contingency theory and situational leadership theory styles. Although Hospital 1 appears to have greater challenges in creating an efficient discharge process, the example set forth by Hospital 2 is encouraging. It seems likely that both Hospitals will continue to more away from more bureaucratic hospital settings with transactional leadership styles and instead embrace the more dynamic situational and contingency leadership styles to enable a more efficient and effective discharge process.

Summary

Understanding organizational culture and change is one of the key challenges that leaders have to manage, especially when problems such as delayed discharges are experienced in hospitals. During periods of change, or in a fluid, complex and dynamic environment where hospital discharges occur, effective strategic leadership is critical to

successful outcomes (Boonstra, 2012). Battilana and Casciaro (2012) asserted that it is essential that leaders have the necessary foundational skills and tools available to implement and manage change effectively in any given situation where there is a need for change, and the finding from the study support their research. Boonstra (2012) provided a framework for managing change that focused on cultural factors.

Certain conditions, such as a willingness to communicate and remain flexible in response to changing circumstances, are essential within an organization to achieve positive cultural and strategic transformation, and this transformation is critically dependent on leadership (Battilana & Casciaro, 2012; Harrison et al., 2016). The study conducted supported these findings and added to the idea that creating change requires a form of leadership that goes beyond transactional leadership roles (Battilana & Casciaro, 2012). Greysen et al.'s (2012) five themes related to the quality of discharge care were competing levels of importance in the discharge process, inadequate coordination within multidisciplinary discharge teams, lack of standardization in discharge procedures, poor patient and family communication, and lack of post-discharge feedback and clinical responsibility. All of Greysen et al.'s (2012) themes connected well with the findings of my study after coding and analyzing the interview transcripts, assessing the observational data, and analyzing hospital discharge documents. For example, Greysen et al.'s (2012) themes were in evidence through the information relayed by Participant 1 and 2, employees of Hospital 1, the larger of the two.

Because individual hospitals and leaders are unique, and because hospital culture is dependent on a variety of different conditions (both internal and external), contingency

theory and situational leadership styles would be most effective for managing the differences found in hospitals and unique situations within hospitals (Moon, 2016). Senot et al. (2015) echoed using contingency theory in this way given that discharging a patient from the hospital can be complex. Interview, observation, and literature findings illustrated the need for flexibility in leadership style to create an effective discharge process as was clearly demonstrated in the success at Hospital 2. Proficient leadership includes understanding the patients' needs, a focus on the final discharge, and the appropriate support (Holland et al., 2016). Leadership strategies such as contingency theory and situational leadership theory both include streamlining the discharge process and facilitating communication.

As a whole, both situational theory and contingency theory were useful for analyzing the discharge process, contributed to framing the findings, and aided in analyzing the findings. Interviews, direct observation, analyzing the documents used in the discharge process, and review of the literature contributed to successfully validating the study. Method triangulation served to integrate the data, make use of preexisting data and previous research to analyze methods, investigations, and theories, and to provide corroborating evidence for this study.

Application to Professional Practice

Through assessing the findings from this study and prior studies, leadership strategies based on contingency theory and situational leadership theory could contribute significantly to the professional practice occurring at hospitals. As established through exploring the findings from the interviews, the observations, and the literature, delayed

discharges are common in hospitals. Without question, patients who remain in the hospital beyond their appropriate discharge date increase the financial burden on hospitals, which results in loss of profit (Skurka, 2017). Inefficiencies in leadership result in patients remaining in the hospital longer than necessary, becoming a financial burden on a hospital, and decreasing hospital profitability. If given more appropriate leadership strategies, such as those used by the administrators in this study, a reduction of delayed hospital discharges could improve both the process and profitability.

The work conducted in the study contributes to business practices by having identified strategies hospital administrators can use to reduce delayed hospital discharges and improve profitability. Using interviews, observations, and discharge documents have promoted an understanding of the types of inefficiencies that exist in the leadership at Hospitals 1 and 2, which at times result in patients remaining in the hospital longer than necessary. What has shown to be a problem, inefficiencies in the process based on communication problems and ineffective leadership strategies, primarily those that are rigid such as transactional leadership styles, is valuable in assessing what needs to be corrected to contribute to a more effective discharge process (Harrison et al., 2016). Nevertheless, some success in both hospitals is apparent, and the discharge process at Hospital 2 evidenced contingency and situational approaches to leadership. Working within the parameters determined in certain situations, and by using contingency theory and situational leadership approaches to leadership will aid the discharge process. Implementing changes in leadership style will ensure patients can leave the hospital in a timely, efficient, and cost-effective way (Holland et al., 2016).

The strategies that have worked, such as more help and streamlined, yet flexible, leadership approaches at Hospital 2, are useful to create efficient discharge processes at hospitals in Chicago and elsewhere. Instituting the use of discharge teams, in which certain teams have different tasks, is beneficial. The discharge guide could allow team members to clearly see their role in the process, especially if all team members are communicating to their colleagues through marking off the completion of their discharge task. A mapping system, in which a process map is hung on a wall, can potentially be manipulated by team members and may be helpful. Another enhancing feature of the discharge process is to establish a potential discharge date from the moment a patient first arrives, based on their condition at the time of admittance.

Patient education is also critical and is discussed more fully in the following section. Adopting some of the above techniques can positively affect the community in which the hospitals serve, create timely discharges, and decrease the backlog of patients trying to get through the system (Harrison et al., 2016; Skurka, 2017). Adoption of the strategies, both present and lacking in the results of this study, will allow for more movement through the discharge system and give patients the opportunity to receive the care they need in a timely manner. The findings, conclusions, and recommendations from this study can contribute to making hospital discharge processes more effective, thereby adding value to hospital business practices (Moon, 2016).

Implications for Social Change

As noted at the start of the study, hospital care for admitted patients accounts for the largest proportion of healthcare spending in the United States (Das, 2013). In many

hospitals, the standard model for a hospital, prolonged LOS not only increases costs but also increases the rates of patient complications (Majeed et al., 2012). Frequently, this leads to further increases in cost (Majeed et al., 2012; Moon, 2016). The results of this research contribute to positive social change by demonstrating how effective organizational strategies reduce delayed hospital discharges. The findings from this study can help hospital administrators implement improved discharge processes, which contribute to positive social change by establishing how effective organizational strategies reduce delayed hospital discharges. The findings from this study can support hospital administrators to implement improved discharge processes that can contribute to positive social change within communities, both local and national. By promoting care that is more efficient, patients will not have to spend unnecessary amounts of time in the hospital, and can return to daily living and contributing to their communities more quickly (Holland et al., 2016).

Furthermore, the positive social implications for this research are that through adopting leadership strategies based on contingency and situational leadership theories, such as streamlining the discharge process and facilitating communication between discharge team members, social hardships associated with delayed discharges such as greater financial burdens and excessive time spent in the hospital, which detract from living well. Creating a more effective and efficient discharge process can aid patients in returning to their jobs, activities, and communities for the social and economic benefit of all citizens. The work conducted in the study can effect change within communities, both local and national, by making tangible improvements to individuals, communities,

organizations, institutions, cultures, or societies as the findings could beneficially affect social change and behaviors.

Recommendations for Action

In deciding what actions need to are critical, it is important to explore which actions are best, who can benefit from the recommended actions, and how to best implement them. In reviewing the literature, Chan et al. (2014) concluded that managers could reduce overtime costs by focusing on improvements to the discharge process. In improving the discharge process, the wages paid to employees to stay after hours or to work overtime, to ensure the discharge of patients, could be mitigated and result in cost savings for hospitals. As seen from the findings, reduced labor hours would make a noticeable difference in expediting discharges at hospitals. Another recommended action would be to ensure that on the discharge day, multi-disciplinary discharge teams, comprised of nurses, managers, physicians, and social workers, are all working toward facilitating the patient's discharge. Another method to improve discharge efficiency would be to link a patient's discharge summaries (DS) with previous patient data. The DS incorporates complications, diagnosis, comorbidities, and anticipated future treatment(s), and would automatically link the DS to information surrounding any patient (Chan et al., 2014). Such a method would be instrumental in knowing what type of care to give the patient to afford a timely and accurate discharge.

Furthermore, Koskinen (2013) found that planning for discharge starts at hospital admittance; this finding is apparent for the participants in the study. It would also be beneficial to ensure that each hospitalized patient receives the required customized

discharge plan and has a thorough understanding of the instructions. Use of the contingency and situational theories would allow for this flexibility and analysis of the hospital discharge phenomenon (Senot et al., 2015).

Additionally, Participant 1 explained how a new procedure, aimed at assisting patients during their stays and discharges, involving "behavioral consultants," "cardiac rehab consultants," and "Congestive Heart Failure (CHF) Champions," is proving to be somewhat effective and could be coupled with greater explanation of the discharge documents. Lastly, the interviewee referred to a final process known as "teach-back (which means we are educating the patients) the entire time that they are here," and stated that the initial results of the implementation of this process are promising. Although not all of these strategies are fully in place and functioning optimally at Hospital 1, they do present beneficial strategies for ensuring the discharge process is more efficient.

The need to operationalize new leadership strategies would serve to explain how the facilitation of hospital processes. Information regarding new approaches can give administrators and policy makers the need to tools to create change within a hospital. Expanding on what is working well, such as how the discharge nurse plays a critical role in Hospital 2, can serve to create better leadership based on situational and contingency theories. The use of both contingency theory and situational leadership theory would improve the patient discharge process in hospitals everywhere.

Implementing changes such as employing more nurses, having translators available, ensuring all time frames are covered, and confirming all members of the discharge process are in a position to have their needs met can positively shift the

hospital culture and support the timely discharge of patients. Furthermore, by engaging hospital administrators and any other staff members involved in the discharge process by holding seminars, trainings, conferences, giving employees more information and literature, and perhaps even some type of reward system will facilitate a more proactive discharge process. Finally, sharing the results through the dissemination of a published journal article, strategy presentations in conferences, efficiency trainings, and healthcare or hospital workshops focused on streamlining the discharge process through effective leadership and communication will help promote more efficient discharge processes.

Recommendations for Further Research

Many of the findings in the study are relevant and can significantly affect the leadership strategies used to facilitate the patient discharge process. Yet, most studies create a number of questions for future pursuit. Below are three recommendations for further research, which may provide greater clarity to this issue.

1. A study should be conducted to gain perspective of the phenomenon from different angles. For example, as this was a qualitative study, the depth of information taken from the interviews and observations surrounding hospital administrators could benefit from further exploration on a broader scale to pursue this topic further. Therefore, quantitative analysis including larger data sets would help to further explain patient discharges in a hospital setting.
2. A study could be conducted to further explore the perceptions of other types of employees at the hospital about the discharge process as they may have a

very different perspective on the process, not to mention a different perspective on the role management plays in facilitating the discharge process.

3. Further research could be undertaken in more hospitals, and especially more hospitals of different sizes. It seems plausible that one of the reasons facilitating the discharge process at Hospital 2 was more effective than what was found at Hospital 1 may have had something to do with the size of the hospital. Generally, as institutions become larger, there is an increased potential for breakdowns in many areas, especially within the area of communication. Simply not having the appropriate number of staff members working at the hospital can make smooth discharge transitions more difficult for everyone. Conducting a study based on differences in hospital sizes, and leadership roles and responses to size, could prove beneficial.

Reflections

As an administrator working in an associated hospital setting, I was an "insider of sorts" as opposed to an outsider regarding the study. Given that I have personally experienced instances of delayed patient discharges, and have seen how inefficient processes, leadership strategies, and communication issues can affect the flow of the discharge process, I have an opinion on this topic. Although I made every effort to treat the study, and any information learned, objectively; and minimized researcher bias by remaining objective and neutral when interviewing the participants and analyzing the data, it was a challenge. As I entered the study knowing that significant challenges are present in the discharge process at hospitals in the Chicago area, being taught, and using

techniques such as method triangulation and member checking have been beneficial tools and have allowed me to engage more fully with the study.

I found that during the course of this DBA, I have learned quite a bit regarding the topic of patient discharge. The issue makes a significant difference in hospitals and communities, and further study and the implementation of contingency and situational leadership practices could benefit the bottlenecks so often seen in the discharge process. I have learned more about what takes place in a hospitals setting and how there are so many variables that need to be accounted for. Undertaking this process has allowed me to gain knowledge surrounding what is necessary to facilitate a more efficient discharge process, save hospitals money, and contribute to the community.

Conclusion

As has been noted throughout this dissertation, an effective discharge process is essential for smooth operational activity at hospitals. Hospital readmissions are costly, and hospital administrators should strive to refine the hospital discharge process. A primary objective for hospital administrators should be to identify and implement efficient processes for making the correct assessments and using appropriate leadership strategies to limit unnecessary expenditures (Greysen et al., 2012; Swain, 2014). Timely identification of barriers to efficient discharge, and making the necessary leadership changes can help to reduce a patient's length of stay and can increase hospital profitability (Hurwitz et al., 2014). Unfortunately, delayed discharges are common; they affect patient flow and increase the costs incurred by the hospital (Costa et al., 2012; Hendy et al., 2012). Streamlining the discharge process by using effective leadership

strategies and facilitating communication between discharge team members must be a priority (Dobrzykowski & Tarafdar, 2015). Effective leadership surrounding the discharge planning processes reduces both LOS and unplanned readmissions (Tak, Kulkarni, & More, 2013).

In conducting a qualitative multiple case study to explore leadership strategies hospital business administrators use to reduce delayed hospital discharges and improve profitability, three hospital administrators, from two different hospitals that are part of a hospital conglomerate in Chicago, IL, were interviewed and observed. Although all of the administrators had efficient strategies to reduce delayed hospital discharges and improve profitability, further steps were occuring to address this even more efficiently in Hospital 1. While Hospital 2 appeared to be having more success in successfully implementing the patient discharge process in a timely and cost efficient manner, both hospitals were actively addressing and improving the discharge process. One factor that facilitates the discharge process is the size of the hospital. Smaller numbers of staff and patients do tend to make discharge flow more smoothly, as do a greater number of individuals taking part in the discharge process.

Researchers can use the findings of the study to identify what is ineffective and effective within the discharge process, and use the example of Hospital 1, and perhaps more so Hospital 2, as a guideline for helping hospital business administrators and hospital policymakers improve profitability. By using more flexible, yet structured, leadership strategies to reduce delayed discharges at all hospitals in the area hospitals can increase their revenue. Results from the study can also contribute to improved patient

care, fulfillment of organizational goals through effective leadership, and promote the health of the community.

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Appendix A: Interview Protocol

STEP 1: Welcome and Overview of Purpose of Interview and Protocol (2-3 minutes)

"Hi. First of all, thank you for being here to participate in this one-on-one interview. My name is Sheree Boyd and I am a doctoral student at Walden University. I am interested in learning more about what specific strategies you utilize within your daily discharge process."

"The interview today should take between 30-60 minutes. I am going to facilitate the interview and would you mind if I taped the interview? It will help me stay focused on our conversation and it will ensure I have an accurate record of what we discuss. After the transcripts are created from the recording, two additional steps will take place."

"First, I will invite individuals who participated to submit additional information that can help provide additional insight into the questions posed. The individual (or I) may want to schedule a follow-up conversation over the phone or via email to clarify or elaborate on any of the responses shared at the interview. This can also take place in a second, follow-up meeting"

"Second, I will erase the audio recording. The typed transcripts will be kept on my computer in a password-protected file for five years. Individuals can decide at any time to discontinue their participation. Please feel free to ask any questions you may have. Shall we get started?"

STEP 2: Introduction (2-3 minutes)

"Please tell me about your background, experience, and credentials."

STEP 3: Ten Questions Posed to Interviewee (4-5 minutes per question)

1) What is your main leadership method for making the discharge process timely?

2) How would you describe the discharge process in relation to leadership strategies employed to reduce discharge time?

3) How much variability is present in individual patient's discharge determinations and needs?

4) How would you describe the communication between diverse hospital staff as it pertains to the facilitation of a timely discharge?

5) What leadership strategies have you put in place within your organization to reduce incidents of delayed discharges?

6) What type of leadership strategies used in the discharge process can you see as being most effective?

7) Are there different leadership strategies that work better in a given situation?

8) How do the current leadership strategies reduce discharge inefficiencies?

9) What aspects of leadership might you change to better facilitate the discharge process in your hospital?

10) Is there anything you would like to add regarding leadership strategies you use in your hospital to decrease delayed hospital discharges and ultimately improve

profitability?
STEP 4: Closing Question (3-5 minutes) "Is there anything you would like share about any leadership strategy you use in the discharge process that I did not ask?"
STEP 5: Thank participants, recap next steps, and member check (2-3minutes) • After the one-on-one interview, the audio recording will be transcribed. • If needed, member checking, or ensuring that participants shared exactly what they intended to share, will take place via email or phone to elaborate or clarify. • Member checking may also take place during a second, follow-up interview if needed.

Appendix B: Email Invitation to Participate

Invitation to participate in the research project titled: "Hospital Administrators' Strategies for Reducing Delayed Hospital Discharges: Improving Profitability"

STUDENT RESEARCHER: Sheree S. Boyd.

PROJECT SUPERVISOR: Dr. Diane Dusick

STUDENT'S PROSPECTIVE DEGREE: Doctor of Business Administration

Dear Prospective Participant,

My name is Sheree Boyd, a doctoral student at Walden University. I am conducting interviews as part of a research study to determine the effect of delayed discharges on hospital profitability. I am also seeking to observe administrators as they engage in the "behind the scenes" discharge process. The selection criteria I am using for administrators is that you will have been employed, in a leadership position, by a hospital for at least two years at the time of the study, that you take part in the discharge process, and that you are responsible for the strategies implemented to improve profitability by reducing delayed hospital discharges. As a hospital employee, and in meeting the criteria, your expertise and participation would enable me to collect the necessary data for establishing the various strategies hospitals use to address delayed discharges. In this way, the healthcare sector can use this study to improve services offered in hospitals to reduce delayed discharges.

If you agree to be interviewed and observed, the interviews will take roughly 30 to 60 minutes. For the interviews, we can meet at the hospital or any other location where

you would feel comfortable. If needed, member checking, or ensuring that you have shared exactly what they intended to share, can take place via email or phone to elaborate or clarify. Member checking may also take place during a second, follow-up interview if needed. In either case, member checking could take anywhere from a few minutes to an additional hour depending on what needs further clarification. However, I will certainly attempt to minimize the time you spend on this process. For the observation process, two discharge process observations, lasting three hours each, should be sufficient. In the event that this does not give me enough information, I will spend additional time observing (at least one other session). In gathering discharge documents during the observation process, I will be requesting that you share the documentation with me. However, this will only be done after consent from the hospital has been obtained and after you have signed the electronic consent form.

I am ultimately trying to capture your thoughts and perspectives as a hospital administrator responsible, at least in part, for the discharge process. Your responses to the questions will be kept confidential. Each interview will be assigned a number code to help ensure that personal identifiers are not revealed during the analysis and write up of the findings. There is no compensation for participating in this study, and you can withdraw from participation at any time. However, your participation will be a valuable addition to this research, and the findings could lead to greater understanding of how to most effectively manage patient discharges. If you are willing to participate, please let me know and I can tell you more about the interviewing and observation processes. If you have any questions, please do not hesitate to ask. Thank you for your time.

Sincerely, Sheree Boyd

Appendix C: Observation Protocol Checklist

	Present	**Not Present**
Order Written		
Comments/Evidence:		
Validated the Order		
Comments/Evidence:		
Conducted Medication Reconciliation		
Comments/Evidence:		
Printed d/c Instructions		
Comments/Evidence:		

Reviewed d/c with Patient (as noted on the d/c forms)		
Comments/Evidence:		

Appendix D: Organization Agreement Letter

I, _____, (full name of hospital administrator), the hospital administrator at _____ hospital hereby authorize_____ (researcher's name) to access existing patient discharge documents and records.

I authorize the release of this information to be used for research purposes only, particularly for the following purpose:

Completion of DBA research dissertation.

However, I do not authorize the use of the information for re-disclosure or any other use.

Name of Hospital Administrator _____

Further, I authorize observation of the discharge process for purposes of collecting information and data to be used in the research. The data collected from the discharge observation events may be viewed by the researcher. Finally, permission is granted to conducted interviews with the administrators being observed.

Name of authorizing Officer _____

Appendix E: Patient Discharge Form

Patient Discharge Form

Medical Record #: _____
Patient Name:
_____
Location:
_____
Physician:
_____
Admit Date: ____/____/_____
Discharge Date: ____/____/_____
Patient Information:
Age: _____ DOB: ____/____/_____ Gender: [__] Male [__] Female
Race:
[__] White [__] Black / African American [__] Asian [__] Hispanic [__] Native American
[__] Multiracial [__] Other_____
Diagnosis:
[__] Chest pain [__] Confirmed AMI [__] Pulmonary Edema [__] Coronary Artery Disease
[__] Unstable Angina [__] Syncope [__] Cerebral Vascular Disease
[__] Peripheral Vascular Disease [__] Other
Procedures:
[__] None [__] Cardiac Catheterization [__] PTCA [__] PTCA with stent [__] PCI
[__] Echocardiogram [__] RVG [__] ETT [__] Nuclear ETT [__] Coronary Artery Bypass Graft
Height / Weight:
Height = _____ inches Weight = _____ lbs. BMI: _____
Blood Pressure: _____/_____ mm/ Hg
Lipids, HbA1C (if diabetic):
Total Cholesterol: _____ mg/dL HDL: _____ mg/dL LDL: _____ mg/dL
Triglycerides: _____ mg/dL HbA1C: _____ mg/dL
Discharge Status:
[__] Discharge Home [__] Discharge to another hospital [__] Discharge to skilled nursing facility
[__] Discharge to intermediate care facility [__] Discharge home health care organization
[__] Left against advice [__] Transfer to chronic or rehabilitation hospital
[__] Discharge to mental health setting [__] Discharge other [__] Expired