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The Feasibility of Transitional Psychiatric Care Service in a city with a population 20, 171 in a Midwestern State

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THE FEASIBILITY OF TRANSITIONAL PSYCHIATRIC CARE SERVICES IN A MIDWESTERN STATE

A Scholarly Project Submitted to the Graduate School
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An Abstract of the Scholarly Project by
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Psychiatric patients are a known vulnerable population. This population often ends up in a cycle of decline post-hospitalization that leads to rehospitalization. The purpose of this study is to establish the feasibility for bringing psychiatric transitional care services to the local community. The methods for the study include a qualitative analysis of common themes discussed from the presentation of the idea of transitional care services for this area to area mental healthcare providers. Using a qualitative approach, the project will involve conducting interviews with mental healthcare providers in a midwestern community via Zoom about the feasibility of transitional psychiatric care services for the area. The moderator will introduce the prompts throughout the Zoom to ensure that all participants were given the opportunity to comment on the same topics. Free discussion will be allowed until discussion for each prompt has ceased. Member checking will be done at the end of the meeting with the moderator summarizing the main ideas that were discussed in the group. Each group meeting will be audio recorded and transcribed verbatim. The author and a professional colleague will then review the transcripts separately to ensure reliability. The author and two professional colleagues will be reviewing the data to find commonalities and themes presented in the discussions. The focus groups will be conducted using a snowball effect until data saturation is obtained. Analysis will begin after the first interviews are completed and will continue until no new themes emerge from the analysis and the material is considered saturated.

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Chapter I

Introduction/Purpose

Psychiatric patients are a known vulnerable population around the world. When psychiatric patients are hospitalized, they often end up in a cycle of decline post-hospitalization that leads to rehospitalization. The purpose of this study is to establish the need for psychiatric transitional care services in a city with a population 20, 171 in a Midwestern State, which will be referred to as "the city studied" for the remainder of the paper.

Description of the Clinical Problem

The aftercare of psychiatric patients post-hospitalization has proven to be a world-wide issue. In fact, studies have been conducted in the United States, Canada, Japan, Iran, Nigeria, and Norway regarding this matter. A 2017 study conducted in Norway stated that 73% of psychiatric patients are readmitted within one year of discharge (Roos et al., 2017). Another study conducted in Iran that same year stated that 30-50% of psychiatric patients are readmitted within a year (Moradi-Lakeh et al., 2017). There are several reasons these patients keep coming back to the hospital. For one, transition periods between inpatient and outpatient treatments are a vulnerable time for those with mental illness (Forchuck et al., 2019). Additionally, disruption in the continuity of care during

this period hinders patient outcomes (Robert et al., 2018; Nwefoh et al., 2018; Forchuck et al., 2019). This disruption can lead to a gap in patient care (Forchuck et al., 2019).

Another problem regarding aftercare of psychiatric patients is the number of patients that miss their outpatient appointments. A 2018 Nigerian study listed the first-appointment default rate at 26-50% (Nwefoh et al., 2018). A study conducted in the United States that same year documented that approximately 40% of psychiatric patients do not attend an outpatient visit within a month of discharge as well (Robert et al., 2018).

These world-wide problems can also be seen locally. In the Midwestern city studied, there are no inpatient psychiatric services, only outpatient services are available. If someone in this community needs inpatient psychiatric services or a psychiatric urgent care, the closest available options are close to 30 miles away in a neighboring state. Additionally, there is nothing for the patients that fall in between such as transitional services. There are no local services that address those patients who are healthy enough to be discharged from inpatient care but may need more care than just outpatient services. This is concerning considering that previous studies have shown that up to 40% of these patients are not seen for outpatient services until over a month after discharge (Forchuk et al., 2018). This indicates the need for transitional psychiatric care services.

Significance

This problem affects patients, the nursing field, and broader society. These patients are in a vulnerable state after being discharged and are expected to go home and be responsible for follow up appointments and managing their mental health, including medications, when their mental health is in a compromised state. Many psychiatric patients who have been recently discharged end up in the emergency room multiple times

for mental health services in the days following discharge (Forchuck et al., 2019; Robert et al., 2018). This leads to them being readmitted to the hospital multiple times a year for the same problem (Forchuck et al., 2019; Robert et al., 2018). This not only costs the patient money but also costs the hospital money, beds, and other resources. The repeated use of emergency services, the multiple readmissions, the increase in healthcare expenditure by patients, are not only significant to the patient but also to the field of nursing (Forchuck et al., 2019; Robert et al., 2018). This problem is also significant to society because of increased healthcare expenditure on those patients. Healthcare dollars spent affect the patient, the hospital, and society as a whole.

Purpose

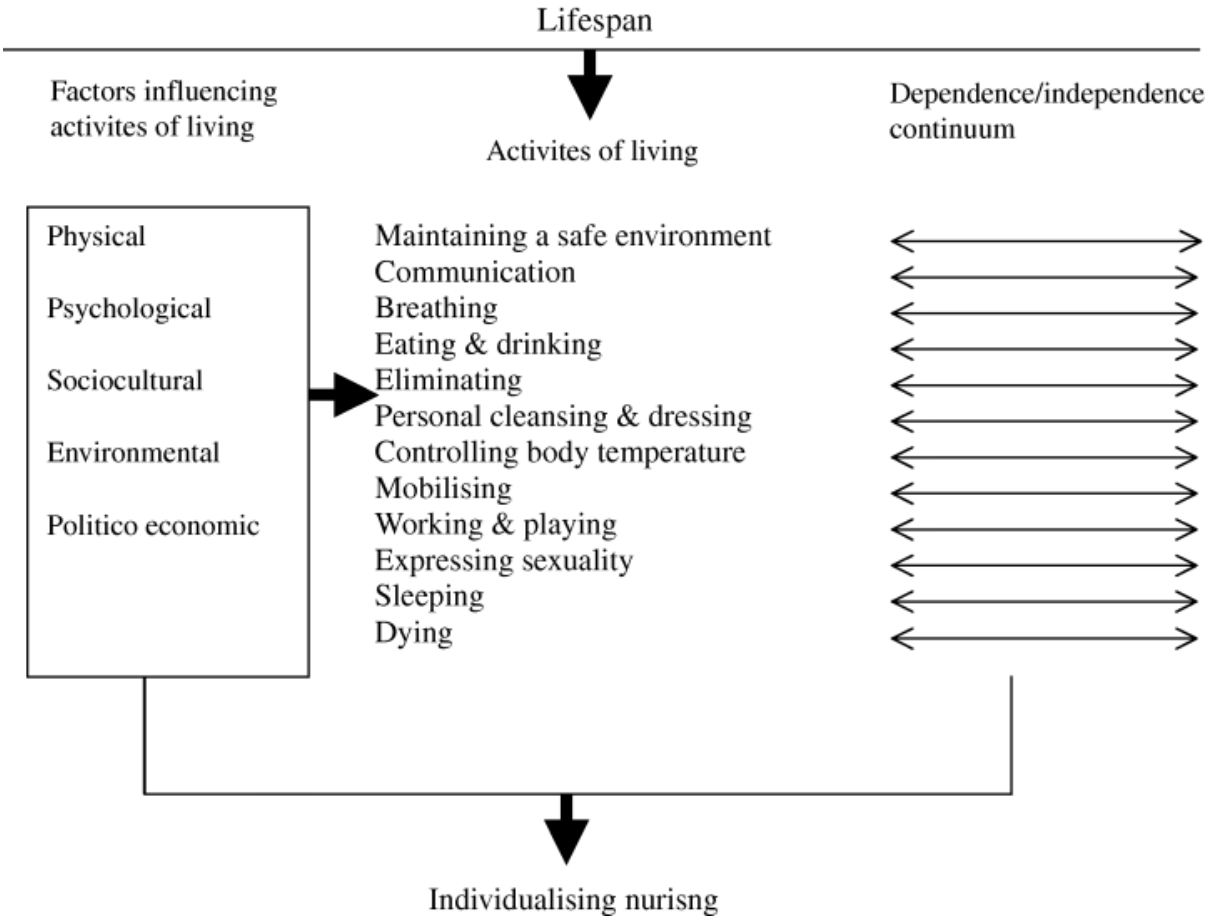
The purpose of this qualitative study is to explore the attitudes and perceptions of healthcare providers in a Midwestern city on the feasibility of transitional psychiatric care services for the area and what stakeholder, resources, and services are needed.

Theoretical Framework

A theoretical framework that correlates to the post-hospitalization care of the psychiatric patient is the Roper, Logan, Tierney Model of Nursing. This theory uses a checklist-like model to form a complete assessment of 11 different Activities of Daily Living (ADL) aspects, specifically how these ADLs have changed since an illness or hospitalization. Being able to perform ADLs is key for patients to continue their care in an outpatient setting. The ADLs are assessed on a continuum based on the patient's ability to complete them and their dependency on others in order to complete them. From there, the staff member can look at the areas in which the patient is most dependent in

order to identify where they need assistance and intervention in order to help them to gain the most independence possible. The checklist is meant to be used several times: on first visit, follow up visits, and upon discharge from the services to show whether the patient is improving. There are 11 ADLs that the model focuses on which include: maintaining a safe environment, communication, breathing, eating, elimination, washing and dressing, controlling temperature, mobilization, working and playing, death and sexuality, and sleeping. These 11 ADLs are influenced by five factors: biological, psychological, sociocultural, environmental, and politicoeconomic. If these five factors are ignored when trying to complete the checklist, the results would be considered incomplete or flawed (Petiprin, 2016). Using a checklist based off the Roper, Logan, Tierney Model of Nursing, the transitional care services will be able to identify which ADLs patients need assistance with and referral to community resources utilized. This model was selected because of its holistic approach as well as the fact that it focuses on the services needed in transitional care. A diagram of the model is shown in Box 1 below.

Figure 1: Roper, Logan, Tierney Model of Nursing



Roper, Logan, Tierney model of nursing. Reprinted

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Research Questions

1. Who are stakeholders for psychiatric transitional care services?
2. What services should be included in transitional psychiatric care?

3. What community resources are currently available that could be used toward psychiatric transitional care?
4. How would transitional care services be set up?
5. How would disparities in the most vulnerable populations be addressed?
6. What is the feasibility of bringing transitional care services to a city with a population 20, 171 in a Midwestern State?

Definition of Key Terms

Psychiatric patient: a patient who has been diagnosed with a mental illness that falls under criteria defined by the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5).

Transitional care services: the Level of Care Utilization System (LOCUS) scoring system for patients. LOCUS scores are based on a rating scale from a level 1 (recovery maintenance and health management) to a level 6 (medically managed residential services). For the sake of transitional care services, patients with LOCUS scores of level 2 (low intensity community based services), level 3 (high intensity community based services), or level 4 (medically monitored non-residential services) are eligible for the services (Sowers et al., 1999).

Activities of daily living (ADL): activities such as maintaining a safe environment, communication, breathing, eating and drinking, elimination, washing and dressing, controlling temperature, mobilization, working and playing, death and sexuality, and sleeping (Petiprin, 2016).

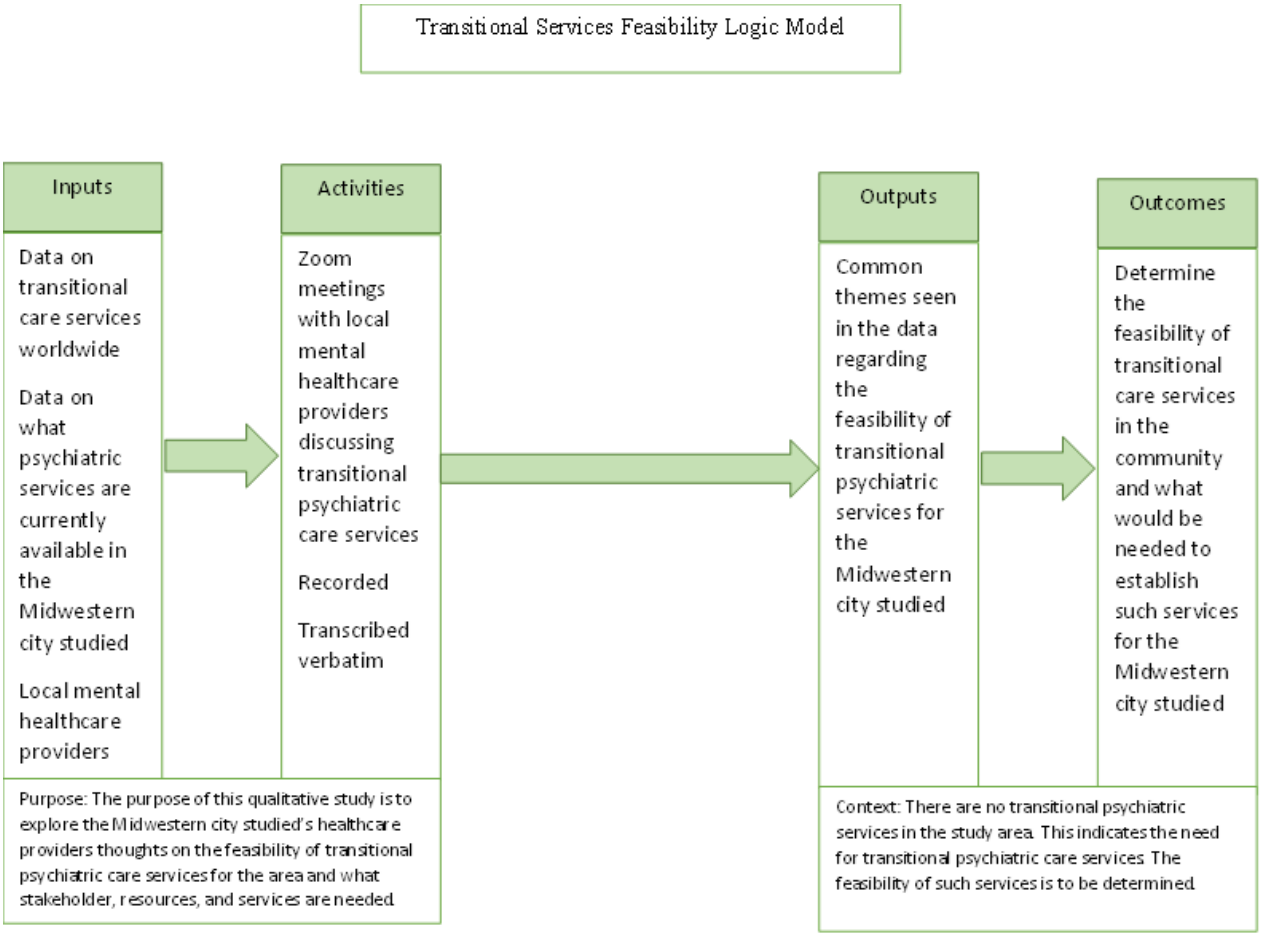
Mental healthcare provider: Those who provide mental health services to patients including but not limited to physicians, nurse practitioners, psychiatrics, and psychologists.

Community resources: community resources will include local transportation, housing, food, pharmacy, and other resources available in the Midwestern city studied.

Logic Model

The logic model for the feasibility of transitional care services can be found listed as Table 1 below.

Table 1: Transitional Services Feasibility Logic Model



Summary

There is currently no form of transitional care psychiatric services offered in the specified Midwestern city. Psychiatric patients in this area only have the option of outpatient services or inpatient services based out of a different location. As shown by previous studies, the transition period between inpatient and outpatient care is a vulnerable time for these patients (Forchuck et al., 2019). Additional studies have shown that these patients experience high readmission rates (Roos et al., 2017). The purpose of this project is to assess the feasibility of such transitional psychiatric services in the specified city.

Chapter II

Review of the Relevant Literature and Evidence

A comprehensive review of the literature was performed using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) database. Search terms included mental illness + step down, psychiatric + aftercare, mental health + post hospitalization, psychiatric + post hospitalization, mental health + aftercare, psychiatric + transitional care, psychiatric + discharge, and mental illness + hospitalization. All sources are from peer-reviewed journals from the last 20 years. The literature review was broken down into several segments including background, theoretical framework, vulnerable populations, reasons for missed appointments, and previously missed appointments. A total of 10 articles were included in the review.

Background

The aftercare of psychiatric patients post-hospitalization has proven to be a world-wide issue. In fact, studies have been conducted in numerous countries around the world regarding this matter. A 2017 Norwegian study stated that 73% of psychiatric patients are readmitted within one year of discharge (Roos et al., 2017). An Iranian study conducted that same year stated that 30-50% of psychiatric patients get readmitted within a one-year time frame (Moradi-Lakeh et al., 2017). There are numerous reasons psychiatric patients

keep presenting to the hospital, including the fact that transition periods between inpatient and outpatient treatments are a vulnerable time for those with mental illness (Forchuck et al., 2019). Additionally, as cited by numerous sources, disruption in the continuity of care during this period also hinders patient outcomes (Robert et al., 2018, 533; Nwefoh et al., 2018; Forchuck et al, 2019). This disruption can lead to gaps in patient care (Forchuck et al., 2019).

Another problem with aftercare of psychiatric patients is the number of patients that miss their outpatient appointments. A 2018 Nigerian study listed the first-appointment default rate at 26-50% (Nwefoh et al., 2018). Additionally, patients do not attend an outpatient visit within a month of discharge (Robert et al., 2018). This is important to the field of nursing because, when the psychiatric patient experiences discontinuity of care, they are more likely to increase the use of emergency medical services, which increases readmission rates, which in turn increases healthcare expenditures (Forchuck et al., 2019; Robert et al., 2018).

Application of Theoretical Framework

A theoretical framework that correlates to the post-hospitalization care of the psychiatric patient is the Roper, Logan, Tierney Model of Nursing. This model of nursing involves the use of activities of daily living (ADLs) such as: maintaining a safe environment, communicating, breathing, eating, eliminating, personal cleansing and dressing, controlling body temperature, improving mobility, working, playing, expressing sexuality, sleeping, dying. An example of how this theory applies to this situation would be the case study done in 2006 by Mooney and O'Brien on a patient with a history of drug abuse. Mooney and O'Brien specifically focused on the ADLs of maintaining a safe

environment, communicating, and breathing. With a multidisciplinary approach, the patient's plan of care was implemented, and the patient experienced a positive response (Mooney & O'Brien, 2006).

Vulnerable Populations

To begin the literature synthesis, the specialty populations that seem to have poorer outcomes post-hospitalization than other groups will be addressed. The first group, patients with a history of substance abuse, particularly cannabis and alcohol, were associated with poorer outcomes (Bahorik et al., 2013). In a quantitative, longitudinal study involving 801 participants by Bahorik and colleagues, (2013) the effects of substance abuse after hospital discharge in psychiatric patients was analyzed. Results of the study showed decreased alcohol and cannabis use in this population one-year following admission (Bahorik et al., 2013).

African American patients are another group with poorer post-hospitalization outcomes. In a quantitative longitudinal study by Eack and Newhill (2012) involving 925 participants, those participants who were African American displayed less improvement in their symptoms than their Caucasian counterpart, specifically, their mania and negative symptoms. Along with less improvement in their symptoms, significantly fewer African American participants were able to return to work following their hospital stay demonstrating poorer outcomes in a specific population of psychiatric patients post-hospitalization (Eack & Newhill, 2012).

Reasons for Missed Appointments

Understanding the reasons patients do not attend their first outpatient appointment is an important part of understanding the aftercare problem as a whole. Nwefoh and colleagues (2018) investigated the potential reasons as to why patients are missing this initial appointment by gathering quantitative data via questionnaire. Of the 311 participants, 25.7% did not keep their initial outpatient appointment (Nwefoh et al., 2018). The patients that missed their appointments were more likely to be males, non-Christians, rural dwellers, live alone, and lacking formal education (Nwefoh et al., 2018). Other contributing factors linked to missing the initial appointment include having to spend more money on transportation to the appointment, being accompanied by numerous people to the hospital, not paying their hospital bill upon discharge, and having a longer period from discharge to first appointment (Nwefoh et al., 2018).

Previously Attempted Solutions

Transitional Discharge Model

Throughout the years, several proposed solutions to this discontinuity of care for psychiatric patients have been tested. In Canada, a proposed solution was the Transitional Discharge Model which consists of two components. The first component consists of peer support from someone who has experienced a mental illness themselves, has completed a peer training program, and is living successfully in the community. The second component includes continued supervision and support by hospital staff until a new therapeutic relationship has been developed with a community healthcare provider and with the previously mentioned peer supporter (Forchuck et al., 2019). The implementation of TDM enhanced social connections and reduced length of hospital stay

which in return reduced costs of hospital expenses (Forchuck et al., 2019). This quantitative study involved 370 participants in 9 hospitals.

Comparison of Interventions

Another proposed solution in Iran used a randomized quantitative study. Through nonprobability sampling, a control group and an intervention group were selected. The intervention in this case involved 3 parts: (1) either a home visit or telephone follow up, or the use of both with the patient (2) psychological education of the caregivers, (3) and social skills training to the patients (Moradi-Lakeh et al., 2017). Results of the study showed that "patients who received community care had shorter wait time to receive services, had better continuity of care, and were more satisfied with the services they received. Health services costs were less for patients treated with community-based methods and the treatment was more cost-effective." (Moradi-Lakeh et al., 2017). The authors go on to explain that their intervention decreased the direct cost of care while increasing patient outcomes (Moradi-Lakeh et al., 2017).

Community Residential Aftercare Program

In Norway, a different proposed solution was to place patients in a Community Residential Aftercare program (CRA). The goal of this program was to reduce the time the patients, who normally would need public community services after discharge, spent in the mental health hospital after they were declared ready for discharge. This was done by supporting self-care and facilitating community health and social services." (Roos et al., 2017). Open 24/7 the CRA was staffed by psychiatric nurses, general nurses, and

nursing assistants and did not offer in-house activities. However, the facility did offer a general practitioner that stopped by once a week. The overall goal of the program was to enable clients to participate in activities in the community and to prepare them for independent living. The authors of this study took a qualitative approach to evaluating the CRA program and came up with five common themes based on the responses given by the participants: 1) Not what I expected; 2) Like a hotel, but boring; 3) Treatment, a place to rest, or preparation for independent living? 4) Coordination with other agencies; and 5) Use of self-referral stay" (Roos et al., 2017).

Short-term Residential Level of Care

The state of North Carolina had a similar proposed solution to the post-hospitalization care of psychiatric patients. The authors of this study referred to their program as a short-term residential level of care. This program was for patients who needed community care but were ready to be discharged from the hospital (Zarzar et al., 2017). Differences between this program and hospitalization include less documentation and staffing requirements. However, with those changes less funding was an issue. The authors performed a quantitative study on 38 patients in the short-term residential level of care. Of the 38 patients studied, 5 were re-hospitalized, 3 were sent to a state hospital, 15 were sent home, 7 were sent to a group home, 4 were sent to a homeless shelter, 2 were sent to assisted living, and 2 were sent to other residences" (Zarzar et al., 2017). Benefits to using this solution include reduced system costs and the fact that it results in available hospital and ER beds for acutely ill patients. The downfall to this solution is that Medicare and private insurance companies don't cover this type of care and the state didn't provide much reimbursement (Zarzar et al., 2017).

Transitional Care Clinic

One of the most detailed solutions found in the review of literature involved a pilot study conducted in Texas. Texas created the Transitional Care Clinic (TCC) designed to give patients rapid access to needed behavioral health services upon hospital discharge or emergency room diversion to provide gap services for up to 90 days and to aggressively link these individuals with existing community services for longer term follow up care. The TCC also functioned as a specialty training program in community mental health. (Robert et al., 2018).

This program allowed for patients to get connected to care as soon as they were discharged. To make this happen, the TCC has an outreach coordinator who attempts to initiate contact while patients are still admitted or as soon as possible. The program also included a HIPAA compliant online referral program that allowed the referring hospital to schedule initial appointments for the patients. Another important aspect of the program it that it used a group intake process yet focused on individualized care. The TCC would see anyone regardless of insurance status. At the TCC, "each group member speaks one-by-one in a 5-10 min discussion about their reasons for presenting to the facility that referred them, the kind of difficulties they have been having, and how they would like the TCC to help" (Robert et al., 2018, p 535). Services offered at the TCC included psychiatric evaluation, follow up by a prescriber, psychologist and counselor visits, in-home wrap around services, and case management.

Although most of the time spent at TCC was in a group, each patient was involved in their own care via a shared decision-making process where the patient and staff select what services they thought the patient would benefit best from trying. Once the patient agreed on services, they completed an individual check out which includes a person directed plan that lists the person's individual appointments, groups, classes or services and a suicide risk assessment. (Robert et al., 2018). Although this solution showed much promise, there was limited data to be evaluated. Patients in this study rated the TCC a 4.4/5 on a Likert-type scale (Robert et al., 2018).

Maintaining Inpatient Care Longer

Aside from the proposed solutions, another factor to consider for psychiatric patients is what is keeping them in the hospital. A quantitative study in Japan looked at factors that kept psychiatric patients in the hospital. "The logistic regression analysis with age and the Occupational Self-Assessment scale results as independent variables revealed only age to be a significant factor associated with hospital discharge." (Ishikawa & Okamura, 2018, p 232). Therefore, the authors showed that being elderly alone is a key factor in lengthened hospital stays for psychiatric patient.

Summary

As previously stated, psychiatric care post-hospitalization is a global problem. It is multi-faceted and involves numerous suggested solutions. Data on these solutions is very limited and most of these solutions have not been replicated at this time. Finding data on psychiatric patients post-hospitalization is very limited to begin with. There seems to be a lack of knowledge on this topic in the nursing field. With the data available

and knowledge of the local community, this proposed project looks to assess the feasibility of bringing transitional care services to the city studied.

Chapter III

Methods/Plan

Currently there are no forms of psychiatric transition care services in the city studied, and the need for such services can be seen by the limited available psychiatric services in the area. The focus of this chapter was the development of a feasibility study regarding psychiatric transitional care services for the local community. It includes the sample/target group, methodology, and common theme analysis. The methods used for this project include a qualitative analysis of common themes discussed from the presentation of the idea of transitional care services for the study area to area mental healthcare providers. The goal for the project was to determine the feasibility of the development of transitional psychiatric care services for the Midwestern city studied.

Project design

Using a qualitative approach, the project involved conducting individual interviews with mental healthcare providers in the study area via Zoom. The topic of each group was the feasibility of transitional psychiatric care services for the area. The moderator introduced the prompts throughout the Zoom to ensure that all participants were given the opportunity to comment on the same topics. Prompts included during the discussion were: Who are stakeholders for psychiatric transitional care services? What

services should be included in transitional psychiatric care? What community resources are currently available that could be used toward psychiatric transitional care? How would transitional care services be set up? How would disparities in the most vulnerable populations be addressed? What is the feasibility of bringing transitional care services to this city? Free discussion was allowed until discussion for each prompt ceased. Member checking was done at the end of the meeting with the moderator summarizing the main ideas that were discussed in the interview. Each individual interview was audio recorded and transcribed verbatim. The author along with Professional Colleague A then reviewed the transcripts separately to ensure reliability. Both the author along with Professional Colleague A and Professional Colleague B reviewed the data to find commonalities and themes presented in the discussions. The individual interviews were conducted using a snowball effect until data saturation was obtained. Analysis began after the first interviews were completed and continued until no new themes emerged from the analysis and the material was considered saturated.

There were multiple steps to the analysis of the data. The first step of the analysis involved the author and Professional Colleague A separately reading the transcribed transcripts with an open mind to obtain a general impression and to identify preliminary themes. In the second step, the transcribed meetings were reviewed line by line to identify meaning units, which were classified and sorted into the preliminary themes. It was during this step that the authors began to discuss themes and subthemes together. In the third step, the meaning units within each subtheme were reduced as far as possible to

facilitate further sorting between the subthemes. In the final step, a final sorting of subthemes into the main themes was finalized. Professional Colleague B then reviewed and verified the main themes.

Sample/Target Population

The sample/target population of this project was mental healthcare providers in the city studied. Recruitment was done via a snowball sampling technique by asking those initially invited to provide contact information for others who might become participants in the project.

Recruitment

Recruitment began initially by reaching out to professional contacts residing in the project area via email request. Email requests included a brief explanation of the project and its goals as well as consent to publish the data obtained (See Appendix A). From there, a snowball sampling technique was employed by asking those initially invited to provide contact information for others who might become participants in the project. The county mental health clinic and the local federally qualified health clinic were also contacted by phone regarding the author speaking at their provider meetings about the study, in order to gain more participants, but return calls on the matter were never received. For all agreeable participants, multiple Zoom meeting links were sent via email to them with different dates and times in order to participate in an individual interview for this qualitative study. Generalizable demographic information was obtained including sex, race, age, years of experience, and licensure.

Inclusion/Exclusion Criteria

Inclusion criteria required that respondents currently work directly with psychiatric patients in the healthcare setting in the study area. Exclusion criteria included individuals under the age of 18 and anyone who does not work directly with psychiatric patients in the healthcare setting in the Midwestern city studied.

Protection of Human Subjects

Protection of the human subjects was obtained by collecting minimal participant information including sex, race, age, years of experience, and licensure. No further identifying information was collected or maintained. IRB approval for the feasibility study was sought by submitting an IRB application to the Irene Ransom Bradley School of Nursing for expedited review. Upon receipt of approval by the Nursing IRB committee, the study was then submitted to the PSU IRB committee where approval was also received.

Instrument

This project utilized multiple individual interview online Zoom meetings which were audio recorded and transcribed verbatim. Participants who responded to the authors request for participation waived consent. Demographics, including sex, race, age, years of experience, and licensure were obtained as part of a web survey that was sent at the end of the Zoom meetings. The decision was made to include respondents who currently work directly with psychiatric patients. Mental healthcare providers included in the Zoom meetings included a licensed psychologist, a psychiatric nurse practitioner, a licensed clinical psychotherapist, and a licensed clinical professional counselor.

A semi-structured question and answer session was utilized. After Zoom meeting introductions, the author began with an introduction of the project and what led them to that area of study. After the initial introduction, several prompts were given to the participants to freely discuss. The following prompts were used: Who are stakeholders for psychiatric transitional care services? What services should be included in transitional psychiatric care? What community resources are currently available that could be used toward psychiatric transitional care? How would transitional care services be set up? How would disparities in the most vulnerable populations be addressed? What is the feasibility of bringing transitional care services to the specified city? Following each prompt, free discussion was allowed until discussion from the participant ceased. The author then presented data at the end of the session on transitional psychiatric services around the world. Each Zoom meeting was audio recorded. Notes from each meeting were transcribed verbatim by the author. Common themes among the notes were identified and included in the feasibility report.

Resources required to complete this project included technology and personal time. Current technology required included a computer in order to send email requests for attendance, Zoom meeting links, and web surveys. Active internet was also needed in order to get on the Zoom meeting links, and the Zoom app. Internet access was vital in order to conduct the Zoom meetings that were used to gather information and feedback. Personal time and effort by the author were also required.

Participants were invited to participate in the individual interview Zoom meetings via personal invitation via email from the author. For those invited via email, a personal

email was sent to the participant that includes a brief description of the project. By agreeing to participate in the Zoom meetings, consent for the project was implied. All contact was made personally by the author and directly to each participant. Participants included mental healthcare professionals that work directly with psychiatric patients in the specified city.

Conclusion

Multiple individual interviews via Zoom meetings were conducted with mental healthcare professionals that directly work with psychiatric patients in the study area. All participants speak English as their primary language and were over 18 years old. All participants were contacted directly by the author and participated voluntarily in the project without coercion. No tool could be found regarding the subject matter, so a qualitative approach was taken to observe themes and implicate them into the project design.

Chapter IV

Results and Discussion

The objective of this qualitative study was to determine the feasibility of psychiatric transitional care services for a specified Midwestern city. One hour Zoom interviews were conducted with each of four area mental health services providers. The interviews were transcribed and analyzed using a multi-step approach. First, the author and Professional Colleague A separately read the transcribed transcripts to obtain a general impression and to identify preliminary themes. In the second step, the transcriptions were reviewed line by line to identify meaning units, which were classified and sorted into the preliminary themes. During this step the authors began to discuss themes and subthemes together. In the third step, the meaning units within each subtheme were reduced as far as possible to facilitate further sorting between the subthemes. In the final step a final sorting of subthemes into the main themes was finalized. The main themes were reviewed and verified by a second professional colleague. Six themes emerged from the data: 1) need for case management; 2) need for reimbursement; 3) key stakeholder collaboration; 4) need for housing; 5) need for inpatient care; and 6) need for psychiatrists.

Demographic Data

Four respondents agreed to be individually interviewed via Zoom. Each of the four respondents represented a different healthcare entity in the community that provides mental health services for patients including the local university, the community hospital, the local federally qualified healthcare center, and the county mental health center. All four participants were Caucasian; 2 were male and 2 were female. One participant was between the ages of 25-34. One participant was between the ages of 35-44, and two participants were between the ages of 45-54. Of the four participants, one had between 5-10 years' experience working in their field, and three had 15-20 years' experience. Professional licenses held by the respondents include that of a licensed psychologist, a psychiatric nurse practitioner and registered nurse, a licensed clinical psychotherapist, and a licensed clinical professional counselor.

Who are Stakeholders for Psychiatric Transitional Care Services?

The question was answered by Theme 3: Key Stakeholder Collaboration. The importance of key stakeholder collaboration to bringing transitional care services to the study area, was an element with unanimous agreement. While all participants agreed that key stakeholder collaboration would be essential for transitional care services to succeed in the area, each participant differed on who they believed those key stakeholders to be. When asked about key stakeholders, one participant listed the county mental health clinic, along with the Midwestern city studied, as well as the citizens of said city, specifically those who own rental properties. Another participant listed the key stakeholders as the community hospital, the county mental health clinic, the local federally qualified health center, along with private practice mental healthcare providers.

A third participant believed key stakeholders to be the community hospital, the university, the county mental health clinic, and the local federally qualified health center, however, they pointed out that getting all four facilities to work together may be a challenge. The fourth participant in the study believed that the stakeholders for transitional care services expanded farther than just the facilities represented in the study stating, “So the stakeholders, when you look at the definition of stakeholders, anybody who could be impacted by this. Everyone… I mean that’s, those are the stakeholders. It’s everyone.” While all participants varied on who they believed the stakeholders for transitional care services were, they all agreed that the stakeholders will have to work together for transitional care services to be a success in the specified city.

What Services Should be Included in Transitional Psychiatric Care?

This question was answered over several themes, including Theme 1: Need for case management. The need for case management was unanimously discussed as an essential piece for transitional care services to be brought to the study area. One respondent stated, “I think … case management, is a huge point to that. Now in order to qualify for case management, there are a lot of factors that go into that that’s complicated. But for me that case management piece is huge because it’s an accountability piece, and so that person is accountable to continue their meds, that person is accountable to make sure they are going to their appointments, and things like that, and so any sort of patient advocate I think is going to be a huge part in that, is making sure that they are staying on track. I think that’s going to be a huge part of it.”

While all four participants agreed that case management would be necessary for transitional care services to succeed in the area, one participant pointed out that these

services are offered at a very limited capacity stating “when you look at… behavioral healthcare in general, …a very large component of severe and persistent mental illness, …is case management. …so, case management and the social determinants of healthcare. When you look at the overall impact of psychiatry, …so the impact of my job when I put on my psych NP hat, …that accounts for about 20-30% of patient outcomes at best… so we’re looking at another 70-80% of social determinant support, …case management, …transitional housing, all of those things, all of which are not offered in [Midwestern state]. … [W]ell, let me restate that. All of those things are offered at a significantly reduced capacity compared to what the demand is in [study area].” That participant went on to point out that current state legislation only allows for community-based mental healthcare centers to be able to code for case management to be reimbursed for such services, therefore limiting the amount of case management services available in the state since other mental healthcare providing facilities cannot be reimbursed for the service.

Theme 4: Need for housing, also addressed this question. Housing was another topic that several of the participants believed to be key to bringing transitional psychiatric services to the study area. Several participants pointed out that the study area doesn’t have a homeless shelter. One participant discussed how this is problematic for homeless patients who are transitioning from being hospitalized at the state level for mental illness since the state hospital requires a plan to be in place before discharging these patients. Because the specified city doesn’t have a homeless shelter, these patients then get displaced to another city in state that is approximately 45 miles away or a city that is approximately 30 miles away, but in another state, where the closest homeless shelters are. While the participants agreed that the study area could benefit from a homeless

shelter, one participant pointed out the challenge of gaining community support for such a shelter stating, “Just like there’s some people within [Midwestern state] who believe that if you build a homeless shelter here, it’ll attract more homeless people. If you build a place where people can go shower, it will attract more people coming into this area, flooding this area of homeless people. I’m here to tell you, they are here.” Overall, the study area’s lack of homeless shelter and available housing are issues that participants believe would need to be part of transitional care services.

This question was also addressed in Theme 5: Need for inpatient care. Another aspect of mental healthcare that the participants found lacking in the study area, was their lack of an inpatient mental health unit. Several participants pointed out that a city approximately 30 miles away, in a neighboring state, has the closest inpatient unit. However, patients who are involuntary or patients who rely on the state for insurance, cannot cross state lines. The next closest inpatient unit is at the state hospital in a city approximately 88 miles away. When discussing the distance from the study area to these inpatient hospitals, one participant discussed how this affected their facility because their facility has to send staff over to transport these patients back to the specified city.

Theme 6: Need for Psychiatrists, also answers this research question. Multiple participants pointed out the lack of psychiatrist in the study area. One participant reported that they have been actively trying to bring a psychiatrist to the area for a long time and that the community hospital hasn’t had a psychiatrist employed in 7 or 8 years. When discussing what they believed should be included in transitional care services, one participant stated, “I think a important piece would be, would be the medicine piece.” The lack of psychiatry to the area was a great concern of multiple participants, with

several indicating that psychiatric services would need to be a part of transitional care services for the area. Overall, the participants agreed mental healthcare services in the area could benefit from more case management, housing options, psychiatrists, as well as an inpatient psychiatric unit.

What Community Resources are Currently Available that Could be Used Toward Psychiatric Transitional Care?

Theme one briefly answered this question when one participant addressed offering case management services at their facility and how difficult it was to qualify for them. This question was also addressed within theme four when the participants discussed the transitional housing currently in place in the study area. Currently one facility represented in the study offers transitional housing, which was full to capacity at the time of this study. One participant discussed the difficulty of getting people out of transitional housing once they are in it, not because of their behavior, but because of limited resources. The participant went on discuss how they have funds to help people pay for rent but can't find rentals to help place the patient into. They also discussed how, even if they can find a rental for the patient, the patient may not be able to afford the utility bills and other expenses that come with the rental, so that brings about additional challenges as well

In theme 6, it was mentioned that only one facility in the specified city currently has a single psychiatrist. Because there is only one psychiatrist in the study area, the participants discussed how the medical side of mental health mostly falls on the primary care providers in the community. The city studied does have case management, housing assistance, and psychiatry available, but at a very limited capacity for the city's needs.

How Would Transitional Care Services be Set up?

While it has previously been identified which services should be included in transitional care services for the study area, how they should be set up brought about different answers, most of which pointed to previous failures. In theme five, one participant discussed that the study area used to offer inpatient psychiatric services, but that they were discontinued in December of 2006. They went on to further discuss how the county has unsuccessfully tried to get inpatient services back in the area in the past, stating "Yeah they do a, …like a needs assessment for the county, I think every three years and, …every three years that they do it, mental health is one of the top three, if not the top two and drawn out of that a few years ago, … it was actually quite a few years ago, it might have been like 2012, but we formed a committee to start looking for a place for inpatient psych, and we toured facilities, we, … at that point they didn't want it in the hospital, [the county]. So we toured facilities, we met with, … groups that come in and start units and can run units for you, and then it just kind of faded and went away." The study area's need for inpatient services was emphasized by several participants.

Theme six also helped to answer this research question. When discussing the need for a psychiatrist, one participant discussed previous failed attempts to do so. They went on to explain how the hospital tried to hire locums, but ultimately the facility had to drop psychiatry from the services offered. While none of the participants had an answer for how to set up transitional care services, they did bring about important failed attempts in the past to help avoid repeating history.

How Would Disparities in the Most Vulnerable Populations be Addressed?

This question was also answered over multiple themes. While in theme four, the need for a homeless shelter in the study area was brought to the forefront by participants, thus addressing the vulnerable population of the homeless, theme two also addressed a vulnerable population, those with comorbid substance abuse disorders. As discussed in Chapter 2 of this paper, those with a history of substance abuse are associated with poorer outcomes (Bahorik et al., 2013). In theme two, one participant discussed the need for equal reimbursement from insurance companies for addiction treatment services. The participant stated, "We need addiction treatment parity when it comes to reimbursement for services. So… there was a lot of laws that looked at behavioral health parity, …basically that insurance plans …would cover behavioral healthcare. There are some insurance plans out there that will not cover addiction treatment. …[S]o there is not parity of addiction treatment services, but if you look at some of the greatest risk and some of our highest risk patients, those are the ones with comorbid substance abuse as well as a behavioral health issue. And in behavioral health it is incredibly difficult to treat one and not the other, and that's what we're asked to do by some insurance providers." Both the vulnerable populations of the homeless and those who suffer from substance abuse were addressed by the participants, who included ideas on how to best address these groups.

What is the Feasibility of Bringing Transitional Care Services to a City with a Population of 20, 171 in a Midwestern State?

Each of the six themes plays a role in the feasibility of transitional care services for the study area. Theme one featured the current case management available in the area

and the need for more in order to make these services work, while theme three discussed the need for key stakeholder collaboration in order to bring such services to the area. Theme four addressed what housing was available and the need for more to be provided with transitional care services. Then, themes five and six discussed the lack of an inpatient unit and psychiatrists in the area and the need for both. Every theme can answer this research question.

While this question can be answered by all of the previous questions and every theme brought about in the study, it is important to highlight Theme 2: Need for reimbursement here. The Midwestern state studied has specific challenges in place at the state level. The first topic for the need for reimbursement looked at case management services. As previously stated, this Midwestern state's laws prohibit the use of case management codes outside of community-based mental healthcare centers. Participants discussed how their facilities have demonstrated a willingness to provide such services to the community, but an amendment to the state constitution does not allow for that. One participant stated, "the challenge is that, when you look at an FQHC (Federally Qualified Healthcare Center), we provide wholistic care for the entire body, and behavioral health and addictions is a small part of that. And, for that reason, that is why we are not permitted access to behavioral health case management codes at a [state] level. Which is an absolute shame for the people who need the services because we demonstrated a willingness and ability to expand behavioral healthcare." Along with case management, transitional housing was also brought up when discussing reimbursement. One participant stated, "we're also limited on offering transitional housing as an FQHC. That's not a reimbursable structure for us. …[S]o once again, …how do we subsidize something that

we receive zero revenue for despite significant costs?" All six themes identify the feasibility of bringing transitional care services to the study and the needs of the area in order to do so.

Summary

After analysis of the data from individual interviews, six final themes were identified by the author and professional colleague number one and finalized by the author, professional colleague number one, and professional colleague number two. These themes emerged from the interviews via Zoom with current mental healthcare providers in the city studied based on their real-life experiences and challenges.

Chapter V

Conclusion and Recommendations

The purpose of the qualitative study was to determine the feasibility of bringing transitional psychiatric care services to the specified city through individual interviews with mental healthcare providers in the study area. This chapter explains the project's implications for nursing, strengths and limitations, and recommendations for future research. Data collection was guided by a semi-structured question and answer sessions with each participant using the following prompts: Who are stakeholders for psychiatric transitional care services? What services should be included in transitional psychiatric care? What community resources are currently available that could be used toward psychiatric transitional care? How would transitional care services be set up? How would disparities in the most vulnerable populations be addressed? What is the feasibility of bringing transitional care services to the specified city?

Nursing Implications

The aftercare of psychiatric patients following hospitalization has proven to be a world-wide problem. Multiple international studies have shown that a majority of psychiatric patients are readmitted to the hospital within a year of discharge (Roos et al., 2017; Moradi-Lakeh et al., 2017). There are several reasons these patients keep coming

back to the hospital, the first being that the transitional period between inpatient and outpatient treatments is a vulnerable time for psychiatric patients (Forchuck et al., 2019). Additionally, patient outcomes may be impeded due to disruption in the continuity of care during this time period (Robert et al., 2018; Nwefoh et al., 2018; Forchuck et al., 2019). Such a disruption leads to a gap in patient care (Forchuck et al., 2019). This is important to the field of nursing because, when the psychiatric patient experiences discontinuity of care, they are more likely to increase the use of emergency medical services, increasing readmission rates and healthcare expenditures (Forchuck et al., 2019; Robert et al., 2018).

The specified city is no exception to this worldwide problem. This qualitative study explored the feasibility of bringing transitional psychiatric care services the specified city by individually interviewing current mental healthcare providers in the study area using a semi-structured question and answer session. The findings of the study illustrated the unique needs of the study area regarding needed transitional care services. These findings included the need for case management, reimbursement, key stakeholder collaboration, housing, inpatient care, and psychiatrists. These identified needs of the Midwestern city studied help to better outline what future transitional care services for the area should include. The goal of transitional care services is to decrease emergency medical services, decrease readmission rates, and decrease healthcare expenditures. It is the hope of the author that this study will be used as the first step in taking action to bring transitional care services to the study area in order to see these changes happen.

Strengths and Limitations of Study

The qualitative study was an effective method to explore the feasibility of bringing transitional psychiatric care services to the specified city. This study design allowed for input from local mental healthcare providers regarding the feasibility of bringing transitional care services to the study area, who the stakeholders would be for said services, what resources are currently available to put towards such services, what services the providers believed should be included in such services, how the services should be set up and how the services would address disparities. This free expression allowed the mental healthcare providers to express their thoughts and share their experiences of working in the study area. The accommodation and willingness to participate in an individual interview regarding the topic of transitional care services was a strength. All participants were allowed to participate via Zoom meeting with the author at their own time and date convenience. Interviews were done in a private atmosphere allowing the participant to feel comfortable to share their thoughts and experiences, which also allowed for longer interview times as needed.

Another strength to the study was the variety of participants. The four participants represent different local mental healthcare facilities, there was an equal distribution of male and female participants, all four participants held different professional licenses within the mental healthcare field, and there was a wide age range represented.

One limitation of the study was the small sample size. Four mental healthcare providers were interviewed, representing four different facilities in the city studied that provide mental health services. Although this number is acceptable for qualitative research and data saturation was achieved, the researcher believes that further themes

could have emerged with more participants. The author did reach out to the two main facilities that provide mental healthcare in the sample area by phone to try to obtain more participants but did not receive a return call. The author also reached out to five other potential participants via email that did not respond as well.

Another limitation to the study is that all participants were Caucasian. An additional limitation would be the time available for the researcher to complete the research study. Data was collected over a 2-month period. Additional data collection after initial analysis was not possible due to the time constraint.

Recommendations for Future Research

The need for additional mental health care services for the Midwestern city studied is evident based on responses from participants during the interviews. Within several of the themes, there are many areas that need to be explored in the future. One future research recommendation is exploring potential reasons for why there is a lack of psychiatrist in the area, taking an in depth look at what psychiatrists would need in order to come to the study area.

A second area for additional research could be the creation of a business model of an inpatient unit in the study area that considers previous failed attempts and what would be needed to make this happen. Additionally, another area for additional future research is the creation of a business model for a homeless shelter or additional transitional housing for the city studied that considers the community's feelings on such, and what would be needed to make this happen.

A fourth research recommendation would be to compare case management reimbursement across multiple states to see how the Midwestern state compares to surrounding states and if this is a state issue or a federal one. A fifth and final future research recommendation would be a business model for transitional psychiatric services for the city studied taking all of the current data into account and incorporating all important aspects to care that have been identified.

Conclusion

The aftercare of psychiatric patients post-hospitalization has proven to be a world-wide issue. Several studies around the world have shown that a majority of psychiatric patients are readmitted within one year of discharge from the hospital (Roos et al., 2017; Moradi-Lakeh et al., 2017). There are numerous reasons psychiatric patients keep presenting to the hospital, including the fact that transition periods between inpatient and outpatient treatments are a vulnerable time for those with mental illness (Forchuck et al., 2019). Additionally, disruption in the continuity of care during this period also hinders patient outcomes (Robert et al., 2018, 533; Nwefoh et al., 2018; Forchuck et al, 2019). This disruption can lead to gaps in patient care (Forchuck et al., 2019). This is important to the field of nursing because, when the psychiatric patient experiences discontinuity of care, they are more likely to increase the use of emergency medical services, which increases readmission rates, which in turn increases healthcare expenditures (Forchuck et al., 2019; Robert et al., 2018).

The city studied shares this problem of needing transitional psychiatric services with the rest of the world. However, the qualitative study conducted to determine the feasibility of bringing such services to the area showed the study area's unique needs.

Data drawn from individual interviews with current mental healthcare providers in the study area has shown the need for case management, reimbursement, key stakeholder collaboration, housing, inpatient care, and psychiatrists. The need for additional psychiatric services in the city studied is evident. It is the author's hope that this study will be the first step to making these unique needs evident so that action can be taken to address them and that additional psychiatric services can someday come to the study area.

Resources

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APPENDIX

Hello. My name is Aubri Ashbacher. I am currently a DNP student at Pittsburg State University completing research on the Feasibility of Transitional Psychiatric Services in a city with a population 20, 171 in a Midwestern State. You have been identified as working with psychiatric patients in the study area. I would like to invite you to participate in a Zoom focus meeting and survey discussing the need for transitional psychiatric services in the area. Your participation would be completely voluntary. I would also ask that if you have others who serve in a similar capacity who may be interested in participating in the focus groups and survey to share my contact information or provide me with their contact information.

Thank you for your time,

Aubri Ashbacher