Scientific Research Publishing

Open Journal of Business and Management, 2026, 14(5), 2672-2708
https://www.scirp.org/journal/ojbm
ISSN Online: 2329-3292
ISSN Print: 2329-3284

Strategies Used by Psychiatric Hospital Directors to Reduce Readmission Rates, Increase Revenue and Improve Patient Outcomes

K'chinwe Ezeokoli, Kim A. Critchlow

College of Management and Human Potential, Walden University, Minneapolis, USA
Email: kim.critchlow@mail.waldenu.edu

How to cite this paper: Ezeokoli, K., & Critchlow, K. A. (2026). Strategies Used by Psychiatric Hospital Directors to Reduce Readmission Rates, Increase Revenue and Improve Patient Outcomes. *Open Journal of Business and Management, 14,* 2672-2708.
https://doi.org/10.4236/ojbm.2026.145136

Received: July 20, 2026
Accepted: August 30, 2026
Published: September 2, 2026

Abstract

High psychiatric readmission rates threaten patient stability, strain hospital finances, and reduce community wellbeing. Psychiatric hospital directors and policymakers need effective strategies to lower readmissions. Grounded in complex adaptive systems theory and the balanced scorecard framework, the purpose of this qualitative pragmatic inquiry project was to identify and explore effective strategies used by psychiatric hospital directors to reduce readmission rates, increase revenue, and improve patient outcomes. The participants were seven psychiatric hospital directors who had implemented strategies for reduced readmission rates. Data were collected through semistructured interviews and relevant public documents. Using thematic analysis, five themes were identified: (a) readmission tracking task force, (b) operation within the state budget, (c) timely and effective discharge planning, (d) multidisciplinary team approach, and (e) readmission rate reductions. Key recommendation include for psychiatric hospital directors to understand the relationships among the variables in the discharge planning system, set short- and long-term goals and objectives, measure the outcomes and adjust as needed. The implications for positive social change include the potential for psychiatric hospital directors and organizations to implement the identified strategies, thereby reducing readmission rates, improving patient outcomes, and increasing revenues that can be used to help create healthy communities. Additionally, the implications may contribute to promoting the systematization of key processes within psychiatric hospitals to inspire and motivate stakeholders to work towards improving services to improve patients' outcomes.

Keywords

Artificial Intelligence, Ethical AI Adoption, Responsible Innovation, AI

Governance, Data Governance, Human Oversight, Workforce Training, Continuous Monitoring, Qualitative Pragmatic Inquiry

1. Introduction

Psychiatric patient readmissions present a significant challenge for facility administrators within the healthcare system, often leading to substantial financial burdens and suboptimal patient outcomes. Cabello-Rangel et al. (2024) defined *readmission* as any admission to the same hospital after discharge, noting that it can adversely affect health outcomes. The definition of *readmission* that was used for this research was unplanned admissions to any hospital within a 30-day period after discharge. High hospital readmission rates are a concern, with approximately 20% of patients being readmitted within 30 days of discharge, costing the healthcare system an estimated $26 billion annually (Glance et al., 2017). High levels of hospital readmissions correlate with unfavorable patient outcomes while imposing significant financial burdens on healthcare facilities (Mcllvennan et al., 2015). Weiss and Jiang (2021) reported that the national average readmission rate was 14% based on data from 2018, resulting in nearly 4 million hospital readmissions. The ramifications of elevated hospital readmission rates indicated that such rates could result in lower hospital ratings, reduced reimbursements, and an overall decline in the ability to attract new patients (Escobar et al., 2019). The impact of readmissions on overall healthcare costs highlights the urgent need for implementing effective strategies and interventions aimed at minimizing these occurrences. These readmissions not only place a financial burden on healthcare systems but also have negative repercussions on patient health and satisfaction.

Psychiatric care, unplanned hospital admissions, and inpatient health care represent significant financial burdens within the realm of mental health treatment. Research conducted by Adu et al. (2024) highlighted that individuals diagnosed with various psychiatric disorders experience the highest rates of hospital readmissions shortly after discharge, surpassing those of any other patient population. The total average cost for a 30-day readmission was $16,037.08 (Ghabowen et al., 2024). This figure encompasses various factors such as medical treatments, procedures, medications, and associated facility charges during the readmission period. Understanding these costs is crucial for healthcare providers and policy makers aiming to improve patient outcomes and manage healthcare expenditures effectively. Annual expenses related to hospital readmissions for the U.S. Centers for Medicare and Medicaid Services are estimated to range from $17 billion to $26 billion (Alvarado et al., 2023). The impact of preventable readmissions on healthcare costs illustrates the need for effective strategies and interventions to reduce these occurrences and improve patient outcomes. An analysis of Medicare spending over one year revealed that patients who experienced readmissions had an average cost of $56,856, indicating a significant 60% increase relative to the average spending

of $35,465 for patients who were not readmitted (Zheng et al., 2019). Combined, the articles discussed the financial impact of frequent psychiatric readmissions and underscored the need for effective strategies psychiatric hospital directors can use to reduce readmission rates, increase revenue, and improve patient outcomes (Adu et al., 2024; Alvarado et al., 2023; Ghabowen et al., 2024; Zheng et al., 2019).

The specific business problem addressed in this project was that some psychiatric hospital directors lack effective strategies to reduce readmission rates, increase revenue, and improve patient outcomes. Therefore, the purpose of this qualitative pragmatic inquiry project is to identify and explore effective strategies used by psychiatric hospital directors to reduce readmission rates, increase revenue, and improve patient outcomes.

2. Literature Review

Hospital readmissions in mental health settings can be as high as 43%, surpassing those in general health settings (Zhou et al., 2023). These readmissions hinder the recovery of patients with mental illness and place financial pressure on healthcare organizations. Zhou et al. (2023) compiled various risk factors related to hospital readmissions within 30 days for patients with mental health issues. Furthermore, Stensland et al. (2012) indicated that adults with a mental or substance use disorder accounted for 29% of all hospital days and 22% of total hospital expenses in that year. Additionally, hospitalizations involving mental or substance use disorders were 29% longer than those for other conditions, with an average length of stay of 5.8 days compared to 4.5 days for other conditions (Stensland et al., 2012). Notably, hospitalizations related to schizophrenia and psychotic disorders ranked as the second most common reason for readmissions within 30 days.

The research project is grounded in the complex adaptive systems (CAS) theory and the balanced scorecard (BSC) theory. A systematic, comprehensive review of the literature was provided. The business problem was examined through the lens of each of the conceptual frameworks, to include an analysis of supporting theories. The analysis and synthesis included scholarly peer-reviewed articles and identified potential themes and phenomena relating to the project's purpose to explore the problem at length and any effective strategies that psychiatric hospital directors can implement to reduce readmissions, increase revenue, and improve patient outcomes. Various professional and scholarly viewpoints on the problem under study were examined, compared, and contrasted.

The available recent scholarly literature emphasized the contributing factors for psychiatric hospital readmission, which varied among the studies. Summers et al. (2023) found that although the hospital is assessed based on the readmission rates, many of the factors leading to a patient's return to the hospital are often beyond the organization's influence. One key factor influencing rehospitalization is the availability of community resources. Supportive ancillary programs play a vital role in maintaining the psychiatric stability of patients and decreasing the occur-

rence of psychiatric crises. All facets of a patient's life are interconnected and affect their psychiatric stability (Summers et al., 2023). In contrast, in a previous study, McGuire et al. (2022) found that recovery orientation did not impact readmission rates. In the study, patients who had a pattern of frequent service utilization, along with those dealing with substance abuse or personality disorders, were more likely to experience readmission. Similarly, Hermer et al. (2022) found no evidence to indicate that timely outpatient care led to a decrease in readmissions for patients with schizophrenia or bipolar disorders. This suggests that, despite the intention of improving continuity of care and stabilizing patients' conditions, the outpatient interventions examined in the study did not yield the desired outcome of lowering the need for subsequent hospitalizations. The study also highlighted a theme where untimely care was associated with an increase in readmissions for patients suffering from depression. Overall, results indicate a complex relationship between outpatient treatment strategies and patient outcomes, indicating that while prompt care may benefit certain populations, it could inadvertently contribute to higher readmission rates in others. Combined, the extant literature has commonly identified the predictors of psychiatric readmission (Hermer et al., 2022; McGuire et al., 2022; Summers et al., 2023).

In recent years, the available scholarly literature contained an emphasis on the need for effective discharge planning, and the continuity of care post discharge. To address the issue of costly psychiatric readmissions, Ojo et al. (2024) advocated for the importance of ongoing care and support for patients. Their study emphasized the critical role of relational continuity in mental health care, which involves sustaining meaningful, ongoing connections between psychiatric patients and their healthcare providers. This continuity can enhance trust, improve communication, and ultimately lead to better health outcomes for patients navigating the challenges of mental illness (Ojo et al., 2024).

In a similar study, the efficacy of a continuity-of-care model tailored specifically for individuals with mental health issues was explored (Maoz et al., 2024). Their comprehensive evaluation focused on how this model fosters consistent and coordinated care across various healthcare settings, minimizing the likelihood of readmissions. The findings from this research indicated that implementing such a model significantly reduces psychiatric hospital readmission rates by facilitating a collaborative approach to patient management and ensuring that individuals receive the necessary support before, during, and after hospital stays. Together, these articles address the problem of high psychiatric readmission rates and propose that adopting a continuity of care model may be an effective strategy to reduce these rates (Maoz et al., 2024; Ojo et al., 2024).

Research by Brom et al. (2024) highlighted that psychiatric patients experience higher rehospitalization rates and poorer outcomes following hospital discharge. Their study examined eight transition-care programs, with a variety of support mechanisms including coaching services, medication management assistance, access to psychiatric providers, and counseling support. These findings were corrobo-

rated, emphasizing that patients often actively seek out guidance and support during the critical phases of healthcare transitions (Hindsbak et al., 2024). Their research identified seven intervention strategies that have shown promise in enhancing patient outcomes. These strategies encompassed effective discharge care planning, integrated care approaches that foster collaboration among various healthcare professionals, and the involvement of dedicated care coordinators who assist patients in navigating the complexities of their postdischarge care. Together, these studies underscore the importance of structured support systems in mitigating rehospitalization risks and promoting healthier outcomes for psychiatric patients.

Rather than exploring various strategies to reduce psychiatric readmission rates, as seen in the studies by Brom et al. (2024) and Hindsbak et al. (2024), researchers demonstrated that a multidisciplinary communication strategy specifically contributes to a reduction in 30-day readmission rates (Hahn et al., 2024). This targeted approach not only supports the well-being of patients but also enhances the overall efficiency of psychiatric care delivery (Hahn et al., 2024). Following the implementation of their strategy, there was a 45% reduction in readmissions, equating to seven fewer admissions per 100 patients. The workflow for multidisciplinary communication regarding transitional care had a 45.2% decrease in the rate of readmission, or roughly seven fewer overall readmissions for every 100 patients. The findings indicate that fostering effective communication and collaboration among various healthcare professionals leads to better patient management and continuity of care, ultimately resulting in fewer instances of readmission within the first month after discharge.

Hindsbak et al. (2024) demonstrated that intervention strategies generally enhance patient experiences. However, additional studies emphasize the necessity for a more detailed understanding of which specific components lead to improvements in outcomes such as quality of life (QOL) and readmission rates (Eboreime et al., 2022; Oyesanya et al., 2021). Eboreime et al. (2022) conducted a study in Alberta, Canada, of 10,000 participants recruited across nine acute care sites and day hospitals. Their research suggested that while various transitional care interventions exist, there is a critical need for studies that better identify which specific components are most effective in improving patient outcomes and QOL. Collectively, it was indicated that although healthcare transition interventions typically enhance patient experiences and outcomes, significant questions remain regarding optimal implementation (Eboreime et al., 2022; Oyesanya et al., 2021). This gap in evidence underscores the importance of developing more targeted, evidence-based approaches. Researchers established an innovative four-item predictive model with the objective of generating a rapid, objective, and accurate estimation of the likelihood of psychiatric readmission within one year following hospital discharge for patients diagnosed with schizophrenia (Hou et al., 2024). They proposed that this predictive tool could serve as a valuable resource for clinicians, enabling them to identify potential risk factors and initiate early interventions aimed at managing the chances of readmission effectively. Similarly, the investi-

gation led by Okoli et al. (2024) focused on the impact of long-acting injectable antipsychotic (LAI) medications compared to traditional oral medications. The research aimed to determine whether LAI medications could enhance treatment adherence, decrease the frequency of re-hospitalizations and improve recovery outcomes for psychiatric patients upon discharge. The results revealed that LAI medications demonstrate significant effectiveness for this patient demographic, providing crucial insights into optimizing treatment protocols for those exiting psychiatric care. Research suggests that implementing comprehensive follow-up care that supports patients after they leave the hospital effectively reduces the likelihood of readmissions, thereby enhancing overall patient outcomes (Yamaguchi et al., 2024). The emphasized theme is that intensive postdischarge services may prevent readmissions. However, implementing preventative interventions remains challenging (Fu et al., 2023). Some interventions have been developed to standardize processes and procedures to reduce 7-day and 30-day readmission rates in behavioral health to address these challenges (Winner et al., 2025). This study demonstrated that rigorous quality improvement efforts can effectively lower these readmission rates (Winner et al., 2025). Implementing consistent protocols and creating tools addressing known factors contributing to readmissions were associated with reductions in both 7-day and 30-day readmission rates. Additionally, involving clinical pharmacists in the process of medication reconciliation during patient discharge can help prevent medication discrepancies and may lead to a reduction in unplanned hospital readmissions (Gallagher et al., 2022). Results revealed that patients identified as high risk for readmission who received pharmacist support for discharge medication reconciliation had a significantly lower 7-day readmission rate than those who did not (Gallagher et al., 2022). Whereas Winner et al. (2025) and Gallagher et al. (2022) provided important insights into applying discharge interventions as a strategy to reduce preventable psychiatric hospital readmission rates, Fu et al. (2023) identified the barriers and facilitators to applying discharge interventions from the viewpoints of both providers and service users. The researchers emphasized that the findings of this study are crucial for creating customized implementation strategies suited to various healthcare systems through formative intervention mapping and consensus-seeking processes (Fu et al., 2023). Combined, the articles highlighted a common theme that adopting multiple interventions can decrease preventable psychiatric hospital readmission rates (Fu et al., 2023; Gallagher et al., 2022; Winner et al., 2025).

2.1. Theoretical Framework

The CAS framework was integrated as a broad perspective, alongside the BSC as a specific management tool. This combined analysis helped me explore and identify effective strategies and innovative approaches to increase revenue generation while enhancing the quality of psychiatric healthcare services.

This combined framework assisted in identifying innovative strategies and ef-

fective approaches aimed at boosting revenue generation. Additionally, it focused on enhancing the quality of psychiatric healthcare services provided. By recognizing the intricate relationships and feedback loops present in a CAS, strategies can be incorporated in real time, ensuring that directors remain responsive to both market demands and patient needs. Ultimately, this comprehensive analysis aims to increase revenue growth while maintaining a high standard of care in psychiatric services.

2.1.1. Complex Adaptive Systems

The CAS theory was developed by Holland (1992). The tenets of the conceptual framework are self-organization, emergence, and the role of agents. Holland identified *self-organization* as the process by which a system spontaneously organizes itself without external direction, leading to a structured state or behavior from initially chaotic conditions. *Emergence* is the phenomenon by which new, coherent patterns or properties arise at a higher level of complexity that cannot be predicted solely from the individual elements of the system. Lastly, *agents* are the individual components or entities within the system that interact with one another and their environment, contributing to the dynamics and adaptability of the system (Holland, 1992). Agents are described by Holland as components of the system. Engebretson and Hickey (2013) found that agents within a psychiatric hospital system may include employees, patients, and families. In a CAS, the interaction and influence among agents is a continuous and ongoing process. Agents such as psychiatric directors can influence readmissions by how well they adapt, respond to challenges, and implement effective strategies for an ever-changing hospital system. The diverse operations within hospital systems demonstrate a complex interplay of medical professionals, technologies, and patient interactions, all aimed at delivering effective healthcare (Begun et al., 2003).

The term *complex* in CAS is a testament to the inherent diversity within these systems. They consist of a wide array of elements that interact in multifaceted ways, including different types of entities such as organisms in nature or various stakeholders in a healthcare setting. *Adaptive* in CAS highlights the system's ability to modify itself in response to external changes or internal experiences, emphasizing the capacity to learn from past events. This adaptability is crucial for survival and evolution, enabling systems to thrive amidst uncertainty and challenges. A *system* in the context of CAS is a cohesive set of interconnected or interdependent components that work together, influencing one another in a dynamic relationship. The interactions within these systems can lead to emergent behaviors that are not easily predictable, making the study of CASs both fascinating and complex. Each of these examples illustrates how CASs operate not merely as isolated entities but in a web of relationships that contribute to their overall functionality and resilience (Begun et al., 2003).

CAS theory extends and enhances the examination of healthcare organizations, broadening the relevant research techniques and improving the capacity of theory to produce valid studies on intricate organizational structures, such as the

healthcare system (Begun et al., 2003). Nilsen et al. (2020) believed that organizations within and among the healthcare sector are becoming increasingly interconnected. The diverse operations within hospital systems demonstrate a complex interplay of medical professionals, technologies, and patient interactions, all aimed at delivering effective healthcare. Effective systems, such as psychiatric hospitals, learn and adapt to environmental changes (Holland, 1992). The CAS approach conceptualizes healthcare and other systems as interconnected components (Barasa et al., 2017). Each component, an agent, plays a vital role within this framework. These agents engage in dynamic interactions, and their behaviors, decisions, and processes significantly influence and shape the overall system. This perspective emphasizes that the relationships and interactions among the agents create patterns and outcomes that are not simply the sum of individual actions but are instead characterized by emergent properties. The healthcare system is a CAS where employees of a psychiatric hospital act as agents that interact with one another to function as a singular system (Holland, 1992). Interactions between agents impact the overall success of the hospital which can lead to fewer readmissions for patients. By viewing the healthcare systems through the CAS lens, I expect that I may better understand the psychiatric healthcare system and the interacting agents.

2.1.2. Balanced Scorecard

The BSC was conceptualized by Kaplan and Norton (1992). The BSC uses a multifaceted approach to measure performance. BSC is linked to strategic planning and execution, serving as a management framework that aids in identifying the essential value drivers that companies can leverage to optimize their strategies (Kaplan & Norton, 2001). BSC tenets allow managers to evaluate a business from the perspectives of the customer, internal, financial, and innovation and learning (Kaplan & Norton, 1992). The first tenet, customer perspective, emphasizes understanding and improving customer satisfaction, loyalty, and overall experience. Managers assess metrics such as customer retention rates, acquisition costs, and the quality of service or product offerings to gauge how well the organization meets the needs and expectations of its customers. In addition the internal processes perspective looks at the internal operational processes that contribute to delivering value to customers. By analyzing key performance indicators related to efficiency, quality, and process improvements, managers can identify areas where the organization can enhance operational effectiveness and optimize resource allocation. Next, the innovation and learning perspective focuses on fostering a culture of continuous improvement and innovation. It involves measuring employee training, knowledge sharing, and developing new products or services. This perspective highlights the importance of investing in employee skills and leveraging technological advancements to maintain competitive advantage. Lastly, the financial perspective is centered on the organization's financial health and sustainability. Managers examine traditional economic metrics such as revenue growth, profitability, and return on investment (ROI). The indicators mentioned provide

insights into the organization's financial performance and help guide strategic investment decisions.

The BSC framework is relevant to my project as it can help psychiatric hospital directors shape their organizations to meet the challenges and take advantage of the opportunities presented by a changing competitive healthcare system (Kaplan & Norton, 2001). The BSC is an open system that considers the interests of all stakeholders, balances both short-term and long-term objectives, and uses performance indicators to monitor progress (Mio et al., 2022). It is a well-established and effective framework that addresses common management challenges (Kumar et al., 2024). Designed as a strategic management tool, the BSC assists organizations in translating their overarching mission and strategic objectives into a comprehensive set of performance measures (Johnsen, 2001). This framework provides insights into how psychiatric hospital directors can develop strategies to successfully reduce readmissions, increase revenue, and improve patient outcomes.

3. Methods

A qualitative research method and pragmatic inquiry research design was used to research effective strategies that are used by psychiatric hospital directors to reduce readmission rates, increase revenue, and improve patient outcomes. This approach was appropriate for the project because it allowed for further inquiry into psychiatric hospital directors' experiences that cannot be easily put into numbers. Qualitative research is characterized by specific key principles, such as its focus on individual cases, its consideration of cultural and historical backgrounds, and its emphasis on reflexivity (Lewis-Beck et al., 2004). Using inductive reasoning and exploring are crucial aspects of qualitative research. The qualitative method is useful for revealing and understanding the viewpoints and experiences of individuals or groups related to the specific business problem (Saunders et al., 2020).

The specific research design was a pragmatic inquiry, which was appropriate for this project because it prioritizes the development of practical and feasible solutions to address research challenges in the business context (Savin-Baden & Major, 2013). The research project was inductive and focused on the individual decision-maker's professional experience as psychiatric hospital directors which aligns with the practicality of the pragmatic inquiry research design.

Specific measures were taken to ensure the ethical protection of participants was adequate, which included masking the identity of the participants and location. Each participant was assigned a unique pseudonym during the data collection, analysis, and final presentation of findings to anonymize the identity of the participants and ensure that their personal information remains confidential throughout the research process. The target population consisted of seven psychiatric hospital directors. These participants were selected based on their demonstrated success with reducing readmission rates, increasing revenue and improving patient outcomes. Participants were selected using purposive sampling and

snowball sampling based on their experience and brought a unique perspective on effective management practices, evidence-based interventions, and collaborative efforts. Eligibility criteria required participants to have successfully implemented effective strategies to reduce readmission rates, increase revenue, and improve patient outcomes. Participants were recruited through LinkedIn and professional networks.

Data were collected through semi-structured interviews with seven psychiatric hospital directors, supplemented by a review of publicly available documents such as published industry/expert reports, trends, benchmarks, and public official statements made by organization leaders. The published industry/expert reports, trends, and benchmarks were compiled and/or published by industry experts affiliated with various organizations with expertise in readmission rates and health outcomes. See Table 1 below for a list of some of the affiliations. As part of the triangulation process document findings were analyzed to confirm or disconfirm the themes that emerged from the interview codes. they were examined to determine whether the converge, complement or contradict one another.

Table 1. Affiliations of the producers of the secondary data documents.

Department of Epidemiology and Global Health	Department of Public Health
Department of Psychiatry	RAND Health
Department of Geriatric Psychiatry	Agile Outcomes Research
Mental Health and Addictions Program	Health Screening
Department of Community Health and Epidemiology	Department of Substance Dependent
Research Innovations and Discovery	Department of Clinical Psychology
Research Department of Psiquiatrico	School of Nursing
Department of Anesthesiology	Graduate School of Medicine

Each participant had demonstrably reduced readmissions, increased revenue, and improved patient outcomes before recruitment through the numbers each of them were tracking in a system to track admission/readmission rates. Revenue was tracked by how much money was saved, including costs and fines, by reducing readmissions. The goal was that patient does not readmit for 30-days after discharge. Patient outcomes were determined through surveys and the establishment of outpatient care network which is deployed through a multidisciplinary team approach. The existence of the tracking systems and the ways to determine patient outcomes was paramount for participant inclusion.

An interview protocol was used to ensure consistency across the interviews. Data saturation was achieved as recurring patterns and themes emerged across participant responses.

The data, interview transcripts, and audio recordings were organized into a directory, assigning pseudonyms to each participant for confidentiality. The data

was systematically analyzed with Braun and Clarke's (2022) six-step data analysis method to identify recurring themes and patterns, and derive insights focused on strategies to reduce psychiatric hospital readmission rates. Secondary data sources were analyzed using the same analytic procedures to support methodological triangulation. To enhance trustworthiness, strategies including member checking, triangulation, and data saturation were employed to ensure the credibility and dependability of the findings.

To strengthen the methodological transparency and reliability of the qualitative coding process, Holsti's method of intercoder reliability assessment was employed. This approach measures the consistency and trustworthiness of the coding process by comparing the degree to which multiple coders assign the same codes to the same data units, providing a quantitative measure of coding reliability within the qualitative research framework.

The intercoder reliability process involved two experienced researchers independently coding a subset of the seven interview transcripts using the established coding framework. The initial coding of 138 text units resulted in agreement on 117 units, yielding an intercoder reliability of 85%. This level of agreement exceeds the commonly accepted threshold of 80% for qualitative research, indicating strong consistency in the coding process. Following the initial reliability assessment, the two coders met to discuss disagreements and refine the coding criteria to address areas of inconsistency. A second round of coding on an additional 100 text units achieved 90% agreement, further confirming the reliability of the coding process. This systematic approach to intercoder reliability assessment ensures that the thematic analysis findings are grounded in consistent and trustworthy interpretation of the data. The final codebook did not change.

4. Results and Discussion

This section presents the five major themes that emerged from the thematic analysis of participant interviews and supporting documentary data. The overarching research question was what effective strategies are used by psychiatric hospital directors to reduce readmission rates, increase revenue, and improve patient outcomes? Five major themes emerged from the research: 1) readmission tracking task force, 2) operation within the state budget, 3) timely and effective discharge planning, 4) multidisciplinary team approach, and 5) readmission rates reductions. Each major theme included at least one subtheme. **Table 2** shows the major themes, the number of participants who referenced the theme, and the number of references made to the theme.

Researchers used Holland's (1992) CAS theory to identify the healthcare system as a system where employees of a psychiatric hospital unit act as agents that interact with one another to function as a singular system. According to Barasa et al. (2017), CAS theory conceptualizes healthcare and other systems as interconnected components. The diverse operations within hospital systems demonstrate a complex interplay of medical professionals, technologies, and patient interactions,

Table 2. Major themes.

Major themes	No. of participants who referenced theme	No. of references made to theme
Theme 1: Readmission tracking task force	7	21
Theme 2: Operation within the state budget	6	18
Theme 3: Timely and effective discharge planning	7	28
Theme 4: Multidisciplinary team approach	6	20
Theme 5: Readmission rates reductions	7	49

all aimed at delivering effective healthcare. Interactions between agents impact the overall success of the hospital which can lead to fewer readmissions for patients. Viewing the healthcare systems through the CAS lens, provides a better understanding of the psychiatric healthcare system and the interacting agents. The themes that emerged aligned with the CAS theory, such as the use of a multidisciplinary team approach. Within the CAS theory, interactions between agents significantly impact the overall success of a system. The implementation of a multidisciplinary team approach enhances the ability to address complex patient needs. For example, psychiatric hospitals utilize treatment teams to provide care to patient and influence the likelihood of the patient being readmitted to reduce higher readmission rates. Within the psychiatric hospital system, the treatment team is typically composed of a diverse group of medical professionals, including psychiatrists, nurses, social workers, and care coordinators. Each member of this multidisciplinary team plays a distinct role: psychiatrists diagnose and manage medications, nurses monitor patient progress and administer care, social workers address psychosocial needs and coordinate with families, while care coordinators ensure smooth transitions between various levels of care. Jordans (2025) argued that CAS helps to better analyze and understand the organization of people and services for psychiatric problems by optimizing mental health services and resources.

The BSC framework helps psychiatric hospital directors shape their organizations to mitigate challenges and improve performance. Designed as a strategic management tool, the BSC assists organizations in translating their overarching mission and strategic objectives into a comprehensive set of performance measures (Johnsen, 2001). This framework provides insights into how psychiatric hospital directors can develop strategies to successfully reduce readmissions, increase revenue, and improve patient outcomes. Employing the four perspectives of the BSC, financial, customer, internal business processes, and learning and growth, aligns every level of the organization with common objectives, supporting successful strategy execution and efficient performance management. The financial perspective focuses on revenue growth, cost management, and overall fiscal health, enabling leaders to track metrics like net income, ROI, and budget efficiency. The

customer perspective emphasizes patient satisfaction, quality of care, and community reputation, allowing directors to assess and improve the hospital experience for patients and their families. The internal business processes perspective examines clinical workflows, their efficiency and effectiveness, discharge planning, and readmission prevention protocols, helping identify operational improvements that drive better outcomes. The learning and growth perspective centers on staff development, training, innovation, and organizational culture, which are critical for adapting to changes and sustaining long-term improvements. All the major themes that emerged aligned with the BSC theory. Winner et al. (2025) conducted a study demonstrating that a standardized process and rigorous quality improvement efforts can effectively lower readmission rates. The BSC framework provides insights into how psychiatric hospital directors can develop strategies to successfully reduce readmissions, increase revenue, and improve patient outcomes.

Theme 1: Readmission Tracking Task Force

Establishing a readmission tracking task force emerged as a theme with participants noting their involvement in or knowledge of a tracking task force or committees dedicated to monitoring and analyzing hospital readmissions. These task forces typically comprise representatives from nursing, case management, and administration. Their responsibilities extend beyond gathering readmission as they regularly review patient charts, identify patterns and root causes of readmissions, and assess the effectiveness of existing interventions. The task force collaborates to develop targeted strategies, such as patient education initiatives, improved discharge planning, and enhanced follow-up protocols. In addition to data analysis, these teams often provide feedback to clinical units and report trends to hospital leadership. Through ongoing meetings and transparent communication, the task force ensures best practices are shared and that continuous improvement efforts align with the hospital's overall goal of reducing readmissions and optimizing patient outcomes.

All seven participants confirmed the importance of establishing a team to track and collect data regarding readmission. P1 noted, "We created a readmission task force that has been active for at least two or three years now." Further, P1 noted, "we actually track our readmission rate each month." P7 noted, "this has allowed me to keep track of individual patients, specifically their readmissions over a 12-month period." P3 stated, "we are full data driven and we have like four committees on this." The authors of newly identified literature confirmed the theme of establishing a readmission task force. Virtanen et al. (2024) suggested that identifying possible risk factors for readmission can be used to plan psychiatric care and can reveal unmet treatment related needs. Interview participants described how tasks forces are utilized. According to P7, key tasks within the readmission tasks force include,

> Gather data regarding the previous discharge date, the readmission date, the patient's diagnosis at the time of admission, where the patient was sent upon

discharge, and the reasons for their transfer. Additionally, outline the patient's discharge plan and review previous admissions for any documented barriers identified by the outpatient or case management teams.

In addition, P4 noted, "the tracker system is a good way of measuring what's going on, especially subprocesses." Hospital readmissions remain a significant issue. Turkington and Stirling (2024) examined patient readmission rates by tracking and identifying specific patient characteristics and medical conditions associated with an increased likelihood of readmission. The researchers stressed that regularly tracking patient information helps identify those most at risk of readmission. This information is also useful for creating care plans and prevention strategies tailored to each patient. With this approach, healthcare teams can focus on the most important risk factors, use resources wisely, and help prevent patients from being readmitted, which leads to better care for patients and improved hospital results (Turkington & Stirling, 2024).

The theme supported CAS and BSC theoretical frameworks. Researchers have found that establishing a readmission task force involves many different people and groups whose complex and evolving interactions impact outcomes. The CAS framework shows that these systems can change and adapt as new patterns develop, leading to surprising and unpredictable results (Kumar et al., 2024). Establishing a readmission tasks force engages complex systems to utilize a flexible, adaptive approach. The ongoing adaptability with CAS is essential for effectively responding to the inherent uncertainties and dynamic nature of such systems. The learning and growth principle of BSC supports successful strategy execution and efficient performance management. Interview participants emphasized the effectiveness of various quality improvement and process improvement metrics. P5 noted, "in our quality improvement efforts, we focus on the patient experience and pay close attention to what patients are asking for." P3 noted, "we're constantly doing performance improvement projects." Further, P3 noted, "We did a training on how to improve compliance of medications, especially after discharge, by reducing the number of medications prescribed and also educated staff on the added side effects for patients."

Subtheme* 1: *Focus on Underlying Reasons for Readmission

Interview participants emphasized that examining the underlying causes of readmissions supplied data for the tracking task force. P1 noted, "So we saw a lot of patients reporting things like, they couldn't refill their medication, they weren't able to meet with their outpatient providers. They had another stressor that occurred after discharge. It was a lot of psychosocial issues." P6 also emphasized the importance of focusing on underlying reasons for admission, "really talking with them, taking the time to really understand what's going on, what's going on that is, contributing to them being in and out of hospitals." P4 noted methods that leaders employ to identify barriers: "one team meets with us administrators to go over all the patient and to make sure that especially with the focus on discharge and what barrier is that preventing them from getting out." By analyzing these

underlying reasons, the task force was better equipped to identify patterns, implement targeted interventions, and develop strategies to reduce future readmissions.

Subtheme* 2: *Determine Which Patients Are Highest Risk for Readmission

Interview participants emphasized that identifying patients at highest risk for readmission enabled the task force to conduct targeted follow-up interventions. P2 stated, "both the nursing staff and the psychiatric staff would determine that someone was higher risk." P6 discussed criteria for readmission: "patients would come in through the emergency department and be evaluated based on their needs, there were certain triggers or flags." P5 noted, "I've noticed that readmission rates are particularly high among homeless patients." By focusing on these vulnerable individuals, the task force could provide additional support, coordinate necessary resources, and implement preventive measures to help reduce the likelihood of future readmissions.

Subtheme* 3: *Implement a Readmission Team to Follow Patients Post Discharge

Interview participants emphasized that establishing a dedicated readmission team to monitor and support patients after discharge is crucial for facilitating a smooth and effective transition from hospital to home. P5 noted,

> One of our nurses calls every single patient to ensure they are following their plan of care. She checks if they have transitioned to the next steps. She also verifies that they are adhering to the medication regimen prescribed by their providers. This process helps us understand how we can improve our discharge planning.

P5 also noted,

> One significant initiative we implemented to support individuals with substance use disorders is the creation of a recovery transition guide position about two years ago. This role involves working one-on-one with patients diagnosed with substance use disorders who are being discharged from the hospital. The guide helps them transition to the next level of care and follows up with them for up to six years.

P6 noted,

> Projects with how to continue to get them to engage and participate, we had different kind of workflows and processes in place to continue following up with patients, to try to get them to take advantage of the different supports and programs that we were offering them.

P2 noted, "making sure they had their appointments and providing follow up care." By maintaining regular contact, providing follow-up care, and addressing any emerging concerns promptly, the readmission team can help prevent complications, reduce the risk of unnecessary readmissions, and ensure patients have the resources and guidance they need for successful recovery in the community.

Theme 2: Operation Within the Budget

The need to operate within the constraints of the state budget emerged as a key theme, with participants noting that financial limitations can have a substantial impact on hospital revenue. Participants highlighted that adherence to state budget guidelines often requires careful prioritization of resources, cost containment strategies, and ongoing evaluation of expenditures to ensure both financial stability and the continued delivery of quality patient care. Financial metrics such as cost per patient and revenue growth help psychiatric hospital leaders deliver quality care while managing costs wisely. Psychiatric hospitals face substantial financial challenges, as mental health care represents a significant share of overall inpatient treatment costs. These expenses stem from a variety of sources, including extended lengths of stay for patients with complex psychiatric conditions, the need for specialized staff such as psychiatrists, psychologists, and psychiatric nurses, and the use of tailored therapeutic interventions and medications.

Interview participants discussed that revenue is difficult to measure and generate. Approximately 86% of participants confirmed the importance of operating within the budget and decreasing readmission rates, to increase psychiatric hospital revenue. P1 noted, "Revenue generation is challenging because we operate under a global budget structure; we receive a set amount of funding from the state." P1 noted, "Under the global budget structure, we do face penalties for hospital readmissions. There is a significant cost associated with each admission, approximately $40,000 per person." Interview participants discussed utilizing creative methods to operate within their state budget. P2 noted, "there's not much that we can do to create profit more than just providing good quality care and providing care that is the most financially reasonable." Participants noted that when psychiatric hospitals offer postdischarge services, such as partial hospitalization programs, they use a fee-for-service billing model. As a result, precise and timely billing is essential to ensure compliance and proper reimbursement, as well as to maximize revenue and support the hospital's financial sustainability. Accurate billing also helps maintain positive relationships with payers and minimizes the risk of denied claims or revenue loss. P3 noted, "a patient's hospitalization is covered by day… billing needs to be accurate." P6 noted, "the costs associated with inpatient hospitalization tend to be higher for insurance companies." P6 also noted, "these initiatives could increase revenue for hospitals, as they can participate in outpatient programs." Interview participants highlighted the correlation between increasing revenue by reducing readmission rates. P7 noted, "the less readmissions that we have, the more money that we, retain as an organization and vice versa, the more readmissions that we have, the less money that we have to utilize within the organization."

The authors of newly identified literature confirmed the theme of operating within the budget, to increase psychiatric hospital revenue. It is difficult for healthcare leaders to control costs. About 1 in 5 patients return to the hospital within 30 days of discharge costing the organization thousands of dollars (March et al., 2022). Health

care systems often struggle to improve outcomes and reduce costs for patients who are both high-need and less involved in their care.

The theme supported the CAS and BSC theoretical frameworks. Recognizing the healthcare system as a CAS helps leaders make better decisions during uncertainty by fostering greater resilience and adaptability throughout the organization (Araja, 2022). Amer et al. (2022) found that implementing BSC improved patient outcomes and strengthened the financial performance of healthcare organizations. Their findings highlighted how the BSC can effectively align hospital operations with strategic goals, resulting in better patient care experiences and more sustainable financial outcomes for organizations. The financial principle of BSC assesses an organization's ability to generate revenue, manage costs, and deliver value to stakeholders. According to Bahri and Al Faruqy (2023), financial performance benchmarks used in the healthcare sector include net income, which measures profitability after all expenses are deducted, and ROI, which evaluates the efficiency of investments by comparing the gains or benefits to the initial costs. Psychiatric hospital leaders can recognize areas of financial strength and weakness, enabling them to make informed, evidence-based choices that support fiscal stability and long-term viability.

Subtheme* 1: *Utilize Cost-Efficient, Readily Available Resources

Mental health costs impose significant financial burdens on healthcare organizations and individuals. Leaders are placing greater emphasis on using robust economic data and cost analyses to inform mental health care planning, resource allocation, and policy development, aiming to maximize positive outcomes within available budgets (Knapp & Wong, 2020).

Interview participants emphasized that leveraging community resources can help psychiatric hospital leaders significantly lower expenses related to patient readmission. P1 noted,

> You might not have a large budget, but look for ways to leverage community resources to provide patients with additional support. Many patients require this type of assistance. I believe starting with resources available in the community can make a significant impact while the hospital works internally on improvements.

P6 noted, "Follow-up methods were also employed to engage patients in utilizing post-hospitalization support programs. Supporting individuals transitioning from a Partial Hospitalization Program (PHP) to postdischarge care. Establishing a connection with the individuals while they are still in the program." P6 further explained that "partial hospitalization program works on both ends to prevent hospitalizations and to prevent readmissions to inpatient hospitalizations; it's an intensive two-week program." P5 noted, "She checks if they have transitioned to the next steps, such as attending a PHP, an addiction center, or if they require a psychiatric consult." Utilizing community resources can help reduce psychiatric healthcare costs. P1 noted, "our main opportunity for revenue lies in outpatient

services, which are not governed by the global budget." P3 emphasized the value of collaboration, stating, "trying to reach out to the agencies that provide services and just trying to collaborate." Assertive community treatment (ACT) cuts hospital admissions by half compared to traditional case management, making it ultimately more cost-effective (Dolber et al., 2025). In addition, technologies, including electronic health records (EHRs) and artificial intelligence (AI), can enhance the accuracy and effectiveness of economic evaluations and mental health care delivery (Fleurence & Chhatwal, 2025). EHRs allow leaders to collect, analyze, and share patient data more efficiently, leading to better-informed clinical and policy decisions. AI technologies can support early identification of mental health risks, personalize treatment approaches, and optimize resource allocation. These strategies and innovations empower psychiatric healthcare leaders to maximize both cost savings and patient outcomes.

Theme 3: Timely and Effective Discharge Planning

Ensure a timely and effective discharge plan emerged as a theme with participants noting that the discharge process is intricate and specific to the patient's individual needs. The discharge planner is vital in creating tailored discharge plans starting from a patient's admission. The discharge process involves gathering comprehensive information about the patient's psychiatric history, social circumstances, and potential postdischarge needs to ensure that the plan is both effective and realistic. Discharge planners also act as liaisons, facilitating open communication between the patient, their family, the medical team, and external agencies such as rehabilitation centers, home care providers, and social services. This coordination helps to address barriers to discharge, such as arranging follow-up appointments, securing necessary medications or equipment, and educating patients and families about ongoing care requirements. Within hospitals, the discharge planning team typically consists of nurses, social workers, and case managers who work in tandem with physicians and therapists. They meet regularly while the patient remains hospitalized, to review patient progress, update care plans, and address issues that may arise. Discharge planning services ensure that all aspects of post-hospital care are addressed, which can promote quality, patient-centered care and greatly enhances the likelihood of a patient's successful transition from the hospital to community-based settings.

All seven participants confirmed the importance of ensuring a timely and effective discharge plan. P7 noted, "giving more attention to the discharge disposition" as an effective strategy to improve patient outcomes. P3 noted, "one of the biggest things that we have done is to make sure the discharge process and discharge planning is robust." P5 noted, "it is crucial for us to have a comprehensive understanding of the discharge process to prepare everything before the patient leaves the hospital." The authors of newly identified literature confirmed the theme of ensuring a timely and effective discharge plan. Fatani et al. (2025) studied the role of the discharge planning team on the length of hospital stay and readmission in patients with neurological conditions. Findings revealed that estab-

lishing a discharge planning team helped more patients discharge from the hospital sooner and reduced readmission rates, which suggests better use of healthcare resources in neurological care. Po et al. (2023) argued that active discharge planning interventions are necessary to facilitate effective transitional care for patients identified as high risk. The researchers also found that age, additional health problems, and certain diseases make discharge planning less effective. Key obstacles to an effective transition from inpatient to outpatient care include patient-specific barriers, insufficient social support, and the impact of stigma (Ojo et al., 2024). These challenges make it difficult for patients to successfully move from the hospital to community-based care. Additionally, the findings of their study underscore the value of effective communication, collaboration, and timely follow-up to ensure consistent, quality care. Lukanski et al. (2023) found that follow-up phone calls to psychiatric patients post discharge decreases risk of readmission and enhances patient outcomes. Research participants supported successful strategies that are used to ensure a timely and effective discharge plan. P2 noted, "making sure that people have appointments scheduled with their providers within the first couple of days post discharge" as a barrier to effective discharge planning. P1 noted, "one of the things we've done recently is to build out the discharge instructions in different languages." Patients can better understand their treatment plan and further discharge recommendations when utilizing their native language using a qualified interpreter.

The theme supported CAS and BSC theoretical frameworks. Ensuring a timely and effective discharge plan requires integrating CAS principles, which emphasize the need for healthcare teams to remain flexible and responsive to each patient's unique needs. CAS emphasizes the importance of flexible, individualized care plans and a holistic approach to healthcare (Notarnicola et al., 2024). It also highlights how collaboration and effective communication among healthcare professionals are key to improving the quality of patient care. This involves close interdisciplinary collaboration among members of the treatment team who continuously assess and adjust the discharge plan based on the patient's evolving clinical status, social situation, and available community resources. The theory explains how different forms of communication and collaboration among team members impact the extent to which patient care can be personalized and tailored to individual needs (Gans et al., 2024). Effective discharge planning often includes comprehensive patient and family education, coordination with outpatient providers, and proactive identification of potential barriers to a successful transition. The ongoing adaptability promoted by CAS is essential for navigating the unpredictable challenges that arise during discharge, ensuring the plan remains patient-centered and outcome-focused despite inherent uncertainties and frequent changes in complex environments like psychiatric hospitals.

The BSC framework can be applied to the key performance area of developing timely, effective discharge plans, which are critical to reducing readmission rates in psychiatric hospitals. By aligning discharge planning processes with the BSC ap-

proach, organizations can better implement and communicate their corporate strategy (Prenestini et al., 2024). BSC ensures that strategic objectives such as improving patient outcomes, enhancing operational efficiency are integrated into daily practices, fostering a culture of continuous improvement across the hospital system.

Subtheme* 1: *Implement transitional interventions

Interventions that provide ongoing support to patients both before discharge and after leaving psychiatric hospitals, often referred to as transitional interventions with linking components, are highly valued by leaders for their role in maintaining continuity of care (Hegedüs et al., 2020). These interventions typically involve a multidisciplinary team approach, in which mental health professionals and members of the treatment team collaborate to create individualized care plans and facilitate communication between inpatient and community services. By addressing the complex needs of patients during the vulnerable transition period, these interventions aim to reduce care gaps, improve patient engagement, and facilitate a smoother transition to community living.

Assertive community treatment (ACT) is an evidence-based approach that involves a multidisciplinary team providing personalized, ongoing support tailored to individual needs and has been shown to improve patient outcomes (Jaffé et al., 2025). Satake et al. (2025) conducted a 7-year follow-up study in Japan that revealed that after 2 years of ACT services, the frequency of readmission for individuals with severe mental illness was mitigated. Approximately 28% of interview participants noted that ACT is useful for patients who struggle to make it to their follow up appointment post discharge from a psychiatric hospital. P4 noted,

> For those who prefer not to come into the clinic for follow-up appointments, we offer a program called Assertive Community Treatment (ACT). This is a team-based approach that includes a psychiatrist, nurse practitioner, and nurse who can visit patients at their homes to provide necessary care, including administering injections when due. This support helps prevent the need for hospitalization.

P3 noted, services where the clients get seen usually at least once a week, twice a week, sometimes every day. And if the client can't come to the team or to come to their appointments, the team goes out to see them in the community.

ACT is used as a transitional intervention that provides ongoing support for effective discharge planning.

Unresolved medication-related issues can significantly undermine the effectiveness of discharge planning. These problems often lead to confusion, noncompliance, and an increased risk of readmission. A timely and effective discharge plan is essential for reducing medication-related problems, especially for psychiatric patients who are at higher risk of medication errors due to complex treatment regimens (Stuhec & Batinic, 2023). Clinical pharmacists are tasked with checking patients' medications to help identify discrepancies, prevent duplications, and minimize harmful drug interactions. In addition, pharmacists work closely with pa-

tients and treatment teams to ensure that any medication changes are clearly communicated to the patient and their caregivers. Smith et al. (2021) investigated the effects of a pharmacist-led transitions of care clinic for individuals with substance use disorders, focusing specifically on retention in medication treatment after hospital discharge. The study demonstrated that pharmacist involvement in the transition process led to significantly higher rates of postdischarge medication adherence and retention compared to standard care. Interview participants noted that medication problems interrupt the effectiveness of discharge planning. Forty-two percent of interview participants noted that improving medication-related issues enhances effective planning and improves patient outcomes. P1 noted, "when they're discharged, they'll know what medication they're on, and they'll know why." P1 noted, "we work to reduce the number of antipsychotics that a patient is on in hopes that they will be medication complaints as well." P4 noted, "we often encounter patients who are reluctant to take medication. In the past, it would take a long time before doctors sought court approval to medicate these patients against their will. Now, we have implemented strategies to submit the necessary paperwork to the court within a few days to a week at most. This allows us to medicate patients in a timely manner, thereby improving their health." P3 noted, "These are pretty serious medications, and the more you add on, the more that a patient will have side effects from these medications. And so we really want to reduce the number of medications." In all, addressing medication-related problems is essential for effective discharge planning and improved patient outcomes.

Theme 4: Multidisciplinary Team Approach

The use of a multidisciplinary team approach emerged as a significant theme, with participants highlighting how these teams enhance patient care by bringing together professionals from various specialties such as physicians, nurses, social workers, psychologists, and case managers. Participants noted that this collaborative structure enables comprehensive assessment and treatment planning by incorporating diverse perspectives and expertise. Multidisciplinary teams facilitate more effective communication among care providers, ensure that all aspects of a patient's medical, psychological, and social needs are addressed, and support continuity of care throughout the patient's treatment journey. Regular team meetings and shared decision-making processes were specifically cited as mechanisms that improve the coordination of care, reduce errors, and foster innovation in treatment strategies. By leveraging the strengths of different disciplines, multidisciplinary teams can develop individualized care plans, respond more rapidly to changing patient needs, and ultimately achieve better patient outcomes and higher satisfaction rates.

Approximately 85.7% of participants confirmed the importance of using a multidisciplinary team approach. P1 noted, "I use a multi-disciplinary approach to go to all the treatment team members." Participants identified multiple disciplines that make up the typical treatment team. P4 noted, "I help the team work together so we have psychiatrists, we have psychologists, we have a team leader that coor-

dinate the whole unit, then we have the nurses, we have social workers." Collaboration amongst the treatment team is necessary for patient and organizational success. P5 noted, "Communication with the care team is very important, as they form a key support system for the patients." P7 noted, "I've been working on this team of different individuals within the organization. We meet monthly, we explore what it looks like as far as an organization, financially to decrease the amount of readmissions that we have." P7 also noted, "I think working as a team helped us to narrow down easier, but it does take some time." A multidisciplinary team approach is important to improve patient outcomes and reduce readmission.

The authors of newly identified literature confirmed the theme of using a multidisciplinary team approach. A multidisciplinary team approach allows for a thorough assessment of a patient's needs, reducing errors and miscommunication (Prabhakaran et al., 2025). Evidence suggests that starting care planning within the first 72 hours supports early discharge planning, enabling timely solutions to potential issues. Berben et al. (2024) found that multidisciplinary team meetings in psychiatric hospitals enhance patient participation and help patients better understand their experiences. Țenea-Cojan et al. (2025) emphasized the importance of coordinated, patient-centered care for individuals with psychiatric conditions. Din et al. (2024) reported that multidisciplinary collaboration improves communication, reduces mistakes, and leads to better management of chronic illnesses. Overall, multidisciplinary teams combine the expertise of various professionals to address complex health problems, delivering care that is both effective and tailored to each patient (Alsubaie et al., 2024).

The theme supported CAS and BSC theoretical frameworks. Multidisciplinary healthcare teams function as complex and multifaced systems that align with the tenets of CAS. The interconnectedness of multidisciplinary treatment teams enables healthcare professionals to facilitate timely responses to address patient needs and develop patient-centered solutions. According to Anderson et al. (2020), the complexity of interactions in health care environments strengthens collaboration, improves communication, and enhances team performance, ultimately leading to better patient outcomes.

BSC is a planning tool that helps organizations achieve their goals by matching their needs with employees, customer relationships, and innovation (Yawson & Paros, 2023). A Multidisciplinary team approach is supported by the BSC framework principles of customer, internal business processes, and learning and growth. A multidisciplinary team not only collaborates with each other, but also with psychiatric patients. A multidisciplinary team collaborates not only among its members but also actively engages psychiatric patients (the customer) in the care process. This inclusive approach ensures that patients' perspectives, preferences, and goals are incorporated into treatment planning and decision-making. A multidisciplinary team approach aligns with the BSC framework principle of internal business processes by encouraging teamwork, smoother processes, and ongoing improvements to enhance patient care. The BSC framework for learning and growth

encourages ongoing education and training for healthcare professionals, where team members share knowledge, build new skills, and stay informed about best practices.

Subtheme* 1: *Clinical Staff Decision Making Methods

The Ensuring Quality in Psychological Support (EQUIP) initiative is designed to enhance standards in psychosocial support and psychological training worldwide (Watts et al., 2021). By providing resources for trainers and managers, EQUIP underscores the importance of competency-based training and evaluation. A global framework is crucial to equip all providers of psychological interventions and mental health services with the necessary skills for safe and effective care. EQUIP's approach centers on achieving consensus on core competencies, identifying essential skills, and assessing the viability of practical training and assessment tools (Kohrt et al., 2025). Interview participants emphasized the need for comprehensive staff training to ensure competency when working with high-acuity populations, such as individuals with psychiatric conditions. P3 noted, "So we did the training. I went to treatment teams, drop-ins, and I listened to these cases and gave recommendations." P4 discussed, "having staff not being trained to really work with that population is a big challenge. The state did implement some kind of training; I am also part of the training. So we help people understand about trauma." They highlighted that specialized preparation equips staff to address the unique challenges and complexities presented by these groups, ultimately improving care quality and safety.

Research indicates that evidence-based practices (EBPs) significantly improve patient outcomes and lower hospital readmissions. EBPs also enhance healthcare system efficiency by maximizing resource use, reducing costs from complications and repeated treatments, and streamlining care processes (Connor et al., 2023). Interview participants emphasized the importance of evidence-based tools to guide clinical care. P6 noted, "measuring their progress using different evidence-based tools, to assess progress, such as PHQ-9 and GAD-7." P5 noted, "We also review the depression screening tools we are using and assess the overall patient experience to find effective ways to assist our patients." Self-assessment tools are widely utilized to evaluate depression and co-occurring anxiety symptoms, aiding clinicians in making informed treatment decisions. These validated instruments are evidence-based and recognized internationally. The PHQ-9 (Patient Health Questionnaire, 9 items) and GAD-7 (Generalized Anxiety Disorder Scale, 7 items) are particularly effective for identifying symptoms of depression and anxiety (Huang et al., 2022). According to Newman (2022), using both measures together improves the detection of clinically significant symptoms and guides treatment decisions. This indicates that each tool is useful, and their combined application offers additional benefits for informing clinical care.

Theme 5: Readmission Rates Reductions

Participants highlighted the theme of reducing readmission rates, emphasizing that a focused effort to lower readmissions can yield multiple benefits for psychi-

atric hospitals. This approach leads to measurable improvements in patient outcomes, including fewer complications, greater satisfaction, and better long-term health. Reducing psychiatric readmission rates also contributes to greater financial stability. By reducing readmission rates, hospitals can avoid penalties for excessive readmissions, optimize resource utilization, and improve overall operational efficiency. Participants also noted that implementing evidence-based intended outcomes, such as enhanced discharge planning, patient education, and postdischarge follow-up, is crucial to achieving these goals. Each participant has the goal that patients do not readmit for 30-days after discharge. Further, they admitted using tracking systems to track readmissions, revenues, and patient outcomes. Ultimately, a comprehensive approach to reducing readmissions supports both the clinical mission of delivering quality care and the financial sustainability of psychiatric hospitals.

All seven participants confirmed the importance of reducing readmission rates. P7 noted, "the less readmissions that we have, the more money that we retain as an organization and vice versa." P2 stated, "having those appointments scheduled following up with patients to make sure that they attend is the biggest, the best outcome to making sure they don't come back to the hospital." The authors of newly identified literature confirmed the theme of reducing readmission rates to increase revenue and improve patient outcomes. Geffen et al. (2025) explored the underlying factors for unplanned psychiatric admissions. Researchers argued that identifying factors associated with unexpected mental health decline helps providers adjust their practices and services, leading to more effective care transitions and more personalized care. Their findings emphasize the importance of integrating hospital and community mental health services, implementing crisis management plans, and fostering collaboration among services to ensure effective care transitions (Geffen et al., 2025). Similarly, Mlay et al. (2025) studied intended outcomes for relapse prevention among people with schizophrenia in South Africa. They argued that quality inpatient care and well-planned transitions to outpatient care are essential to reducing readmissions. Their findings suggested that intended outcomes include preparing patients and caregivers for discharge, building therapeutic relationships, actively managing transitions, involving both patients and caregivers, fostering interagency collaboration, and offering alternative treatment options. In addition, the researchers found that effective discharge planning, adequate staffing, and multidisciplinary teamwork are necessary for effective transitions and better outcomes. Intharit et al. conducted a study in 2021 in northeastern Thailand that identified the risks and protective factors of readmission in patients with first-episode schizophrenia. Their findings revealed that factors affecting relapse in first-episode schizophrenia included family factors, drug abuses, and a concurrent health status. Mental health is strongly affected by social factors such as income, jobs, education, housing, and support networks. Addressing these social determinants can help prevent psychiatric hospitalizations (Kirkbride et al., 2024).

The theme supported CAS and BSC theoretical frameworks. Using complex systems approaches allows for a better understanding of psychiatric disorders' dynamic and interconnected nature (Öngür & Paulus, 2025). By looking at these disorders as CAS, leaders can evaluate how symptoms and causes are connected and change over time. Understanding psychiatric disorders complexity and interacting factors can lead to improved diagnosis and more personalized mental health care treatments to reduce readmission (Öngür & Paulus, 2025). Using CAS theory in psychiatric hospitals helps leaders to use both positive and negative feedback to apply change and innovative practices (Kamøy & De Boer, 2021).

Psychiatric hospital leaders use BSC to set specific, measurable objectives, track progress with key performance indicators, and identify gaps or areas for improvement. BSC is used to measure and improve performance by helping plan and guide actions. By mapping strategic goals to operational activities, BSC helps ensure that all departments and staff are aligned with the hospital's mission and long-term strategy (Panjaitan et al., 2022).

Subtheme 1: Measure Patient Performance

Patient-reported outcome measures (PROMs) are increasingly recognized as essential tools in clinical care, providing critical insights to guide decision-making. Campbell et al. (2022) demonstrated that both patients and clinicians value PROMs for their ability to inform care across a variety of health conditions and settings, though some challenges remain in their implementation. Bonsel et al. (2024) conducted a systematic review to identify the most effective ways PROMs are used, finding that simply collecting these measures can enhance patient outcomes, while their integration into decision aids further improves decision quality. Kaplan et al. (2021) examined the complexities of measuring treatment success, noting that outcome assessments depend on factors such as the patient's baseline health, provider expertise, facility standards, and adherence to best practices. Advances in technology and validated measurement tools have made it possible to consistently track patient data throughout the care process, which supports process improvement, informed decision-making, increased accountability, and better-aligned payment models. As a result, healthcare professionals are now more capable of transparently reporting and owning patient outcomes. PROMs not only capture the real-world impact of illness and treatment from the patient's perspective but also help ensure that care remains focused on what matters most to individuals, fostering a more tailored and patient-centered approach (Carfora et al., 2022). Together, these studies underscore the transformative potential of PROMs in healthcare. Interview participants discussed the importance of measuring patient performance. P6 noted, "We use patient satisfaction survey, it's facilitated by a third-party vendor, and we ask them questions related to their experience in the program." Using more standardized and frequently revised questionnaires to assess patient experience and satisfaction could help improve patient outcomes (Friedel et al., 2023).

Subtheme 2: Build Medication Compliance

Medication compliance is a significant challenge, with 74% of patients discon-

tinuing their medication within 18 months (Kim et al., 2020). To address this, psychiatrists often recommend LAIs to support adherence and reduce the risk of relapse. LAIs are particularly effective at reducing the likelihood of rehospitalization, especially among individuals with multiple prior admissions. For those diagnosed with schizophrenia spectrum disorder, low treatment adherence contributes to a high mortality rate (Okoli et al., 2024). Researchers advocate for educating patients about both the benefits and potential side effects of LAIs during hospitalization and at discharge, as this education may further decrease readmission rates. Interview participants highlighted the effectiveness of building medication compliance to reduce readmission rates. P4 noted, "Many do not have a way to manage their condition without medication. To address this, we are now emphasizing the use of long-acting medications. These treatments enable patients to maintain stability in the community." Evidence indicates that LAIs are associated with approximately a 65% reduction in psychiatric readmissions among patients with psychotic disorders (Patel & Tankersley, 2022). In addition to reducing readmission rates, LAIs improve patient QOL and offer significant cost savings to psychiatric hospitals (Patel & Tankersley, 2022). Collectively, these findings highlight the multifaceted benefits of LAIs in the management of psychotic disorders to decrease readmission rates, increase revenue, and improve patient outcomes.

Subtheme* 3: *Understand Underlying Factors for Readmission

Understanding the underlying factors contributing to patient readmission enables psychiatric hospital leaders to develop more effective interventions and strategies to reduce readmission, increase revenue and improve patient outcomes. By addressing the specific underlying issues, leaders can implement comprehensive strategies. These measures help reduce readmission rates, increase revenue by optimizing resource utilization, and improve patient outcomes by enhancing the quality and continuity of care. Identifying patients who are frequently readmitted and anticipating future rehospitalizations supports the creation of proactive intervention strategies and highlights possible shortcomings within current healthcare delivery systems (Barbosa & Marques, 2023). Bui and Moriuchi (2021) found that economic and social factors affect readmission rates in distinct ways for different patient populations. They also highlighted the need for policymakers and hospital leaders to develop tailored strategies to address the unique needs of complex patient groups. Underlying implications that contribute to worsening mental health and can increase psychiatric readmission include social factors such as income, jobs, education, housing, and support networks. Addressing these social determinants can help prevent mental health problems (Kirkbride et al., 2024). According to Russolillo et al. (2023), homelessness is strongly linked to higher rates of hospital readmission among individuals with mental illness and substance use disorders. A comprehensive understanding of the underlying factors contributing to patient readmission enables healthcare organizations to design targeted interventions that reduce readmission rates, enhance revenue through more efficient resource allocation, and significantly improve patient outcomes.

Roughly 71% of interview participants highlighted the importance of understanding the underlying factors contributing to psychiatric readmission. P4 noted, "we focus on treating the underlying issues that lead to patient admissions." In addition, P6 noted, "understanding individually what's going on and then helping the patients and their families get what they need to prevent them from being hospitalized." By systematically investigating these root causes, psychiatric hospital leaders can implement targeted solutions. P2 noted, "knowing their reasons for not wanting to join with us around reducing their admission back to the hospital." Also, P1 noted, "So now we were trying to create the whys, like what's attributing." Comprehensive approaches address the multifaceted nature of readmission while also promoting long-term recovery, reducing hospital costs, and improving patient outcomes. P7 noted, "Because when you're thinking about the patient, you're really trying to assess any evaluate and make sure that you're treating them as a whole person." By treating patients with a patient centered approach, leaders can identify potential barriers to recovery and anticipate challenges to deliver more personalized, effective care.

5. Professional Practice and Implications for Social Change

The research findings in this qualitative pragmatic inquiry project indicate notable business contributions and recommendations for psychiatric hospital leaders to reduce readmission, increase revenue, and improve patient outcomes. Effective strategies are essential in reducing psychiatric readmission, optimizing resource utilization within healthcare systems, and enhancing patient outcomes. I recommend that leaders prioritize several actionable strategies to address psychiatric patient readmission and improve overall hospital performance:

- establishing a dedicated readmission tracking task force composed of representatives from nursing, psychiatry, social work, case management, and data analytics to monitor readmission trends, identify root causes, and develop targeted interventions
- operating within the state budget by implementing cost-saving measures, optimizing the use of available resources, and seeking additional funding streams, such as grants and community partnerships, to support new initiatives
- ensuring timely and effective discharge planning through comprehensive patient assessments, early involvement of outpatient providers, clear communication with families, and scheduled follow-up appointments to support continuity of care
- using a multidisciplinary team approach that fosters collaboration among mental health professionals, primary care providers, pharmacists, peer support specialists, and community agencies to deliver holistic, patient-centered care
- reducing readmission rates by integrating EBPs, such as transitional care programs, patient education, adherence monitoring, and robust aftercare services

These evidence-based recommendations advance both practice and theory by providing a detailed framework for psychiatric hospital leaders to systematically

reduce readmission, optimize financial performance, and enhance patient outcomes. The project findings underscore the importance of coordinated, data-driven, and patient-focused strategies for sustained improvement.

It is essential to thoroughly understand the demographics and behaviors of patients, as this knowledge will inform the design and implementation of these interventions. P1 noted, "It is important to recognize that preventing all patients from returning to the hospital is not always feasible, as stressors in life cannot simply be eliminated." P7 noted, "we are going to have to continuously work at it and continue to make changes in order to reduce readmissions and increase the revenue and avoid you know decreases in revenue due to new readmissions." The recommendations focus on reducing psychiatric patient readmission by forming a dedicated tracking task force, optimizing budgets, improving discharge planning, fostering multidisciplinary teamwork, and using EBPs. These coordinated strategies aim to enhance patient care, financial performance, and long-term outcomes in psychiatric hospitals. One of these strategies include exploring innovative care coordination practices. Gallagher et al. (2022) found that involving clinical pharmacists in the discharge medication reconciliation process for patients at high risk of readmission was linked to lower rates of unplanned readmissions. The implementation of evidence-based treatment protocols has proven beneficial for psychiatric hospital revenue. According to Winner et al. (2025), follow-up phone calls made within 48 hours of discharge are thought to enhance the successful transfer of care for psychiatric patients who were recently hospitalized. The effectiveness of community-based support systems enhances understanding of successful psychiatric healthcare management strategies to reduce the likelihood of readmission. Additionally, investigating the role of patient education and engagement in treatment adherence may also provide valuable insights and improve patient outcomes. Understanding the impact of socioeconomic factors and access to ongoing mental health services is crucial for developing targeted interventions that prove beneficial in minimizing readmissions and increasing revenue.

Lastly, leaders should critically evaluate the efficacy of existing community support services, assessing their impact on patient outcomes and overall community health. In addition, leaders are responsible for disseminating the knowledge obtain through their evaluates, to their staff via annual conferences and trainings. The findings extend current understanding of strategies used by psychiatric hospital leaders to reduce readmission, increase revenue, and improve patient outcomes.

Positive social change entails the improvement of human or social conditions by promoting the worth, dignity, and development of individuals, communities, organizations, institutions, cultures, or societies. The findings from this project reveal significant implications for positive social change for psychiatric hospital directors to reduce readmission, increase revenue, and improve patient outcomes. Positive social change is a potential benefit by promoting and facilitating the systematization of key processes within psychiatric hospitals. These implications are

profound, with the potential to inspire and motivate stakeholders to work towards reducing readmission rates within psychiatric hospitals to increase revenue and improve patients' QOL globally. According to Luke and Chu (2013), implications include comprehending the necessity of taking steps to bring about social change and acknowledging the risk involved when current measures do not produce the desired results. Engaging with stakeholders, including community members and experts, during this process is crucial in creating strategies that are both practical and impactful. This comprehensive approach will enable leaders to better align resources with the needs of their communities, ultimately enhancing the quality of care provided. Additionally, there should be an emphasis on the role of multidisciplinary teams in providing holistic care, as well as the importance of continuous monitoring and follow-up practices to ensure sustained patient stability. Different strategies and techniques can be employed to explore how individuals understand, experience, interpret, and influence their social surroundings (Lewis-Beck et al., 2004). The evidence-based recommendations contribute to practice and theory by illuminating how psychiatric hospital leaders can reduce readmission, increase revenue, and improve patient outcomes.

6. Directions for Further Research

There are several specific areas of further research that would improve practice in the business of psychiatric healthcare management. Psychiatric hospital leaders who seek to implement strategies to reduce readmission, increase revenue, and improve patient outcomes would benefit from expanded research addressing the current project's limitations regarding sample size, data verification, and implementation assessment.

Future researchers should expand beyond seven participants to achieve a more representative and comprehensive understanding of psychiatric hospital leaders' perspectives and experiences. Including a wider range of participants such as leaders from different geographic regions, hospital types (i.e., public, private, academic, community-based), and organizational sizes will enhance the diversity of viewpoints and increase the generalizability of the study's findings. Researchers who draw from a larger, more varied sample can better identify trends, challenges, and best practices specific to different contexts. Additionally, incorporating objective data sources such as hospital readmission records, performance metrics, and third-party evaluations in addition to self-reported information will reduce bias and improve the reliability of the results. Exploring comparative case studies across multiple organizational contexts, such as urban versus rural hospitals or facilities serving different patient populations, will provide deeper insights into the factors influencing psychiatric readmission and the effectiveness of various intervention strategies. These approaches collectively strengthen the validity and applicability of research findings, offering a more robust evidence base to inform policy and practice improvements in psychiatric healthcare. More comprehensive studies focused on these areas could lead to more effective policies and practices

in psychiatric care aimed at reducing readmission, increasing revenue, and improving patient outcomes.

7. Limitations

The project had potential limitations. A sampling limitation may arise from the relatively small number of psychiatric directors who were interviewed during the research process. This restricted sample size could impact the diversity of perspectives and insights gathered, possibly leading to a skewed representation of opinions within the broader population of directors. Additionally, the experiences shared by participants may not fully represent the challenges of readmission in organizations of different sizes or locations. Lastly, the project relied on participants' subjective self-reported data regarding the use of strategies, making independent verification challenging.

8. Conclusion

The research was centered on the strategies used by psychiatric hospital leaders to reduce readmission, increase revenue, and improve patient outcomes. The project involved semistructured interviews with seven participants, all leaders of psychiatric hospitals located across the United States, and I used Braun and Clarke's (2022) thematic analysis to identify five major themes: 1) establish a readmission tracking task force, 2) operate within the state budget, 3) ensure timely and effective discharge planning, 4) use a multidisciplinary team approach, and 5) reduce readmission rates. The major themes included at least one subtheme each. The five major themes aligned with the CAS theory's attributes of how the psychiatric healthcare system comprises multiple, interacting agents such as patients, providers, administrators, families, and community organizations, whose relationships and behaviors are constantly evolving. By applying CAS principles, leaders can better analyze how these agents interact, adapt, and influence outcomes within the broader system. Understanding the healthcare system through the lens of CAS provides a comprehensive framework for understanding the dynamic, interconnected nature of psychiatric care.

The five major themes also aligned with the BSC theory's four attributes of the financial, customer, internal business processes, and learning and growth. By integrating the four perspectives, the BSC framework provides a comprehensive, actionable plan for psychiatric hospital directors to design and implement strategies that effectively reduce readmissions, increase revenue, and enhance patient outcomes through coordinated efforts across the entire organization. BSC ensures that every level of the organization is aligned with shared goals and priorities. Findings revealed several key strategies for psychiatric hospital leaders to reduce patient readmission and improve hospital performance. These included forming a multidisciplinary task force to track and address readmission trends, implementing cost-saving measures and seeking additional funding, ensuring effective discharge planning, fostering collaborative care among providers, and using EBPs

such as transitional care and patient education. Collectively, these coordinated, data-driven, and patient-centered approaches are designed to enhance patient outcomes and optimize psychiatric hospital resources. The findings extended current understanding of strategies used by psychiatric hospital leaders to reduce readmission, increase revenue, and improve patient outcomes. Further research would improve practice in the business of psychiatric healthcare management for leaders who seek to implement strategies to reduce readmission, increase revenue, and improve patient outcomes.

Author Contributions

K'chinwe Ezeokoli was the primary researcher. Dr. Kim A. Critchlow was the mentor/advisor/reviewer of the research being performed.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

Adu, M. K., da Luz Dias, R., Obuobi-Donkor, G., Ezeanozie, N., Sridharan, S., Morrison, J. et al. (2024). Reducing Wait Times and Avoiding Unnecessary Use of High-Cost Mental Health Services through a Rapid Access and Stabilization Program: Protocol for a Program Evaluation Study. *BMC Health Services Research, 24,* Article No. 247. https://doi.org/10.1186/s12913-024-10697-7

Alsubaie, S. S., Bukhamseen, Z. F. A., Alyami, F. S. A., Alotaibi, M. F., Alkahtani, F. A., Alkhamsan, M. S. et al. (2024). Multidisciplinary Approaches in General Medical Practice: Enhancing Collaboration for Better Patient Care. *Journal of Ecohumanism, 3,* 2659-2669. https://doi.org/10.62754/joe.v3i7.4665

Alvarado, M., Lahijanian, B., Zhang, Y., & Lawley, M. (2023). Penalty and Incentive Modeling for Hospital Readmission Reduction. *Operations Research for Health Care, 36,* Article 100376. https://doi.org/10.1016/j.orhc.2022.100376

Amer, F., Hammoud, S., Khatatbeh, H., Lohner, S., Boncz, I., & Endrei, D. (2022). The Deployment of Balanced Scorecard in Health Care Organizations: Is It Beneficial? A Systematic Review. *BMC Health Services Research, 22,* Article No. 65. https://doi.org/10.1186/s12913-021-07452-7

Anderson, J. E., Lavelle, M., & Reedy, G. (2020). Understanding Adaptive Teamwork in Health Care: Progress and Future Directions. *Journal of Health Services Research & Policy, 26,* 208-214. https://doi.org/10.1177/1355819620978436

Araja, D. (2022). Resilience and Complex Adaptive Systems: A Perspective on Healthcare. *Journal of Business Management, 20,* 23-35. https://doi.org/10.32025/jbm22006

Bahri, E. S., & Al Faruqy, M. Z. (2023). The Measurement Model of Business Entity Performance with Balanced Scorecard Approach. *Journal of Multi-Disciplines Science (ICECOMB), 1,* 9-15. https://doi.org/10.59921/icecomb.v1i1.4

Barasa, E. W., Molyneux, S., English, M., & Cleary, S. (2017). Hospitals as Complex Adaptive Systems: A Case Study of Factors Influencing Priority Setting Practices at the Hospital Level in Kenya. *Social Science & Medicine, 174,* 104-112. https://doi.org/10.1016/j.socscimed.2016.12.026

Barbosa, F. J., & Marques, G. J. (2023). The Revolving Door Phenomenon in Severe Psy-

chiatric Disorders: A Systematic Review. *International Journal of Social Psychiatry, 69,* 1075-1089. https://doi.org/10.1177/00207640221143282

Begun, J. W., Zimmerman, B., & Dooley, K. (2003). Health Care Organizations as Complex Adaptive Systems. In S. S. Mick, & M. E. Wyttenbach (Eds.), *Advances in Health Care Organization Theory* (pp. 253-288). Jossey-Bass. https://www.researchgate.net/profile/Kevin_Dooley/publication/228384399_Health_care_organizations_as_complex_adaptive_systems/links/00463534941356a9b5000000.pdf

Berben, K., Walgrave, E., Bergs, J., Van Hecke, A., Dierckx, E., & Verhaeghe, S. (2024). The Patient's Perspective on Participation in a Multidisciplinary Team Meeting: A Phenomenological Study. *International Journal of Mental Health Nursing, 33,* 1532-1542. https://doi.org/10.1111/inm.13351

Bonsel, J. M., Itiola, A. J., Huberts, A. S., Bonsel, G. J., & Penton, H. (2024). The Use of Patient-Reported Outcome Measures to Improve Patient-Related Outcomes—A Systematic Review. *Health and Quality of Life Outcomes, 22,* Article No. 101. https://doi.org/10.1186/s12955-024-02312-4

Braun, V., & Clarke, V. (2022). Thematic Analysis: A Practical Guide. *QMiP Bulletin, 1,* 46-50. https://doi.org/10.53841/bpsqmip.2022.1.33.46

Brom, H., Sliwinski, K., Amenyedor, K., & Brooks Carthon, J. M. (2024). Transitional Care Programs to Improve the Post-Discharge Experience of Patients with Multiple Chronic Conditions and Co-Occurring Serious Mental Illness: A Scoping Review. *General Hospital Psychiatry, 91,* 106-114. https://doi.org/10.1016/j.genhosppsych.2024.10.007

Bui, Q., & Moriuchi, E. (2021). Economic and Social Factors That Predict Readmission for Mental Health and Drug Abuse Patients. *Sustainability, 13,* Article 531. https://doi.org/10.3390/su13020531

Cabello-Rangel, H., Estrada-Martínez, M., & Martinez-Torres, M. (2024). Factors Associated with Readmission within 30 Days of Hospital Discharge of Psychiatric Patients: Case-Control Study. *Actas Españolas de Psiquiatría, 52,* 405-411. https://doi.org/10.62641/aep.v52i4.1651

Campbell, R., Ju, A., King, M. T., & Rutherford, C. (2022). Perceived Benefits and Limitations of Using Patient-Reported Outcome Measures in Clinical Practice with Individual Patients: A Systematic Review of Qualitative Studies. *Quality of Life Research, 31,* 1597-1620. https://doi.org/10.1007/s11136-021-03003-z

Carfora, L., Foley, C. M., Hagi-Diakou, P., Lesty, P. J., Sandstrom, M. L., Ramsey, I. et al. (2022). Patients' Experiences and Perspectives of Patient-Reported Outcome Measures in Clinical Care: A Systematic Review and Qualitative Meta-Synthesis. *PLOS ONE, 17,* e0267030. https://doi.org/10.1371/journal.pone.0267030

Connor, L., Dean, J., McNett, M., Tydings, D. M., Shrout, A., Gorsuch, P. F. et al. (2023). Evidence-Based Practice Improves Patient Outcomes and Healthcare System Return on Investment: Findings from a Scoping Review. *Worldviews on Evidence-Based Nursing, 20,* 6-15. https://doi.org/10.1111/wvn.12621

Din, B. R. U., Anjum, F., & Malik, A. (2024). Cross-Disciplinary Collaboration in Healthcare: Enhancing Outcomes through Team-Based Care. *Multidisciplinary Journal of Healthcare (MJH), 1,* 11-19. https://doi.org/10.66320/1rcx0q15

Dolber, T., Runnels, P., & Pronovost, P. J. (2025). Assertive Community Treatment for Complex and Costly Patients. *The American Journal of Managed Care, 31,* e173-e175.

Eboreime, E., Shalaby, R., Mao, W., Owusu, E., Vuong, W., Surood, S. et al. (2022). Reducing Readmission Rates for Individuals Discharged from Acute Psychiatric Care in Alberta Using Peer and Text Message Support: Protocol for an Innovative Supportive Pro-

gram. *BMC Health Services Research, 22,* Article No. 332. https://doi.org/10.1186/s12913-022-07510-8

Engebretson, J. C., & Hickey, J. V. (2013). Complexity Science and Complex Adaptive Systems. In J. B. Butts, & K. L. Rich (Eds.), *Philosophies and Theories for Advanced Nursing Practice* (2nd ed., pp. 111-138). Jones & Bartlett Learning. https://books.google.com/books?hl=en&lr=&id=ZPCVAgAAQBAJ&oi=fnd&pg=PA111&dq=Engebretson+%26+Hickey,+(2013)+&ots=mCXH2HdyC0&sig=NMextXkgFdqbJ7PegBAH-Puz8N6E#v=onepage&q&f=false

Escobar, G. J., Plimier, C., Greene, J. D., Liu, V., & Kipnis, P. (2019). Multiyear Rehospitalization Rates and Hospital Outcomes in an Integrated Health Care System. *JAMA Network Open, 2,* e1916769. https://doi.org/10.1001/jamanetworkopen.2019.16769

Fatani, A., Alzebaidi, S., Alghaythee, H. K., Alharbi, S., Bogari, M. H., Salamatullah, H. K. et al. (2025). The Role of the Discharge Planning Team on the Length of Hospital Stay and Readmission in Patients with Neurological Conditions: A Single-Center Retrospective Study. *Healthcare, 13,* Article 143. https://doi.org/10.3390/healthcare13020143

Fleurence, R. L., & Chhatwal, J. (2025). Advancing Mental Health Economics: Insights from the Themed Section. *Value in Health, 28,* 323-325. https://doi.org/10.1016/j.jval.2024.12.007

Friedel, A. L., Siegel, S., Kirstein, C. F., Gerigk, M., Bingel, U., Diehl, A. et al. (2023). Measuring Patient Experience and Patient Satisfaction—How Are We Doing It and Why Does It Matter? A Comparison of European and U.S. American Approaches. *Healthcare, 11,* Article 797. https://doi.org/10.3390/healthcare11060797

Fu, B. Q., Zhong, C. C., Wong, C. H., Ho, F. F., Nilsen, P., Hung, C. T. et al. (2023). Barriers and Facilitators to Implementing Interventions for Reducing Avoidable Hospital Readmission: Systematic Review of Qualitative Studies. *International Journal of Health Policy and Management, 12,* Article 7089. https://doi.org/10.34172/ijhpm.2023.7089

Gallagher, D., Greenland, M., Lindquist, D., Sadolf, L., Scully, C., Knutsen, K. et al. (2022). Inpatient Pharmacists Using a Readmission Risk Model in Supporting Discharge Medication Reconciliation to Reduce Unplanned Hospital Readmissions: A Quality Improvement Intervention. *BMJ Open Quality, 11,* e001560. https://doi.org/10.1136/bmjoq-2021-001560

Gans, E. A., de Ruijter, U. W., van der Heide, A., van der Meijden, S. A., van den Bos, F., van Munster, B. C. et al. (2024). A Grounded Theory of Interdisciplinary Communication and Collaboration in the Outpatient Setting of the Hospital for Patients with Multiple Long-Term Conditions. *Journal of Personalized Medicine, 14,* Article 533. https://doi.org/10.3390/jpm14050533

Geffen, N., Rodriguez, I., Wyder, M., & Kar Ray, M. (2025). Identifying Barriers to Seamless Mental Health Care Transitions: A Mixed Methods Study Exploring the Lead-Up to Unplanned Psychiatric Admissions. *Journal of Psychiatric and Mental Health Nursing, 32,* 1412-1420. https://doi.org/10.1111/jpm.70036

Ghabowen, I., Epane, J. P., Shen, J. J., Goodman, X., Ramamonjiarivelo, Z., & Zengul, F. D. (2024). Systematic Review and Meta-Analysis of the Financial Impact of 30-Day Readmissions for Selected Medical Conditions: A Focus on Hospital Quality Performance. *Healthcare, 12,* Article 750. https://doi.org/10.3390/healthcare12070750

Glance, L. G., Li, Y., & Dick, A. W. (2017). Impact on Hospital Ranking of Basing Readmission Measures on a Composite Endpoint of Death or Readmission versus Readmissions Alone. *BMC Health Services Research, 17,* Article No. 327. https://doi.org/10.1186/s12913-017-2266-4

Hahn, B., Ball, T., Diab, W., Choi, C., Bleau, H., & Flynn, A. (2024). Utilization of a Multidisciplinary Hospital-Based Approach to Reduce Readmission Rates. *SAGE Open Medicine, 12,* 1-11.

Hegedüs, A., Kozel, B., Richter, D., & Behrens, J. (2020). Effectiveness of Transitional Interventions in Improving Patient Outcomes and Service Use after Discharge from Psychiatric Inpatient Care: A Systematic Review and Meta-Analysis. *Frontiers in Psychiatry, 10,* Article ID: 969. https://doi.org/10.3389/fpsyt.2019.00969

Hermer, L., Nephew, T., & Southwell, K. (2022). Follow-Up Psychiatric Care and Risk of Readmission in Patients with Serious Mental Illness in State Funded or Operated Facilities. *Psychiatric Quarterly, 93,* 499-511. https://doi.org/10.1007/s11126-021-09957-0

Hindsbak, N., Morsø, L., Hvidtjørn, D., & Walløe, S. (2024). Identification of Interventions to Improve Patient Experienced Quality of Care in Transitions between Healthcare Settings: A Scoping Review. *BMC Health Services Research, 24,* Article No. 1155. https://doi.org/10.1186/s12913-024-11609-5

Holland, J. H. (1992). Complex Adaptive Systems. *Daedalus, 121,* 17-30. https://philpapers.org/rec/HOLCAS-4

Hou, M., Wu, Y., Xue, J., Chen, Q., Zhang, Y., Zhang, R. et al. (2024). A Predictive Model for Readmission within 1-Year Post-Discharge in Patients with Schizophrenia. *BMC Psychiatry, 24,* Article No. 573. https://doi.org/10.1186/s12888-024-06024-3

Huang, X. J., Ma, H. Y., Wang, X. M., Zhong, J., Sheng, D. F., & Xu, M. Z. (2022). Equating the PHQ-9 and GAD-7 to the HADS Depression and Anxiety Subscales in Patients with Major Depressive Disorder. *Journal of Affective Disorders, 311,* 327-335. https://doi.org/10.1016/j.jad.2022.05.079

Jaffé, M. E., Moeller, J., Rabenschlag, F., Aebersold, C. A., Eysell, J., Bruttel, C. et al. (2025). Pilot Study Results from the Assertive Community Treatment Transitional Intervention Program in Switzerland. *Scientific Reports, 15,* Article No. 8945. https://doi.org/10.1038/s41598-025-93470-y

Johnsen, Å. (2001). Balanced Scorecard: Theoretical Perspectives and Public Management Implications. *Managerial Auditing Journal, 16,* 319-330. https://doi.org/10.1108/02686900110395460

Jordans, M. J. D. (2025). Applying Systems Theory to Global Mental Health. *Cambridge Prisms: Global Mental Health, 12,* e2. https://doi.org/10.1017/gmh.2024.147

Kamøy, M. J. A., & De Boer, L. (2021). CAS Theory: An Innovative Lens to Public Sector Health Services? In *The International Society for Professional Innovation Management (ISPIM).* https://www.proquest.com/docview/2617200755?pq-origsite=gscholar&fromopenview=true&sourcetype=Conference%20Papers%20&%20Proceedings

Kaplan, R. S., & Norton, D. P. (1992). The Balanced Scorecard: Measures that Drive Performance. *Harvard Business Review Journal, 70,* 71-79. https://hbr.org/1992/01/the-balanced-scorecard-measures-that-drive-performance-2

Kaplan, R. S., & Norton, D. P. (2001). The Strategy-Focused Organization. *Strategy & Leadership, 29.* https://doi.org/10.1108/sl.2001.26129cab.002

Kaplan, R. S., Jehi, L., Ko, C. Y., Pusic, A., & Witkowski, M. (2021). Health Care Measurements That Improve Patient Outcomes. *NEJM Catalyst, 2.* https://doi.org/10.1056/cat.20.0527

Kim, H. O., Seo, G. H., & Lee, B. C. (2020). Real-World Effectiveness of Long-Acting Injections for Reducing Recurrent Hospitalizations in Patients with Schizophrenia. *Annals of General Psychiatry, 19,* Article No. 1. https://doi.org/10.1186/s12991-019-0254-2

Kirkbride, J. B., Anglin, D. M., Colman, I., Dykxhoorn, J., Jones, P. B., Patalay, P. et al. (2024). The Social Determinants of Mental Health and Disorder: Evidence, Prevention and Recommendations. *World Psychiatry, 23,* 58-90. https://doi.org/10.1002/wps.21160

Knapp, M., & Wong, G. (2020). Economics and Mental Health: The Current Scenario. *World Psychiatry, 19,* 3-14. https://doi.org/10.1002/wps.20692

Kohrt, B. A., Pedersen, G. A., Schafer, A., Carswell, K., Rupp, F., Jordans, M. J. D. et al. (2025). Competency-Based Training and Supervision: Development of the WHO-UNICEF Ensuring Quality in Psychosocial and Mental Health Care (EQUIP) Initiative. *The Lancet Psychiatry, 12,* 67-80. https://doi.org/10.1016/s2215-0366(24)00183-4

Kumar, S., Lim, W. M., Sureka, R., Jabbour, C. J. C., & Bamel, U. (2024). Balanced Scorecard: Trends, Developments, and Future Directions. *Review of Managerial Science, 18,* 2397-2439. https://doi.org/10.1007/s11846-023-00700-6

Lewis-Beck, M. S., Bryman, A., & Liao, T. F. (2004). *Qualitative Research* (Vol. 3, pp. 893-894). SAGE Publications, Inc.

Lukanski, A., Watters, S., Bilderback, A. L., Buchanan, D., Hodges, J. C., Burwell, D. et al. (2023). Implementing a Discharge Follow-Up Phone Call Program Reduces Readmission Rates in an Integrated Health System. *Journal for Healthcare Quality, 45,* 315-323. https://doi.org/10.1097/jhq.0000000000000400

Maoz, H., Sabbag, R., Mendlovic, S., Krieger, I., Shefet, D., & Lurie, I. (2024). Long-Term Efficacy of a Continuity-of-Care Treatment Model for Patients with Severe Mental Illness Who Transition from In-Patient to Out-Patient Services. *The British Journal of Psychiatry, 224,* 122-126. https://doi.org/10.1192/bjp.2024.9

March, K. L., Peters, M. J., Finch, C. K., Roberts, L. A., McLean, K. M., Covert, A. M. et al. (2022). Pharmacist Transition-of-Care Services Improve Patient Satisfaction and Decrease Hospital Readmissions. *Journal of Pharmacy Practice, 35,* 86-93. https://doi.org/10.1177/0897190020958264

McGuire, A. B., Flanagan, M. E., Myers, L. J., Kukla, M., Rollins, A. L., Garabrant, J. et al. (2022). Recovery-Oriented Inpatient Mental Health Care and Readmission. *Psychiatric Rehabilitation Journal, 45,* 331-335. https://doi.org/10.1037/prj0000533

Mcllvennan, C. K., Eapen, Z. J., & Allen, L. A. (2015). Hospital Readmissions Reduction Program. *Circulation, 131,* 1796-1803. https://doi.org/10.1161/circulationaha.114.010270

Mio, C., Costantini, A., & Panfilo, S. (2022). Performance Measurement Tools for Sustainable Business: A Systematic Literature Review on the Sustainability Balanced Scorecard Use. *Corporate Social Responsibility and Environmental Management, 29,* 367-384. https://doi.org/10.1002/csr.2206

Mlay, J. P., Naidu, T., Ramlall, S., Patankar, K., Israel, K., Esquivel, L. et al. (2025). Strategies for Relapse Prevention among People with Schizophrenia in Kwazulu-Natal Province, South Africa: Healthcare Providers' Perspectives. *PLOS ONE, 20,* e0316313. https://doi.org/10.1371/journal.pone.0316313

Newman, M. W. (2022). Value Added? A Pragmatic Analysis of the Routine Use of PHQ-9 and GAD-7 Scales in Primary Care. *General Hospital Psychiatry, 79,* 15-18. https://doi.org/10.1016/j.genhosppsych.2022.09.005

Nilsen, P., Seing, I., Ericsson, C., Birken, S. A., & Schildmeijer, K. (2020). Characteristics of Successful Changes in Health Care Organizations: An Interview Study with Physicians, Registered Nurses and Assistant Nurses. *BMC Health Services Research, 20,* Article No. 147. https://doi.org/10.1186/s12913-020-4999-8

Notarnicola, I., Lommi, M., Ivziku, D., Carrodano, S., Rocco, G., & Stievano, A. (2024). The Nursing Theory of Complex Adaptive Systems: A New Paradigm for Nursing. *Healthcare,*

12, Article 1997. https://doi.org/10.3390/healthcare12191997

Ojo, S., Okoye, T. O., Olaniyi, S. A., Ofochukwu, V. C., Obi, M. O., Nwokolo, A. S. et al. (2024). Ensuring Continuity of Care: Effective Strategies for the Post-Hospitalization Transition of Psychiatric Patients in a Family Medicine Outpatient Clinic. *Cureus, 16,* e52263.

Okoli, C. T. C., Abufarsakh, B., Wang, T., Makowski, A., & Cooley, A. (2024). Assessing the Impact of Long-Acting Injectable Compared to Oral Antipsychotic Medications on Readmission to a State Psychiatric Hospital. *Journal of Psychiatric and Mental Health Nursing, 31,* 1155-1163. https://doi.org/10.1111/jpm.13075

Öngür, D., & Paulus, M. P. (2025). Embracing Complexity in Psychiatry—From Reductionistic to Systems Approaches. *The Lancet Psychiatry, 12,* 220-227. https://doi.org/10.1016/s2215-0366(24)00334-1

Oyesanya, T. O., Loflin, C., Byom, L., Harris, G., Daly, K., Rink, L. et al. (2021). Transitions of Care Interventions to Improve Quality of Life among Patients Hospitalized with Acute Conditions: A Systematic Literature Review. *Health and Quality of Life Outcomes, 19,* 1-12. https://doi.org/10.1186/s12955-021-01672-5

Panjaitan, L. F. Y., Sjaaf, A. C., & Falinda, R. (2022). Hospital Performance Assessment Balanced Scorecard Method—Its Implementation in the Third Decade: Scoping Review. *Journal of Community Health, 8,* 586-589.

Patel, R. S., & Tankersley, W. E. (2022). Real-World Effectiveness of Long-Acting Injectable Antipsychotics to Reduce 90-Day and Annual Readmission in Psychotic Disorders: Insights from a State Psychiatric Hospital. *CNS Spectrums, 27,* 626-633. https://doi.org/10.1017/s109285292100050x

Po, H.-W., Lin, F.-J., Cheng, H.-J., Huang, M.-L., Chen, C.-Y., Hwang, J.-J., & Chiu, Y.-W. (2023). Factors Affecting the Effectiveness of Discharge Planning Implementation: A Case-Control Cohort Study. *Journal of Nursing Research, 31,* e274. https://doi.org/10.1097/jnr.0000000000000555

Prabhakaran, N., Magon, H., Kelly, B., & Marques, M. (2025). Enhancing Patient Care through Streamlined 72-Hour Meetings: A Multidisciplinary Approach. *Journal of Psychosocial Rehabilitation and Mental Health, 13,* 261-269. https://doi.org/10.1007/s40737-025-00455-1

Prenestini, A., Calciolari, S., & Rota, A. (2024). Keep-or-Drop Multidimensional Control Systems in Professional Organisations: Evidence on the Use of the Balanced Scorecard in Healthcare. *Journal of Health Organization and Management, 38,* 157-174. https://doi.org/10.1108/jhom-09-2023-0287

Russolillo, A., Moniruzzaman, A., Carter, M., Raudzus, J., & Somers, J. M. (2023). Association of Homelessness and Psychiatric Hospital Readmission—A Retrospective Cohort Study 2016-2020. *BMC Psychiatry, 23,* Article No. 459. https://doi.org/10.1186/s12888-023-04945-z

Satake, N., Yamaguchi, S., Sato, S., & Fujii, C. (2025). Long-Term Outcomes of Assertive Community Treatment in Japan: 7-Year Follow-Up of a Randomized Controlled Trial. *BMC Psychiatry, 25,* Article No. 870. https://doi.org/10.1186/s12888-025-07311-3

Saunders, M. N. K., Thornhill, A., & Lewis, P. (2020). *Research Methods for Business Students* (8th ed.). Pearson International Content.

Savin-Baden, M., & Major, C. H. (2013). *Qualitative Research: The Essential Guide to Theory and Practice* (1 ed.). Routledge.

Smith, A., Hansen, J., & Colvard, M. (2021). Impact of a Pharmacist-Led Substance Use Disorder Transitions of Care Clinic on Postdischarge Medication Treatment Retention. *Journal of Substance Abuse Treatment, 130,* Article 108440.

https://doi.org/10.1016/j.jsat.2021.108440

Stensland, M., Watson, P. R., & Grazier, K. L. (2012). An Examination of Costs, Charges, and Payments for Inpatient Psychiatric Treatment in Community Hospitals. *Psychiatric Services, 63,* 666-671. https://doi.org/10.1176/appi.ps.201100402

Stuhec, M., & Batinic, B. (2023). Clinical Pharmacist Interventions in the Transition of Care in a Mental Health Hospital: Case Reports Focused on the Medication Reconciliation Process. *Frontiers in Psychiatry, 14,* Article ID: 1263464. https://doi.org/10.3389/fpsyt.2023.1263464

Summers, F., Schmidt, R. N., Flores, D., Dayama, N., & House, M. (2023). Reducing Inpatient Behavioral Health Readmissions. *Journal of Business and Behavioral Sciences, 35,* 102-130. https://www.proquest.com/scholarly-journals/reducing-inpatient-behavioral-health-readmissions/docview/2851281445/se-2

Ţenea-Cojan, Ş. T., Dinescu, V. C., Gheorman, V., Dragne, I. G., Gheorman, V., Forţofoiu, M. et al. (2025). Exploring Multidisciplinary Approaches to Comorbid Psychiatric and Medical Disorders: A Scoping Review. *Life, 15,* Article 251. https://doi.org/10.3390/life15020251

Turkington, A., & Stirling, E. (2024). Predictors of Readmission to an Acute Psychiatric Inpatient Unit. *BJPsych Open, 10,* S208-S209. https://doi.org/10.1192/bjo.2024.518

Virtanen, M., Peutere, L., Härmä, M., & Ropponen, A. (2024). Factors Associated with Readmissions in Psychiatric Inpatient Care: A Prospective Cohort Study Based on Hospital Registers. *BMC Psychiatry, 24,* Article No. 734. https://doi.org/10.1186/s12888-024-06193-1

Watts, S., Hall, J., Pedersen, G. A., Ottman, K., Carswell, K., van't Hof, E. et al. (2021). The WHO EQUIP Foundational Helping Skills Trainer's Curriculum. *World Psychiatry, 20,* 449-450. https://doi.org/10.1002/wps.20880

Weiss, A. J., & Jiang, H. J. (2021). *Overview of Clinical Conditions with Frequent and Costly Hospital Readmissions by Payer, 2018.* https://pubmed.ncbi.nlm.nih.gov/34460186/

Winner, K., Sandberg, K., Saia, B., Calabro, M., & Blankenship, K. (2025). A Quality Improvement Initiative to Decrease Behavioral Health Unit Readmission Rates. *Pediatrics, 155,* e2023064917. https://doi.org/10.1542/peds.2023-064917

Yamaguchi, S., Ojio, Y., Koike, J., Matsunaga, A., Ogawa, M., Kikuchi, A. et al. (2024). Associations between Readmission and Patient-Reported Measures in Acute Psychiatric Inpatients: A Multicenter Prospective Longitudinal Study. *Social Psychiatry and Psychiatric Epidemiology, 60,* 79-93. https://doi.org/10.1007/s00127-024-02710-5

Yawson, R. M., & Paros, A. K. B. (2023). Systems Perspective of the Use of the Balanced Scorecard for Organization Development and Change. *Sage Open, 13,* 1-15.

Zheng, S., Hanchate, A., & Shwartz, M. (2019). One-Year Costs of Medical Admissions with and without a 30-Day Readmission and Enhanced Risk Adjustment. *BMC Health Services Research, 19,* Article No. 155. https://doi.org/10.1186/s12913-019-3983-7

Zhou, H., Ngune, I., Albrecht, M. A., & Della, P. R. (2023). Risk Factors Associated with 30-Day Unplanned Hospital Readmission for Patients with Mental Illness. *International Journal of Mental Health Nursing, 32,* 30-53. https://doi.org/10.1111/inm.13042