Reducing Unplanned Hospital Readmissions:

A Qualitative Exploratory Multiple-Case Study

Kathleen Janet Weatherspoon

A Dissertation Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Health Administration

University of Phoenix

The Dissertation Committee for Kathleen Janet Weatherspoon certifies approval of the following dissertation:

REDUCING UNPLANNED HOSPITAL READMISSIONS:

A QUALITATIVE EXPLORATORY MULTIPLE-CASE STUDY

Committee:

Richard Schuttler, PhD, Chair

Maureen Marzano, PhD, Committee Member

Patricia Finch-Guthrie, PhD, Committee Member

_____
Richard Schuttler

_____
Maureen Marzano

_____
Patricia Finch-Guthrie

_____
Hinrich Eylers, PhD
Vice Provost, Doctoral Studies
University of Phoenix

Date Approved: 12/4/2018

ABSTRACT

Healthcare quality measurement and care reimbursement have become a central focus for leaders and administrators of healthcare organizations. The provision of high-quality healthcare is contingent on the skills and abilities of leaders and clinical staff who support evidence-based clinical practice through implementation strategies. The problem defined in this qualitative exploratory multiple-case study was concerned with the frequency of unplanned hospital readmissions occurring in the state of Florida specifically, in healthcare facilities located in Broward, Miami-Dade, and Monroe Counties (tri-county area). Healthcare stakeholders working in organizations located in the tri-county area report hospital readmission rates of 23%, that resulted in higher financial penalties. The purpose of this qualitative exploratory multiple-case study was to explore the reasons for higher than expected unplanned hospital readmissions in healthcare facilities located in the tri-county area of south Florida to help hospital administrators to improve healthcare quality through reducing unplanned rehospitalizations. Thirteen participants contributed to this study: 4 (31%) healthcare leaders, 4 (31%) clinicians, and 5 (38%) registered nurses. Through the collective experiences of healthcare stakeholders, two primary and two secondary themes emerged to provide a clearer understanding of the contributing factors related to unplanned hospital readmissions. Four themes namely, education, population, and cultures and resources supported existing literature and provided new knowledge related to the importance of executive leader knowledge, nurse educational and skill levels, patient literacy and language, and cultural elements when applying evidence-based clinical practices in complex healthcare environments.

DEDICATION

I dedicate the completion of my doctoral degree to my husband Jamel Weatherspoon. I would not have been as successful in navigating the roadblocks and hurdles without your patience, support, and hours of proofreading my work for the past four years. You were always there to refocus me on my mission and continued to believe in me through my moments of doubt. Thank you for your unwavering support. I dedicate this to my friend and fellow doctoral student Christine Capaci, who provided me with spiritual and emotional support. Thank you for the regular phone calls when we talked each other "off the ledge," thank you for the trips away to study and thank you for your consistent unbiased feedback that was invaluable to me as we travelled on this journey together. Finally, this doctoral degree is dedicated *in loving memory to my mother, Jacqueline Grainger,* who was a constant support to me during this long journey. Your resounding love and unwavering belief that I was smart enough and strong enough to get to the finish line. My mother fought her final battle with cancer during the last two years of this journey with me and transitioned to spirit in June 2018. I love you mom. This is for you.

ACKNOWLEDGMENTS

I would like to acknowledge my family, mentors, and friends who supported me on this journey. Completing this research study was made possible through the constant support and love from my husband, Jamel. The guidance received from faculty members and staff at the University of Phoenix helped to prepare me for the preparation and presentation of this dissertation. I would like to acknowledge the members of my dissertation committee: Dr. Maureen Marzano for her guidance and the expert knowledge she shared in the healthcare field in two of my core classes, and Dr. Patricia Finch-Guthrie who agreed to become my committee member at the last moment. Both provided significant feedback, guidance, and support that contributed to the successful completion of this dissertation. I would particularly like to thank my dissertation chair Dr. Richard Schuttler, whose firm, consistent, and unwavering guidance throughout this journey helped me to stay the course and to "*keep it simple.*" I am very fortunate to have had Dr. Schuttler as my chair and will be forever grateful for his time and commitment to me during this journey. Thank you, Dr. Schuttler.

TABLE OF CONTENTS

List of Tables

List of Figures

Chapter 1

Introduction to the Study

The incidence of chronic medical conditions has contributed to the rising cost of healthcare in the United States (US). Healthcare spending in the US accounts for 18% of the Gross Domestic Product. This is partially due to the acuity of patients with complex chronic medical conditions, the cost of pharmaceuticals and supply costs, and the expense of recurrent inpatient hospitalization for unmanaged health conditions (Committee on Quality Health Care in America, Institute of Medicine 2010; Kohn, Corrigan, & Donaldson, 2000; Smedley, Stith, Nelson, & Institute of Medicine, 2003; The National Quality Forum, 2013). In 2015, the national unplanned hospital readmission rate due to chronic health conditions was 18%. In contrast, the frequency of unplanned hospital readmissions in the state of Florida was 19%. In south Florida the frequency of unplanned readmission is presently 23% and required further study (Health Services Advisory Group, 2017).

The purpose of this qualitative exploratory multiple-case study was to explore the reasons for higher than expected unplanned hospital readmissions in healthcare facilities located in the tri-county area of south Florida to help hospital administrators to improve healthcare quality through reducing unplanned rehospitalizations. Although chronic medical conditions are more likely to be present in older people and typically incidence increases with age, chronic illnesses have now emerged in younger age-groups (Tubbs-Cooley et al, 2013; U.S. Department of Health, 2017). When patients with chronic medical conditions are not appropriately managed, they are more likely to require frequent inpatient hospitalization (Leykum et al., 2014; McClellan, 2011).

Healthcare administrators and other stakeholders will benefit from the results of this study as they have a responsibility to reduce healthcare cost. The study revealed new knowledge helpful to healthcare leaders as they continue to develop and implement strategies focused on quality improvement. Strom et al, (2017) indicated that leaders should consider integrating evidence-based practices and standardized processes into quality improvement strategies. Chapter 1 includes clarification of the subject area through the problem and purpose statements, the significance of the study, the conceptual framework, and the scope of the study to healthcare stakeholders.

Background of the Problem

The most common causes of unplanned hospital readmissions are the results of diagnostic errors, therapeutic errors, and adverse drug reactions (Agency for Healthcare Research and Quality, 2013). CMS uses risk-adjusted, 30-day unplanned readmission rates to rank hospital quality (Centers for Medicare & Medicaid Services, 2016). Healthcare stakeholders are successful in reducing readmissions when applying evidence-based methods to address chronic medical conditions.

The Affordable Care Act (ACA) contains provisions for advancing existing healthcare policies to a more accessible, high-quality, and affordable healthcare system (U.S. Department of Health and Human Services, 2017). This required healthcare providers to simultaneously increase access, reduce cost, and improve outcomes. The consequences of reporting excessive readmission rates resulted in reimbursement penalties.

Implementation of CMS value-based reimbursement programs were expected to decrease unplanned hospital readmissions (Centers for Medicare & Medicaid Services, 2017). Quality data reported from the state of Florida indicated that unplanned hospital readmissions continue to

be problematic. State data revealed that in 2016, 80% of Florida hospitals incurred penalties (Centers for Medicare & Medicaid Services, 2017).

Despite the use of best practices, clear policies, and available resources, readmission rates administrators working in healthcare facilities located in Broward, Miami-Dade, and Monroe Counties (the tri-county) reported quality metrics above state and national benchmarks (Centers for Medicare & Medicaid Services, 2017). Penalties are imposed on healthcare providers located for failing to meet quality benchmarks. Thus, further research was necessary to discover the reasons unplanned hospital readmissions are significantly higher in the identified geographical location.

Healthcare stakeholders were asked the reasons for failure in reducing unplanned hospital readmissions. Reducing unplanned hospital readmissions is an important measure of the quality of care patients received while hospitalized (Alyahya et al., 2016). The results of this study uncovered new knowledge that is specific to healthcare administrators working in tri-county healthcare facilities. This new knowledge is useful to healthcare stakeholders experiencing difficulties in reducing unplanned hospital readmissions.

Statement of the Problem

The general problem is that unplanned hospital readmissions are higher than the national benchmark in the state of Florida. Care reimbursement is structured around patient outcomes, and penalties are applied when quality measures are not met. Multiple root causes prevent healthcare stakeholders from meeting quality targets (Clark & Allison-Jones, 2011; McHugh, Berez, & Small, 2013; Pandhi et al., 2012; Sheingold, Zuckerman, & Shartzer, 2016). The rate of unplanned hospital readmissions for chronic health conditions in Florida is currently 19%, in contrast to the national rate of 18% (Centers for Medicare & Medicaid Services, 2016). There are

financial consequences for the viability of healthcare providers that do not meet state and federal quality benchmarks (Kellis & Ran, 2015). Improvements in healthcare quality are accomplished when healthcare clinicians and nurses are motivated to implement best practices. Higher quality standards help to improve patient care, structural factors, and processes (Davidson et al., 2017; Salleh & Grunewald, 2013).

The specific problem is that the unplanned readmission of patients with chronic conditions are higher in hospitals located in the tri-county area (Centers for Medicare & Medicaid Services, 2016). Healthcare administrators working in organizations in the tri-county area are reporting readmission rates of 23%, resulting in additional financial penalties. Stakeholders provided new knowledge regarding factors related to unplanned hospital readmissions and acute care facilities in the tri-county area not meeting quality benchmarks .

Purpose of the Study

The purpose of this qualitative exploratory multiple-case study was to explore the reasons for higher than expected unplanned hospital readmissions in healthcare facilities located in the tri-county area of south Florida to help hospital administrators to improve healthcare quality through reducing unplanned rehospitalizations. The units of analysis for this multiple-case study are three separate groups of healthcare stakeholders specifically; leaders, clinicians, and registered nurses and one combined group. Each of the cases were studied as individual cases and the results combined to understand the collective themes concerning unplanned hospital readmissions (Stake, 1995). The general population were healthcare stakeholders located in acute care facilities in south Florida. The sample comprised leaders, clinicians, and registered nurses within the tri-county area. A literature review of state and national healthcare quality data revealed information regarding standardized treatment and management protocols related to

unplanned hospital readmissions (Health Services Advisory Group, 2017). Study data revealed common understandings among stakeholders that provided knowledge regarding the factors related to unplanned hospital readmissions and practices used to manage chronic health conditions in the tri-county area.

Collected data included participant responses to semi-structured, open-ended interview questions and demographic information. The interview questions encouraged participants to share experiences and provide understanding of the reasons unplanned readmission rates are higher in the tri-county area. Triangulation of data sources was used to converge information that confirmed the consistency of the results (Yin, 2014).

Population and Sample

The study population consisted of healthcare stakeholders who had worked in one or more acute healthcare facilities located in the tri-county area. Each participant had knowledge of chronic medical conditions, and an understanding of the implications of unplanned hospital readmissions. A purposive sampling method was used to gain multiple insights about data concerning unplanned hospital readmissions and to enlist study participants who are healthcare leaders, hospital-based clinicians, and registered nurses to garner multiple perspectives of the phenomenon.

A sample of 13 participants was an appropriate sample size for this multiple-case study. Participants were knowledgeable of the implications of unplanned hospital readmissions and provided new knowledge through multiple perspectives. In qualitative research, sample sizes are typically small and generate large amounts of “rich” or “thick” descriptive data (Merriam & Tisdell, 2016). The sample size for this qualitative multiple-case study included four to six participants from each stakeholder group. Through observation, semi-structured interview

questions, documents, and artefacts, an understanding of the study participants' experiences were explored. Data gathered provided knowledge of the study participants' experiences of chronic medical conditions and understanding of the implications of unplanned hospital readmissions that enabled an in-depth analysis of the problem.

Significance of the Study

The findings of this study provided significant insight for healthcare leaders, clinicians, nurses, and healthcare administrators. When healthcare is provided to a patient, healthcare institutions expect to receive reimbursement. However, when unplanned hospital readmissions are higher than the set benchmarks, there are significant financial consequences (Agency for Healthcare Research and Quality, 2013). Insurance companies deny reimbursement and impose penalties when quality metrics are not met.

Significance of the study to healthcare leadership. Healthcare leaders are responsible for the ongoing surveillance of hospital quality and for implementing strategies to remedy variances in processes and outcomes. Healthcare leaders are also accountable for the financial viability of healthcare organizations and the safety of the patients therefore, leaders must ensure that the clinical staff are adhering to hospital policies and applying evidence-based practices. The results of this study contribute to the body of knowledge regarding executive leader competencies. Leaders must possess current knowledge concerning healthcare regulations and population-specific factors to develop strategies that address quality failures.

Significance of the study to healthcare clinicians. Healthcare clinicians are responsible for designing and implementing evidence-based plans of care that maximize patient outcomes, and for implementing quality protocols that reduce repeated unplanned hospitalization. The importance of patient and family inclusion in care planning and decision-making was revealed

by this study. Clinicians must have access to medical information when providing care for patients with chronic health conditions. The results of this study encourage clinicians to function as change agents and facilitators in the design and development of new approaches to manage the care of chronically ill patients (Zoutman & Ford, 2017).

Significance of the study to nurses. Nurses are responsible for implementing plans of care and ensuring that patients are educated and prepared for discharge. Preparation for discharge begins upon admission with an assessment that is intended to identify potential precursors to an unplanned readmission (Tubbs-Cooley, Cimiotti, Silber, Sloane, & Aiken, 2013). Nurse participants shared unique experiences about the reasons patients with chronic health conditions are frequently hospitalized tri-county area hospitals.

The results of this study revealed themes and generated insights that benefited healthcare administrators and stakeholders. The researcher identified solutions that will prevent the readmission of patients with chronic medical conditions within 30 days of discharge. The newly discovered data extends relevant knowledge to additional study populations and provides healthcare stakeholders with a deeper understanding about the importance of the nurse's role in preventing unplanned hospital readmissions.

Nature of the Study

The qualitative method and exploratory case study design was used for this study. Qualitative inquiry examines how groups and individuals make meaning through the analysis and interpretation of interviews, documents, and fieldwork (Patton, 1990). Qualitative studies are guided through substantive research questions and philosophical influences that use theoretical frameworks to inform the study (Merriam & Tisdell, 2016). Analyses and interpretations of the perspectives and experiences of healthcare stakeholders yielded information that may help

reduce unplanned hospital readmissions. The selected research method of qualitative study uses a conceptual approach to capture the experiences, thoughts, and perceptions of individuals and groups (Yin, 2014). This qualitative study gleaned new knowledge regarding the challenges of caring for people with chronic medical conditions.

Quantitative methodologies can provide validation or refutation of a hypothesis through the analysis and interpretation of data (Neuman, 2011). In quantitative studies, deductive reasoning is used to analyze phenomena and identify similarities and frequencies through the design and standardization of measures prior to data collection, thereby allowing for the statistical analysis of variations in the data collected**.** However, quantitative methodology is not appropriate for this study as the problem calls for the independent observation of healthcare stakeholders describing their experiences in their own words.

Case study design. Case study design is used to examine the specific circumstances of complex problems within a complicated system (Stake, 2006). The results of this case study explored actions taken to investigate the factors related to unplanned hospital readmissions to understand the reasons for the problem. This case study included context (opinions) in relation to the phenomena being studied (unplanned hospital readmissions) (Yin, 2014).

Multiple-case study design. Multiple-case study design is appropriate to examine more than one case. The context of a phenomenon described through multiple cases increased generalizability of study findings. In this study, experiences and perceptions of three groups of healthcare stakeholders are explored.

Exploratory case studies. An exploratory case study design is an intensive study of a small number of cases or a single case (Perecman & Curran, 2006). Exploratory case study design is appropriate in determining factors related to unplanned readmissions through the

experiences of three groups of healthcare stakeholders. Exploratory case studies do not provide categorical evidence; they discover new information to explore the nature of an undefined problem. There were three methods used in this exploratory research study: demographic survey, open-ended interview questions, and literature review to identify gaps.

Alternative Study Designs

Qualitative designs discover answers to unanswered questions through discovering new knowledge through the collection and analysis of information provided by the study participants. Analysis of human artefacts, actions, and experiences generates meaning and understanding, thereby adding to existing knowledge (Vandermause & Fleming, 2011). Qualitative researchers select study designs to contextualize and interpret descriptive meanings of the study.

Phenomenological design. Phenomenological researchers explore and interpret the lived experiences of participants A phenomenological design provides a forum for participants to respond spontaneously to carefully crafted, open-ended questions that can uncover meaning in a self-directed way to derive meaning from their experiences (Mathison, 2005). A phenomenological design is not appropriate to gain an understanding of the relationships between transitions of care, chronic medical conditions, and healthcare quality through insights and opinions of healthcare stakeholders.

Ethnographic design. Ethnographic studies reveal information about a culture or group and how people within the culture or group see themselves (Hamersley, 1992). Depth and understanding of the study data were captured through the researcher's interactions with study participants at the micro-level (Bunce et al., 2014). A key informant or community member is a trusted advisor willingly responding to detailed questions that are descriptive in nature. Ethnographic research entails conducting a cultural micro study of the individual behaviors,

attitudes, beliefs, and patterns of a defined group of people that requires the researcher to approach participants with flexibility and openness. This multiple-case study documents the observations and experiences of healthcare stakeholders thereby the ethnographic approach does not lend itself to this study.

Research Question

Case study research explores, describes, and interprets a circumstance, synthesizes meaning, and brings clarity and understanding to a problem (Yin, 2014). This qualitative exploratory multiple-case study intended to identify and examine the determinants associated with higher than expected all-cause unplanned readmission rates in the tri-county area of south Florida. A single central research question was used to enable the reader to understand the question guiding this study. A study of the common experiences of healthcare leaders, clinicians, and nurses regarding the causes of unplanned hospital readmissions should offer solutions and improve performance and quality in tri-county healthcare facilities.

> The central research question (RQ1) guiding this study was as follows: What are the common experiences of healthcare leaders, clinicians, and nurses concerning the reason there are higher than expected unplanned hospital readmissions for patients with chronic health conditions in healthcare facilities located in Broward, Miami-Dade, and Monroe Counties in the state of Florida?

Conceptual Framework

Donabedian's conceptual framework is a method applied to assess healthcare quality problems through structure, process, and outcome (Donabedian, 1980). Structure and process failures within healthcare settings influence patient outcomes (Dooney & Esen, 2009). This study

examined the connections between structure, process, and outcome to measure factors related to readmission in the tri-county.

Evaluating healthcare quality. Healthcare policies and processes originate from federal and state directives that require adoption into clinical practice. A reliable foundational platform and assessment method is critical to evaluating healthcare quality (Donabedian, 1966). The flexibility of Donabedian's conceptual framework facilitates the modification of structures and processes that create outcomes in simple and complex healthcare settings. Consequently, Donabedian's conceptual framework is appropriate to evaluate the elements related to unplanned hospital readmissions in this study.

Structure, process and outcomes. Structure is observed within the environment where care is provided. Factors identified within this study pertaining to structure included location, resources, and staff education and training. Process is defined by the method in which care is provided. Information concerning process was obtained through interviewing leaders, clinicians, and nurses. The procedural and interpersonal processes needed to provide healthcare included the clinical care, nursing care, education, and the actions taken by caregivers. The outcomes of this study comprise the consequences of healthcare include changes to health status, changes to quality of life, changes in knowledge, and changes in the frequency of hospital readmissions.

Assumptions of the Study

In the tri-county area there appear to be a higher level of unplanned hospital readmissions, despite the application of best practices, methods, or standards of care. The participants selected for this study were assumed to be willing to discuss their experiences and to remain truthful when answering interview questions. Honesty in answering questions is central to data collection and critical to the credibility of the data collection methods and data analysis.

Definitions of Key Terms

The study included the following conceptual and operational definitions that were essential for this study.

Evidence-Based Practice, also referred to as best practice, is the integration of scientific knowledge and research to guide the decision-making process for patient care (Sackett, 2002).

Chronic Medical Conditions are defined as health conditions that last for more than one year and require ongoing medical management and/or negatively affect a person's ability to perform activities of daily living (U.S. Department of Health, 2017). Conditions that are long lasting, incurable once acquired, require ongoing medical management, and have a sustained impact on physical limitations are chronic illnesses. Heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis are among the most common, costly, and preventable of all health problems (Centers for Disease Control and Prevention, 2017, p. 1)

Google Docs is a password protected design and editing tool that is used to create online surveys. Survey responses are accessed through a google account login. The form is web-based and was shared through a link or attached to an email message. (Google, 2018).

GoToMeeting is an encrypted online password protected teleconferencing tool that is accessed from most platforms and mobile devices with capability to schedule, record, and video conference online meetings. The host organizes the meetings and provides participants a personal meeting room with custom URL (Gartner Inc, 2018).

Tri-county area refers to Region 6, consisting of Miami-Dade, Broward, and Monroe Counties, which are located in south Florida. The state of Florida is divided into eight regions with aggregate readmission rates “calculated for each region using the hospitals located in the region” (Health Services Advisory Group, 2017, p. D).

Transitions of care refers to the movement of patients through different healthcare settings, for example, movement from the emergency room to a medical unit, movement from a medical unit to a long-term care facility, or discharge from the hospital to the home. Changes in healthcare clinicians refer to the collaboration and coordination needed to safely hand off patients to other caregivers, thereby providing continuity and the safe transition of patients with chronic or acute illnesses (Kamermayer, Leasure, & Anderson, 2017).

Unplanned Readmissions occur when a recently discharged patient is readmitted to hospital for any cause within 30 days after discharge. Hospital readmissions are an adverse event irrespective of cause. Readmission rates for heart failure, pneumonia and acute myocardial infarction are included in quality benchmarking for health systems (Centers for Medicare & Medicaid Services, 2017).

Scope of the Study

The scope of this study provides information concerning breadth and depth of the research population. Study participants with experience working in facilities experiencing high rates of readmission had unique perspectives related to chronic health conditions and quality initiatives related to discharge processes. This study was limited to the analysis of data from 13 different healthcare stakeholders from hospital facilities in the tri-county area. Three separate stakeholder groups define the three cases and units of analysis identified for this multiple-case study.

The sample included healthcare leaders, clinicians, and nurses who have observed and experienced unplanned hospital readmissions. The selection of study participants delimits the data collection to healthcare stakeholders with experience working in the tri-county area. The rationale for the choice of participants was justified by the variety of individual perspectives and

experiences that each stakeholder can contribute. There is a gap in the literature that described the experiences and observations of stakeholders with experience working in acute care facilities located in the tri-county area.

Limitations of the Study

The limitations of this study are factors related to the use of a qualitative multiple-case study method and data collection and the collation of multiple sources of evidence (Merriam & Tisdell, 2016). The case study design is considered subjective due to the researcher's reliance on previous experiences and assertions concerning data, and generalizations made regarding the cases at the beginning of the study. A comprehensive portrayal of each case was achieved using plain language and narratives that describe the whole and generalizations were refined through organizing data into cross-case findings to compile the final report (Stake, 2006).

Potential researcher bias may limit the interpretation of the information collected from stakeholders. To mitigate potential bias, generalizations were modified as the common themes were discovered in each case. The researcher's own experiences in healthcare may inhibit critical thinking and limit the researcher's abilities to triangulate the data. Triangulation protocols were used to confirm the criticality of assertions and to mitigate bias.

State reported healthcare data are available to the public and reveal the quality and outcomes of healthcare facilities. Despite receiving participants' agreement after providing clear explanations regarding consent and confidentiality, participants may perceive participation in the study as a threat by, for example, having the potential to jeopardize their healthcare organizations or personal and professional standing. Each case was be selected for its ability to add to the richness of the data and to create a common understanding of healthcare quality.

Delimitations of the Study

Delimitations include specific factors related to the study that are guided by the researcher (Lincoln & Guba, 1985). The selection of participants, choice of setting, methods of data collection and analysis, and data triangulation processes are delimitations of the study. An additional delimitation of the study is the choice to limit participants to specific healthcare stakeholders. Healthcare leaders, clinicians, and nurses provided experiences and observations concerning the subject that yielded a common understanding of the phenomenon.

Chapter Summary

The purpose of this qualitative exploratory multiple-case study was to explore the reasons for higher than expected unplanned hospital readmissions in healthcare facilities located in the tri-county area of south Florida to help hospital administrators to improve healthcare quality through reducing unplanned rehospitalizations. The researcher's intention for this study was to discover common themes that influenced unplanned hospital readmission rates. The answers were revealed by interviewing healthcare stakeholders concerning their work in healthcare facilities located in the tri-county area. The results of the study warrant further investigation through selecting alternative study participants, demographic locations, methodologies, and designs.

The study results revealed increased cultural and ethnic diversity have created new challenges for healthcare providers. Healthcare stakeholders with knowledge of chronic medical conditions, and an understanding of the implications of unplanned hospital readmissions identified that the complexity of a multi-cultural healthcare environment characterizes healthcare delivery in the tri-county area. The researcher answered these questions through the experiences

of multiple stakeholders with experience working in healthcare facilities and anticipates that the results will apply to similar contexts, groups, or organizations (Merriam & Tisdell, 2016).

Chapter 2

Review of the Literature

The purpose of this qualitative exploratory multiple-case study was to explore the reasons for higher than expected unplanned hospital readmissions in healthcare facilities located in the tri-county area of south Florida to help hospital administrators to improve healthcare quality through reducing unplanned rehospitalizations. Despite the implementation of best practices, methods, or standards of care, healthcare stakeholders reported quality data that did not meet national quality benchmarks. The researcher provided contextual information regarding the significance of the problem for healthcare stakeholders in chapter 1.

Chapter 2 consisted of a review of literature concerning factors that influenced the care and management of patients with chronic medical conditions. A review of best practices, disease surveillance and monitoring, evidence-based practices, standards of care, and patient non-compliance was conducted. The researcher reviewed information regarding connections concerning unplanned hospital readmissions, quality, outcomes, and reimbursement. Similarities in findings, meaningful connections, and consistent themes relevant to the challenges of reducing unplanned hospital readmissions were revealed within the data. Information reviewed identified connections between quality challenges, system vulnerabilities, the distribution of penalties, and communities, patients, and demographics.

Chapter 2 contained a scholarly review of the literature specific to the conceptual framework of the study, which included publications on the influence of healthcare policy and legislation on healthcare organizations, and the challenges for healthcare stakeholders to implement policies and best practices. Documents and studies that addressed transitions of care and the medical management of complex patients confirmed the challenges associated with

unplanned hospital readmissions. Stakeholders involved in the care and management of patients with chronic medical conditions provided an understanding of the reasons unplanned readmission rates are higher in healthcare facilities located in the tri-county area (Health Services Advisory Group, 2017).

Documentation of Sources

A purposeful review of the literature was critical in evaluating existing information communicated the factors associated with hospital readmissions (Yin, 2014). Literature search conducted by the researcher provided clarification of the methods and findings necessary to understand and consider the research problem. Literature review included review of the internal and external factors that were relevant to the deployment of evidence-based practices (Bönigk & Steffgen, 2013; Langstrand, 2016; Shang, Huang, & Guo, 2010).

Literature selected for this study was pertinent to the phenomena of healthcare quality. The researcher selected literature pertaining to healthcare policy and legislation specific to hospital quality measures. Articles and studies related to care healthcare structure, process, and outcome pertaining to transitions of care, discharge processes, the management of chronic health conditions, regarding unplanned hospital readmissions received further appraisal and were included.

Databases Searched

The databases searched included the University of Phoenix Library database, ProQuest, SAGE, JSTOR, EBSCO, Google Scholar, textbooks from the University curriculum for the Doctorate in Healthcare Administration, professional associations, and ProQuest Digital Dissertation and Theses databases. Federal and state government websites were searched and provided a collection of empirical evidence that facilitated the analysis of contemporary studies

related to government healthcare policies. A focused literature search began in 2015 and concentrated on healthcare quality measures and known factors identified as reasons for the prevalence of chronic illness and medical conditions that resulted in unplanned hospital readmissions.

Social factors, such as income, access to primary care, racial and ethnic origin, socio-economic status, and environmental issues were identified as some of the reasons for unplanned hospital readmissions. The comprehensive literature search included peer-reviewed journals, academic articles, books, state and federal government websites, reports, and healthcare quality-related information. A Boolean search was used to identify the relationships between words and keyword sets and included single phrases and combinations of the following terms: unplanned hospital readmissions, chronic health conditions, chronic medical conditions, transitions of care, discharge process, discharge planning, healthcare quality, Hospital Readmissions Reduction Program, HRRP, healthcare legislation, healthcare stakeholders, healthcare policy, healthcare, quality, and leadership. An overview of the literature reviewed, and the sources used is provided in Table 1. Although the literature review provided rich and detailed information concerning the problem, it did not constitute a complete search of all studies and research on the study subject.

Title Searches, Articles, Research, Documents, and Journals

The identification of peer-reviewed studies, articles, and other information collected was a discerning synthesis and scholarly review of the study subject (Cone & Foster, 2006). The process used to review the collected works consisted of title searches to summarize the available literature and to identify gaps in the literature. The common themes identified indicated connections between unplanned hospital readmissions and evidence-based practices, healthcare quality, patient demographics, and socio-economic factors. The reviewed works included

numerous solutions, suggestions, and information concerning the prevention of unplanned hospital readmissions, the treatment of chronic health conditions, and transitions of care.

Table 1

Overview of Sources in the Literature Review

Source Types	Sources Used	# Reviewed
Books	21	25
Journals	73	209
Dissertations and Theses	1	30
Online Reference Sites	20	32
State and Federal Websites	16	40
Totals	131	336

Historical Overview

The literature reviewed was a compilation and assessment of the published works related to healthcare quality and the structure, process, and outcomes, pertaining to unplanned hospital readmissions within the tri-county area. A synthesis of literature revealed gaps in literature relevant to unplanned readmissions of single patients with multiple physical and social determinants. More qualitative data were needed to contribute to our overall understanding of the connections between patients with chronic medical conditions and unplanned hospital. Specifically, there was little information that explored existing healthcare systems and processes

reduced unplanned hospitalizations and improved the quality of healthcare for patients with chronic conditions (Manchikanti, Helm, Benyamin, & Hirsch, 2017).

There was a large body of work related to healthcare quality that has been published over the last 100 years. A review of the germinal and current literature provided a clear indication of the literature that was focused on healthcare quality and was relevant to current healthcare delivery. Current and emerging practices and publications that incorporated the contextual and foundational history of healthcare quality were presented in relation to unplanned hospital readmissions.

Historical timeline. The purpose of establishing a historical timeline (Figure 1) was to provide a visual representation of the works that have influenced healthcare over the past 100 years. The principal works of Deming, Juran, and Donabedian provided the foundation for evidence-based practices that have continued to guide healthcare quality research. Joseph Juran formulated the principles of healthcare quality in his seminal doctrine, which have continued to be relevant in today's healthcare environment. Juran (1988) identified several opportunities for healthcare performance improvement and the standardization of clinical processes, which included patient outcomes, patient satisfaction, access to healthcare, and cost containment. Donabedian's conceptual model (1966) incorporated structure, process, and outcomes that remains relevant in evaluating healthcare quality. Donabedian's model is a guiding framework used to assess and measure the quality of medical care and healthcare practices. The researcher identified Donabedian's model as an appropriate framework to examine and evaluate healthcare quality, to provide structure and dimension, and to examine diverse populations or groups. Although the historical timeline did not catalogue an exhaustive list of research, the seminal works reviewed, and literature related to healthcare quality are relevant to the present study. The

information contained in the historical timeline is a compilation of reviewed documents, articles, and sources generated by the literature review for this research study.

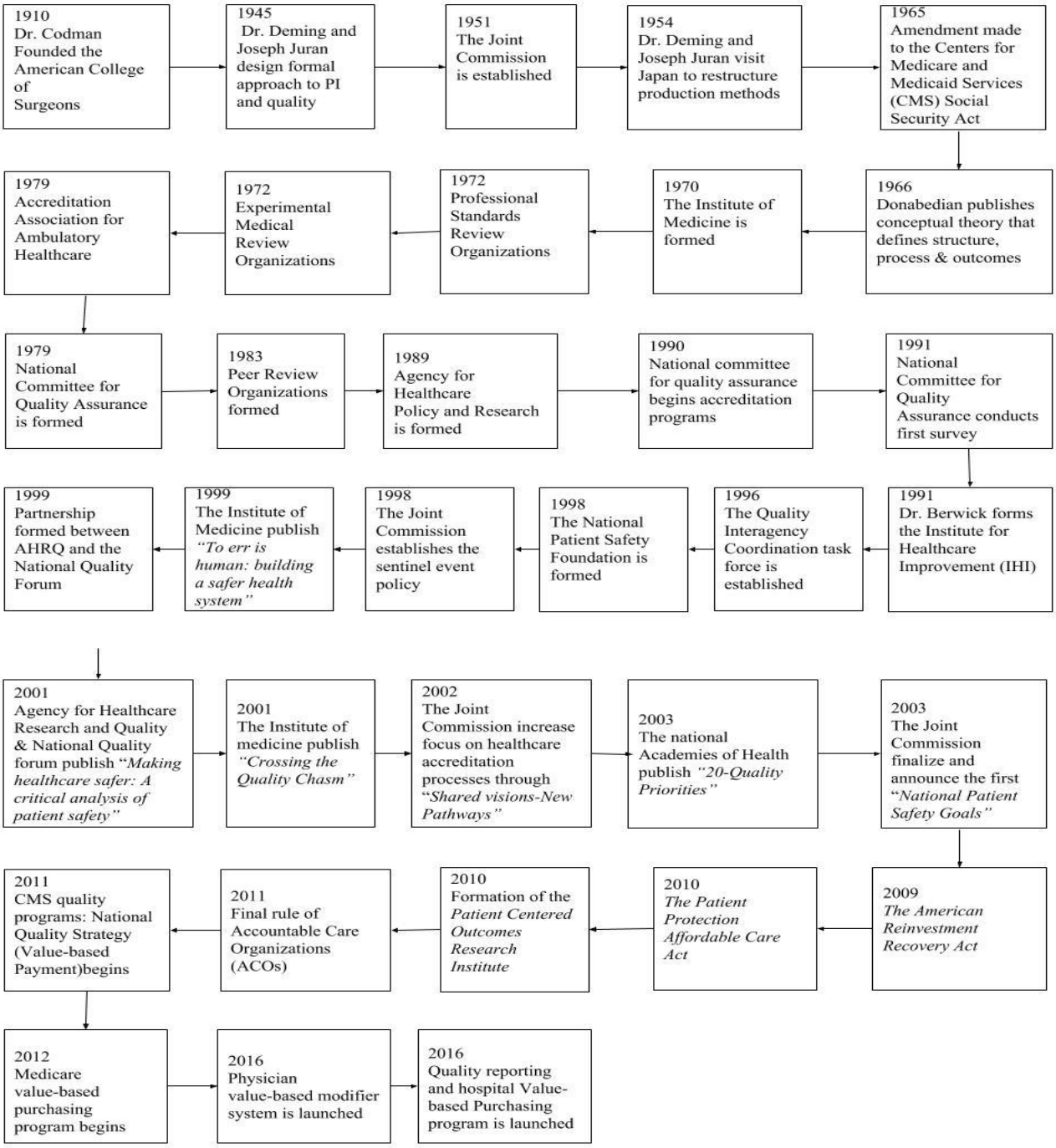

Figure 1. Historical Timeline of Healthcare Quality, 1910–2016.

Conceptual Framework Literature

When applying conceptual frameworks to complex healthcare problems, one must consider the possible consequences for organizations and stakeholders. The shared experiences of stakeholders working in healthcare formed the conceptual framework used to guide this study (Lincoln & Guba, 1985). This research study established a theoretical foundation by defining and articulating themes and concepts revealed within the data collected.

Donabedian's Conceptual Model

Donabedian's conceptual model comprises three interconnected factors: structure, process, and outcome. The model represented information used to evaluate healthcare quality in a healthcare organization (Donabedian, 1966). Alignment exists between healthcare structures and processes to achieve the outcomes required to meet national benchmarks. For this reason, Donabedian's conceptual model was relevant to the study of unplanned hospital readmissions.

Structure included the specific characteristics of a healthcare organization that influenced the environment where healthcare was provided. Clinicians, leadership, nurses, patients, available equipment, and physical facilities were identified as examples of structural dimensions. Structural factors were observable and provided salient information related to the incumbent processes and causes of unplanned hospital readmissions.

Process factors included healthcare activities, such as technical and interpersonal activities that were part of patient care, diagnostics, discharge planning, and patient education. The act of healthcare delivery was identified through interviews, and fieldwork. This study identified additional factors pertinent to unplanned hospital readmissions and chronic medical conditions and how they are related to healthcare quality.

Outcome measures described the resulting health status of a patient's aftercare, treatment, and ongoing disease management. Patient outcomes were represented by the patient's condition after treatment and provided an indication of the quality of clinical care and follow-up that was provided. The connections between care processes and outcomes when related to frequent hospitalizations were difficult to measure and not fully explored in current literature (Shah, Luo, Winterbauer, & Madamala, 2016).

Healthcare Quality

The purpose of healthcare quality measures was to provide a framework that supported the foundation of evidence-based healthcare delivery. The implementation of evidence-based practices was intended to reduce the frequency of unplanned hospital readmissions. Successful introduction of quality initiatives required clear strategies with demarcated starting points (Donabedian, 1966). Donabedian's conceptual model to assess structure, process, and outcome, was appropriate for this study as it provided a systematic framework that assessed and evaluated healthcare quality measures specifically those related to unplanned hospitalization.

Quality Benchmarks

Mandated quality reporting is connected to reimbursement by the Centers for Medicaid and Medicare Services (CMS). Data submitted through the Quality Reporting Program (QRP) must meet clearly defined benchmarks to ensure maximum compensation. It is unclear the reasons some healthcare stakeholders meet quality benchmarks and others do not (Zoutman & Ford, 2017). Discrepancies in reported data do not adequately explore the connections between clinical outcomes and healthcare quality. Widespread disparities in managing chronic health conditions are created by inconsistent clinical practices and policies (Leykum et al., 2014).

There are relationships between healthcare quality, health outcomes, individual characteristics, and health-seeking behaviors and co-morbidities requiring further study (Rosenberg et al., 2016; Shah, Luo, Winterbauer, & Madamala, 2016). This research study originated from an understanding that healthcare facilities possess adequate structure and equivalent processes regardless of geographical location or community demographics. Although studies regarding strategies concerning healthcare quality are well represented in the literature, published healthcare quality data from south Florida hospitals illustrated variances in patient outcomes requiring further study. Carretta et al. (2013) outlined connections, concerning variances in structural characteristics and processes, in Florida hospitals were associated with mortality outcomes. Due to continued inconsistencies in outcomes and local and regional variations in risk-adjusted health outcomes in south Florida, further study was warranted.

Performance Measurement in Healthcare

Hospital Compare is a government website that publishes the performance results of Medicaid and Medicare-certified healthcare facilities. Published information provides patients, customers, and competitors with hospital specific quality data and information concerning hospital performance and clinical outcomes associated with specific quality measures (Medicare.gov, 2016). Clinical studies corroborated the linkage between performance measures, public reporting, and the adoption of evidence-based guidelines (Eymin & Jaffer, 2014). Medicare's value-based purchasing (VBP) and pay for performance (P4P) models are outcome-based quality measures.

The VBP model, established by Congress in conjunction with the ACA, is administered by the Centers for Medicare & Medicaid Services (CMS). VBP improved the quality of care and reduced cost (Tompkins, Higgins, & Ritter, 2009). P4P, used by CMS to control the actions taken by healthcare clinicians, connects care delivery processes to specific performance metrics

(Tanenbaum, 2009). Each performance measure is evidence-based and incorporates consistent processes, that eliminates outcome variations.

Safety-Net Providers

Safety-net hospitals incur higher penalties despite using processes to reduce variances in outcome (Gunnells et al., 2016). Sheingold et al. (2016) suggest that penalties negatively affected hospitals that provided indigent care in Medicaid non-expansion states, despite risk adjustment strategies intended to ease variances in the payor mix and other intangible factors (Rosenberg et al., 2016). Literature revealed changes in reimbursement structure had increased penalties levied on safety-net hospitals (Zuckerman, Joynt-Maddox, Sheingold, Chen, & Epstein, 2017). Imbalance in the application of penalties for safety-net hospitals, required further investigation to determine whether safety-net providers located in the tri-county area were contributing to readmission rates.

Evidence-Based Practices

Evidence based practice is the orchestrated, strategic use of current best evidence in establishing a plan of care. Evidence-based practices form the foundation for CMS quality measures. Evidence based management and clinical pathways provide a consistent approach to patient care and to the management of disease with an emphasis on coordinated transitions of care. The implementation of an evidence-based clinical plan eliminates variations in clinical practices through providing consistent protocols and algorithms that standardize treatment regimens and pathways (Hipp, Abel & Weber, 2016). Evidence based disease management protocols are used to assess patient wellbeing and reinforce the discharge treatment plan (Messina, 2016). Disease prevention protocols, care coordination practices, and strategies for the medical management of chronic diseases are necessary to reduce unplanned hospital readmissions (McClellan, 2011).

Further study of evidence-based practices used in hospitals within the tri-county area helped to explore factors related to unplanned hospital readmissions.

Societal Variables

Federal and state regulations influence healthcare structure and delivery strategies through standardization of care through pay-for performance and quality data reporting. Salient organizational factors and societal variables are relevant to healthcare leaders and critical in defining short and long-term strategic plans. Strategy development incorporating societal and market components are important to healthcare planning within dynamic healthcare environments (Zhang et al., 2016). This study provided empirical evidence of societal variables present in the tri-county area that influenced unplanned hospital readmissions.

Environmental and Social Factors

Healthcare outcomes have remained static despite progressive paradigm shifts in healthcare delivery. Rapid advancements in information technology, science, medicine, and healthcare infrastructure have contributed to data collection and availability. Care coordination and appropriate care transitions are critical for preventing unplanned hospital readmissions. Shah et al. (2016) suggested that process failures were revealed when the patient was readmitted to a hospital and insinuated that there was no consistent method available to assess failures to prevent unplanned hospital readmissions.

A review of the current literature suggested that there have been national reductions in hospital readmission rates for chronic medical conditions (Carey & Lin, 2015). Unfortunately, there continued to be higher than expected unplanned hospital readmissions in some areas of the nation. The prevention of unplanned hospital readmissions depended on patient compliance, careful monitoring, and disease management. An article by Feemster and Au (2014) confirmed

that chronically ill patients without access to primary care were more likely to be readmitted to within 30 days of hospital discharge.

A further review of the literature revealed internal and external environmental factors that underlined processes present within healthcare organizations. Healthcare is a diverse and complex entity in a constant state of flux, linked by commonalities in purpose, policies, and state and federal legislation and regulations (Martin, 2014). Internal environmental factors such as staffing levels, educational levels, and the leadership skills of nurses continued to impede the development of adaptive solutions to mitigate emerging internal and external forces in the healthcare milieu.

McHugh et al. (2013) examined associations between hospital performance, nursing care, and staffing levels in relation to unplanned readmission rates. Adequate resources and planned discharge preparation were directly related to nursing skills, educational level, and workload. Petterson, Liaw, Tran, and Bazemore (2015) attributed unplanned readmissions to the shortage of Primary Care Providers (PCPs) that were related to societal and professional factors.

Failure of healthcare leadership to consider the experiences of healthcare stakeholders when looking for solutions to healthcare-quality issues was a consistent factor found within the literature. Martin (2014), corroborated the need for perspectives from multiple stakeholders to establish common understandings in relation to healthcare quality. The reviewed literature provided information regarding the interface between environmental factors and healthcare quality and identified commonalities in system vulnerabilities related to unplanned hospital readmissions.

Chronic diseases are the leading cause of disability and death in the developed world (Carretta et al., 2013). US health data confirmed that one or more chronic health conditions were present in more than half of the adult population. McHugh et al. (2013) suggested that race, ethnicity, socioeconomic status, age, and community demographics influenced health status. This

study discovered unique characteristics present in the tri-county area that influenced the frequency of hospital readmissions.

Community Characteristics

There appeared to be a higher incidence of payment penalties for hospitals with proportionally higher numbers of low-income patients, which suggested that non-modifiable factors outside of the healthcare setting affected the readmission rate (Feemster & Au, 2014). Socioeconomic and environmental factors have disproportionately influenced healthcare accessibility and health outcomes. Appropriate primary care and timely management of newly discharged patients reduced unplanned hospitalization. Communities experiencing shortages of PCPs demonstrated higher rates of unplanned hospital readmissions (DeNyse, Ellis, Fisher, Foster, & Kalvaitis, 2011).

Shih, Ryan, Gonzalez, and Dimick (2015), suggested that hospitals located in less affluent socioeconomic areas with specific community characteristics were more likely to pay higher penalties for failing to meet quality benchmarks. Although there were defined best practices for treating complex medical conditions, there appeared to be a connection between specific community characteristics and hospital readmissions (Zhang et al., 2014). A thorough review of the literature revealed similarities in socio-economic findings, meaningful connections, and consistent themes concerning the effects of quality benchmarking on healthcare delivery and quality in safety-net hospitals. Existing best practices conflicted with specific cultural and ethnic characteristics present in the patient population in tri-county area that contributed to unplanned hospitalization.

Healthcare Accessibility

The US healthcare model is a medical model grounded in curative medicine that diagnoses and treats illnesses. The healthcare system is predominantly private and comprised of for-profit (FP) and not-for-profit (NFP) healthcare organizations, with Medicaid and the Veterans Administration as the only significant government funded national health programs. Historically, preventative and health promotion services were not prioritized healthcare needs within a medical healthcare model (Shaw, Asomugha, Conway, & Rein, 2014).

The essential characteristics of an FP healthcare organization included shareholders, the ability to raise money from investors, and the requirement to pay taxes on income and real estate. The features of a NFP healthcare organization contained tax exemptions from state and federal taxes, mandated reporting of community benefits, and the reinvestment of profits into the company. Typically, NFP healthcare organizations provide indigent care as part of reported community benefits to maintain tax exemption status.

Healthcare accessibility comprises four interconnected dimensions including individual's right to receive nondiscriminatory, accessible, and affordable healthcare, and to receive healthcare information. The ACA increased accessibility to healthcare insurance that initiated unintended consequences to accessibility (U.S. Department of Health and Human Services, 2013). The increased numbers of people who had health insurance began utilizing primary care services; yet, there were increased wait times due to the systemic shortages of primary care providers (Huang & Finegold, 2013).

Access to non-discriminatory care includes comprehensive access to healthcare services regardless of a person's beliefs, race, religion, sexual orientation, identity, and nationality (Snipelisky, Carter, Sundsted, & Burton, 2016). When measuring healthcare accessibility, one

must consider factors that affect an individual's access to care that included an individual's health needs, the acceptability of services offered, the financial resources that were available (McIntyre, Thiede, & Birch, 2009). Access to healthcare is dependent on the availability, supply, acceptability of services, and opportunity to utilize services. Some patient choose not to use information and resources provided.

Provisions in the ACA were successful in increasing access to healthcare by mandating employers to provide health insurance coverage to employees and their families. The formation of the state-based healthcare exchanges was intended to provide individuals on low and moderate incomes with the ability to purchase subsidized health insurance plans. In actuality, many of the healthcare exchange plans were associated with high deductibles and out-of-pocket expenses that were too expensive for low and moderate income people (Association of Health Care Journalists, 2017).

Healthcare provisions within the ACA required healthcare clinicians to reevaluate existing policies and practices and redesign processes that were focused on improving accessibility to preventive healthcare services with a view to preventing chronic and acute illness (Snipelisky et al., 2016). As a result, primary care utilization has increased due to preventative services being provided to all at no cost (Han, Yabroff, Guy, Zheng, & Jemal, 2015). Increased availability of primary healthcare improved access to healthcare has provided the medical management needed to prevent hospital readmissions.

Healthcare Infrastructure

Mandated healthcare changes incorporated in the ARRA were associated with cost reduction by connecting Medicare and Medicaid reimbursement to outcomes. The prospect of reduced reimbursement for healthcare services has resulted in widespread changes to healthcare

process. Requirements for performance-based data reporting, interoperability of medical records, and added value has focused healthcare providers on achieving state and federal requirements associated with reimbursement (Centers for Medicare & Medicaid Services 2017). Certified Electronic Health Record (CEHR) are necessary to comply with American Recovery and Reinvestment Act (ARRA) and Meaningful Use (MU) requirements. The guiding principles of MU required that eligible professionals use a CEHR to improve healthcare quality, safety, and efficiency. Interoperability and compliance to ARRA and MU is relevant to healthcare leaders and stakeholders who were concerned regarding unplanned readmissions.

Legislative Changes

Access to primary care is critical in preventing and managing chronic illness. Changes in legislation altered the way providers and hospitals provided healthcare. The most influential legislative changes; ARRA, also known as the stimulus bill, and the ACA, also known as Obama Care, were targeted to reduce healthcare spending. The ACA outlined a comprehensive plan that revolutionized the healthcare industry specifically, in promoting primary and preventative programs that improved access to healthcare. Measures outlined in the ARRA provided the foundation for the ACA through outcome based reimbursement, enhanced quality benchmarking, and mandatory data reporting (Centers for Medicare & Medicaid Services, 2016).

Medicaid Expansion

In 2013, national, state, and regional healthcare-quality data were published. Florida healthcare data revealed an 18% Medicaid coverage gap (Florida Policy Institute, 2016). South Florida has a higher proportion of residents over the age of 65 than other regions in Florida (16.6% vs. 13.0%). Data reveals disparate numbers of unplanned hospital readmissions in non-Medicaid groups (Health Services Advisory Group, 2017; Strom et al., 2017). There are disproportionate

numbers of residents, over the age of 46, living in the state of Florida (Howden & Meyer, 2011). In the state of Florida, Medicaid-eligible adults were more likely to be uninsured and diagnosed with chronic medical conditions (Garfield, Damico, & Orgera, 2018).

Medicaid expansion was intended to improve access to primary healthcare services (Lyon, Douglas, & Cooke, 2014). In states where Medicaid expansion was not implemented, one being Florida, emergency room clinicians continued to manage chronic health conditions (Qin & Liu, 2013). The use of emergency room services continues to be the most expensive method of healthcare. Medicaid expansion states have reported improvements in accessibility to primary care through the formation of primary care health centers and medical homes (Lyon, Douglas, & Cooke, 2014).

Decreases in emergency room utilization were thought to be the result of improved primary care access (National Association of Community Health Centers, 2015). The reduction in emergency room use was attributed in part to improvements in access to primary and ambulatory care services by developing primary healthcare and medical homes. A recent comparison of emergency room and primary physician utilization between Medicaid expansion and non-expansion states showed a significant reduction in emergency room use (from 20% in 2011 to 11% in 2014) and an increase in primary care in Medicaid expansion states (Agency for Healthcare Research and Quality, 2013).

In comparison, healthcare facilities located in non-expansion states reported no significant reduction in uninsured emergency room visits (National Association of Community Health Centers, 2015). Due to the proportionate number of people with chronic illness over the age of 65, Medicaid expansion was thought to be critical reducing emergency room utilization for non-

emergency conditions. This study did not reveal additional knowledge that supported the need for Medicaid expansion in Florida.

Individual Healthcare Exchanges

Healthcare exchanges have added an increased level of complexity to health insurance. The high out-of-pocket expenses (deductibles and co-pays) of some healthcare insurance plans have resulted in higher costs to consumers (Healthcare.gov, n.d.). Provisions related to healthcare access necessitated insurance companies provide plans that included a broad range of healthcare services. Wellness checks and annual health screenings were essential health benefits included in healthcare exchange insurance plans (Snipelisky et al., 2016; Koh & Sebelius, 2010).

Lower enrollment has resulted in limited availability of insurance exchange plans. Healthcare marketplace consolidation and health subsidies have resulted in increased healthcare costs. Narrow options have resulted in restricted provider networks that have reduced the accessibility and affordability of healthcare services. Further investigation was needed to explore whether limited health insurance plans factored into the reasons for unplanned hospital readmission rates.

Uncompensated Care

Uninsured people receive healthcare services through safety-net providers, community and migrant health centers, public health clinics, hospital emergency departments, and some private providers (Galarneau, 2011). Emergency room utilization has increased as federal grants and funding for community health services have declined. Uninsured or low-income people are more likely to delay seeking care. The lack of accessibility to a primary care provider results in higher emergency room utilization of people with chronic illness resulting in hospital admission (Kim, Mortensen, & Eldridge, 2015).

Mental Health

An estimated 9.6 million citizens aged 18 and older represents 4.1% of all adults have serious mental illness (SMI). In 2015, 19% of adults were diagnosed with mental illness (National Institute of Mental Health, 2015). Providing acute and chronic mental health services has become a challenge for healthcare providers. Reasons for recent increases in mental health conditions are attributed to veterans returning from deployment. Severity of symptoms related to Post Traumatic Stress Disorder (PTSD) are associated with waiting periods for mental health appointments (Treatment Advocacy Center, 2012).

Clinicians working in Emergency Departments (ED) are safety-net providers for uninsured critically-ill patients needing care. Patients experiencing acute mental health crisis require inpatient admission to stabilize. Often, psychiatric patients experience prolonged ED wait times for an available bed. Despite the connections regarding prolonged ED wait times and increased cost and the public health impact of mental illness remains underrecognized (Stone, Rogers, Kruckenberg, & Lieser, 2012). The results of inadequate care and treatment of a mental health condition are frequent ED returns and hospital admissions.

Homelessness and mental health. A higher proportion of homeless people are diagnosed with physical and mental disabilities. Over 80% of homeless are diagnosed with one or more chronic medical conditions. Fifty-percent of homeless are diagnosed with mental illness. Fifty percent of the nation's chronically homeless are reported to live in three states; California (42%), New York (6%), and Florida (6%). Although Florida's homeless population has decreased 5,000 chronically homeless people are permanent Florida residents (The U.S. Department of Housing and Urban Development, 2017). Homeless people are more likely to be hospitalized for chronic health problems and are at higher risk of mortality and morbidity.

Chronic Homelessness

The chronically homeless have unique health challenges that deserve greater examination. Despite the focus on decreasing healthcare costs, the public health impact of homelessness and mental illness remains underrecognized and underfunded (Stone, Rogers, Kruckenberg, & Lieser, 2012). Although age, community demographics, physical, and mental health influence health status (McHugh et al., 2013), the current study did not reveal a connection between chronic homelessness and the frequency of unplanned hospital readmissions in the tri-county area.

Seasonal Migration

There are increases in Florida's older population due to seasonal migration in the winter months (Smith & House, 2006). Temporary residency of approximately 800,000 people residents over the age of 65 requires healthcare providers to plan for increased patient volumes. Temporary residents referred to as "snowbirds" return on an annual basis to move between campgrounds and hotels or return to the same location. Most have established temporary primary care and are insured through Medicare or commercial insurances.

Cultural Factors

Considerable international migration from Europe, Australasia, Latin America, the Caribbean, South America, and Central America, has resulted in south Florida being one of the most culturally and ethnically diverse regions in the US. The patients cultural practices and beliefs influence health-seeking behaviors and acceptance of disease management methods. Education and health management is complicated due to deficits in healthcare literacy and understanding. There are cultures who respond to illness differently that may contradict traditional models of care (Shaw, Huebner, Armin, Orzech, & Vivian, 2009). Cultural awareness and focused education are important components in providing disease management to culturally diverse populations. Due to

cultural and ethnic diversity within a population, healthcare providers must provide culturally appropriate care by adapting traditional care models to accommodate dominant cultural factors within the population.

Healthcare Deserts

Medical (Healthcare) deserts are geographical areas devoid of primary care and hospital services. The deficiency in healthcare resources affects minorities, people of color, low-income communities, and older adults (Dosen et al., 2017). The US healthcare delivery system is a fragmented, multi-tiered system providing high-quality healthcare, yet presents healthcare access challenges to some demographic groups. As provision of healthcare transitions to a leaner and more efficient business, hospital mergers and closures in rural and metropolitan areas has reduced availability of healthcare providers. Transportation is a barrier to healthcare access in rural areas. People without financial means are less likely to attend doctor appointments (Dosen et al., 2017). The results of this study revealed the importance of resources when associated with successfully managing chronic illnesses.

Primary Care Provider Availability

In the last decade, the availability of family practice and primary care physicians has decreased. The demand for primary care is projected to exceed the supply of primary care providers. Increased demand for primary healthcare, initiated financial incentives to increase primary care clinician numbers (U.S. Department of Health and Human Services, 2013). Additionally, the increase in Advanced Registered Nurse Practitioners (ARNPs) has alleviated physician shortages through alleviating access to primary care.

ARNPs practice in diverse healthcare settings and provide high-quality healthcare services in acute and community settings (Naylor & Kurtzman, 2010). Credentialing restrictions present in

place constraints on ARNP scope and practice. In Florida, ARNPs are limited by clauses requiring direct supervision of practice by a physician. There was empirical evidence that supported the connection between ARNPs and improved patient outcomes (Institute of Medicine, 2010).

The reinvigoration of primary and preventative care is reliant on availability of sufficient qualified clinicians. The expansion of ARNP responsibilities will alleviate decreases in physician numbers. Recommendations that support ARNPs as licensed independent practitioners has positively impacted healthcare quality and improved access to primary and preventative care (Kleinpell et al., 2014).

Care Transitions

Evidence-based protocols facilitate reductions in preventable hospital readmissions. Common measures used to support transitions of care from hospital to home included standardized discharge instructions, patient and family education, discharge phone-calls, and pre-scheduled primary care appointments (Kamermayer, Leasure, & Anderson, 2017). The most critical component of successful care transition is communication and the transfer of medical data between care providers. Interoperability of healthcare data facilitates coordinated care, improves outcomes, and was a critical component in the restructuring of healthcare delivery (Centers for Medicaid & Medicare Services, 2016).

Safe care transitions of care are central to preventing unplanned hospital readmissions. Clinician and patient communication needs are met when healthcare organizations posess integrated Electronic Health Records (EHR). An integrated EHR provides consumers' access to medical records and encourages autonomy and health-seeking behaviors (Sirgy, Lee, & Yu, 2011). Barriers to safe care transition included delayed conversion to improved workflows due to slow provider adoption (Ajami & Arab-Chadegani, 2013).

Electronic Health Records

Provider computer skills, computer literacy, and the cost of buying and installing Information Technology (IT) infrastructure are related to the adoption of EHRs (Kumar & Aldrich, 2010). Integrated EHR's enhance medical record accessibility for clinicians and improve patient safety through eliminating indecipherable handwriting. Concerns regarding physician handwriting legibility is a frequent patient safety concern controlled by EHRs (Ajami & Arab-Chadegani, 2013). Autonomous accessibility to an EHR improves informed clinical decision-making and is critical to safe patient care. Integration EHR provides access to medical records from medical offices through secure networks, thereby accelerating patient care and management (Ajami & Arab-Chadegani, 2013). The results of this study identified opportunities for improved interoperability of EHR in the tri-county area.

Behavior Modification

Efficacious management of chronic medical conditions requires consistent health focused practices that modify behaviors. Patients make better lifestyle choices and comply to care plans when educated and instructed regarding their chronic medical condition (Edwards, Charani, Sevdalis, Banos, & Sibley, 2012). Preventive measures such as complying with vaccination recommendations, smoking cessation, dietary changes, exercise plans, adherence to treatment regimens, and weight control measures are relevant to preventing hospital admissions. Chronic health conditions are exacerbated by variables that are out of the clinician's control for example, diet and domestic living arrangements.

Managing exacerbations of chronic disease is challenging when the physical home environment is not conducive to recovery. Non-compliant behaviors are frequently enabled by well-meaning family members. Family engagement is critical to successful behavioral change and

chronic disease management. The successful management of chronic disease requires education and cooperation of household members. Frequent rehospitalization is more likely when family members are not committed to complying to the plan of care.

Although non-compliance is a common problem in patients with chronic conditions behavior modification measures are considered essential to improve accountability and implementing strategies (Edwards et al., 2012).

Discharge Teaching and Education

High-quality patient and family education is individualized, consistent, and initiated upon hospital admission. Early discharge preparations provide time to arrange additional resources to assist the patient when discharged. Additional resources include home health, durable medical equipment, and arranging specialty and follow-up clinic appointments. Each condition is associated with clinical guidelines that provided recommendations that are specific to the condition (Ho, Caughey, & Shakib, 2014). Nursing staff that provide discharge teaching and patient education must be aware of the recommendations and be able to identify learning barriers before the patient is discharged.

Patient and family education are critical to successful disease management, and clear discharge instructions are the first step in a multi-disciplinary plan of care (Ho, Caughey, & Shakib, 2014). Patients and family caregivers must be provided information regarding plan of care through clear discharge instructions to recognize health deterioration. Nurse knowledge is important to evaluating patients' and caregivers' understanding of the discharge instructions. Clear understanding facilitates self-management once discharged home. The results of this study identified nurse related barriers to providing appropriate discharge education and teaching that

contribute to high readmission rates. Deficits related to discharge processes in tri-county area hospitals contribute to readmission rates.

Self-Efficacy

Planned behaviors and self-efficacy are interconnected and emulate the perception of self-control (Fishbein & Cappella, 2006). When self-efficacy is associated with patient education and teaching, perceived control facilitated ownership and accountability for the disease or illness. Once education is provided, the patient gains the confidence to perform the steps required to manage their chronic illness. The power of planned behavior empowers patient decision-making and aligns behavior to intention (Krueger & Carsrud, 1993). There is need for further study that connects patient behavior to self-management and factors in reducing the incidence of readmission.

Community Health Resources

Challenges in managing chronic diseases have been caused through widespread under-funding community health resources. Investment in community-based infrastructure, disease prevention, and health promotion is required to reduce the rate of unplanned hospital readmissions (Strycker & Glasgow, 2002). When necessary community resources are available patients requiring close surveillance are more likely to remain at home when discharged.

Home healthcare provides ongoing surveillance and assessment of chronic health conditions. Home visitation nurses, physical therapists, and other resources specific to the person's health needs improves outcomes and enhances compliance to discharge instructions (Health Quality Ontario, 2013). The results of this study revealed deficits in the availability of community resources in the tri-county area that, if available, keep patients at home rather than admitting them to hospital.

Integrated Healthcare Delivery Systems

The viability of a healthcare organization is achieved by developing a collaborative system that connects healthcare services and clinicians with a specified patient group or community (The Joint Commission, 2013). The consolidation of healthcare delivery systems support a cost effective, coordinated, and delineated healthcare service. Integrated Health Delivery Systems (IHDS) promote inter-professional collaboration and quality from a clinical standpoint; thus, provide and maintain optimum clinical and financial outcomes (Hartgerink et al., 2014).

Long Term Acute Care Hospitals

The long term acute care hospital (LTACH) is a reliable care option used to transition complex patients. When complex patients require more than 25 days of long-term care and disease management, LTACHs provide a viable solution. The advantages associated with LTACHs are the licensing regulations and adjusted insurance provisions that deem LTACHs as acute care facilities. Insured patients with ongoing care healthcare needs may be transferred to an LTACH. When acute care facilities transfer complex patients to LTACHs patient outcomes improve and rehospitalizations reduced.

Approximately 70% of LTACH patients in the 65 or older age group have Medicare insurance. Patients under the age of 65 and receiving LTACH care are typically enrolled in Medicare due to long-standing chronic health conditions (Kahn, Benson, Appleby, Carson, & Iwashyna, 2010). The results of this study identify information that assists healthcare leaders, clinicians, and nurses identify transitional care opportunities in the tri-county area.

Evolving Healthcare Policy

Presently, the all-cause hospital readmission measure is limited to Medicaid recipients aged 65 or older readmitted to a short stay, critical access, or acute care hospital for any reason within

30 days. Although, some readmissions are unavoidable, readmissions are considered negative outcomes and related to sub-optimal care, unsatisfactory discharge preparation, and sub-standard care transitions (Centers for Medicaid & Medicare, 2015). Although this measure limits readmission penalties to the 65 or older age group, discussion is ongoing regarding expanding measures to all ages and conditions. Rationale for transitioning from condition-specific to hospital-wide specific measures for unplanned readmissions is to broaden provider eligibility and reduce the frequency of readmission across all patient groups and conditions (Zuckerman et al., 2017). Comparisons made between condition-specific and hospital-wide measures regarding the severity of penalties predicted higher penalties in hospitals with disproportionate Medicaid patient numbers.

Customer Experience

Healthcare reimbursement depends on the level of patient satisfaction and clinical outcomes with data that are mandatorily reported through the CMS database. Patient satisfaction is a relationship-marketing variable described as a personal, reciprocal, and positive connection between consumers and healthcare clinicians. Relationship marketing changes the emphasis from a transactional to an individualized customer focus. The measurement of patient experience is one of the metrics that are mandatorily reported to CMS as part of a hospital's quality data.

Patient experience is a condition of pay-for-performance that is closely tied to clinical outcomes. Yang, Liu, Huang, and Mukamel (2018) suggested that there are statistical connections between staff responsiveness and the likelihood of hospital readmission. Staff responsiveness to patient requests is closely associated with patient outcomes and the quality of healthcare. The low response to patient needs from hospital staff results in higher adverse outcomes. Positive experiences are shown to create an environment where patients feel valued and listened to, a factor

often associated with responsiveness to treatment. Further study may identify other elements that affect readmission rates that are related to patient experience.

Co-morbid Conditions

Co-morbidity is the presence of one or more health conditions and is connected to a primary disease. Cancer, obesity, heart disease, and diabetes are among the most common and costly primary health conditions that, if left untreated, result in hospital admissions. Chronic health conditions have increased rapidly in the last 20 years and are the leading cause of death and disability in the US. When a chronic health condition is diagnosed, underlying health conditions are discovered that complicate treatment of the primary illness.

The most common, heart disease and cancer, account for nearly 50% of all deaths in the US. The medical cost in treating people with chronic physical and mental conditions equates to 80% of all healthcare expenditures (Centers for Disease Control and Prevention, 2017). The causes of chronic conditions are often the result of genetics, unhealthy behaviors, and underlying etiologies. The rapid increase in chronic health conditions requires further studies that explore factors that increase the potential for chronic illnesses. The common experiences of healthcare stakeholders provided further insight into the reasons chronic health conditions continue to rise despite advances in care and treatment.

Affluence and Hospital Readmissions

The connection between hospital readmission, socio-economic status, and socio-demographic factors has been clearly described. To understand the connections between social determinants and unplanned readmissions one must understand whether personal affluence influences the likelihood of readmission. Factors beneficial to managing chronic illness include educational level, income, health insurance, and available family support systems. A Canadian

study by Smith et al. (2017) studied socio-demographic connections to readmission and found a relationship between previous hospital use and readmissions yet concluded that there were no connections between socio-demographic status and readmission.

One might question the relevance of this study to the US healthcare model, as the Canadian healthcare system is a socialized system that provides patients the resources needed to manage chronic health conditions at home. Wealth and prosperity provide the means to afford health insurance, pay out-of-pocket deductibles, afford prescription medications, pay for home health, and acquire other resources that are needed to manage chronic illnesses. Affluence provides the patient with additional options, for example, short stay residential care, convalescent care, and additional in-home resources.

Patients who are uninsured or have limited insurance plans do not have the means to pay out-of-pocket for continued chronic disease management and stabilization after they are discharged from hospital; therefore, they are more likely to be readmitted to hospital. Post-discharge care has a positive effect on health status, enhances care transitions, and provides options that are not available to patients with lower socio-economic status (Kripalani, Theobald, Anctil, & Vasilevskis, 2014). Further studies may help to define the role of home-based resources, convalescent placement, or other short stay residential options to manage chronic conditions after hospitalization. Patients who are at greater risk of readmission may benefit from short-term or in-home support that reinforces discharge planning and promotes health maintenance.

Relevance to Healthcare Leadership

The viability of a healthcare organization can be achieved by developing a collaborative system that connects healthcare services and clinicians to provide care to a specified patient group or community. Consolidated healthcare delivery systems provide coordinated and delineated

healthcare services at a reasonable price. The stability of a healthcare organization requires proactive leaders who understand the complexity of Integrated Health Delivery Systems (IHDS).

Berwick (2003) discussed clusters of influence that affected how innovation was diffused throughout a healthcare organization. These clusters included: stakeholder perceptions, potential adopter characteristics, and leadership experience and traits (Berwick, 2003). Recommendations highlighted the need for healthcare executives to self-reflect on implementation within an organization and how leadership styles influence early adopters to become change agents.

Healthcare leaders who recognize the importance of inter-professional collaboration and accountability for high performance and quality are more likely to achieve optimum clinical and financial outcomes (Hartgerink et al., 2014). The need for rigorous cost control has refocused healthcare leaders on efficiency and quality, galvanized by the advent of value-based payments. The current study aims to provide insight through the experiences of healthcare leaders who continue to develop and refine system processes to reduce unplanned hospital readmissions.

Gaps in the Literature

Gaps in literature are defined as an area of missing or insufficient knowledge in an existing research subject, or an area that has not yet been explored (Cone & Foster, 2016). Gaps providing rationale for further study were identified as system, process, and outcome gaps related to unplanned hospital readmissions in the tri-county. The central research question(RQ1) guiding this study: What are the common experiences of healthcare leaders, clinicians, and nurses as to reasons for higher than expected unplanned hospital readmissions for patients with chronic health conditions in healthcare facilities located in Broward, Miami-Dade, and Monroe Counties in the state of Florida?

Healthcare stakeholders demonstrated integrated processes that provided high-quality care

evidence-based care. Healthcare stakeholders must have awareness of contributory factors associated with managing chronically ill patients. Although there are studies and articles concerning financial implications of unplanned hospital readmissions, the body of knowledge lacked qualitative research related to social and population-specific factors that contributed to process failures associated with unplanned readmissions.

When planning solutions that address process failures, healthcare leaders must consider the experiences of all healthcare stakeholders (Martin, 2014). Collaborative efforts between stakeholders are needed to identify the components connected with unplanned hospital readmissions. Collaboration with healthcare stakeholders will identify existing healthcare practices that are misaligned or conflicting with community characteristics.

Self-efficacy and accountability. Self-efficacy is contingent on the patients' beliefs associating their own competence to oversee their health needs (Ho, Caughey, & Shakib, 2014). Efficacy in self-care is developed through instilling confidence through education and teaching. When patients are confident in self caring they make choices regarding health practices that lead to health behavior changes. The collective experiences of healthcare stakeholders provided insight regarding the importance of including patients and families in decision-making, specifically in assessing and facilitating self-care capabilities.

Gaps between Theory and Practice

Close relationships exist between theory and practice when connected to healthcare. Conceptualization of practice is connected to the practical actions needed and desirable when treating patients. Multiple factors contribute to the theory-practice gap (Lewin, 1947). Despite clearly delineated clinical pathways, healthcare clinicians seem unable to prevent rehospitalization.

Gaps between theory and practice specific to reducing unplanned hospital readmissions appear to be a result of variations dependent on socio-economic factors and available resources.

Change implementation is difficult due to inconsistency between evaluation and assessment of healthcare quality (Donabedian, 1966). There are inconsistencies in policies and processes in managing unplanned hospital readmissions. Variations in the availability of resources, create inconsistency within internal departments and between healthcare facilities in the application of theories and practices. Theories supporting patient and family involvement; discharge planning, plans of care, and disease management, conflict with variations in nurse experience and nursing skill levels affect the quality of patient education and discharge preparation.

Conclusion

Unplanned readmissions are a quality indicator therefore, it is important to understand the factors related to unplanned readmissions through the experiences of healthcare stakeholders. Knowing the perceptions of stakeholders offers in-depth understanding of reasons healthcare policies and practices lead to positive patient outcomes. Literature review identified unplanned hospital readmissions and untreated chronic medical conditions as financial burdens for hospitals. The assumptions concerning unplanned readmissions is that when evidence-based practices are adhered to and patients are not readmitted to hospital.

The ability to identify other factors that affect hospital readmission rates through the experiences of stakeholders is beneficial to the administrators of healthcare organizations in the tri-county area and other leaders of healthcare organizations who are experiencing challenges caring for chronically ill patients. Healthcare reimbursement is connected to patient outcomes through multiple data collection and reporting processes. New knowledge discovered connections between

the management of chronic illness and achieving quality metrics. Each of these elements was identified to be critical to improving healthcare outcomes.

Chapter Summary

In Chapter 2, the literature search revealed gaps in publications on the connections between healthcare policy and healthcare quality in hospitals located in the tri-county area. The need for additional studies is supported as policies and quality initiatives influence the financial viability of healthcare organizations, specifically when associated with patient outcomes (Park & Shaw, 2013). The literature search revealed theories used to describe the complex healthcare environment. There are few studies that explored the experiences of unplanned hospital readmissions from the healthcare stakeholder's perspective.

A theoretical framework validated the propositions found in the existing literature to answer the central research question (Lune & Berg, 2017). The literature reviewed in this chapter identified studies related to the question of unplanned hospital readmissions and how social determinants influenced the provision of healthcare services to complex populations. There is evidence that healthcare facilities located in less affluent areas received lower financial reimbursement and higher penalties. There also appears to be disproportionate outcomes related to unplanned hospital readmissions in healthcare facilities that provide indigent healthcare. Chapter 2 included a discussion of the rationale for selecting a qualitative multiple-case study design and how the results contribute to the existing body of knowledge.

Chapter 2 consisted of a review of the literature associating factors that influence the care and management of patients with chronic medical conditions. A review of best practices, disease surveillance and monitoring, evidence-based standards of care, and patient non-compliance was conducted. Chapter 3 is a review of the methods and designs that are relevant to the qualitative

exploratory multiple-case study approach. The rationale for the research questions, population, informed consent, location, trustworthiness, reliability, and validity was examined. Data collection and analysis methods were discussed, as well as ethical concerns regarding confidentiality that related to this qualitative exploratory multiple-case study.

Chapter 3

Research Methodology

The purpose of this qualitative exploratory multiple-case study was to explore the reasons for higher than expected unplanned hospital readmissions in healthcare facilities located in the tri-county area of south Florida to help hospital administrators improve healthcare quality through reducing unplanned rehospitalizations. There is great opportunity for the improvement of healthcare performance and processes (Juran, 1988). The results of this research study added qualitative knowledge to the existing body of literature and serve as a motivator to include the experiences of stakeholders in the decision-making process while designing quality measures for health outcomes.

This chapter includes a comprehensive overview of the research methodology, information regarding research methods and designs, and validation of the appropriateness of a qualitative exploratory multiple-case study. This chapter also includes a description of the population, sample, data collection methods, instrumentation, and selected geographic location of the study. Chapter 3 contains a detailed account of the research questions, procedures governing informed consent, assurance of confidentiality, and interview procedures. The feasibility of the chosen methodology and design clarified and demonstrated a qualitative methodology and exploratory multiple-case study design is supported by the research question to discover the perceptions of healthcare stakeholders who worked in hospitals with frequent unplanned hospital readmissions.

Analysis of collected data facilitated in-depth common understandings concerning the reason readmission rates were higher in healthcare facilities located in the tri-county area and provided information for stakeholders to be more successful when managing patients with chronic medical conditions (Health Services Advisory Group, 2017). Through the perspectives

of healthcare stakeholders, this exploratory study contributes to the body of knowledge related to unplanned hospital readmissions and transitions of care. Triangulation of the data was achieved through a description of the data, which included a detailed account of the study participants and setting, and a review of peer-reviewed journal articles, dissertations, books, government reports, and other data sources. The findings of this study contribute new knowledge to healthcare stakeholders regarding the factors associated with unplanned readmissions in a diverse population.

Research Methods Flowchart

The results of this study provide further understanding of the experiences of healthcare stakeholders regarding the reason there are higher than expected unplanned hospital readmissions in hospitals located in the tri-county area. The research methods flowchart (Figure 2) illustrated the research process used by the researcher to organize the development and design of this study. Each element provided visual prompts and sequential steps that facilitated a clear direction and focus in the development of the study. Figure 2 shows the sequential order of the research methods established by the researcher for this study.

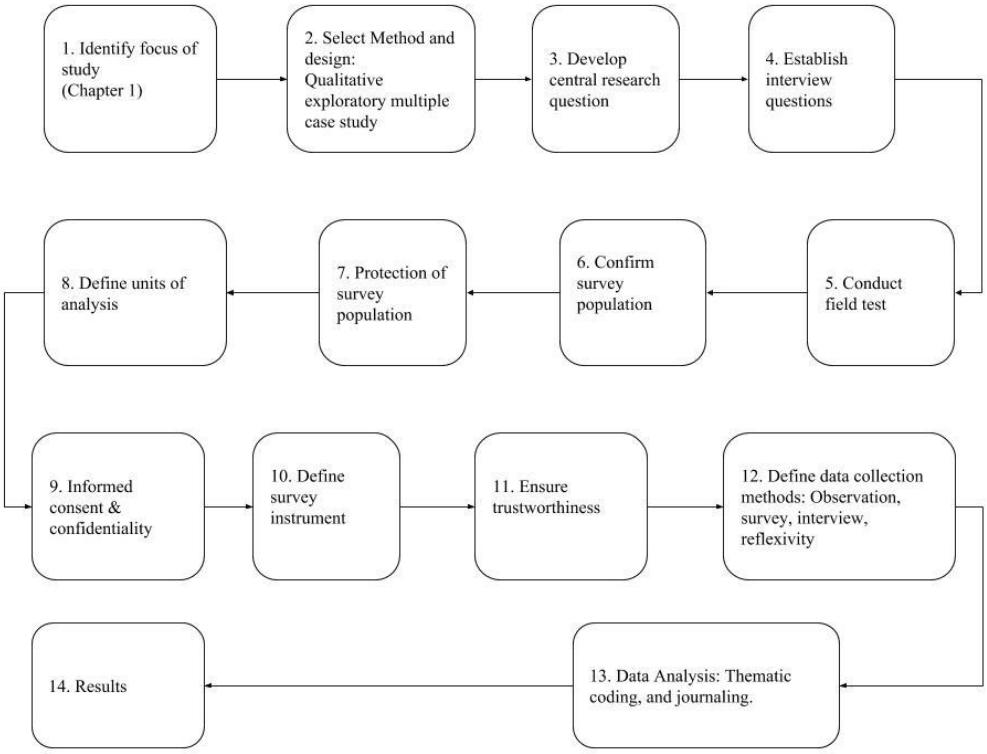

Figure 2. Research Methods Flowchart.

Research Method and Design Appropriateness

The methodology, design, and feasibility were appropriate for this study and promoted an understanding of the reasons unplanned hospital readmissions are higher in healthcare facilities located in the tri-county area. Exploration of the experiences of healthcare stakeholders provide insight into the importance of outcomes measurement related to unplanned readmissions. The results of this research study provide insight into the determinants that contributed to the care and management of patients with chronic medical conditions.

Qualitative Methodology. The results of this qualitative study provide empirical evidence of societal elements present in the tri-county area. The rationale for conducting this

qualitative multiple-case study, compared to other methods, was the researcher's need to understand how and why unplanned hospital readmissions are higher in the tri-county area. Understanding was achieved through the results of carefully crafted research questions (Stake, 2006). The research questions provide an indication of the most appropriate method and design that was used for the study; thus, the study questions matched the method.

The researcher employed a qualitative approach that established flexibility and trust in the collected data and allowed the study participants to guide the research (Gomm et al., 2011; Hamel et al., 1993). The qualitative method used for this study was the most appropriate method to consider healthcare stakeholders' experiences and to provide explanations concerning unplanned readmissions are a problem for the administrators of some healthcare organizations. The principle of this researcher was to explore additional insights or new understandings regarding the phenomenon of hospital readmissions (Hamel et al., 1993; Yin, 2014). In south Florida, there was a need to understand the reason higher numbers of patients were being readmitted within 30 days of hospitalization due to chronic health conditions.

A qualitative method was considered appropriate for this research study that required an inductive approach to reveal insights into reported data. The researcher collected data through semi-structured, open-ended interview questions to discover the experiences of healthcare stakeholders. The collection of ontological and epistemic perspectives from healthcare stakeholders helped to the healthcare experience of repeated hospitalizations (Willis, 2007).

This qualitative research study was conducted primarily in a natural setting to understand the ontological perspectives of individuals or groups by identifying their personal realities, motivations, and beliefs. Concurrently, the qualitative interview questions used to collect data were open-ended and obtained the descriptions and perceptions of the study participants (Stake,

1995). The interview questions were field tested and revised to incorporate the suggestions of subject matter-experts prior to commencement of the study.

Feedback from the field test helped the researcher redesign and define the interview questions. This increased data reliability and improved the structure used to collect accurate data regarding the problem (Yin, 2014). This philosophical investigation of healthcare stakeholder experiences was focused on alternative realities that were already ingrained in the study participants' impressions of the phenomenon (Ravitch & Carl, 2016). A qualitative method was considered appropriate to explore the experiences of multiple healthcare stakeholders related to their perceptions regarding unplanned hospital readmissions.

Research methodology literature. The literature reviewed for this study revealed an apparent shortage of qualitative studies pertaining to the potential connections between social factors and the frequency of unplanned hospital readmissions. The opinions and experiences of healthcare stakeholders revealed evidence that supported further qualitative studies regarding patients who are frequently hospitalized. In this study, the interview questions were formed to allow participants to share their experiences concerning the reason unplanned readmissions are a challenge in healthcare facilities located in the tri-county area. The motivator for conducting this multiple-case study was to gain a greater understanding of the problem. The study participants were asked how and why questions to document their experiences concerning the effectiveness of processes in reducing unplanned readmissions and how quality initiatives related to discharge processes may be more effective (Yin, 2014).

Research design literature. When selecting a design for this study, consideration was given to the alternative designs associated with qualitative research. The research designs that were considered for this study included ethnography, phenomenology, and grounded theory. Each of these designs shared similar characteristics that were applicable to qualitative studies: all

possess a foundation of social constructivism or knowledge through interactions, experience, or the perspectives of others; the research questions identified problems through prior research studies; sample sizes are generally small and generate large amounts of data; data collection methods included interviews, observation, and archival data; interpretation was achieved through data collection and the researcher's evaluation of the data; and the designs relied on the transcription and coding of the data that revealed common themes that described the patterns and phenomenon as results (Merriam & Tisdell, 2016).

An exploratory multiple-case study approach was an appropriate design that enabled the researcher to discover recurrent patterns and themes from the experiences of the multiple stakeholders experiencing the problem (Gomm, Hammersley, & Foster, 2011). This study adopted a framework that focused on data triangulation, dependability, and trustworthiness while examining the experiences of healthcare stakeholders. In qualitative research, the experience of "meaning making" from experience and perceptions was widely criticized due to the potential for researcher subjectivity (Hesse-Biber & Leavy, 2011). The concepts of transferability, credibility, dependability, and confirmability were used by the researcher to determine the trustworthiness of this qualitative study (Lincoln & Guba, 1985).

The results of this exploratory case study initiated the discovery of new knowledge by gaining insights and the ideas of the participants. The results enabled comprehension of the problem for which little information existed. The focus of this exploratory case study was not to provide conclusive answers or decisions but to produce a theory of why two or more factors exist (Yin, 2014). The flexibility of an exploratory research design allowed each facet of the problem that were examined through considering the thoughts and ideas of various healthcare professionals. Exploratory design was used in healthcare settings to investigate problems with quality, compliance, and care outcomes through the study participants' thoughts and ideas.

Nguyen (2014) proposed that unplanned hospital readmissions were the result of poor care quality and outlined the operational, technical, and clinical deficiencies that caused many unplanned hospital readmissions from the perspectives of frontline staff in a safety-net hospital. Despite evidence that hand washing is the most effective method of preventing transmission of disease, Moore (2015) explored the perceptions of healthcare clinicians concerning factors associated with non-compliance with hand hygiene practices. The purpose of this qualitative exploratory multiple-case study was to gain an understanding of healthcare stakeholders' experiences with factors associated with the frequency of unplanned hospital readmissions in the tri-county area.

There are five main designs in qualitative inquiry and methods, and all are similar in their data collection procedures. The design selected by the researcher was dictated by the type of data collection method used and depended on the researcher's view of the research problem. The results of this study were achieved through exploring, describing, and interpreting circumstances, and synthesizing meanings, to brings clarity and understanding to the problem (Yin, 2014). Case study researchers collect thick or rich descriptive data in everyday contexts through fieldwork and participant experiences. The stance of this case study researcher was to ask how and why a phenomenon existed to contextualize the problem through an in-depth analysis (Merriam & Tisdell, 2016).

Case study design appropriateness. The case study design was selected by the researcher because the concept that care quality and evidence-based processes bind the cases of healthcare leaders, clinicians, and nurses. While selecting targeted and relevant cases for this study, consideration was given to individual cases that were contextually diverse and provide opportunities for complex learning (Stake, 2006). The units of analysis consisted of healthcare organizations located in Broward, Miami-Dade, and Monroe Counties in the state of Florida.

Three cases are comprised of stakeholder groups; healthcare leaders, clinicians, and registered nurses. Each case provided descriptions and explanations of the phenomenon from different experiences and positions within a bounded healthcare system (Lune & Berg, 2017).

This case study is a suitable design and provides the foundation for an in-depth and detailed description and analysis of each case, bounded by healthcare facilities located within the tri-county area (Stake, 1995). A case study design is an appropriate approach when multiple data sources are used to create an in-depth understanding of an issue or phenomenon.

The research plan and design were established and carefully organized prior to commencing this multiple-case study. The plan included delineated cases that had a connection with the issue being studied (Yin, 2014). This exploratory multiple-case study was an appropriate design to demonstrate the rationale and direction that guided the experiences of stakeholders working in healthcare who had knowledge of chronic medical conditions, an understanding of the implications of unplanned hospital readmissions, and connections to healthcare quality through asking how and why (Yin, 2014). The results of this study revealed relationships between clinical and leadership practices and quality processes to answer the research question. The researcher investigated the experiences of healthcare stakeholders related to healthcare quality, and the factors that they believed contributed to unplanned hospital readmissions.

A case study design was used to discover an in-depth contextual understanding of a real-life phenomenon that involved data collection and analysis from a unit or set of units in which a contrast or comparison is made to establish the boundaries of the study (Gomm et al., 2011). This study contrasted and compared the experiences of multiple stakeholders to reveal their understanding of how healthcare quality initiatives influenced unplanned hospital readmissions. The cases consisted of study participants who embodied the case study design, namely, each had

experiences to share regarding unplanned hospital readmissions that they considered relevant to people working in healthcare.

Each case revealed a unique perspective of how unplanned hospital readmissions occurred and the reason some hospitals had higher readmission rates than others and yielded an abundance of information that provided an understanding of the problem. The researcher investigated the reasons for variability in the success of implementing quality measures believed to reduce unplanned hospital readmissions through defined research questions that can be used in future research studies.

The intent of the researcher was to use a case study design to describe a phenomenon or collective concern through developing a personal connection with the participants (Hamel, Dufour, & Fortin, 1993). Given this knowledge, the case study design was considered suitable for a research study concerning healthcare strategies that are designed to prevent unplanned hospital readmissions. Through the experiences and observations of healthcare stakeholders, this multiple-case case study analyzed the effectiveness of existing healthcare paradigms. The new data gathered through interviews with healthcare stakeholders revealed challenges and opportunities associated with unplanned hospital readmissions.

The decision to use a qualitative multiple-case study was deemed essential to assess how healthcare outcomes are connected to evidence-based practices. The multiple-case study design assisted the researcher in addressing information that had not been previously identified in current literature. When compared to other qualitative designs, such as grounded theory and phenomenological studies, multiple-case studies added to the depth of current research. Use of a multiple-case study design enabled study participants to provide thick descriptions and rich data through their own experiences and observations (Lincoln & Guba, 1985).

Through employing a practice-based, multiple-case study design the researcher was able to provide meaningful information concerning specific problems not previously investigated; use of the case study design obtained information from practitioners in specific situations, incorporated theoretical ideas, and considered individual observations and experiences. By studying the existing realities related to unplanned hospital readmissions and the consequences for healthcare stakeholders, the researcher was able to gain insight and understanding into the phenomenon and suggest realistic solutions. The multiple-case study design is not appropriate to prove a hypothesis, but rather intended to provide a better understanding of the variables, limitations, and dynamics of the cases being studied (MacDonald & Walker, 1975).

Quantitative methodology. The use of a quantitative research methodology results in statistical interpretation of data obtained from survey instruments and large sample sizes to enable the generalization of results to larger population (Leedy & Ormrod, 2010). In quantitative research, the evaluation of statistical results establishes reliability and credibility by proving or disproving a hypothesis. The use of a quantitative method facilitates the collection of data through predefined, validated, data-collection instruments (Leedy & Ormrod, 2010). A quantitative methodology was not appropriate for this study due to difficulties in determining the connections and characteristics between a single variable and the positive or negative influences of other identified variables studying the common experiences of healthcare stakeholders regarding the reasons for unplanned hospital readmissions (Leedy & Ormrod, 2010).

Research Questions

The research questions prepared by the researcher for this study provided focus for the concept under examination (Flick, 2006). The focus of the researcher was to explore the common experiences of healthcare stakeholders regarding the higher frequency of unplanned hospital readmissions. Martin (2014) suggested that healthcare practices and policies conflict with some

community characteristics. The review of the literature identified opportunities for further research into healthcare stakeholders' perceptions of the reason's community characteristics influenced unplanned readmissions.

This study involved an exploration of stakeholders' experiences concerning the reasons for unplanned hospital readmissions and why there are barriers to achieving quality benchmarks. One central research question led to the development of interview questions: What are the common experiences concerning higher than expected unplanned hospital readmissions for patients with chronic health conditions in healthcare facilities located in Broward, Miami-Dade, and Monroe Counties? The researcher's use of an exploratory case study design facilitated an in-depth examination of healthcare stakeholders' common experiences of the uniqueness of the tri-county population and whether cultural diversity had bearing on the frequency of hospital readmissions.

Population and Sample

A case study population is defined as a case or cases (Gerring, 2004; Neuman, 2011). Neuman (2011) defines a case as a bounded unit or the observation of events, people, groups, or geographic locations. The participant population included healthcare individuals with experience working in acute healthcare in the tri-county area in Florida were considered representative of the general population for this qualitative exploratory multiple-case study. There are 52 acute healthcare facilities in the tri-county area where healthcare administrators are mandated to submit regular quality data to the CMS database (Florida Hospital Association, 2017).

The study population consisted of healthcare personnel with experience working within the 52 acute healthcare facilities in the tri-county area. The study sample included three stakeholder groups, namely, healthcare leaders at director level and above, clinicians specifically, hospital based physicians and advanced nurse practitioners, and registered nurses

with experience working in acute care hospitals in the tri-county area. Participants were required to have knowledge of chronic medical conditions, and an understanding of the implications of unplanned hospital readmissions.

Units of Analysis (Defining the Case)

Defining the units of analysis required detailed information regarding the qualifications of those who were involved in this research study. The units of analysis for this multiple-case study consisted of three defined cases of healthcare stakeholders who had knowledge of chronic medical conditions, and an understanding of the implications of unplanned hospital readmissions. Each case has specific roles and responsibilities that generated similar and contrasting experiences regarding unplanned hospital readmissions.

Healthcare leaders. Healthcare leaders are responsible for operational and strategic planning and the management of healthcare facilities. The professional experiences of the chief executive officer (CEO), chief nursing officer (CNO), and department directors were identified as being relevant to this study. These executives had knowledge of the challenges of preventing unplanned hospital readmissions and have frequent communication with clinicians, nursing staff, and other stakeholders. Healthcare executives are responsible for the quality of care provided and for the accuracy of quality data submitted to the CMS database.

Clinicians. Clinicians are professionals who are responsible for the care and management of patients. Clinicians are responsible for setting treatment regimes, prescribing medications, providing daily supervision of care plans, and evaluating readiness for discharge. The clinicians eligible to participate in this study included physicians, advanced registered nurse practitioners (ARNPs), and physician assistants (PAs) who regularly treated patients with chronic medical conditions.

Registered Nurses. Registered Nurses (RNs) are responsible for implementing orders and ensuring that patients' care-plans are executed. RNs play an important role in evaluating and assessing patient response, communicating with clinicians, and for the pre-discharge preparation of patients. The RNs' role is to provide ongoing care and surveillance of patients to ensure that their care transitions from hospital to home are successful. Discharge planning, discharge teaching, providing information for patients and caregivers, the identification of the need for durable medical equipment, and arranging for home-care and other supportive services are critical for successful care transitions.

Recruitment Process

The recruitment process was initiated through a recruitment flyer posted on the researchers personal LinkedIn page. The recruitment flyer included the following information: A brief description of the research purpose, the researcher's name and university affiliation, eligibility criteria, time commitments required, location of the research, and the researcher's contact information. The recruitment flyer included and a link to an online 9-question demographic survey developed by the researcher in Google Docs®. When survey responses were submitted, the researcher received email notification after which, each demographic survey was reviewed for eligibility criteria by the researcher.

Respondents meeting inclusion criteria were contacted via their preferred email address. Each was informed of the purpose, appraisal of the data collection method, how data is used, and methods to protect, store and destroy data. The participants were informed that their decision to take part in the study is voluntary, there are no potential risks to participation, and they may withdraw from the study at any time without consequence. An informed consent form was attached for review and signing prior to scheduling an interview. Once a signed consent was

returned an alphanumeric pseudonym was assigned and an interview, estimated to last 30-50 minutes, was arranged via GoToMeeting ® by the researcher.

Inclusion and Exclusion Criteria

Inclusion required participants to be over 21 and to experience working in healthcare facilities located in the tri-county area. Participants would be healthcare leaders, director level and above, clinicians to include, physicians and ARNPs, and registered nurses who had knowledge regarding chronic medical conditions and unplanned hospital readmissions. Participants under 21 and those who did not have experience working in healthcare within the tri-county area were excluded from the study.

Sampling Methods

Despite complexities or obstacles encountered, case study researchers must identify and synthesize the experiences affecting a population (Zucker, 2009). To achieve multiple perspectives and an appropriate sample size for this multiple-case study. Purposive sampling and snowball sampling techniques were used to select and interview 13 participants from 3 different cases from the tri-county area.

Purposive sampling. Purposive sampling was used to draw a sample of director level and above leaders, physicians and nurse practitioners, and registered nurses from a population of healthcare professionals able to provide a description of their experiences concerning unplanned hospital readmissions. The use of a purposive sampling method ensured multiple insights concerning unplanned hospital readmissions was collected. Purposive sampling methods ensured reliable results were generated through the selection of participants familiar with chronic health conditions, unplanned hospital readmissions, awareness of healthcare quality:

- Narrow the problem;
- Reconcile bias;

- Expansively research the case and the context to generate associations and meaning;
- Recognize the uniqueness of participants as they relate to the context;
- Abide by ethical requirements; and
- Develop a systematic data collection protocol and plan to validate the collected data (Bromley, 1986).

Snowball sampling. Snowball sampling is a nonprobability sampling method used to identify subsequent participants for this study. Snowball sampling was an appropriate method to recruit participants in the tri-county area due to difficulties in accessing healthcare stakeholders. On conclusion of each interview, snowball sampling method was used to recruit subsequent participants for the study by asking whether their acquaintances would be interested in participating in the study (Merriam & Tisdell, 2015).

Sample size. Qualitative research does not mandate sample size as the sample size is dependent on the information needed to explore the research question (Patton, 2002). The study sample size was comprised of 13 participants from the three stakeholder groups: four healthcare leaders, four clinicians, and five registered nurses. A purposive, tailored sample of cases provided variety and created opportunities to study the phenomenon of unplanned hospital readmissions (Stake, 2006). The exploratory nature of this study relied on the researcher's knowledge of the sample's specific characteristics. Through the discovery of stakeholder experiences, the results of this study provided new knowledge of potential solutions to unplanned hospital readmissions (Knol, Slottje, Van der Sluijs, Jeroen, & Lebret, 2010).

Research Interview Questions

The research question was investigated through the review of healthcare data and quality indicators. Healthcare data and quality indicators established a common point of view

concerning the reasons for unplanned hospital readmissions. In keeping with the case study design an unbiased, conversational approach was used when interviewing study participants (Yin, 2014). According to Stake (2014), issue questions force the researcher to pay attention to the complexity and context of the data collected. The interview questions were open-ended that encouraged the participants to provide rich, thick descriptions and provided information needed to find data points that were able to be triangulated. They were designed to explore common points of view from multiple healthcare stakeholders to gain an understanding of unplanned hospital readmissions (Appendix B).

Field Test

The field test is a method used to validate a study's research methodology and design prior to commencing data collection and analysis. Additionally, a field test was conducted to obtain feedback on the accuracy of the research design, to verify the time needed to complete interviews, and to confirm the alignment of the questions, method, and design. Case studies explore phenomena within real-world contexts and include essential elements needed to define and design the case study (Yin, 2014). The field test was conducted by sending the content of Chapter 1 and the original interview questions (Appendix A) to 10 University of Phoenix faculty case study experts. Six of the ten (60%) approached faculty members responded with feedback.

Field test responses from case study experts helped the researcher make adjustments to align the interview questions with the case study design. Original interview questions were not appropriately structured and did not allow the participant to openly share their experiences concerning unplanned hospital readmissions. Questions one and two were identified as demographic questions that were removed from the amended interview questions (Appendix B). The central research question (RQ1) was revised to clarify the identity of the sample population to align with the interview questions.

Geographic and Demographic Profile

The racial, ethnic, and demographic structure of a region may influence health status and contribute to the overall health of a community (Ranstad, Midlöv, & Halling, 2017). The south Florida region, which encompasses Broward, Miami-Dade, and Monroe Counties, is a culturally and ethnically diverse region due to substantial international migration from Latin America, the Caribbean, South America, and Central America. Data retrieved from the 2010 census describe the diversity within the main ethnic categories: Black, non-Hispanic White, Hispanic/Latino, non-Hispanic Black/African American, and other non-Hispanic. The most common countries of origin include Cuba, Haiti, Colombia, Jamaica, Nicaragua, Mexico, Venezuela, Honduras, Peru, and the Dominican Republic (United States Census Bureau, 2011).

South Florida has a higher proportion of older residents (65+ years) than other regions in the US, and a lower proportion of people below 25 years of age. Current projections indicate that the population aged 65 and older is increasing more than any other group, as the "baby boom" generation reaches retirement. Citizens in the "over 65" population are projected to account for more than 21% of the total population by 2030, an increase from 14% in 2010 (United States Census Bureau, 2011). The results of this study identified evidence that was specific to cultural and social determinants namely, language, ethnic and cultural practices, and family influences that are influencing health-seeking behaviors within culturally diverse populations.

Collection and Protection of the Survey Data

For this qualitative multiple-case study the researcher developed a delineated protocol that guided the process of selecting study participants, obtaining consent, scheduling, and conducting interviews, analyzing data, and reporting study results. Initial contact was made through an email that contained the description and purpose of the study, a demographic form, and a consent form that described the participation requirements, time required, risks and

benefits, the right to withdraw, and the researcher's contact information. The sample selection process presented a consistent process for the recruitment of study participants.

To ensure confidentiality, participants were assigned an alpha numeric pseudonym after an informed consent form was reviewed, signed, dated, and returned to the researcher. Participants who did not sign the informed consent form were removed from consideration. An audio recording of each interview was made, which was then transcribed verbatim by the researcher.

Informed Consent

Informed consent is a legal requirement that protects the participant, researcher, and university by documenting permission from the participants involved in the study. The consent process informed the participant regarding their involvement in the study and outlined the expectations of participation. Consent for the study included informing participants of their right to withdraw from the study at any time without penalty. Participants were informed of the purpose of the study and the low risk associated with participation in the study.

Participants were apprised of the data collection method, how the data were to be used, and given information regarding the subsequent protection, storage, and destruction of the data. The participants were provided with a description of the study, the number of questions, and their anticipated involvement. Participants were informed that participation would include a 30-50 minute interview and their participation in member-checking the transcribed data. Incomplete and partial data were eliminated from the study and destroyed.

Member Checking

Member checking is a method used by field researchers to validate interviewee responses and to ensure the accuracy of the transcribed data before it is included in the study results. Participants were asked to review and check the transcription of their interview responses for

accuracy. Member checking by each participant improved interpretation, contributed to transcription revision, and shielded against misrepresentations of the interview data and researcher bias (Stake, 2006).

The transcribed interviews were returned to each study participant within 72 hours of each interview to review the data, to determine accuracy and authenticity, and to make amendments. Participants were asked to return the document within seven days for data analysis. New meanings were incorporated into the data and an explanation was provided for each amendment to ensure that the views of the participants, and not the researcher, were accurately reflected. Participants who did not return a revised transcript within the specified timeframe were considered as consenting to the accuracy of the transcribed data and its inclusion in the study. The cyclical process of the acceptance and elimination of participants and ongoing data collection and analysis continued until no new themes emerged, as outlined in Figure 3 (the data collection and analysis flowchart).

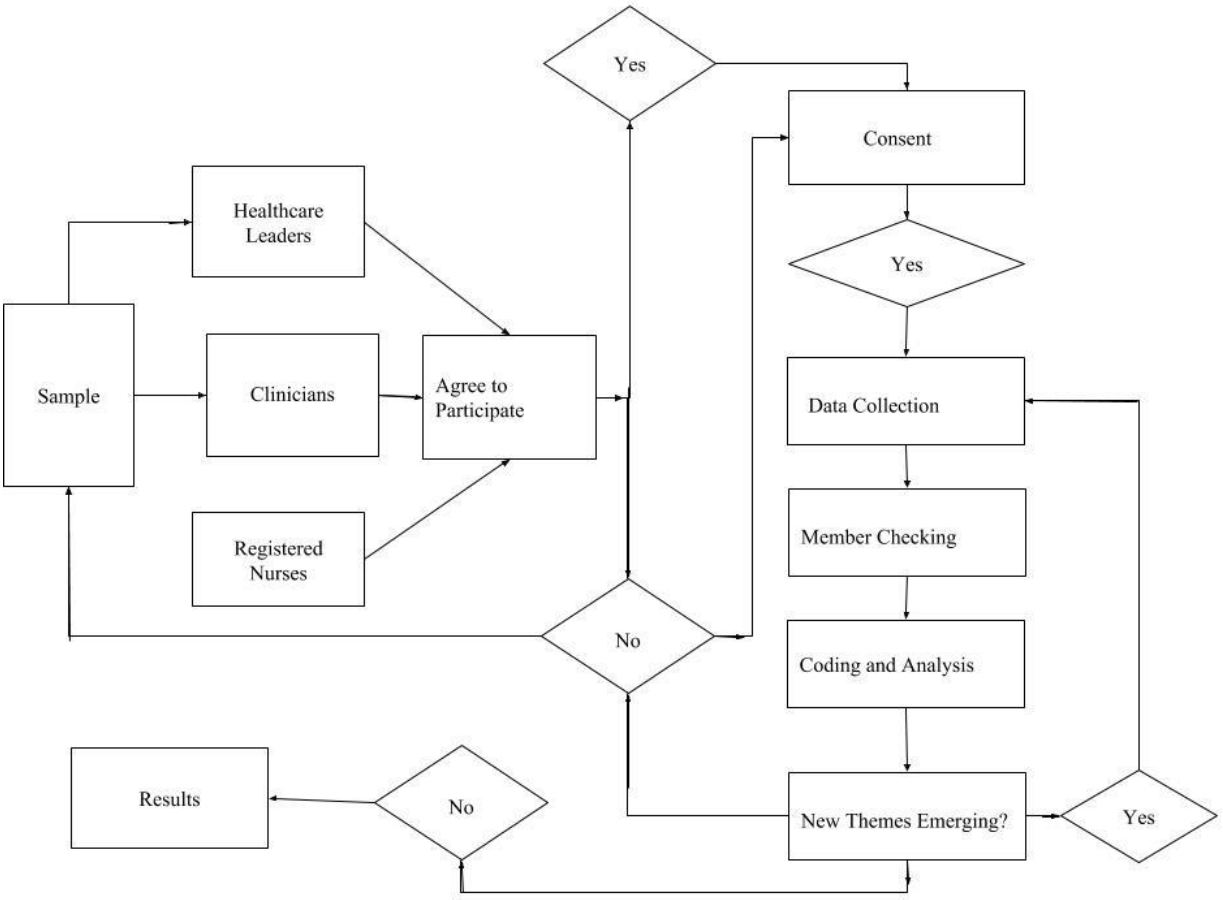

Figure 3. Data Collection and Analysis Flowchart.

Data Collection

The researcher conducting this explorative multiple-case study investigated interpretive patterns of meaning by examining symbolic interaction, related theories, and ideas that were applicable to the problem (Lune & Berg, 2017). Data collection and analyses occurred simultaneously as themes are revealed. The researcher analyzed data to reveal common themes and patterns collected through open-ended, semi-structured interviews with multiple healthcare stakeholders. Interview questions were crafted to allow for further exploration of the problem and the incorporation of new themes during data collection. Four open-ended interview questions were used; questions two and three include probe questions and were created to establish a shared understanding regarding the phenomenon of unplanned hospital readmissions (Appendix

B). The researcher began analysis and coding at the start of data collection and continued until no new themes emerged. Semi-structured interview questions were used to gain an understanding of the study participants' perceptions of unplanned hospital readmissions. Interviews were conducted in a random order in each participant group to collect purposeful data from different perspectives.

Results of the data provided knowledge of the participants' understanding of best practices and yielded an in-depth analysis of why hospitals in the tri-county area have higher than expected unplanned hospital readmissions. Data collection included semi-structured interviews, non-participant observations, demographic data collection, and reflexive journaling. Prior to the interviews, a demographic data form was collected from study participants to define the sample. A semi-structured interview guide, consisting of open-ended questions, was used to conduct participant interviews. Interviews were audio recorded and transcribed verbatim as soon as possible after each interview to reduce bias and ensure data integrity.

Interview questions included a series of probing questions to prompt deeper insight into the perceptions shared by previous participants. Similarities identified in the data were probed to provide further explanation of emerging themes and to ascertain unanimity (Stake, 1995). Field notes and observations were documented through descriptive notes of the interview location, and included the participants' demeanors, insights, reflections, and personal feelings, and the observations and perceptions of the researcher.

Survey Instrument

Data collection methods were explicit, planned, and well defined, by using a protocol that increased the reliability of data and kept the researcher on course while conducting interviews (Yin, 2014). The results of this multiple-case study revealed the perceptions and opinions of healthcare stakeholders to discover the reasons for unplanned hospital readmissions.

The survey instruments used for this qualitative multiple-case study consisted of an open-ended, semi-structured interview questionnaire, (Appendix A) and a demographic survey (Appendix D).

Interviews were audio recorded to ensure accuracy and transcribed verbatim by the researcher within 24 to 48 hours. The selected survey instrument was designed to elicit participants' experiences to explore how and why factors that influenced unplanned hospital readmissions and were known by the survey population (Stake, 1995). Researcher field observations were documented throughout the interview.

Confidentiality

To ensure confidentiality each participant was assigned an alphanumeric pseudonym that included the participant number and the month and year. A list of names and corresponding pseudonyms was kept in a separate password protected file. An electronic folder was created for each participant, labelled with the alphanumeric pseudonym and stored on a password protected file on the researcher's computer. Original field notes, completed interviews, and all other data were transcribed immediately after each interview and placed into the participant folder.

Transcribed interview notes were returned to the interviewee by email within 72 hours for review and member checking (Lincoln & Guba, 1985). Participants were given seven days to return the transcribed data. The consent forms and all transcribed data are stored on a password protected digital portable storage device and secured in a home safe. Consent forms are kept in compliance with the university's document maintenance requirements.

Trustworthiness

The experience of meaning making in qualitative research is widely criticized due the subjectivity (Hesse-Biber & Leavy, 2011). Qualitative researchers implement strategies to assure rigor in their research. Analytic generalization or the act of applying the findings of the research to new a population assumes that the researcher has abided by rigorous standards of reliability,

objectivity, and internal and external validity. From a qualitative standpoint, the concepts of credibility, transferability, dependability, and confirmability demonstrated trustworthiness within this qualitative study (Lincoln & Guba, 1985). The emergence of themes revealed new knowledge and provided clarity for the leaders of other healthcare organizations who are experiencing problems with unplanned hospital readmissions (Merriam & Tisdell, 2016).

Credibility. To safeguard credibility, member checking was used to ensure the participants were included in the analysis and interpretation of the transcribed interviews before the data were entered for analysis and coding. Triangulation allowed for the verification of individual viewpoints and experiences through using different data collection methods: semi-structured interview data, questionnaires, field notes, and researcher reflexivity. According to Patton (1990), the researcher is the primary data collection and analysis instrument. Due to the researcher's background, experience, and expertise in the healthcare field, credibility was enhanced which in turn reinforced the credibility of the study findings.

Transferability. Transferability is a process of comparing similarities or patterns to other environments or situations (Gomm et al., 2011). Although the results of this study pertained to specific stakeholders within a delineated demographic location, the results of this study were applicable to a broader group of stakeholders and the leaders of other healthcare organizations. The researcher detailed the process used in the identification of participants to confirm the relevance of the research findings. The study results provide comparisons for leaders, clinicians, and other stakeholders to be able to understand the contextual evidence found within the study results and to be able to apply the information to similar situations.

Dependability. Dependability confirms the consistency and reliability of the study results and the ability of other researchers to replicate the study results (Moon, Brewer, Januchowski-Hartley, Adams, & Blackman, 2016). The researcher coded and recoded the data

over a period of several weeks using a code-recode strategy that allowed for multiple reviews and comparisons of the data to confirm dependability. Multiple examinations confirmed the stability of the data through the emergence of consistent themes and patterns.

Confirmability. Confirmability verifies that the results and conclusions of the study are grounded in the experiences of the participants and not the ontological and epistemological viewpoints of the researcher (Guba, 1981). The researcher provided a detailed description of the methods and processes used to collect and analyze data (Figure 3). Member checking was used to affirm the participants experiences were accurately transcribed.

Data Analysis

Data analysis was conducted in an open and iterative manner with a critical review of the interview data, field notes, and researcher observations. The exploratory nature of this study required the researcher to be open and receptive to the voices of the participants. To ensure the impartiality of the coded data, triangulation and member checking were used to demonstrate coding consistency (Merriam & Tisdell, 2016). The central research question (RQ1) guiding this study was as follows: What are the common experiences of healthcare leaders, clinicians, and nurses concerning higher than expected unplanned hospital readmissions for patients with chronic health conditions in healthcare facilities located in Broward, Miami-Dade, and Monroe Counties in the state of Florida?

Thematic Coding

Thematic coding required capture of the main themes that were identified in the research questions. Words, quotations, and phrases were recorded verbatim and categorized under specific headings. Through the thematic coding of the main themes, phrases and words emerged to facilitate an understanding and awareness of the text. In thematic coding, participants' comments and perceptions were recorded and areas of uncertainty, hesitation, or contradiction were

documented, to reveal meaning (Merriam & Tisdell, 2016).

Thematic coding process. The thematic coding process entailed:

- Reading and re-reading the data (extraction);
- Labeling (coding) the text;
- Discovering broad themes and sub-themes within the text;
- Reviewing themes to validate their relevance to the data;
- Defining and labeling themes and sub-themes; and
- Creating a clear narrative to include interviewee phrases and quotes from the interviewees (Merriam & Tisdell, 2016).

The thematic coding process described occurred with each case, data from the first case was analyzed to identify themes and patterns. Data from subsequent cases were then analyzed to reveal common themes and patterns that were incorporated into successive interviews. Themes were refined as similarities in experiences emerged in the data. Once no new themes emerged, the software application, NVivo12, facilitated data analysis and synthesis of multiple sources of data. Word clouds were generated to illustrate the most frequent words.

Thematic synthesis. Thematic synthesis was used to identify, analyze and report themes found in the data. Thematic synthesis preserved a transparent connection between the primary data and study conclusions. Themes and patterns were organized into data sets to describe the experiences, and realities shared by the participants (Thomas & Harden, 2008). A three step process; thematic coding, development of descriptive themes, and development of analytical themes. Finally, the findings of each case were integrated to form collective primary and secondary themes or sub-themes, reported as one combined group in this multiple-case study.

Triangulation

Triangulation strengthened the validity of the study by synthesizing multiple perspectives related to a common problem (Cunliffe, 2016). Analytic generalization is the application of research findings to an alternative population or setting and demonstrates the use of rigorous protocols that confirm the reliability, objectivity, and validity of a study (Yin, 2014). While a single method was adequate in solving the problem, the process of triangulation honored different perspectives. Triangulation was used to legitimize the research findings and validated each participant's perceptions of the phenomena. When explanations were inconsistent, triangulation provides a multiple method that clarified and validated data analysis (Patton, 1990). To ensure the credibility, transferability, dependability, and confirmability of the collected data, the triangulation of multiple sources of evidence was employed through a consistent data collection and protocol analysis process (Yin, 2014).

Secondary sources of data included the quality data submitted to the CMS database by healthcare administrators (Florida Hospital Association, 2017). Researcher reflexivity was also entered for triangulation to help ensure the transparency and validity of the study results. Reflexivity was used as a method to control researcher situatedness and to validate structures of meaning and themes through reflexive analysis (Darawsheh & Stanley, 2014). Interpretative data and narrative descriptions were revealed through semi-structured interviews, secondary data, demographic information, and researcher reflexivity. The triangulation of the transcribed data was achieved through the validation of study participants' responses through member checking, the review of CMS quality data, and documentation of the researcher's observations during interviews (Merriam & Tisdell, 2016).

Chapter Summary

The researcher used a multiple-case study design to explore, describe and interpret circumstances, synthesize meaning, and to bring clarity and understanding to a problem (Yin, 2014). The purpose of this qualitative exploratory multiple-case study was to explore the reasons for higher than expected unplanned hospital readmissions in healthcare facilities located in the tri-county area of south Florida to help hospital administrators to improve healthcare quality through reducing unplanned rehospitalizations. Case study researchers collect thick, descriptive data using everyday contexts through fieldwork and participant experiences. The stance of a case study researcher is to ask how and why a phenomenon exists to be able to contextualize a problem through in-depth analyses (Merriam & Tisdell, 2016).

In chapter 3, the researcher reviewed the chosen method and design and justified the appropriateness of a qualitative exploratory multiple-case study approach. The interview questions, study population, and potential ethical issues were discussed. A detailed description of the methods was used to ensure the protection of the study participants. This included a description of the informed consent process, interview questions, the population, sample, data collection methods, instrumentation, and selected geographic location for the study. In chapter 4 the researcher documented and presented the results of this qualitative exploratory multiple-case study.

Chapter 4

Results

The purpose of this qualitative exploratory multiple-case study was to explore the reasons for higher than expected unplanned hospital readmissions in healthcare facilities located in the tri-county area of south Florida to help hospital administrators to improve healthcare quality through reducing unplanned rehospitalizations. A single central research question was applied to guide this study. The central research question (RQ1) guiding this study is as follows: What are the common experiences of healthcare leaders, clinicians, and nurses concerning higher than expected unplanned hospital readmissions for patients with chronic health conditions in healthcare facilities located in Broward, Miami-Dade, and Monroe Counties in the state of Florida?

The researcher chose a qualitative methodology and exploratory case study design to explore why unplanned readmissions continue to challenge healthcare stakeholders. The discovery of common experiences was important in identifying factors that predisposed patients to be readmitted less than 30 days after discharge. The participants of this study included stakeholders with experience working in tri-county hospitals and had knowledge of chronic medical conditions, and an understanding of the implications of unplanned hospital readmissions. Data were collected between May 2018 and August 2018 through audio-recorded interviews or at a venue chosen by the participant.

Data analysis included the researcher manually reviewing and coding transcribed interview data collected through semi-structured individual interviews. In chapter 3, the researcher outlined the method, study design, and appropriateness of a qualitative exploratory multiple-case study approach. A description of the methods used to ensure the protection of study participants included informed consent, interview questions, the population, sample, data

collection methods, instrumentation, and the selected geographic location for the study was also discussed. The sections outlined in chapter 4 includes an analysis of the interview question responses of 13 healthcare stakeholders who have experience working in the tri-county area. The researcher addresses the following themes: recruitment of participants, participant characteristics, instrumentation, data collection and analysis, and the presentation of the data. This is followed by the chapter summary.

Demographic Attributes

The eligibility criteria for this study required that participants had experience working in hospitals located in the tri-county area, knowledge of chronic medical conditions, and an understanding of the implications of unplanned hospital readmissions. Purposive sampling was used to gain individual experiences from participants concerning unplanned hospital readmissions. A purposive, tailored sample of cases provided multiple insights and created opportunities for the researcher to study unplanned hospital readmissions in the tri-county area. Demographic attributes were obtained from each participant prior to interview and included data points that related to gender, county, role, age, and experience (Tables 2 to 4).

The results of the study included the responses of thirteen participants, eleven females (85%) and two males (15%). Four participants were clinicians (31%), four were healthcare executives (31%), and five were registered nurses (38%). All participants shared experiences as they relate to working in healthcare facilities located in the tri-county area. Eight participants had experience working in Miami-Dade County (62%) and five within Broward County (38%). No participants were recruited from Monroe County for this study. The participants' collective experiences helped the researcher to identify themes and repetitions that were unique to the role of the participants.

Table 2

Clinician Attributes

	Gender	County	Role	Age Range	Years of Experience
P110818	Male	Miami-Dade	Physician	51–60	More than 20 years
P120818	Male	Broward	Physician	51–60	6–10 years
P130818	Female	Miami-Dade	ARNP	41–50	More than 20 years
P150818	Female	Broward	ARNP	41–50	More than 20 years

Table 3

Registered Nurse Attributes

	Gender	County	Role	Age Range	Years of Experience
P20518	Female	Broward	Registered Nurse	31–40	6–10 years
P30618	Female	Broward	Registered Nurse	31–40	6–10 years
P40818	Female	Broward	Registered Nurse	41–50	16–20 years
P50618	Female	Miami-Dade	Registered Nurse	21–30	6–10 years
P60618	Female	Miami-Dade	Registered Nurse	41–50	More than 20 years

Table 4

Healthcare Leader Attributes

	Gender	County	Role	Age Range	Years of Experience
P10518	Female	Miami-Dade	CNO	51–60	More than 20 years
P70618	Female	Miami-Dade	Assistant CNO	41–50	More than 20 years
P90718	Female	Miami-Dade	Director	Over 60	More than 20 years
P100718	Female	Miami-Dade	Director	Over 60	More than 20 years

Research Setting

This qualitative exploratory multiple-case study included three cases: healthcare executives, clinicians, and registered nurses who had worked in the tri-county area. This qualitative study relied on interviewing participants as one of the methods of data collection to obtain comprehensive information from healthcare experts. Once consent was signed and returned, interview times were arranged. Confidentiality was maintained through unique

alphanumeric pseudonyms assigned to participant and subsequent data collected from the participant. Between May and August 2018, 13 participants were interviewed via one-on-one audio recordings either in person or via videoconferencing software. Twelve participants (92%) chose the videoconferencing option. One participant (8%) preferred to be interviewed in person (P1) in the participant's home office.

GoToMeeting, a password protected videoconferencing software program facilitated the interviewer and interviewee to meet in real time. Due to the extended geographical locations, interviewee time constraints, interviewee work schedules, and the challenges associated with planning face-to-face meetings, a videoconferencing option provided flexibility for the interviewees and the researcher. To ensure privacy, interviews took place in a private home office at a pre-planned time that was convenient to the interviewees' work schedules. The researcher used a headset during each interview to ensure the privacy of the responses. Sound and video checks were conducted at the beginning of each videoconferencing meeting to ensure that clear audio-recordings were obtained during the interview.

Recruitment of Participants

Initial contact of study participants was achieved by posting a recruitment flyer on the researcher's personal LinkedIn page. The flyer provided information that included a brief description of the study purpose, eligibility criteria, time commitments, location of the research, and researcher contact information. Personal LinkedIn acquaintances were invited to complete a short demographic survey (Appendix D). The researcher identified study participants through a thorough review of each survey answer to ensure that the eligibility criteria were met. Respondents were then contacted via email, consented to the study, and scheduled for an interview via videoconference or in person at a place of their choosing. The snowball sampling method was used to recruit subsequent participants for the study.

Participant Characteristics

A purposive sample of healthcare stakeholders included healthcare leaders, clinicians, and registered nurses. Eligible participants were required to have experience working in hospitals located in the tri-county area and to be knowledgeable of chronic medical conditions and the implications of unplanned hospital readmissions. Demographic data were collected from each participant prior to consent and interview to establish eligibility for the study. Initially, 32 respondents completed a demographic survey. After careful review, 20 respondents met the eligibility criteria and were contacted. Of the 20 respondents, 12 expressed preference for a videoconference interview, and 1 preferred a face-to-face interview. All respondents returned the consent form after reviewing and signing it.

To maintain privacy and confidentiality, interviews using the videoconferencing software program were conducted from a private office with a headset to ensure only the researcher was able to hear participant responses. The researcher personally transcribed each interview within 24 to 48 hours and returned the transcribed interview to the participant for member checking. Member checking confirmed the validity and accuracy of the transcribed data before commencing data analysis. One of the participants (P1) made minor grammatical changes to the transcribed interview, which did not alter the context or thematic meaning of the transcribed data. No other participants made changes to the transcribed data.

Data Collection

Approval to conduct this study was received from the University of Phoenix Institutional Review Board in May 2018. Prior to data collection, a study recruitment flyer was posted to the researcher's personal LinkedIn page. Information included an introduction of the researcher, the purpose of the study, participation criteria, a confidentiality statement, and the ability to withdraw at any time without consequences. The flyer invited interested parties to complete a

short demographic survey by contacting the researcher via email or accessing the survey through a hyperlink. Once responses were received, the researcher reviewed each survey to confirm eligibility criteria.

Instrumentation

Initial data collection utilized two instruments: a demographic survey (Appendix D) to establish the basic demographic information and eligibility of the study participants and a semi-structured interview protocol (Appendix B). The interview protocol aligned with the central research question and served as the second half of the data collection instrument. Semi-structured interviews facilitated conversations and solicited experiences from healthcare stakeholders concerning the challenges in caring for patients with chronic medical conditions and unplanned hospital readmissions. Each participant was interviewed using the interview protocol to ensure that key questions important to the study were not omitted during the interview. Documentation of the participant's tone of voice, level of engagement, and descriptions of the researcher's reactions to emerging data were notated during and after the interview.

Demographic survey instrument. The Demographic survey questions one to six provided information regarding facility location, age, gender, years of healthcare experience, current role or position, and years in the current role. Survey question seven, "*Does your job role cause you to make decisions related to unplanned hospital readmissions?"* and eight, *"Do you provide care for patients with chronic medical conditions?"* established the respondent's experience level, knowledge of chronic medical conditions, and understanding of the implications of unplanned hospital readmissions. Question nine asked respondents, "*Would you be willing to participate in a 30 to 45 minute in-person or videoconference interview?"* Initially, 22 respondents completed the demographic survey. Twelve (55%) of the initial respondents did not meet the eligibility criteria: three respondents had not worked in the tri-county area, one was

not included in the sample group, five participants met the study criteria yet declined to participate in a further interview, and three respondents provided non-verifiable contact information. All data gathered from non-eligible respondents were erased and eliminated from the study.

Initially, 10 respondents meeting the study criteria were recruited through LinkedIn in response to the study recruitment flyer. Respondents who met the study criteria were contacted using their preferred email address. An email was sent to the respondents providing a brief description of the study, statements regarding confidentiality, the participants' right to withdraw at any time without consequence, and the study consent form. Each consent form was identified with a unique alphanumeric pseudonym to ensure the participants' confidentiality.Respondents who did not return signed consent forms within three days were sent an email reminder. Following the email reminders, and prior to receiving the signed consent forms, six of the ten (60%) eligible respondents decided that they no longer wished to participate in the study. Data related to these six participants were erased and eliminated from the study. Subsequent study participants for the study were recruited through the snowball sampling method that involved the study participants recruiting other potential participants for the study from their professional acquaintances and contacts.

Interview instrument. The scope of unplanned hospital readmissions was explored through the responses of 13 healthcare stakeholders over a three-month period using a field-tested interview protocol that comprised of four interview questions and two probe questions (Appendix B). Responses were extracted from each participant in their own words through a series of four semi-structured, open-ended research questions. Interview questions were focused on collecting detailed information regarding factors associated with unplanned hospital readmissions and chronic medical conditions.

The researcher interviewed 13 healthcare stakeholders to understand the elements of why hospitals located in the tri-county area report higher than expected unplanned hospital readmission rates. The participants' audio-recorded interview responses were de-identified by assigning alphanumeric pseudonyms to ensure confidentiality and transcribed into a Word document. On completion of each interview, field notes documented during and after the interview were reviewed. Field notes collected during interviews provide validation for the understanding of the data collected from the participants. The researcher documented any participant reactions and behaviors noticed during the interview in a Word document.

Data Analysis

The researcher conducted manual coding and comparative analysis of each interview transcript through thematic synthesis as the primary data analysis method. To facilitate understanding and awareness of the text, a consistent thematic coding process captured words, quotations, and phrases related to the main themes as described in Chapter 3. The coding process entailed: reading and re-reading the data; highlighting and labeling text; identifying broad and sub-themes; validating thematic relevance through further review; definition and labeling of themes and sub-themes; and finally, including participant quotes and phrases within the narrative to support themes and conclusions. Thematic synthesis consist of a three step process; thematic coding, development of descriptive themes, and development of analytical themes to incorporate and develop the primary and secondary themes of combined cases reported in this multiple-case study.

Organization of data. Transcribed statements from semi-structured, open-ended interviews, demographic documentation, and field notes taken during and after the interviews facilitated the data analysis process. The themes and patterns were classified by coding and categorizing data into words or word phrases that were then entered into a spreadsheet to capture

and report thematic frequency. After manual coding, NVivo12 was used to analyze, sort, and validate the themes and data into connected ideas. During the thematic coding and constant comparative analysis process, common themes and patterns were revealed. An evolving document was created by incorporating emerging themes and patterns into subsequent interviews.

The results of the study are presented in chronological order of the interview questions by each case and as a combined whole. Using four research questions and two probe questions, data were coded using constant comparative analysis until no significant collective experiences or new themes emerged. The themes revealed the experiences of individual healthcare stakeholders and, as a combined whole, from a healthcare industry perspective. Upon completion of each interview, the results were transcribed and returned to the participant for member checking to be returned within seven days. One participant made minor grammatical and punctuation changes to the transcribed interview (P1) that did not alter the narrative context. After confirming the accuracy of the 13 interviews through member checking, the data were organized in a spreadsheet and the themes were arranged by participant responses.

The results were then analyzed to explore the themes identified in the data before the next interview was scheduled. Once the first three interviews were completed, the data were imported into the NVivo12 software program to validate the emerging codes and themes. The data is being kept in compliance with the university's document maintenance requirements. Transcribed data and digitally signed consent forms are saved on a password protected USB flash drive and stored in a home safe for three years, then crushed before discarding.

Illustration of data. As the researcher became immersed in the data, the themes and patterns were classified into words or word phrases. The themes and patterns were classified through coding, categorizing, and labeling words or word phrases. Words that had similar

meaning, for example, education, training, and information, were noted to be used interchangeably in some participant responses, such as “patients are educated through discharge information and health related training,” while another participant stated, “I think more education and training for them to get the feedback that they actually understand that they should follow-up.” These word phrases were placed within the same category. Demographic data and field notes were pivotal in assigning meaning to participant experiences.

Data Analysis and Coding Process

The data analysis and coding process began with organizing and categorizing the participants’ words, quotations, and phrases under specific headings and entering them into a Word document. The first three interviews were hand coded after each interview, and constant comparative analysis and synthesis was applied to each subsequent interview. The researcher compared each transcript, comparing experiences and using reflexive journaling to check and reconcile bias. The thematic coding synthesizing process revealed frequently used themes, phrases, and words that facilitated an understanding and awareness of the text.

Each participant’s responses were divided into questions and compared using symbols to identify common statements and arrows between each participant to connect ideas. Participants’ comments, statements, experiences, and perceptions were recorded, and areas of uncertainty, hesitation, or contradiction were documented. Audio-recorded interviews were reviewed to help reveal the meaning of utterances. The researcher coded and recoded the data over a period of several weeks to allow for multiple reviews and comparison of the data.

Thematic synthesis helped the researcher to identify high-level themes and patterns relevant to healthcare stakeholders. Transcribed data was coded line by line and entered verbatim onto a Word document. Text was coded according to meaning and content and concepts

translated from one case to another then categorized by identifying similarities and differences between codes.

The thematic coding process continued until no new themes emerged and then NVivo12 software was used to validate the identified themes and to contribute to the analysis, classification, and presentation of the data. The NVivo12 software validated emerging themes through word frequency queries and text search queries. First, filters were applied and included for stemmed words with a minimum length of three letters and the 1,000 most frequently used words.

Extraneous words that did not add value or provide contextual significance to the data were added to the "stop words list." Finally, word frequency and text search queries of the most frequently used words, weighted percentages measuring 3% or higher, were conducted. Filters applied to this final round of coding and analysis included the 100 most frequently used words with a minimum length of three letters. The results were entered into a spreadsheet along with participant statements, quotations, and phrases. The resulting data were then examined, leading to the development and formation of themes and patterns.

Evidence of Trustworthiness

The elements to ensure trustworthiness are credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). The trustworthiness of this study was achieved through the data collection and analysis processes outlined in chapter 3. Field-testing was conducted for reviewing the interview questions and providing feedback to ensure that the interview questions would elicit the maximum information regarding the phenomenon. During data analysis, the researcher made logical choices concerning the appropriateness and suitability of the data collected from healthcare stakeholders.

Study Results

The results of this study were established through stakeholder responses to four interview questions and two probe questions (Appendix B) as they related to the research question and the literature review conducted for this study. The common experiences for each interview question were grouped to reveal primary themes and patterns for each case. Second, the combined themes illustrated the collective experiences of healthcare stakeholders related to the research question.

Thematic Findings

While interviewing study participants, recurring themes and patterns began to emerge from the data. The frequency of words or expressions within the participants' statements revealed themes and patterns. Table 6 illustrates themes from the healthcare leader case, Table 7 illustrates themes from the clinician case, and Table 8 illustrates themes from the registered nurse case. Each case revealed common and unique characteristics that warranted further analysis. Finally, Table 9 illustrates combined primary and secondary themes of all the cases. The code-recode process was used to perform multiple reviews of the transcribed data; coded data was aside for the researcher to gestate ideas and thoughts.

Themes were ordered from the highest to the lowest frequency and entered into a spreadsheet to illustrate primary and secondary themes of each case: healthcare leaders, clinicians, and registered nurses. NVivo12 software was used to confirm primary and secondary themes through word frequency criteria and to assign a weighted percentage word frequency.

Identifying Primary and Secondary Themes

Primary themes contain both a minimum weighted value and word frequency. Secondary themes meet either the minimum weighted value or the minimum word frequency. Themes whose weighted percentages measured 3% or higher and word frequency of greater than or equal to 50% were identified as primary themes. Themes that exhibited either weighted percentages of

3% or higher or a word frequency of greater than or equal to 50% were labeled secondary themes.

Defining and Labeling Themes

Primary and secondary themes were captured through the participants' responses to the interview questions. The researcher analyzed the data through a consistent thematic coding and recoding process that facilitated the identification of common themes and patterns. After appraisal of the participants' collective experiences, emerged themes and patterns and words and phrases were categorized by subject and each category was coded.

Word Clouds

Word clouds for each case were generated through NVivo12 software. Word clouds visually display the most frequently occurring words within the data. A visual representation of the top 100 most frequently occurring words provided the researcher with confirmation of major themes and patterns. The word clouds (Figures 4 to 7) provide an illustration of the primary and secondary themes identified for each case and the combined cases.

The healthcare leader word cloud. The healthcare leader word cloud (Figure 4) provides clear visualization of the primary themes. The themes education, culture, and population were mentioned by 100% of healthcare leaders. There were no secondary themes within the healthcare leader case.

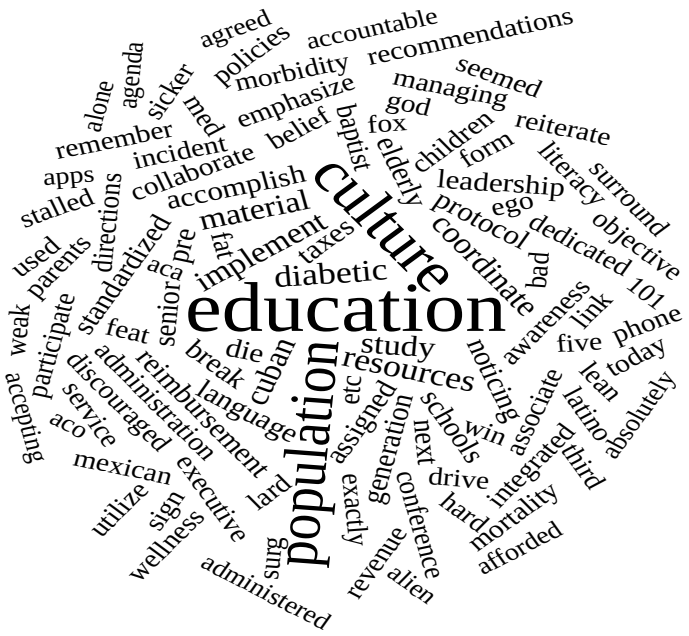

Figure 4. Healthcare Leader Word Cloud.

Case 1. Healthcare Leaders

Four out of four (100%) healthcare leaders identified education, culture, and population to be the key factors related to unplanned hospital readmissions (Table 6). Education illustrated the highest weighted value of 5.4%, followed by culture (3.9%) and population (3.5%). All themes are labelled as primary themes. No secondary themes were identified. Healthcare leaders linked education, culture, and population as important in meeting healthcare quality benchmarks.

Table 5

Themes Emerged from Healthcare Leaders

Healthcare Leader Themes	Percentage Frequency	Weighted % Values	Frequency
Education	100%	5.4	Primary
Culture	100%	3.9	Primary
Population	100%	3.5	Primary

Theme 1: Education. Four out of four (100%) healthcare leaders agreed that patient and family education is an important component in preventing hospital readmissions. Participant P70618 clarified how patient literacy is connected to understanding discharge education and the teaching provided by nursing staff: “Lack of literacy prevents education from actually getting through to the patient and prevents the patient's understanding of what they need to do.” When patients do not understand their plan of care, they are more likely to return to the hospital.

Two out of four (50%) healthcare leaders shared that a nurse’s educational and skill level is significant in unplanned hospital readmissions. Participant P90718 shared their observations of how the educational level of nursing staff affects the quality of patient teaching: “Associate degree nurse training doesn’t emphasize education teaching. Maybe they were not up to that level of teaching.” Participant P70618 shared insight into the importance of nursing staff skill level: “I think more focus needs to be on educating the staff. Looking at things like infection control, sterility, making sure that the staff are well educated.” Staff educational level and skill level may be an important factor in preventing hospital readmissions.

One out of four (25%) healthcare leaders identified executive knowledge of healthcare regulations and quality initiatives to be a concern. Participant P10618 shared the following:

> There’s a lot of regulations that surround home care and a lot of the regulations that surround home care are not fully understood. You may have executive leadership that possibly don't completely understand the regulations and so there would be some barriers there in that sense that we needed to do a better job educating.

Healthcare leaders shared their experiences concerning the significance of education for patients, caregivers, healthcare executives, and other healthcare stakeholders.

Theme 2: Culture. Four out of four (100%) healthcare leaders identified cultural complexity to be a factor in the management of chronic health conditions in the tri-county area. The experiences of participant P10518 provided further insight into how culture influenced the management of chronic health conditions:

> I remember the first experience that I had to work with a very strong cultural component. In Miami-Dade area you deal with a lot of Cubans that are very set in their ways and very culturally driven in their healthcare models. The culture overrides the plan of care that makes it difficult to keep them healthy.

Healthcare leaders shared the challenges of incorporating strong cultural beliefs into plans of care that meet existing healthcare quality initiatives and how cultural complexity influenced unplanned readmissions.

Theme 3: Population. Four out of four (100%) healthcare leaders shared their experiences regarding the challenges of applying quality initiatives in a diverse patient population. Participant P100718 notes: “The biggest challenge that we have is with migrant population and it was really difficult to apply initiatives when the quality measures weren't as impactful.” The importance of population-specific healthcare cannot be underestimated when seeking the answers to unplanned hospital readmissions.

The clinician word cloud. The clinician word cloud (Figure 5) elucidates two primary themes, information and population, and one secondary theme, education. Education was labeled a secondary theme as it did not meet the weighted percentage value threshold.

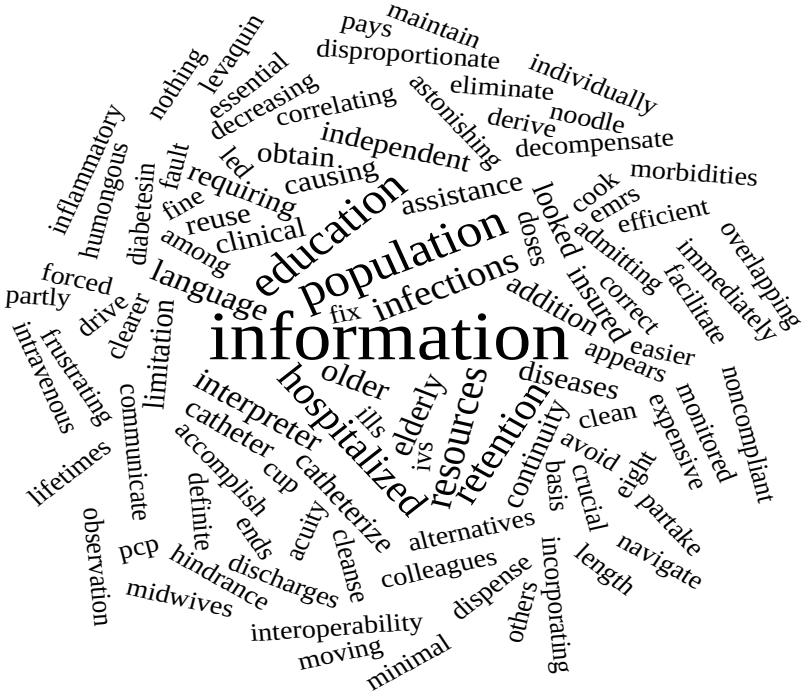

Figure 5. Clinician Word Cloud.

Case 2. Clinicians

Two out of four (50%) clinicians identified information to be the most important factor related to unplanned hospital readmissions. A high weighted percentage value of 5.8% placed information as a primary theme. Three out of four (75%) clinicians mentioned population; however, a lower weighted percentage value of 3.1% placed population as the second labeled primary theme. Two out of four (50%) clinicians mentioned education; however, a weighted percentage value of 2.8% below the threshold assigned education as a secondary theme (Table 7). Clinicians connected the availability of patient specific information, population-specific plans of care, and effective patient education to be critical in the management of chronic medical conditions.

Table 6

Themes Emerged from Clinicians

Clinician Themes	Percentage Frequency	Weighted % Values	Frequency
Information	50%	5.8	Primary
Population	75%	3.1	Primary
Education	50%	2.8	Secondary

Theme 1: Information. Two out of four (50%) clinicians identified information as being critical to effective decision-making. Clinicians indicated that it is difficult to manage patients without accurate, timely, and available patient information. Participant P120818 describes the importance of timely information when caring for patients with chronic medical conditions:

> When I see patient in the ED, I see them in a crisis situation. I have not met them before so unless the patient has information with them or I can talk to their PCP I don't have any information. They might not need admission, but if I can't be sure they have the services they need, or I need more information to evaluate them properly, I have to either admit them under 24-hour Observation or inpatient depending on how sick they are.

Clinicians highlighted the importance of having patient information readily available to be able to make safe clinical decisions. Availability of electronic medical records medical records informs clinical decision-making that is critical to safe patient care.

Theme 2: Population. Three out of four (75%) clinicians described multiple unique elements within the tri-county population that influenced the management of chronic medical conditions. Participant P130818 provides clarification:

> The keyword 'population' in Miami is [and just] different hospitals have completely different populations. You'll have one hospital that most of the patients are insured [the majority are insured] and they actually have preventative medicine. Another hospital,

> which is right down the street, they may not have the insurance and do not have follow-ups and by the time to get to the hospital their condition is that much worse with no preventative medicine at all.

Clinicians shared their observations concerning multiple population-specific factors such as affluence, access to insurance, and preventative care, factors that prevented some people from accessing healthcare.

***Sub-theme 1: Education*.** Two out of four (50%) clinicians communicated the need for patients to participate in their care and comply with care plans. Participant P130818 illuminated the importance of patient education, understanding, and participation when managing chronic medical conditions: “Teaching I know has gone a long way with these patients however, it still depends on the patient; on their level of education and their actual willingness to [you know] partake in their own treatment.” Clinicians identified patient participation, compliance, follow up, and effective discharge education to be connected to unplanned readmissions.

The registered nurse word cloud. The registered nurse word cloud (Figure 6) reveals the common themes identified by the registered nurse case. Education, culture, and language are identified and labeled as primary themes. Resources and information were identified and labeled as secondary themes.

Figure 6. Registered Nurse Word Cloud.

Case 3. Registered Nurses

Five out of five (100%) registered nurses identified education to be the most important factor related to unplanned hospital readmissions. A high weighted percentage value of 8.7% placed education as the most important primary theme. Four out of five (80%) registered nurses identified culture as the second theme with a weighted value of 5.5%. Four out of five registered nurses (80%) identified resources with a weighted percentage value of 3.1% to be the third primary theme (Table 8).

Table 7

Themes Emerged from Registered Nurses

Registered Nurse Themes	Percentage Frequency	Weighted % Values	Frequency
Education	100%	8.7	Primary
Culture	80%	5.5	Primary
Resources	80%	3.1	Primary

Theme 1: Education. Five out of five (100%) registered nurses considered patient education to be the most important factor related to unplanned hospital readmissions. Recurring words, information and teaching, were used synonymously by registered nurses to describe their experiences related to educating patients and families. Discharge process includes a combination of verbal and written information, in the patient's language, at a level the patient understands. Registered nurses shared their experiences concerning challenges related to educating patients in tri-county area hospitals. Participant P30618 shared personal experience of a patient who was non-English speaking: " I was discharging a Guatemalan patient. She spoke Spanish, but didn't understand Spanish through the Spanish interpreter, who said the patient's dialect was different. One of the other nurses told me she had this problem before." Participant P40818 provided further insight:

> In my experience the challenge with language barrier for example, I'm educating the patient from Guatemala from South America. I'm teaching them education regarding chronic high blood pressure or diabetes and then they just nodding their heads stating yes, yes, sometimes they are completely clueless; because they are nodding and smiling saying yes but they don't understand. They are coming back again for the same diagnosis over and over again.

Understanding discharge information is considered important to prevent unplanned hospital readmissions. Registered nurses described their challenges in providing education and teaching in the appropriate language and at the correct level to ensure that the patient understood the information provided. Participant P20518 highlighted the connectedness between patient education and language: “The patient's inability to follow directions whether it's educational, language, or that they just don’t want to do it [I mean] is a big barrier to preventing readmissions.”

Availability of appropriate discharge literature was problematic. Registered nurses shared that while printed discharge information is available in Spanish and English, there is limited printed information available in other languages.

Participant P50818 provided further insight into the complex nature of patient and family education. The process of educating patients and families in a multi-cultural environment were salient in registered nurse experiences:

> Education [you know] they're getting it when they're being discharged, but they're really not listening when they're being discharged because all they can think about is getting the hell out of the hospital and they haven't heard half of the things that you said on your discharge teaching. Then they get home and they're looking through the papers and a lot of time [in Miami] the papers are in English and they speak Spanish or Creole. They really don't understand they’re not reading this information. All this information is great, but they don't understand it, so that is a huge hurdle that I don't think that in healthcare we really do a good assessment of what is the patient's capability of learning [like] what is their level of understanding.

Registered nurses identified the benefits of having designated patient and family educators whose primary role focused on discharge teaching and patient education. Participant

P60618 shared their experiences concerning the challenges of patient education being the responsibility of bedside nurses:

> Patient educators who can actually go to the patient and sit with them and educate them on their disease process; help make those follow-up appointments, take some of that responsibility off of the nursing staff providing the day-to-day care.

Theme 2: Culture. Four out of five (80%) registered nurses concurred that the influence of culture cannot be underestimated. Participant P30618 described the importance of family and culture in south Florida:

> To the South American patient [you know] food is love. With South American patients and [you know] the family cooks and eats together. She [you know] prepares the pig at the family thanksgiving with lots of salt and fat- the family, the friends, everybody, loves food and they show love through food. It's a huge part of the culture and it's very difficult to tell somebody that they cannot participate in their own culture, but we haven't figured out how we incorporate that into our processes.

Participant P40818 confirms that culture influences care and has bearing on hospital readmissions: "In Haitian culture [a lot of times] they don't believe in Western medicine they think that it's a bunch of "phooey" [You know] they just have to pray, and they'll get better until they return to the ED."

Theme 3: Resources. Four out of five (80%) registered nurses identified the accessibility and availability of resources to be contingent on preventing readmissions. Registered nurses shared their common experiences of patients being readmitted because they had not filled medication prescriptions. Participant P50618 shared their personal experiences of a patient who was readmitted within six days of discharge:

> He was on hypertensive medication and we give him the prescription, and the patient came back with sky high blood pressure, very hypertensive. Later after doing research on my history and physical, my head to toe assessment, I found out the patient had never filled the medication. The patient didn't have the resources or insurance, so the readmission was for hypertension the same diagnosis he came in for the first time.

Participant P40818 provided further experiences related to accessible resources:

> Not having access to primary care is not as easily as one would think. When they call primary care a lot of times, they don't have an appointment for weeks, by the time that week passed by, they are already in full pulmonary edema heading back to the hospital.

The combined cases word cloud. The combined cases word cloud (Figure 7) reveals the common themes identified by all stakeholder cases. There are two labeled primary themes, education and population. Culture and resources are identified and labeled secondary themes.

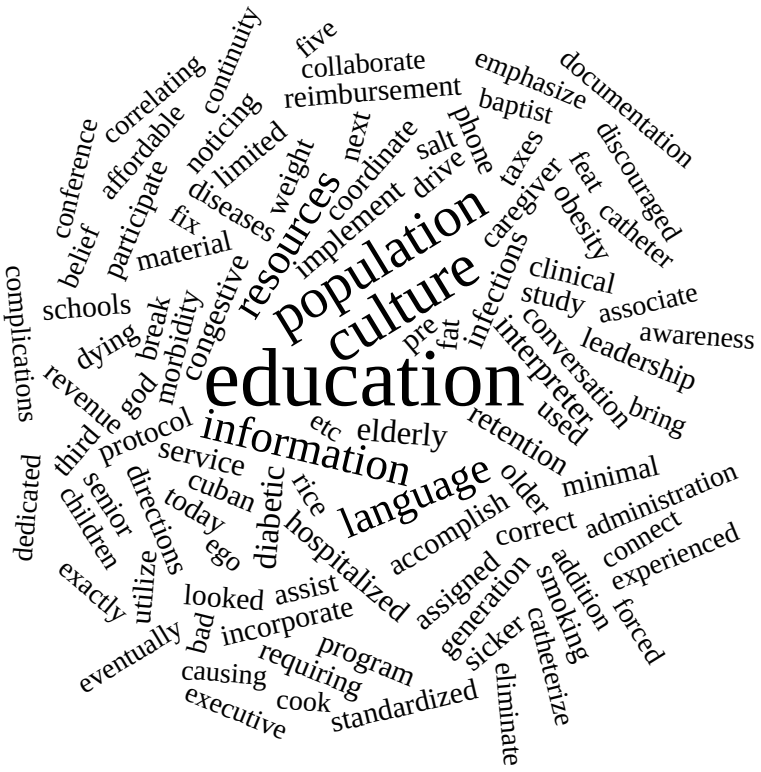

Figure 7. Combined Themes Word Cloud.

Collective Themes and Patterns

Collective themes and patterns emerged from the three cases. Eleven out of 13 (84%) participants agreed that education is an important component related to the management and care of patients with chronic medical conditions. Education displayed a weighted percentage value of 5.8% and was identified as a primary theme in all cases (Table 9).

Table 8

Themes Emerged from Combined Cases

Coded Themes (Combined)	Questions	Participants	Word Frequency	Percentage Frequency	Theme	Weighted %	Word Count
Education	Q1, Q2, Q3, Q4	P1, P2, P3, P4, P5, P6, P7, P9, P10, P11, P13.	11/13	84%	Primary	5.8	66
Population	Q1, Q2, Q3, Q4	P1, P3, P4, P5, P7, P9, P10, P11, P13, P15.	10/13	77%	Primary	3.1	35
Culture	Q1, Q2, Q3, Q4	P1, P3, P4, P5, P7, P10.	6/13	46%	Secondary	3.5	40
Resources	Q2, Q3, Q4	P1, P2, P4, P5, P6, P10, P11, P13, P15.	9/13	69%	Secondary	1.9	21

Theme 1: Education. Education was considered the most important element in managing chronic health conditions and preventing unplanned hospital readmissions. The level of patient understanding was identified as an important factor in preventing hospital readmission. The patients' compliance with treatment regimens is connected to the patient understanding discharge instructions. The patient's willingness to participate in care was also identified as an important element as described by participants' experiences. Participant P110818 provided further understanding of the importance of compliance to discharge teaching and education:

> In sending a patient home, certainly education is crucial, but I've gotten feedback that some of the patients are not even reading, [you know] you give them education, discharge

> information, clinical information. I try to give them the easy to read versions of them, but I don't think they are effectively reading and following up in an appropriate way.

The patients' ability to understand discharge instructions and their willingness to follow instructions are critical in preventing unplanned hospital readmissions.

Theme 2: Population. Ten out of 13 (77%) participants identified population as a primary theme in two of the three cases (healthcare leaders and clinicians). Participant P40618 wondered whether quality initiatives were helpful when population-specific elements were present: "I don't know if quality initiatives really meet the needs of the majority of our population who is struggling with chronic medical conditions." Participant P150818 shared the challenges of caring for high numbers of elderly population: "The elderly population has high comorbidities and the need of specialty care but, in the same respect, we lack the ability to provide the effective care management needed to prevent hospital readmissions." Population focused healthcare requires healthcare stakeholders to have working knowledge of the evidence-based guidelines needed to care for an individual or group of patients and to have the resources available to meet quality initiatives.

***Sub-theme 1: Culture*.** Six out of 13 (46%) participants identified culture as a primary theme in two of the three cases (healthcare leaders and registered nurses). Participant P40818 described the responses and reactions some Latin patients have toward illness:

> In Latin cultures you have a lot of co-dependent behaviors within the family and many a time the women can be very histrionic. Even the males are very histrionic and find that is a way of them calling attention: and that's very cultural.

Participant P30618 further described how cultural influences contradict plans of care:

> In south Florida people like to eat what they like to eat. When they get home, they want the food that they've grown up with, the comfort food. The one thing that makes them

> feel at home or brings them comfort is eating the foods that are typical to their country of origin. which might not be the best meal for their disease process. I worked on the CHF floor and every year and never fail we would discharge everybody we would get down to the 51 bed unit we would get down to maybe 15 patients on the 24th. By the 26th all 51 beds would be filled, because you cannot tell a Latin person not to have their pork, rice, and beans on the 24th!

The rich cultural blend in south Florida plays a significant role in unplanned hospital readmissions. If healthcare stakeholders are to meet quality initiatives, they must be knowledgeable regarding social, traditional, and ethnic customs of the patient population.

Sub-theme 2: Resources. Nine out of 13 (69%) participants identified resources as a primary theme. The ability of the patient to access resources was identified as a factor in the reasons for unplanned readmissions. Participant P40818 pointed out that income level, access to resources, and family support have a direct influence on unplanned hospital readmissions:

> Patients who live in Coral Gables have the resources to actually comply with what they're being told to do. The patient in Homestead [a lot of them are] with no income, no resources are available to them, poor support system- it is sad. I had patients that had to choose whether or not to take medications or eat.

The experiences shared by participant P20518 expanded on the complex social factors that highlighted the importance of having access to resources:

> Multiple factors; language and cultural barriers are a problem, [could be] not having insurance, some patients don't have transportation, some patients they are elderly and don't have a caregiver to take them to appointments or to help them keep track of all the medications. They see multiple providers, or the providers don't even know all of the medications that the patient is taking. They prescribe a medication that the patient is

> already taking. They take [the patient] the same medication twice from lack of education and are readmitted.

Participant P60618 identified multiple resources that have bearing on successful care transitions:

> Lack of access to care and follow-up care. At least, if we involve the family, or a main point of contact, to ensure that the patient will get follow-up care and we have somebody to call and make sure that it's happening.

Personal income is an important resource to consider when managing elderly patients with chronic medical conditions. Participant P130818 further clarified the challenges of patients who are coping with chronic conditions on a fixed income: “We see it a lot with the elderly population with CHF they don't have a lot of money, they don’t want to cook, so they will have Rahman noodle in a cup and so much sodium.”

Chapter Summary

Healthcare stakeholders shared experiences that helped the researcher explore the uniqueness of providing healthcare in south Florida. Participants shared valuable insights into how distinctive social determinants were connected to chronic medical conditions and unplanned hospital readmissions. While methods of measuring and reporting healthcare quality were consistent, participants revealed that generic evidence-based practices were insufficient in preventing unplanned hospital readmissions in a culturally and ethnically diverse population.

This chapter included a presentation of the data collected and analyzed from 13 study participants. Participants were required to have experience working in hospitals located in the tri-county area and to be knowledgeable of chronic health conditions and the implications of unplanned hospital readmissions. The results of this study provided distinctive determinants specific to the tri-county area that influenced unplanned hospital readmissions. Specifically, in

this study, two primary themes (education and population) and two secondary themes (culture and resources) emerged from the collective analyzed data of three cases.

Themes were connected to the research question: What are the common experiences of healthcare leaders, clinicians, and nurses concerning higher than expected unplanned hospital readmissions for patients with chronic health conditions in healthcare facilities located in Broward, Miami-Dade, and Monroe Counties in the state of Florida? The results of the study illustrated the collective experiences of healthcare stakeholders regarding the unique demographic characteristics of patients coping with chronic medical conditions in the tri-county area. The shared experiences of the participants revealed the importance of healthcare planning that is customized to meet individual patient needs. In chapter 5 the researcher continued the discussion and interpretation of the study findings and offered suggestions for further research.

Chapter 5

Conclusions and Recommendations

The purpose of this qualitative exploratory multiple-case study was to explore the reasons for higher than expected unplanned hospital readmissions in healthcare facilities located in the tri-county area of south Florida to help hospital administrators improve healthcare quality through reducing unplanned rehospitalizations. A review of the literature exposed gaps in the research regarding healthcare delivery in highly diverse settings. A purposive sampling method was used to recruit participants with experience working as healthcare leaders, clinicians, and registered nurses in the tri-county area.

Rigorous data collection and analysis provided an understanding of the common experiences of healthcare stakeholders and the insight needed to answer the research question. Data collection included each participant completing a demographic survey and providing answers to four semi-structured, open-ended questions and two probe questions. Participant interviews were audio-recorded, transcribed verbatim, and returned to the participants for member checking. Analysis included manual coding, constant comparative analysis, and a thematic coding process that revealed frequently used themes, phrases, and words. NVivo12 software was used to validate thematic frequencies and to create a clear visualization of the main themes. Chapter 5 concludes with a summary of the study findings, study limitations, implications, and recommendations for further study.

Discussion of Findings and Common Themes

Three cases were identified for this study, namely, that of healthcare leaders, clinicians, and registered nurses, to provide comprehensive knowledge regarding unplanned hospital readmissions. Thirteen participants contributed to this study: 4 (31%) healthcare leaders, 4 (31%) clinicians, and 5 (38%) registered nurses. A qualitative methodology and exploratory multiple-

case study design provided an in-depth understanding of unplanned hospital readmissions in healthcare facilities located in the tri-county area. An explanation by Gomm, Hammersley, and Foster (2011) confirmed that a qualitative exploratory multiple-case study approach was an appropriate methodology to discover recurrent patterns and themes. The analysis of data collected through multiple participant experiences provided an understanding of the recurrent patterns and themes regarding unplanned hospital readmissions in south Florida.

Application to Donabedian's Conceptual Model

Donabedian's conceptual model is the dominant paradigm when assessing conceptual and operational quality factors and has made significant contribution to quality improvement in healthcare. Linear relationships between structure, process, and outcome must be present to assess quality (Mitchell, Ferketich, & Jennings, 2007). Structure, processes, and outcomes were illustrated through participant experiences. Structural characteristics; hospital buildings, equipment, staff ratios, processes; clinical interventions, diagnosis, treatment, discharge teaching, and education, and outcomes; the consequences of care and treatment on health status influenced the quality of care in the tri-county area. Deterioration in health status requiring hospital readmission indicates a negative outcome.

The results of this study revealed the presence of poly-factorial determinants within the tri-county patient population interrupted the linear sequence of Donabedian's model (Figure 8). Within the tri-county area, study participants shared experiences related to multiple co-morbid conditions within a singular patient that lead to repetitive readmissions. Patients requiring multiple clinical interventions, for each chronic medical condition, were complicated by additional social determinants such as literacy, language, lack of resources, lack of family support and cultural-specific needs.

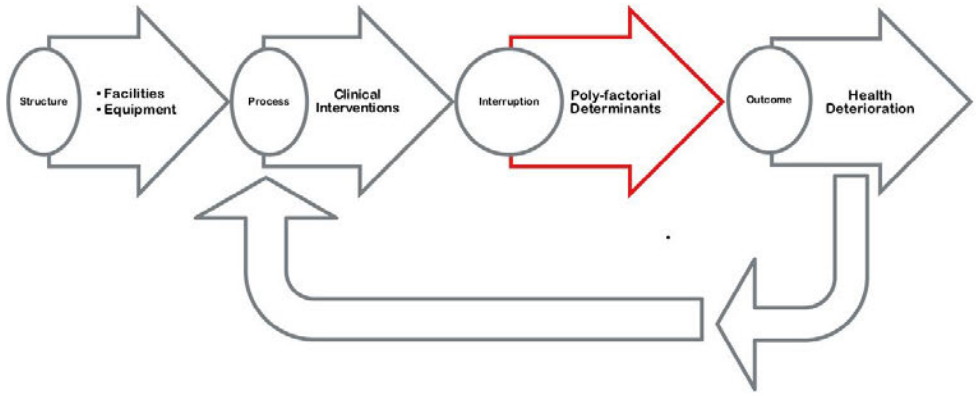

Figure 8. Interruption of Donabedian's Conceptual Model

Common Themes

Through the collective responses of the 13 participants, from three cases; case one, healthcare leaders; case two, clinicians; and case three, registered nurses two primary, education and population, and two secondary or sub-themes, culture and resources were discovered. The collected data consisted of analyzed participant responses to four questions and two probe questions. Primary themes demonstrated weighted percentages measuring 3% or higher, and word frequency of greater than or equal to 50%. Secondary themes demonstrated either the minimum weighted value or minimum word frequency percentages. Subsequent interpretations were compared to the reviewed literature and study results presented in this section.

Theme 1: Education

Eleven of the thirteen (84%) participants confirmed that education was important to managing chronic health conditions and preventing repeated hospitalizations. Healthcare stakeholders agreed that successful hospital discharge is contingent on safe transitions of care. Through integration of coordinated discharge planning, patient and caregiver education, and post-discharge management, patients are better prepared for health management at home (Kamermayer, Leasure, & Anderson, 2017). There continue to be barriers associated with patient education and transition (Davidson et al., 2017; Carretta et al., 2013; Carey & Lin, 2015; Alyahya et al., 2016). The results of this study exposed factors in the tri-county area related to patient and staff education that contributed to unplanned rehospitalization rates.

Discharge processes require initial nursing assessment of patient ability to perform self-care. Discharge information includes written and verbal instruction intended to guide patient self-care (Polster, 2015). Although study data revealed there were attempts to educate patient before discharge, study results revealed there were persistent failures in discharge processes related to nurse assessment of self-care deficits and appropriate verbal and written information to patients in tri-county area hospitals.

Sporadic adherence to discharge processes specifically, nursing staff assessment of patient self-care deficits created failures in discharge processes. Nurses play vital roles in early identification of patient barriers to learning during the patient's hospital stay. Initial nursing assessment identifies modifiable factors that increase the likelihood of rehospitalization for example; lack of home support, inadequate follow-up, poly-medications, and previous adverse outcomes (Polster, 2015). Once patient self-care deficits are identified, care plans are established, and discharge preparation begins. Leaders identified the level of nurse education, clinical skills,

and experience to appropriate assessment of patient risk factors and formation of individualized care plans for discharge planning.

Study results identified stakeholder concerns pertaining to Associate degree nurses' abilities to appropriately assess and educate patients. The results of this study revealed three of the four (75%) healthcare leaders were concerned that nursing education and skill levels were contributing to unplanned readmissions. Hand hygiene is recognized as the most effective method of preventing transmission of disease. s (Nguyen, 2014; Moore, 2015). Healthcare leaders inferred nurses required additional education and training regarding infection control measures to prevent hospital acquired infection and rehospitalization.

Connections between patient educational level, literacy and understanding, are consistent with literature reviewed that identified patient education and literacy as critical to the management of chronic disease (Ho, Caughey, & Shakib, 2014). Literature reviewed connected patient understanding to accountability and participation (Edwards et al., 2012). Management of chronic medical conditions is contingent on patient education level, in a preferred language, at the patient's level of comprehension. Although, health literacy, inadequate communication skills, reading abilities, and learning capabilities are recognized patient self-care deficits (Polster, 2015), this study revealed additional patient characteristics namely, cultural and population-specific elements that increased likelihood of rehospitalization.

Language and cultural educational elements. The results of this study identified existing discharge literature to be a problem. When patient discharge documentation is completed patient information is automatically printed for the patient to take home. Discharge information includes instructions to help the patient or caregiver continue the care plan after discharge. Shaw, et al. (2009) highlighted the importance of culturally appropriate care when caring for a culturally diverse population. Some cultures react differently to illness in ways that

contradict traditional medicine. The results of this study identified patient participation to be complicated by cultural beliefs and language barriers.

Study participants shared experiences specific to the patient/family component required for successful patient education specifically, the patient's level of education and their willingness to be an active participate in care and treatment. Study data confirmed the role of family caregivers cannot be overlooked as a salient resource in preventing hospital readmissions (Ansel, 2014). Study results disclosed multiple intersecting factors in the tri-county patient population that increased the involvedness of patient education.

Leadership knowledge. Care quality and patient outcomes are the responsibility of hospital leadership (Agency for Healthcare Research and Quality, 2013). Healthcare leaders knowledgeable of healthcare regulations and quality initiatives are able to achieve and maintain quality. Available literature corroborated the importance of healthcare leaders being knowledgeable of changes in quality initiatives and healthcare regulations (McHugh et al., 2013). Healthcare leaders identified executive leadership knowledge to be a concern specifically, leaders must be educated regarding healthcare regulations and quality initiatives.

Theme 2: Population

Population is comprised of the inhabitants, residents, and citizens of a specific demographic area. Ten of the thirteen (77%) participants identified population-specific components in south Florida to be significant to the frequency of unplanned readmissions. The study participants shared their experiences and challenges concerning providing healthcare for a distinctive population present in the tri-county area.

Population-specific determinants. Specific components necessary to understand and respond to culturally and ethnically diverse communities continues to pose a challenge for healthcare providers (Diaz & Kumar, 2018). The results of this study conferred with current

literature; race, ethnicity, socioeconomic status, age, and community demographics influence health status (Shaw, Huebner, Armin, Orzech, & Vivian, 2009). Results revealed multiple cultural and ethnic characteristics present within the south Florida population. Each demonstrated unique social, economic, and cultural factors that influenced responses to treatment, acceptance to care plans, and outcomes The experiences of study participants highlighted population-specific cultural, linguistic, religious, and individual healthcare beliefs that increased the complexity of healthcare delivery.

Elderly population. Chronic medical conditions are more prevalent in older age groups and the elderly population is more likely to have social constraints that prevent them from following a plan of care (Finney-Rutten, et al., 2016). Two of the four (50%) clinicians identified relational coordination to be more important when integrating care delivery for elderly patients. Integrated care delivery included an appraisal of the patient's ability to understand and follow disease-specific instructions and the presence of a caregiver who could assist with homecare. The study results were consistent with those of Hartgerink et al. (2014), confirming the importance of care coordination and family involvement when managing elderly patients with chronic health conditions.

Sub-theme 1: Culture

The tri-county area is one of the most culturally and ethnically diverse populations in the US. Culture is the collective customs, values, beliefs, and characteristics of a defined group in a specific time and place. McHugh et al. (2013) confirmed that race, ethnicity, socioeconomic status, age, and community demographics influenced health status. Culture influences health-seeking behaviors and compliance healthcare instructions. Six of the thirteen (46%) participants identified three cultures with significant connections to unplanned readmissions within the tri-county population. South American, Cuban, and Haitian cultures are relevant to this study. Study

participants shared experiences relating to cultural practices and beliefs that are in conflict when managing chronic illness.

Shaw et al. (2009) confirmed that conflicts can occur between cultures and traditional medical models. Literature enhanced the importance of using culturally competent care models when caring for multi-cultural populations. However, experiences shared by study participants were related to the challenge of incorporating cultural beliefs and practices with traditional care models. Participants shared real life experiences of identified the difficulties in applying quality initiatives to an extremely culturally diverse population specifically when there are linguistic, educational, ethnic, and other cultural related factors present within a solitary patient. Participants shared experiences of the challenges of caring for immigrant patients from Latin America, Haiti, and Cuba whose chronic health condition is often exacerbated by cultural practices.

Sub-theme 2: Resources

Healthcare resources are comprised of many components required to provide healthcare services that include personnel, funding, supplies, and facilities (Ransom & Olsson, 2017). The participants of this study identified specific staffing resources, namely, nurse staff ratios and designated patient educators, that are known to influence discharge planning. The results of this study are also consistent with the literature that connected socio-economic status to the most important resources identified by study participants, namely, healthcare insurance and access to medications. Kripalani et al. (2014) confirmed that affluence positively influenced health status and provided options that were not available to patients with lower socio-economic status. When patients with chronic medical conditions did not have resources available, they were more likely to be readmitted to hospital.

Family and caregiver support. Family support was connected to successful and unsuccessful care transitions. Caregiver support improves access to community services and resources and provides surrogate care in home settings. Participants identified the benefits of a family member as a point of contact to reinforce discharge instructions. The role of family caregivers cannot be overlooked as a salient resource in preventing hospital readmissions (Ansel, 2014), especially when providing healthcare to culturally and ethnically diverse populations.

Nurse staffing factors. Nurse staffing levels are closely connected to healthcare quality and connected to the frequency of adverse patient events (American Nurses Association, 2018). Current quality initiatives are contingent on the numbers of trained nurses to provide care, and adequate numbers for implementation of evidence-based nursing practices. Effective discharge education takes time, patience and skill.

Effective discharge teaching requires nursing staff knowledgeable of multiple health conditions and able to answer questions from patients and families (Kamermayer, Leasure, & Anderson, 2017). Discharge teaching, when appropriately accomplished, prepares the patient and family to assume responsibility for on-going care. Although, the results of this study are consistent with the literature reviewed, experiences shared by study participants identified patient factors specific to the tri-county that complicated patient discharge. Specifically, high acuity patients with multiple morbidities, specific educational needs, strong cultural beliefs, and additional education and linguistic needs requiring focused discharge preparation from an experienced nurse.

Limitations of the Study

Although the study's findings answered the research question and validated researcher perceptions, the study results did not provide answers to all questions concerning higher than expected unplanned hospital readmissions. The participants shared a broad range of experiences

regarding unplanned readmissions that added to the contextual understanding of the healthcare stakeholders' perspectives. A comprehensive depiction of each case was achieved using the narratives from each participant to describe the whole. Generalizations were clarified by organizing the participants' narratives into cross-case findings (Stake, 2006). As a result, the findings of this study are subjective because the results represent the experiences and assertions of the participating stakeholders and the researcher's generalizations documented regarding the cases at the beginning of this study.

Although the processes and methods used to collect and analyze data were described in detail, the replicability of the study results are not guaranteed. The duplication of the results is limited by the personal experiences, beliefs, perspectives, and opinions shared by the study participants. Initially, the researcher planned to recruit study participants from three counties. The researcher was not successful in recruiting participants from Monroe County; however, this did not influence the findings of the study.

The inclusion of participants with experience working in hospitals in Monroe County may have provided additional themes for consideration. In the tri-county area healthcare provision is dominated by three large healthcare systems that cross county lines. The demographic survey only asked for primary practice location data. Throughout data collection, some participants working in these large healthcare systems are credentialed to work in multiple hospitals within a single company or in different companies. Some participants shared that they have worked in hospitals located in Monroe County and have experience working in multiple healthcare facilities within the tri-county area.

The subjects and factors discussed in this study did not reflect all healthcare stakeholder experiences regarding unplanned hospital readmissions. The inclusion of data from Monroe County may have yielded significant or opposing study results. The data revealed by this study

does substantiate that healthcare stakeholders with a broad range of experiential and professional knowledge share common experiences concerning unplanned hospital readmissions in their respective healthcare roles.

Study Implications

The general problem of the high numbers of unplanned hospital readmissions in healthcare facilities located in Florida (Centers for Medicare & Medicaid Services, 2016) and the gaps in the literature identifying unique social determinants that contributed to unplanned hospital readmissions made this study possible. The results of this research study provided information that is helpful to healthcare stakeholders, researchers, and scholars. The implications of this research study are discussed in this section.

Implications for scholars. The results of this study added to the body of knowledge that may be referenced by scholars embarking on research concerning unplanned hospital readmissions and chronic health conditions. The results of this study are helpful to scholars interested in further study concerning healthcare quality related to unplanned admissions and social determinants related to chronic medical conditions within a diverse population. Through the experiences of healthcare stakeholders, the results of this study provided knowledge related to challenges of providing care to a highly complex cultural and ethnic patient population in south Florida and can be transposed to other populations.

Implications for practitioners. The results of this study highlighted the complexity of providing care to patients in the tri-county area. Despite the wide adoption of evidence-based practices, practitioners continued to observe increased frequency of unplanned hospital readmissions (Alyahya et al., 2016). While the results of this study confirmed the socio-economic factors that influenced the rate of hospital readmissions, there was scant literature that addressed the challenges of managing a person who presented multiple comorbid conditions

along with multiple socio-economic factors (Osmun, Kim, & Harrison, 2015). Healthcare practitioners must continue to refine the treatment and monitoring of complex patients while incorporating the principles of culturally competent care to include the patient and caregiver's inclusion in decision-making.

Implications for healthcare leaders. Despite the use of evidence-based practices and strategies by clinical staff, the conceptualization of theory was closely connected to the actions taken by healthcare leaders. The results of this study identified concerns of executive leader knowledge deficits with regards to healthcare regulations. It is important that healthcare leaders understand the operational and strategic components needed to comprehend existing and future healthcare trends and regulatory changes (Pillay & Morris, 2016). As reimbursement remains connected to patient outcomes, lower financial reimbursement and higher penalties will continue to be levied when quality metrics are not met.

Although value-based reimbursement programs have decreased unplanned hospital readmissions, unplanned hospital readmissions in the state of Florida continue to be problematic (Centers for Medicare & Medicaid Services, 2017) therefore, quality measurement and reimbursement will continue to be a central focus for healthcare leaders and administrators. The personal experiences of healthcare stakeholders helped to provide understanding of the reasons some healthcare stakeholders failure in meeting quality benchmarks (Zoutman & Ford, 2017). The results of this study provide information helpful to leaders seeking solutions to improve unplanned rehospitalizations.

Recommendations for Further Research

The study explored the experiences of healthcare stakeholders to gain an understanding of the causes of higher than expected unplanned hospital readmissions for patients with chronic health conditions in healthcare facilities located in Broward, Miami-Dade, and Monroe Counties

in the state of Florida. Recommendations for further research consist of expanding the area of study to include additional study participants and different geographic areas. The addition of study participants who are patients with chronic medical conditions would provide information from the patients' perspective. Analysis and interpretation of the patients' perspectives and experiences yielded additional information that may refine healthcare processes for patients and families to manage chronic health conditions (Finney-Rutten, et al., 2016).

Results indicate a need for deeper understanding of the influence of cultural and ethnic characteristics in healthcare delivery processes. The results of the study revealed that some cultures possess unique healthcare beliefs that require further study. Discovery of new knowledge exposed challenges associated with managing patients with specific cultural needs and social determinants that increase medical complexity. A further recommendation for study includes investigation regarding the influence of cultural beliefs and practices to patient compliance with the plan of care.

Summary

The results of this qualitative multiple-case study identified the challenges of providing high-quality healthcare to patients with multi-factorial determinants within a complex population. A population comprised of patients from multiple cultures who speak different languages in different dialects has presented a challenge for healthcare providers working in the tri-county area. Elderly people coping with chronic conditions without caregiver support have demonstrated a higher possibility of being readmitted to hospital due to issues related to medications, resources, and transportation.

Educating patients and caregivers is complicated due to the different levels in healthcare literacy, language, cultural considerations, and patient self-determination. The behaviors of the patient and caregiver are critical to disease management and are associated with the frequency of

unplanned hospital readmission. The inclusion of patient responsibilities into the plan of care is an important component of self-determination that is absent in current practice and must be considered.

There is increased necessity for healthcare stakeholders to be knowledgeable regarding healthcare regulations, quality initiatives, and resources. Integrated medical records ensure there is unencumbered access to electronic medical records and a valuable decision-making tool that facilitates the transfer of medical information between clinicians. Lack of available patient information is a component identified by participants that contributes to unplanned hospital readmissions.

Conclusion

The purpose of this qualitative exploratory multiple-case study was to explore the reasons for higher than expected unplanned hospital readmissions in healthcare facilities located in the tri-county area of south Florida to help hospital administrators to improve healthcare quality through reducing unplanned rehospitalizations. Despite advances in medical care and treatment, the prevalence of chronic health conditions has continued to rise. The findings of this multiple-case study suggested that increased cultural and ethnic diversity have created new challenges for healthcare providers.

Healthcare stakeholders with knowledge of chronic medical conditions, and an understanding of the implications of unplanned hospital readmissions identified that the complexity of a multi-cultural healthcare environment characterizes healthcare delivery in the tri-county area. Participants identified that multiple health factors and unique cultural and ethnic traits present in a solitary patient have contributed to the frequency of unplanned hospital readmissions. The common experiences of healthcare stakeholders presented in this study have substantiated the current literature regarding higher rates of unplanned hospitalizations and

managing patients with chronic health conditions. This study has added new knowledge regarding increased cultural and medical complexity of patients in the tri-county area, the importance of patient accountability and self-determination, and necessity for focused executive leader education and development regarding healthcare regulations. The analysis and synthesis of results contained within this study provide information to healthcare stakeholders, researchers, and health and social care professionals regarding the reasons for and opportunities to reduce unplanned hospital readmissions.

References

Agency for Healthcare Research and Quality (US). (2013). *Making health care safer II: An updated critical analysis of the evidence for patient safety practices*. (Evidence Reports/Technology Assessments, No. 211). Rockville, MD: Author. Retrieved October 4, 2016, from https://www.ncbi.nlm.nih.gov/books/NBK133363/

Ajami, S., & Arab-Chadegani, R. (2013). Barriers to implement Electronic Health Records (EHRs). *Materia Socio-Medica, 25*(3), 213–215. doi:10.5455/msm.2013.25.213-215

American Nurses Association. (2018). *Safe staffing.* Retrieved July 9, 2018, from https://www.nursingworld.org/practice-policy/advocacy/state/nurse-staffing/

Ansel, D. E. (2014). Are family caregivers an overlooked resource? *Becker's Hospital Review.* Retrieved August 15, 2017, from https://www.beckershospitalreview.com/hospitalmanagement-administration/are-family-caregivers-an-overlooked-resource.html

Alyahya, M. S., Hijazi, H. H., Alshraideh, H. A., Alsharman, M. A., Al Abdi, R., & Harvey, H. L. (2016). Integrating the principles of evidence based medicine and evidence based public health: Impact on the quality of patient care and hospital readmission rates in Jordan. *International Journal of Integrated Care, 16*(3), 12. doi:10.5334/ijic.2436

Berwick, D. M. (2003). Disseminating innovations in healthcare. *JAMA: The Journal of the American Medical Association, 289*(15), 1969–1975. doi:10.1001/jama.289.15.1969

Bönigk, M., & Steffgen, G. (2013). Effects of habitual anger on employees' behavior during organizational change. *International Journal of Environmental Research and Public Health, 10*(12), 6215–6234. doi:10.3390/ijerph10126215

Bromley, D. B. (1986). *The case-study method in psychology and related-disciplines.* Chichester: John Wiley & Sons.

Bunce, A. E., Gold, R., Davis, J. V., McMullen, C. K., Jaworski, V., Mercer, M., & Nelson, C. (2014). Ethnographic process evaluation in primary care: Explaining the complexity of implementation. *BMC Health Services Research, 14*(1), 91–109. doi:10.1186/s12913-014-0607-0

Carey, K., & Lin, M. (2015). Readmissions to New York hospitals fell for three target conditions from 2008 to 2012, consistent with Medicare goals. *Health Affairs, 34*(6), 978–985. doi:10.1377/hlthaff.2014.1408

Carretta, H. J., Chukmaitov, A., Tang, A., & Shin, J. (2013). Examination of hospital characteristics and patient quality outcomes using four inpatient quality indicators and 30-day all-cause mortality. *American Journal of Medical Quality, 28*(1), 46–55. doi:10.1177/1062860612444459

Centers for Disease Control and Prevention. (2017). *Chronic diseases: The leading causes of death and disability in the United States*. Retrieved April 17, 2018, from https://www.cdc.gov/chronicdisease/overview/index.htm

Centers for Medicare & Medicaid Services. (2016). *Readmissions reduction program (HRRP)*. Retrieved April 7, 2018, from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

Centers for Medicare & Medicaid Services. (2017). *What are value-based programs?* Retrieved April 7, 2018, from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html

Clark, R. C., & Allison-Jones, L. (2011). Investing in human capital: An academic-service partnership to address the nursing shortage. *Nursing Education Perspectives, 32*(1), 18–21. doi:10.5480/1536-5026-32.1.18

Committee on Quality Health Care in America, Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, D.C.: National Academy Press.

Cone, J. D., & Foster, S. L. (2006). *Dissertations and thesis from start to finish* (2nd ed.). Washington, DC: American Psychological Association.

Cunliffe, A. L. (2016). Republication of "on becoming a critically reflexive practitioner". *Journal of Management Education, 40*(6), 747. doi:10.1177/1052562916674465

Darawsheh, W., & Stanley, M. (2014). Reflexivity in research: Promoting rigor, reliability and validity in qualitative research. *International Journal of Therapy & Rehabilitation, 21*(12), 560–568. doi:10.12968/ijtr.2014.21.12.560

Davidson, G. H., Austin, E., Thornblade, L., Simpson, L., Ong, T. D., Pan, H., & Flum, D. R. (2017). Improving transitions of care across the spectrum of healthcare delivery: A multidisciplinary approach to understanding variability in outcomes across hospitals and skilled nursing facilities. *The American Journal of Surgery, 213*(5), 910–914. doi:10.1016/j.amjsurg.2017.04.002

DeNyse, A., Ellis, B., Fisher, S. L., Foster, M., & Kalvaitis, K. (2011). Increased number of family physicians reduced hospital readmission rates. *Endocrine Today, 9*(6), 48. Retrieved March 22, 2016, from https://search-proquest-com.contentproxy.phoenix.edu/docview/871816837

Diaz, E., & Kumar, B. N. (2018). Health care curricula in multicultural societies. *International Journal of Medical Education, 9,* 42–44. doi:10.5116/ijme.5a7e.bd17

Donabedian, A. (1980). Explorations in quality assessment and monitoring: Explorations in quality assessment and monitoring, (Vol.1). *Health Administration Press,* Ann Arbor, MI.

Donabedian, A. (1966). Evaluating the quality of medical care. *Milbank Quarterly, 83*(4), 691–729 (Reprinted 2005, Milbank Memorial Fund), Blackwell Publishing.

Dooney, J., & Esen, E. (2009). HR salaries weaken with the economy. *HR Magazine's 2009 HR Trend book*, 5–19. Retrieved March 17, 2016, from http://search.proquest.com/docview/205062760?accountid=35812.

Dosen, K. M., Karasiuk, A. A., Marcaccio, A. C., Miliak, S., Nair, M. H., & Radauskas, V. J. (2017). Code grey: Mapping healthcare service deserts in Hamilton, Ontario and the impact on senior populations. *Cartographica*, *52*(2). 125–131. doi:10.3138/cart.52.2.5103

Edwards, R., Charani, E., Sevdalis, N., Banos, A., & Sibley, E. (2012). Optimisation of infection prevention and control in acute health care by use of behavior change: A systematic review. *The Lancet Infectious Diseases, 12*(4), 318–329. doi:10.1016/S1473-3099(11)70283-3

Everhart, D., Neff, D., Al-Amin, M., Nogle, J., & Weech-Maldonado, R. (2013). The effects of nurse staffing on hospital financial performance: Competitive versus less competitive markets. *Health Care Management Review, 38*(2), 146–155. doi:10.1097/HMR.0b013e318257292b

Eymin, G., & Jaffer, A. K. (2014). Evidence behind quality of care measures for venous thromboembolism and atrial fibrillation. *Journal of Thrombosis and Thrombolysis, 37*(2), 87–96. doi:10.1007/s11239-013-0874-3

Feemster, L. C., & Au, D. H. (2014). Penalizing hospitals for chronic obstructive pulmonary disease readmissions. *American Journal of Respiratory and Critical Care Medicine, 189*(6), 634–639. doi:10.1164/rccm.201308-1541PP

Finney-Rutten, L. J., Hesse, B. W., St. Sauver, J. L., Wilson, P., Chawla, N., Hartigan, D.B.,…Arora, N. K. (2016) Health self-efficacy among populations with multiple chronic conditions: The value of patient-centered communication. *Advances in Therapy, 33*(8), 1440-1451. doi:10.1007/s12325-016-0369-7

Fishbein, M., & Cappella, J. N. (2006). The role of theory in developing effective health communications. *Journal of Communication, 56*(suppl. 1.), S1-S17. doi:10.1111/j.1460-2466.2006.00280.x

Flick, U. (2006). *An introduction to qualitative research design* (3rd ed.). Thousand Oaks, CA: Sage.

Florida Hospital Association. (2017). *Reports and resources: Hospital directory*. Retrieved June 5, 2017, from http://www.fha.org/reports-and-resources/hospital-directory.aspx

Florida Policy Institute. (2016). *Benefits of Medicaid* e*xpansion in Florida*. Retrieved December 14, 2016, from http://www.fpi.institute/222-2/

Galarneau, C. (2011). Still missing: Undocumented immigrants in healthcare reform. *Journal of Healthcare for the Poor and Underserved,* (22), 422–428. doi:10.1353/hpu.2011.0040

Garfield, R., Damico, A., & Orgera, K. (2018). *The coverage gap: Uninsured poor adults in states that do not expand Medicaid*. Retrieved July 1, 2018, from https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ Gerring, J. (2004). What is a case study and what is it good for? *American Political Science Review, 98*(2), 341–354. doi:10.1017/S0003055404001182

Gomm, R., Hammersley, M., & Foster, P. (2011). *Case study method* (Rev ed.). Thousand Oaks, CA: SAGE Publications.

Gartner Inc.(2018). LogMeIn: A Leader in the 2018 Gartner Magic Quadrant for meeting solutions. Retrieved November 4, 2018, from http://learn.logmeininc.com/Gartner-Magic-Quadrant.html

Google. (2018). *Privacy policy: Terms of service*. Retrieved November4, 2018, from https://support.google.com/docs/answer/6281888?co=GENIE.Platform%3DDesktop&hl=en

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Technology Research and Development, 29,* 75–91.

Gunnells, D. J., Jr., Morris, M. S., DeRussy, A., Gullick, A. A., Malik, T. A., Cannon, J. A.,Chu, D. I. (2016). Racial disparities in readmissions for patients with inflammatory bowel disease (IBD) after colorectal surgery. *Journal of Gastrointestinal Surgery*, *20*(5), 985–993. doi:10.1007/s11605-015-3068-9

Hamel, J., Dufour, S., & Fortin, D. (1993). *Case study methods*. (Rev ed.). Newbury Park, CA: SAGE Publications.

Hammersley, M. (1992) *What's Wrong With Ethnography? Methodological Explorations.* London, UK: Routledge Publications.

Han, X., Yabroff, K. R., Guy, G. P., Zheng, Z., & Jemal, A. (2015). Has recommended preventive service use increased after elimination of cost-sharing as part of the Affordable Care Act in the United States? *Preventive Medicine, 78,* 85–91. doi:10.1016/j.ypmed.2015.07.012

Hartgerink, J. M., Cramm, J. M., De Vos, A., Bakker, T., Steyerberg, E. W., Mackenbach, J. P., & Nieboer, A. P. (2014). Situational awareness, relational coordination and integrated care delivery to hospitalized elderly in The Netherlands: A comparison between hospitals. *BMC Geriatrics, 14*(3),1-11. doi:10.1186/1471-2318-14-3

Healthcare.gov. (n.d.). *Out-of-pocket maximum/limit.* Retrieved June 6, 2016, from https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/

Health Quality Ontario. (2013). In-home care for optimizing chronic disease management in the community: An evidence-based analysis. *Ontario Health Technology Assessment Series, 13*(5), 1–65. Retrieved February 15, 2017, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3804052/

Health Resources and Services Administration. (2016). *U.S. Department of Health: HRSA health center program*. Retrieved February 15, 2017, from http://bphc.hrsa.gov/.../healthcenterfactsheet.pdf

Health Services Advisory Group. (2017). *Regional readmission reports for Florida*. Retrieved March 6, 2018, from https://www.hsag.com/es/medicare-providers/states-of-service/florida/care-coordination/readmission-data/

Hesse-Biber, S. N., & Leavy, P. (2011). *The practice of qualitative research* (2nd ed.). Los Angeles, CA: SAGE Publications

Hipp, R., Abel, E., & Weber, R. J. (2016). A Primer on clinical pathways. *Hospital Pharmacy, 51(*5), 416-421. doi:10.1310/hpj5105-416

Ho, T. H., Caughey, G. E., & Shakib, S. (2014). Guideline compliance in chronic heart failure patients with multiple comorbid diseases: Evaluation of an individualized multidisciplinary model of care. *PLoS One, 9*(4). doi:10.1371/journal.pone.0093129

Howden, L. M., & Meyer, J. A. (2011). *Age and sex composition: 2010*. United States Department of Commerce: Economics and Statistics Administration. Retrieved November 22, 2017, from https://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf

Huang, E. S., & Finegold, K. (2013). Seven million Americans live in areas where demand for primary care may exceed supply by more than 10 percent. *Health Affairs, 32*(3), 614-621. doi:10.1377/hlthaff.2012.0913

Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health*. National Academies Press.

Juran, J. M. (1988). *Juran's quality handbook.* (5th ed.). New York, NY: McGraw-Hill.

Kahn, J. M., Benson, N. M., Appleby, D., Carson, S. S., & Iwashyna, T. J. (2010). Long-term acute care hospital utilization after critical illness. *Journal of the American Medical Association, 303*(22), 2259–2259. doi:10.1001/jama.2010.761

Kamermayer, A. K., Leasure, A. R., & Anderson, L. (2017). The effectiveness of transitions-of-care interventions in reducing hospital readmissions and mortality: A systematic review. *Dimensions of Critical Care Nursing, 36*(6), 311–316. doi:10.1097/DCC.0000000000000266

Kellis, D. S., & Ran, B. (2015). Effective leadership in managing NPM-based change in the public sector. *Journal of Organizational Change Management, 28*(4), 614–626. doi:10.1108/JOCM-11-2013-0229

Kim, T.Y., Mortensen, K., & Eldridge, B. (2015). Linking uninsured patients treated in the emergency department to primary care shows some promise in Maryland. *Health Affairs, 34*(5), 796-804. doi:10.1377/hlthaff.2014.1102

Kleinpell, R., Scanlon, A., Hibbert, D., Ganz, F., East, L., Fraser, D., Wong, F., & Beauchesne, M. (2014). Addressing issues impacting advanced nursing practice worldwide. *The Online Journal of Issues in Nursing, 19*(2), 1. doi:10.3912/OJIN.Vol19No02Man05

Knol, A. B., Slottje, P., Van der Sluijs, J. P., Jeroen, P., & Lebret, E. (2010). The use of expert elicitation in environmental health impact assessment: A seven step procedure. *Environmental Health, 9*(1), 9-19. doi:10.1186/1476-069X-9-19

Koh, H. K., & Sebelius, K. G. (2010). Promoting prevention through the affordable care act. *The New England Journal of Medicine,* (363), 1296–1299. doi:10.1056/NEJMp1008560

Kohn, L. T., Corrigan, J., & Donaldson, M. S. (2000). *To err is human: Building a safer health system*. Washington, DC: National Academy Press.

Kripalani, S., Theobald, C. N., Anctil, B., & Vasilevskis, E. E. (2014). Reducing hospital readmission: Current strategies and future directions. *Annual Review of Medicine, 65,* 471–485. doi:10.1146/annurev-med-022613-090415

Krueger, N. F., Jr., & Carsrud, A. L. (1993). Entrepreneurial intentions: Applying the theory of planned behavior. *Entrepreneurship and Regional Development,* 5, 315–330. doi:10.1080/08985629300000020

Kumar, S., & Aldrich, K. (2010). Overcoming barriers to electronic medical record (EMR) implementation in the US healthcare system: A comparative study. *Health Informatics Journal, 16*(4), 306–318. doi:10.1177/1460458210380523

Langstrand, J. (2016). The missing link in systems thinking. *International Journal of Quality and Service Sciences, 8*(2), 197–208. doi:10.1108/IJQSS-09-2015-0061

Leedy, P. D., & Ormrod, J. E. (2010). *Practical research: Planning and design* (9th ed.). Upper Saddle River, NJ: Prentice Hall.

Lewin, K. (1947). Group decisions and social change. In T. M. Newcomb, & E. L. Hartley (Eds.), *Readings in Social Psychology,* 197-211. New York, NY: Henry Holt.

Leykum, L. K., Lanham, H. J., Pugh, J. A., Parchman, M., Anderson, R. A., Crabtree, B. F.,...McDaniel, R. R. (2014). Manifestations and implications of uncertainty for

improving healthcare systems: An analysis of observational and interventional studies grounded in complexity science. *Implementation Science, 9*, n/a–165. doi:10.1186/s13012-014-0165-1

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications.

Lune, H., & Berg, B. L. (2017). *Qualitative research methods for the social sciences* (9th ed.). New York, NY: Pearson Education Inc.

MacDonald, B., & Walker, R. (1975) Case study and the philosophy of educational research. *Cambridge Journal of Education, 5*(1), 2–11. Retrieved March 4, 2018 from https://www.researchgate.net/publication/233260731_Case-Study_and_the_Social_Philosophy_of_Educational_Research

Manchikanti, L., Helm Ii, S., Benyamin, R. M., & Hirsch, J. A. (2017). A critical analysis of Obamacare: Affordable care or insurance for many and coverage for few? *Pain Physician, 20*(3), 111–138. Retrieved May 19, 2018, from https://www.ncbi.nlm.nih.gov/pubmed/28339427

Martin, G. (2014). Viewpoint: Competition policy in health care markets: Navigating the enforcement and policy maze. *Health Affairs, 33*(6), 1088–1093. Retrieved February 4, 2016 from http://search.proquest.com/docview/1534525058?

Mathison, S. (2005). *Encyclopedia of evaluation*. Thousand Oaks, CA: SAGE Publications.

McClellan, M. (2011). Reforming payments to healthcare providers: The key to slowing healthcare cost growth while improving quality? *The Journal of Economic Perspectives, 25*(2), 69–92. doi:10.1257/jep.25.2.69

McHugh, M. D., Berez, J., & Small, D. S. (2013). Hospitals with higher nurse staffing had lower odds of readmissions penalties than hospitals with lower staffing. *Health Affairs, 32*(10), 1740–1747. doi:10.1377/hlthaff.2013.0613

McIntyre, D., Thiede, M., & Birch, S. (2009). Access as a policy-relevant concept in low- and middle-income countries. *Health Economics, Policy and Law*, *4*(2), 179–193. doi:10.1017/S1744133109004836

Medicare Chronic Conditions Dashboard: County Level (2015). Retrieved May 19, 2018, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CCDashboard.html

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation* (4th ed.). San Francisco, CA: Wiley & Sons.

Messina, William (2016). Decreasing congestive heart failure readmission rates within 30 days at the Tampa VA. Nursing Administration Quarterly 40(2).146-152. DOI: 10.1097/NAQ.0000000000000154

Mitchell, P.H., Ferketich, S., Jennings, B. M., (2007). *Quality health outcomes model.* American Academy of Nursing Expert Panel on Quality Health Care. https://doi.org/10.1111/j.1547-5069.1998.tb01234.x

Moon, K., Brewer, T. D., Januchowski-Hartley, S. R., Adams, V. M., & Blackman, D. A. (2016). A guideline to improve qualitative social science publishing in ecology and conservation journals. *Ecology and Society*, *21*(3), 17. doi:10.5751/ES-08663-210317

Moore, C. (2015). *A qualitative case study of nurse, physician, and allied clinicians' perceptions on hand hygiene compliance* (Doctoral dissertation). Retrieved from ProQuest Dissertations & Theses database. (UMI No. 1760148537).

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: SAGE Publications.

National Association of Community Health Centers. (2015). *State funding for community health centers (Fiscal Year 2016)*. Retrieved from http://www.nachc.com

Naylor, M. D., & Kurtzman, E. T. (2010). The role of nurse practitioners in reinventing primary care. *Health Affairs, 29*(5), 893-899. doi:10.1377/hlthaff.2010.0440

Neuman, W. L. (2011). *Social research methods: Qualitative and quantitative approaches* (7th ed.). Boston, MA: Allyn & Bacon.

Nguyen, T. (2014). *The staff's perception of the hospital discharge process: A qualitative case study* (Doctoral dissertation). Retrieved from ProQuest Dissertations & Theses database. (UMI No.1671726484).

Osmun, W. E., Kim, G. P., & Harrison, E. R. (2015). Patients with multiple comorbidities: Simple teaching strategy. *Canadian Family Physician, 61*(4), 378–379. Retrieved May17, 2017 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4396766/

Pandhi, N., DeVoe, J. E., Schumacher, J. R., Bartels, C., Thorpe, C. T., Thorpe, J. M., & Smith, M. A. (2012). Number of first-contact access components required to improve preventive service receipt in primary care. *Journal of General and Internal Medicine, 27*(6), 677–684. doi:10.1007/s11606-011-1955-7

Park, T., & Shaw, J. D. (2013). Turnover rates and organizational performance: A meta-analysis. *Journal of Applied Psychology, 98*(2), 268–309. doi:10.1037/a0030723

Patton, M. Q. (1990). *Qualitative evaluation methods* (2nd ed.). Thousand Oaks, CA: Sage.

Perecman, E., & Curran, S. R. (2006). Essentials for the case study method: The case study and causal inference. In E. Perecman, & S. R. Curran (Eds.). *A handbook for social science field research: Essays & bibliographic sources on research design and methods* (pp. 169–174). Thousand Oaks, CA: SAGE Publications.

Pillay, R., & Morris, M. H. (2016). Changing healthcare by changing the education of its leaders: An innovation competence model. *The Journal of Health Administration*

Education, *33*(3), 393-410. Retrieved October 2, 2018, from https://search-proquest-com.contentproxy.phoenix.edu/docview/1822455792

Polster, D. (2015). Patient discharge information: Tools for success. *Nursing*, *45* (5), 42-49. doi: 10. 1097/01.nurse.0000463652.55908.75

Ransome, H. & Olsson, J. (2017). Allocation of health care resources: Principles for decision-making. *Pediatrics in Review, 38*(7) 320–329. doi:10.1542/pir.2016-0012

Ranstad, K., Midlöv, P., & Halling, A. (2017). Socioeconomic status and geographical factors associated with active listing in primary care: a cross-sectional population study accounting for multimorbidity, age, sex and primary care. *BMJ Open, 7*(6). doi:10.1136/bmjopen-2016-014984

Ravitch, S. M., & Carl, N. M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological.* Thousand Oaks, CA: SAGE Publications.

Rosenberg, B. L., Kellar, J. A., Labno, A., Matheson, D. H. M., Ringel, M., VonAchen, P.,...Moses III, H. (2016). Quantifying geographic variation in health care outcomes in the United States before and after risk-adjustment. *PLoS One, 11*(12), 1-21. doi:10.1371/journal.pone.0166762

Sackett, D. L. (2002). The arrogance of preventive medicine. *CMAJ: Canadian Medical Association Journal*, *167*(4), 363–364. Retrieved September 6, 2017, from http://www.cmaj.ca/content/167/4/363/tab-related-content

Salleh, M., & Grunewald, D. (2013). Organizational leadership - the strategic role of the chief exec. *Journal of Leadership, Accountability and Ethics, 10*(5), 9–20. Retrieved July 8, 2016, from https://search-proquest-com.contentproxy.phoenix.edu/docview/1502748635

Shah, G. H., Luo, H., Winterbauer, N., & Madamala, K. (2016). Addressing psychological, mental health and other behavioural healthcare needs of the underserved populations in

the United States: The role of local health departments. *Perspectives in Public Health, 136*(2), 86–92. doi:10.1177/1757913915597960

Shang, H., Huang, P., & Guo, Y. (2010). Managerial cognition: The sources of sustainable competitive advantage in hyper-competition. *Nankai Business Review International, 1*(4), 444–459. doi:10.1108/2040874101108258

Shaw, F., Asomugha, C., Conway, P., & Rein, A. (2014). The Patient Protection and Affordable Care Act: Opportunities for prevention and public health. *The Lancet, 384*(9937), 75–82. doi: 10.1016/S0140-6736(4)60259-2

Shaw, S. J., Huebner, C., Armin, J., Orzech, K., & Vivian, J. (2009). The role of culture in health literacy and chronic disease screening and management. *Journal of Immigrant and Minority Health, 11*(6), 460–7. doi:10.1007/s10903-008-9135-5

Sheingold, S. H., Zuckerman, R., & Shartzer, A. (2016). Understanding Medicare hospital readmission rates and differing penalties between safety net and other hospitals. *Health Affairs, 35*(1), 124–131A. doi:10.1377/hlthaff.2015.0534

Shih, T., Ryan, A. M., Gonzalez, A. A., & Dimmick, J. B. (2015). Medicare's hospital readmission reduction program in surgery may disproportionately affect minority-serving hospitals. *Annals of Surgery, 261*(6), 1027–1031. doi:10.1097/SLA.0000000000000778

Sirgy, M. J., Lee, D., & Yu, G. B. (2011). Consumer sovereignty in healthcare: Fact or fiction? *Journal of Business Ethics, 101(3),* 459–474. doi:10.1007/s10551-010-0733-5

Smedley, B. D., Stith, A. Y., Nelson, A. R., & Institute of Medicine (U.S.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academy Press. Retrieved June 28, 2016, from https://ebookcentral-proquest-com.contentproxy.phoenix.edu

Smith, R. W., Kuluski, K., Costa, A. P., Sinha, S. K., Glazier, R. H., Forster, A., & Jeffs, L. (2017). Investigating the effect of socio-demographic factors on 30-day hospital readmission among medical patients in Toronto, Canada: A prospective cohort study. *British Medical Journal Open, 7(12)*. doi:10.1136/bmjopen-2017-017956

Smith, S. K., & House, M. (2006). Snowbirds, sunbirds, and stayers: Seasonal migration of elderly adults in Florida. *The Journals of Gerontology, 61*(5), S232–S239. doi:10.1093/geronb/61.5.S232

Somers, J. M., Moniruzzaman, A., & Rezansoff, S. N. (2016). Migration to the downtown eastside neighbourhood of Vancouver and changes in service use in a cohort of mentally ill homeless adults: A 10-year retrospective study. *British Medical Journal Open*, 6(1). doi:10.1136/bmjopen-2015-009043

Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: SAGE Publications.

Stake, R. E. (2006). *Multiple case study analysis*. New York, NY: The Guilford Press.

Stone, A., Rogers, D., Kruckenberg, S., & Lieser, A. (2012). Impact of the mental health delivery system on California emergency departments. *Western Journal of Emergency Medicine, 13*(1), 51–56. doi:10.5811/westjem.2011.6.6732

Strom, J. B., Kramer, D. B., Wang, Y., Shen, C., Wasfy, J. H., Landon, B. E.,...Yeh, R. W. (2017). Short-term re-hospitalization across the spectrum of age and insurance types in the United States. *PLoS One, 12*, 7. doi:10.1371/journal.pone.0180767

Tanenbaum, S. J. (2009). Pay for performance in Medicare: Evidentiary irony and the politics of value. *Journal of Health Politics, Policy, and Law, 34(*5), 717–746. doi:10.1215/03616878-2009-023

The Joint Commission. (2013). *Hot topics in healthcare issue # 2: The need for collaboration across the entire care continuum.* Retrieved August 18, 2016, from https://www.jointcommission.org/assets/1/6/TOC_Hot_Topics.pdf

The National Institute of Mental Health (2015). *Mental health information and statistics.* Retrieved January 12, 2016 from http://www.nimh.nih.gov

The National Quality Forum. (2013). *NQF report of 2012 activities to Congress and the Secretary of the Department of Health and Human Services*. Retrieved August 18, 2016, from http://www.qualityforum.org/Publications/2013/03/2013_NQF_Report_to_Congress.as

The U.S. Department of Housing and Urban Development. (2017). *The 2017 Annual Homeless Assessment Report (AHAR) to Congress.* Retrieved March 21, 2018, from https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf

Thomas, J. & Harden,. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. BMC Medical Research Methodology. 8(45). doi: 10.1186/1471-2288-8-45.

Tompkins, C. P., Higgins, A. R., & Ritter, G. A. (2009). Measuring outcomes and efficiency in Medicare value-based purchasing. *Health Affairs, 28*(2), w251. doi:10.1377/hlthaff.28.2.

Treatment Advocacy Center. (2012). *No room at the inn: Trends and consequences of closing public psychiatric hospitals. 2005 – 2010.* Retrieved April 7, 2018 from http://www.treatmentadvocacycenter.org/storage/documents/no_room_at_the_inn-2012.pdf

Tubbs-Cooley, H. L., Cimiotti, J. P., Silber, J. H., Sloane, D. M., & Aiken, L. H. (2013). An observational study of nurse staffing ratios and hospital readmission among children

admitted for common conditions. *BMJ Quality & Safety*, *22*(9), 735–742. doi:10.1136/bmjqs-2012-001610

United States Census Bureau. (2011). *U.S. census bureau quick facts.* Retrieved April 7, 2018, from https://www.census.gov/search-results.html?q=Miami-Dade+County%2C+FL&page=1&stateGeo=none&searchtype=web&cssp=Typeahead

U.S. Department of Health and Human Services. (2017). *About the affordable care act*. Retrieved from https://www.hhs.gov/healthcare/about-the-aca/index.html

Vandermause, R. K., & Fleming, S. E. (2011). Philosophical hermeneutic interviewing. *International Journal of Qualitative Methods*, *10*(4), 367–377. doi:10.1177/160940691101000405

Willis, J. W. (2007). Worldviews, paradigms, and the practice of social science research. (pp.1). Thousand Oaks: SAGE Publications, Inc. doi:10.4135/9781452230108.n1

Yang, L., Liu, C., Huang, C., & Mukamel, D. B. (2018). Patients' perceptions of interactions with hospital staff are associated with hospital readmissions: a national survey of 4535 hospitals. *BMC Health Services Research*, 18(1), 50. doi:10.1186/s12913-018-2848-9

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

Zhang, D. J., Gurvich, I., Van Mieghem, J. A., Park, E., Young, R. S., & Williams, M. V. (2016). Hospital readmissions reduction program: An economic and operational analysis. *Management Science*, *62*(11), 3351–3371. Retrieved February 5, 2018, from https://www.kellogg.northwestern.edu/faculty/gurvich/personal/hrrp.pdf

Zoutman, D. E., & Ford, B. D. (2017). Quality improvement in hospitals: Barriers and facilitators. *International Journal of Health Care Quality Assurance*, *30*(1), 16–24. doi:10.1108/IJHCQA-12-2015-0144

Zuckerman, R. B., Joynt Maddox, K. E., Sheingold, S. H., Chen, L. M., & Epstein, A. M. (2017). Effect of a hospital-wide measure on the readmission's reduction program. *The New England Journal of Medicine*, *377*(16), 1551–1558. doi: 10. 1056/NEJMsa1701791

Appendix A: Interview Questions Before Field Test

1. Please describe your current role and position.
2. How long have you been serving in your current role?
3. Why is it important to reduce unplanned readmissions?
4. Why are patients with chronic medical conditions being readmitted to the hospital?
5. Why are unplanned readmissions a problem?
6. Why are there higher unplanned readmissions in your community?
7. How can healthcare leaders, clinicians, and nurses help to reduce unplanned readmission rates?
8. How effective are current processes to address the problem of unplanned readmissions?

Appendix B: Interview Questions After Field Test

1. Based on your experience with hospital quality initiatives, why are unplanned readmissions a challenge?
2. Based on your experience in hospital admissions, what are the three major conditions you see as reasons for patients with chronic medical conditions needing to be readmitted? (PROBE: In your view, out of every 10 patients with chronic medical conditions, how many are readmitted? How soon after discharge did readmission occur?)
3. Based on your experience in the field of healthcare, how effective are processes in reducing unplanned readmissions at your hospital. (PROBE: Based on your experience in the field of healthcare administration/hospital admissions/patient care in the state of Florida, are other communities having the same level or different levels of effectiveness with their current unplanned readmissions processes?)
4. How might current discharge processes become more effective in your hospital, based on your experiences with unplanned hospital readmissions?

Appendix C: Informed Consent

Dear _____,

My name is Kathleen Weatherspoon and I am a student at the University of Phoenix working on a Doctorate in Healthcare Administration. I am conducting a research study titled “Reducing Unplanned Hospital Readmissions: A Qualitative Exploratory Multiple-Case Study.”

The purpose of this qualitative exploratory multiple-case study was to explore the reasons for higher than expected unplanned hospital readmissions in healthcare facilities located in the tri-county area of south Florida to help hospital administrators to improve healthcare quality through reducing unplanned rehospitalizations. Irrespective of implementing best practices, methods, and standards of care, I believe there are other factors that prevent reductions in unplanned hospital readmissions. Data collected will identify in-depth common understandings from stakeholders who have knowledge of chronic medical conditions, and an understanding of the implications of unplanned hospital readmissions.

Your participation will involve completing and returning the signed informed consent form, accepting the terms outlined. Once received, I will contact you via email to arrange a 20 to 30 minute interview consisting of four semi-structured, open-ended questions. The interview will be conducted via GoToMeeting™ or at a meeting place of your choice. The interview will be audio recorded and transcribed within 24 to 48 hours and returned to you for your review.

After you begin to participate in the study, you may withdraw from it at any time without any penalty or loss of benefits, and any data collected will be eliminated from the study and destroyed. The results of the research study may be published, but your identity will remain confidential and your name will not be made known to any outside party. In this research, there are no foreseeable risks to you.

Although there may be no direct benefit to you, a possible benefit from your being part of this study is your contribution to the body of knowledge about unplanned hospital readmissions and an understanding of why they are higher in healthcare facilities located in Broward, Miami-Dade, and Monroe Counties located in south Florida.

If you have any questions about the research, please call me at (786) 972-0236 or email me at kjgw@email.phoenix.edu. For questions about your rights as a study participant or any concerns or complaints, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.

As a participant in this study, you should understand the following:

1. You may decide not to be part of this study or you may want to withdraw from the study at any time. If you want to withdraw, you can do so without any problems. To withdraw please send an email to kjgw@email.phoenix.edu stating that you wish to withdraw from the study, the date and time, and reason for withdrawal. I will reply with a confirmatory email within 72 hours.

2. Your identity will be kept confidential. Your interview responses and demographic information will be assigned a unique pseudonym by the researcher to ensure your anonymity.
3. Kathleen Weatherspoon, the researcher, has fully explained the nature of the research study and has answered all of your questions and concerns.
4. Interviews will be recorded and you must give permission for the researcher, Kathleen Weatherspoon, to record the interviews. The data will be coded to assure that your identity is protected.
5. Data will be kept secure on a password protected USB flash drive. The data will be kept for three years and then destroyed by crushing the password protected USB Flash drive.
6. The results of this study might be published.

"By signing this form, you agree that you understand the nature of the study, the possible risks to you as a participant, and how your identity will be kept confidential. When you sign this form, this means that you are 18 years or older and that you give your permission to volunteer as a participant in the study that is described here."

☐ **I accept the above terms.** ☐ **I do not accept the above terms.**

(CHECK ONE)

Participant email address_____

Signature of the research participant _____ Date _____

Signature of the researcher _____ Date _____

Appendix D: Demographic Questionnaire

Name_____

Preferred Email Address_____

Location of Healthcare Facility (Check one)

[ ] Broward County
[ ] Miami-Dade County
[ ] Monroe County

Question 1. What is your Age?

[ ] 21–30

[ ] 31–40

[ ] 41–50

[ ] 51–60

[ ] Over 60

Question 2. What is your Gender?

[ ] Male

[ ] Female

[ ] Choose not to respond

3. How Many Years of Experience do you have in Healthcare?

[ ] Less than 1 year

[ ] 1–5 years

[ ] 6–10 years

[ ] 11–15 years

[ ] 16–20 years

[ ] More than 20 years

4. Please Indicate your Current Role and Position.

Healthcare Executive/Leader

[ ] Chief Executive Officer

[ ] Chief Nursing Officer

[ ] Director

[ ] Other: Please Explain

Clinician

[ ] Physician

[ ] Advanced Registered Nurse Practitioner

[ ] Other: Please Explain

Nurse

[ ] Registered Nurse

[ ] Licensed Practical Nurse

5. How Long have you been Serving in your Current Role?

[ ] Less than 1 year

[ ] 1–5 years

[ ] 6–10 years

[ ] 11–15 years

[ ] 16–20 years

[ ] More than 20 years

6. An unplanned hospital readmission is when a patient is readmitted to the hospital within 30 days of discharge.

Does your job role cause you to make decisions related to unplanned hospital readmissions?

[ ] Yes

[ ] No

7. Chronic medical conditions are health conditions that last for more than one year and require ongoing medical management and/or negatively affect a person's ability to perform activities of daily living.

Do you provide care for patients with chronic medical conditions?

[ ] Yes

[ ] No