Staff evaluations and perceptions of organizational culture: Implications for performance improvement and mental healthcare service evaluation

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Staff evaluations and perceptions of organizational culture:
Implications for performance improvement and mental healthcare
service evaluation

by

Jeffrey Scott Kerber

A dissertation submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of
DOCTOR OF PHILOSOPHY

Major: Human Development and Family Studies (Marriage and Family Therapy)

Major Professor: Harvey Joanning

Iowa State University

Ames, Iowa

1997

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has met the dissertation requirements of Iowa State University

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Results

Themes

1. Understanding the entire process of service provision, depends on which roles staff occupy.

2. Focus groups are helpful as they validate participants, enhance understanding of staff interdependency and emphasize the need for effective communication.

3. Staff perceive upper administration as nonsupportive and out of touch with their needs and concerns.

4. Other than serving patients better, staff perceive "performance improvement" as ambiguous and/or not relevant.

5. Staff recognize the complexity of change as an emotional process resulting in frustration, isolation and compromised quality of service to patients.

6. Attaining important information for quality service is compromised by both the unique challenges inherent with mental healthcare and the frustrating complexity of the system.
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ABSTRACT

The researcher studied staff perceptions and evaluations regarding the provision of adult outpatient mental health services at a county medical center. Methods to improve the quality of adult outpatient mental health services were examined. Qualitative methods were employed to conduct a process and cultural assessment. The researcher addressed: 1) staff evaluations of crucial issues regarding performance improvement, 2) cultural issues relating to organizational change and development, 3) the interventive impact of focus group involvement, 4) the utility of qualitative methods for data analysis, 5) specific considerations for mental healthcare staff, and 6) how the evaluative process of a specific service and/or program impact the greater organizational system. All facets of service provision except confidential information expressed within the confines of the therapeutic relationship were examined.

Results yielded six themes indicating cultural, system and leadership issues that compromise the quality of service provision. The final themes include: 1) understanding the entire process of service provision, depends on which roles staff occupy, 2) focus groups are helpful as they validate participants, enhance understanding of staff interdependency and emphasize the need for effective communication, 3) staff perceive upper administration as non supportive and out of touch with their needs and concerns, 4) other than serving patients better, staff perceive “performance improvement” as ambiguous and/or not relevant, 5) staff recognize the complexity of change as an emotional process resulting in frustration, isolation and compromised quality of service to patients, and 6) attaining important information for
quality service is compromised by both the unique challenges inherent with mental healthcare and the frustrating complexity of the system. Implications from this study support the salience of qualitative process research to develop strategies for change in mental healthcare organizations. In addition, the study outlines creative strategies for family therapists to apply clinical training, systems theory and qualitative methods to work with larger systems.
CHAPTER 1

INTRODUCTION

Before we can begin doing things right, we must learn and decide what
the right things are to do.

—Stephen R. Covey, 1989

The changes taking place in mental healthcare today are pervasive and foundational (Chowanec, 1996). Learning the right things to do in a healthcare organization is a complicated, dynamic and crucial undertaking. The most important expression of quality improvement is discerning what the right things are to do and then focusing on doing those things well.

From the beginning, the spirit of better quality in healthcare was clearly focused on improving patient care. Initially based on an “end results” thesis that focused on patient outcomes, and intended to promote public accountability for physicians, formal efforts to improve the quality of healthcare can be traced back to 1910 (Luce, Bindman, & Lee, 1994; O’Leary, 1995). The outcome focused “end results” thesis was unpopular with physicians of the time, and was eventually replaced by standardization. With standardization came the assumption that if healthcare organizations determined what they ought to be doing and if they were found to be doing those things well, then those organizations would have good outcomes (O’Leary, 1995).
Within fifty years of the standardization initiative, a variety of medical associations in both the United States and Canada formed the Joint Commission on Hospital Accreditation (Roberts, Coale, & Redman, 1987). In 1953 efforts to improve quality were voluntary as the Joint Commission began to offer accreditation to hospitals. However, by the mid 1960’s prompted by growing regulatory conditions tied to federal reimbursement along with increasing sophistication of quality improvement methods, the Joint adopted a new philosophy called the “optimal achievable standards” (Luce et al., 1994; Roberts et al., 1987). The new philosophy was an initial step toward greater partnership with government, mandatory accreditation and more aggressive quality improvement efforts. Fully utilizing Quality Assurance (QA) methods, the Joint’s optimal achievable standards process heavily emphasized outcomes determined by inspection or audit (Berwick, 1989; Luce et al., 1994).

In 1987 the Joint Commission on Hospital Accreditation changed its name to the more inclusive Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (Luce et al., 1994). Along with the change of name and responding to public demand for greater value in healthcare, the JCAHO adopted a new focus for quality improvement (Duncan, Fleming, & Gallati, 1991; Laffel & Blumenthal, 1989). Borrowing from business and industry, the principles of Total Quality Management (TQM) and Continuous Quality Improvement (CQI) became the basis for quality improvement in healthcare and mental healthcare (Berwick, 1989; Gaucher & Coffey, 1993; Chowanec, 1996). The new focus was now on evaluation and improvement of systems and processes rather than isolated outcomes, quality is built in by design not determined by inspection (Deming, 1982).
The latest expression of quality improvement in healthcare is Performance Improvement (PI). The 1996 JCAHO Accreditation Manual emphasizes two dimensions of performance improvement: 1.) Doing the right things, and 2.) Doing the right things well (JCAHO, 1996). The sub-standards under performance improvement include: planning, designing, measuring, assessing, and improving (JCAHO, 1996). The JCAHO does not provide detailed guidelines regarding the planning, designing or improving stages of performance improvement. Therefore, considerable flexibility exists for individual organizations to proactively address their idiosyncratic needs and wants regarding performance improvement.

The literature regarding quality improvement has focused on three central issues: 1.) cost containment, 2.) competitive viability and 3.) organization cultural change (Barnette & Clendenen, 1996; Batalden & Stolz, 1993; Campion & Rosenblatt, 1996; Covey, 1990; Duncän et al., 1991; Eddy, 1990, 1994; Juran, 1964; Laffel & Blumenthal, 1989; McFarland, Harmann, Lhotak, & Wieselthier, 1996; McGuire & Longo, 1993; Nolan, 1994; Senge, 1990; Shelton, 1995; Sluyter, 1996; Wakefield & Wakefield, 1993; Waress, Pasternak, & Smith, 1994). The challenge for contemporary quality improvement in healthcare is to provide quality service with greater value than the competition. Further, the absence of staff involvement in planning and designing will seriously compromise performance improvement efforts (Barnette & Clendenen, 1996; Senge, 1990; Sluyter, 1996). Superior quality of service provision will necessitate staff commitment to changes brought about by performance improvement (Barnette & Clendenen, 1996; Covey, 1990; Sluyter, 1996). The present
research involved staff persons in planning and designing performance improvement. In essence, the staff participants taught the researcher about the right things to do.

**Purpose of the Study**

The purpose of the research was to learn from staff what the “right things are to do” regarding quality improvement for adult outpatient mental healthcare service provision. Two guiding premises set the parameters for the study. The two premises were evaluation and improvement. Evaluation in the sense the researcher actively explored staff responses to various forms of the question, “How well are we doing?” Improvement in the sense the researcher actively sought staff responses to various forms of the question, “How can we improve what we are doing?”

Specifically, the research focused on evaluating and improving the provision of adult outpatient mental healthcare services at a small, midwestern, urban medical center. A combination of focus groups and individual interviews were facilitated by the author and co-researcher, with the author serving as the primary analyst and researcher for the present dissertation. The researcher collected staff input and expertise in the form of transcript narratives derived from audio taped interviews. The culmination of staff input was the delineation of six themes grounded in the experience and language of participants.

In addition to assessing staff evaluations and suggestions for improving services, the method of inquiry and intervention was also under study. The researcher is developing processes of data collection and analysis that might be utilized in other mental healthcare
and/or medical settings. The present study provided opportunity for the researcher to refine existing skills and evolve new competencies for applied research.

**Collaborative Project Introduction**

The research was part of a collaborative project involving two doctoral students working together to learn about quality improvement in a mental healthcare organization. Two distinct yet complementary research agendas guided the inquiry. The primary researcher agenda explored staff evaluations of service provision and generated suggestions for improvement. Correspondingly, the co-researcher agenda explored patient evaluations of service provision and generated suggestions for improvement (Angera, 1997). The agendas were recursive and the researchers worked interdependently.

The collaborative project involved both staff and patient participation. The researchers conducted focus groups over a period of six months. During the first month and a half of the study, three staff only focus groups were conducted in parallel sequence with four patient only focus groups (see Figure 1). At the conclusion of the staff and patient only focus groups, the groups merged to form conjoint patient/staff focus groups. In addition to the focus groups two individual interviews were conducted by the primary researcher.

Participant expertise was accessed primarily through transcripts derived from audio taped interviews. Following qualitative methodology (Creswell, 1994; Gummesson, 1991; Lincoln & Guba, 1985; Tesch, 1990) data were collected and analyzed in a recursive and emergent fashion. Both researchers worked autonomously as well as collaboratively
Figure 1. Collaborative Project Overview
with several observers throughout data collection and analysis. At several stages during the interview process researchers extrapolated themes from the transcripts and shared the themes with the participants and auditors for critique and refinement. As indicated by Figure 1, information was shared from group to group in order to facilitate greater learning (Senge, 1990). In the final form, themes reflected both cultural issues and pragmatic suggestions for consideration when designing and implementing performance improvement.

**Questions Posed by the Study**

In qualitative research, the questions posed by the study ought to be the broadest questions that can be asked (Creswell, 1994). Based on the researcher's native understanding of the system under study and the review of related literature, the following questions were addressed:

- How do staff evaluate the process of providing adult outpatient mental health services?
- How do staff perceive performance improvement regarding service provision?
- What are the most salient issues regarding improving performance?
- How do staff evaluate the focus group process?
CHAPTER 2

REVIEW OF RELATED LITERATURE

The review of related literature serves several purposes. First, to delineate the historical context out of which the current state of the art regarding quality improvement in healthcare has emerged. Second, to comment on quality improvement in its most recent expression as relevant to healthcare. Third, to highlight the current utilization of systems theory in conceptualizing change in organizations. Fourth, to comment on the quality improvement effort in mental healthcare. Finally, to provide a rational basis for the appropriateness of the research.

History of Quality Improvement in Healthcare

Throughout the healthcare quality improvement literature there is numerous mention of the relationship between "quality and cost" (Campion & Rosenblatt, 1996; Duncan et al., 1991; Eddy, 1990, 1994; Luce et al., 1994; Nolan, 1994; Sprinkle, 1994; Waress et al., 1994). It is safe to assert the "bottom line" has been a central motivation for quality reform in healthcare, just as in industry (Laffel & Blumenthal, 1989; Senge, 1990). However, quality in medical healthcare began for less tangible reasons.

Not quite 100 years old, formal efforts to improve the quality of healthcare can be traced to 1910 with the synergistic work of the American Medical Association (AMA) and Dr. Ernest Codman of Massachusetts General Hospital (Luce et al., 1994). As such, it is clear their historic efforts were focused on improving hospital conditions and assuring patient care had been effective. Dr. Codman's initial ideas were based on an "end results" thesis,
intended to promote public accountability for physicians (O'Leary, 1995). Less threatening to physicians of the time and thereby ensuring greater physician support, the “end results” notion quickly evolved into a standards initiative, based on a different thesis. As such, the new thesis suggested healthcare organizations determine what they ought to be doing and if they are found to be doing those things well, then those organizations will have good outcomes (O’Leary, 1995).

In 1917 the standardization effort was formalized by the American College of Surgeons; hence, they established the “five minimum standards” (Luce et al., 1994). The essence of these standards can be summarized by the following:

1. Organizing hospital medical staffs;
2. Limiting staff membership to well-educated, competent, and licensed physicians and surgeons;
3. Framing rules and regulations to ensure regular staff meetings and clinical review;
4. Keeping medical records that included the history, physical examination, and laboratory results; and
5. Establishing supervised diagnostic and treatment facilities such as clinical laboratories and radiology departments (Roberts et al., 1987).

For the contemporary student of quality in healthcare, the minimum standards absence of cost containment rhetoric is refreshing. As indicated by the title “five minimum standards,” the early quality movement was easily characterized as an effort to standardize healthcare. As such, these early thinkers/doers in healthcare quality were striving to bring uniformity to
hospital practices with the belief such uniformity would enhance the quality of care received by patients. Also, the focus on “minimum” would seem to indicate the early efforts were geared towards avoiding sub-standard care rather than pursuing excellence, or above standard care. It seems arguable that early on quality equaled standardization. Although only a beginning, the minimum standards set the tone of contemporary quality via what would become, “accreditation” (Roberts et al., 1987).

The standardization process took a significant shot in the arm when in 1917 John Bowman, Ph.D., attained a gift from the New York Carnegie Foundation of $30,000 to launch the Hospital Standardization Program (Roberts et al., 1987). Acting as the director of the American College of Surgeons, Dr. Bowman’s efforts virtually secured the College’s continued leadership role in healthcare standardization. By 1950, with nearly 3300 hospitals approved by the College’s Hospital Standardization Program, and with the rapid sophistication and complexity of healthcare delivery, the task was too big for the College to handle alone (Roberts et al., 1987). The need to continue the standardization/quality effort remained and with the need came the opportunity for partnership. Therefore, in 1951 the American College of Physicians, the American Hospital Association, the American Medical Association, and the Canadian Medical Association joined the American College of Surgeons to form the Joint Commission on Accreditation of Hospitals (JCHA) (Roberts et al., 1987). One should note the Canadian Medical Association withdrew in 1959 to participate in the development of its own program (Roberts et al., 1987).
Joint Commission on Hospital Accreditation

From essentially 1910 to 1950 the American College of Surgeons had carried the brunt of responsibility for standardization and quality in healthcare, now it was the Joint Commission's task. In January of 1953 the Joint Commission began to offer accreditation to hospitals (Roberts et al., 1987). Early JCHA accreditation efforts maintained the spirit of the College's voluntary minimum standards ethic. However, by the mid 1960s growing regulatory conditions tied to federal reimbursement, the evolving sophistication of methods to improve quality, and feedback suggesting most hospitals were already meeting standardization, prompted the JCHA to abandon the minimum standards model (Luce et al., 1994). Responding to the above developments, in 1966 the JCHA adopted a new philosophy called the "optimal achievable standards" (Luce et al., 1994; Roberts et al., 1987). This new philosophy could easily be seen as an initial step toward the more aggressive quality initiatives demanded by current competitive industry developments.

As mentioned above, the JCHA had necessarily been involved with responding to legislation and associated regulation. As the JCHA partnered with government, such changes pushed the development of quality improvement in healthcare. Throughout the 1970s the JCHA's optimal achievable standards process can be characterized as outcome oriented, steeped in the vernacular of "quality assurance" (QA) (Luce et al., 1994).

QA is focused on outcome and sets minimum "thresholds" which become the method by which unacceptable "exceptions" are identified and corrective action is taken, or at least documented (Berwick, 1989; Welch-D'Aquila, Habegger, & Willwerth, 1994).
Traditionally, QA is a paper trail exercise. As such, the thresholds, or indicators, are evaluated retrospectively by an audit, or review of medical records. The usefulness of such QA efforts were frequently dependent on the subjective expertise of the evaluator; thus, the JCHA sought to develop methods making the review more structured and objective (Roberts et al., 1987). Yet with such objectivity built into the audit process, the essence of improving quality care was confounded if not lost. "Preoccupation with the audit requirement rather than quality of care had left hospitals at the periphery of meaningful quality assurance activities" (Roberts et al., 1987, p. 940). QA dominated the quality movement in healthcare into the 1980s and is still a widely utilized and partially effective philosophy of improving quality.

By the mid 1980s the JCHA's burden of accreditation was growing to include a variety of healthcare organizations beyond the traditional focus on hospitals. Therefore, in 1987 the JCHA changed its name from the Joint Commission on Accreditation of Hospitals to the more inclusive Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (Luce et al., 1994).

**Joint Commission on Accreditation of Healthcare Organizations**

In the early 1980s, motivated by the public demand to control costs, it was evident QA was not enough. The JCAHO began looking to business and industry for improving healthcare quality improvement methods (Duncan et al., 1991; Laffel & Blumenthal, 1989; O'Leary, 1995; Sales et al., 1995; Wakefield & Wakefield, 1993). As the name, and therefore the mission changed, and as the pressure for fiscal accountability steadily grew, in 1988 the
JCAHO announced its “Agenda for Change” (Benson, 1994; Luce et al., 1994). As such, the new quality effort provided focus for improving the performance of entire groups, rather than identifying isolated “poor performers” as had become the norm of QA practices (Luce et al., 1994). In the spirit of this new focus, and fueled by quality technologies developed in business, understanding processes of healthcare service took precedence. However, it is important to note outcome improvements were not wholly substituted with efforts to improve processes. Rather, the JCAHO began to espouse a systemic appreciation for improving both outcome and process.

The two most popular concepts/tools borrowed from business and industry are Total Quality Management (TQM) and Continuous Quality Improvement (CQI). Respectively, W. Edwards Deming and J. M. Juran are widely recognized as the developers and most articulate promoters of TQM and CQI (Gaucher & Coffey, 1993). In addition to such conceptual frameworks, is the broadly utilized tool introduced by Walter Shewhart, the P-D-C-A (Plan-Do-Check-Act) Cycle (Duncan et al., 1991; Gaucher & Coffey, 1993; Leebov, 1991). The P-D-C-A cycle, developed by Shewhart in the 1920s, has been vigorously promoted by Deming (Leebov, 1991). Such quality improvement technologies emphasize learning the source of process variation and then controlling those variations (Batalden & Stoltz, 1993; Duncan et al., 1991; Goonan & Jordan, 1992; Laffel & Blumenthal, 1989; Sales et al., 1995). Nearly every piece of literature concerning quality in healthcare has attributed significant praise on both TQM and/or CQI as cornerstones for their motivation to implement improvement efforts (Batalden & Stoltz, 1993; Berwick, 1989; Caldwell, 1993; Duncan et al., 1991; Kaluzny &
Mc Laughlin, 1992; Laffel & Blumenthal, 1989; Lewis, 1993; Sales et al., 1995; Wakefield & Wakefield, 1993). Even so, although the healthcare quality improvement literature does not make a meaningful distinction between TQM and CQI, in 1992 the JCAHO began using the language of CQI in its Accreditation Manual (Batalden & Stoltz, 1993; Gaucher & Coffey, 1993; Welch-D’Aquila et al., 1994).

There is no ebb to the flow of contemporary quality improvement effort in healthcare. TQM and CQI continue to evolve from applications in industry to applications in healthcare, and the JCAHO is still quality’s strongest advocate. Quality improvement is continuing to expand for the following reasons:

- Cost containment;
- Managed care market competitiveness;
- Social and political pressure for accountability and value; and
- Survival of healthcare organizations (Benson, 1994; Gaucher & Coffey, 1993).

Although not exhaustive, the above reasons/motivations are jugular, and will require sustained responsive effort in both the short and the long term.

**Performance Improvement**

The latest expression of the JCAHO’s Agenda for Change is the language of Performance Improvement (PI) (Benson, 1994; Carter & Meridy, 1996; JCAHO, 1996). As mentioned above, meaningful differences among TQM, CQI and now PI are not obvious in the literature. Therefore, the reader is put in a position to extrapolate and discern a useful, albeit idiosyncratic, distinction. Whereas TQM and CQI seem to emphasize the
improvement of processes and thereby outcomes within organizations, PI seems to emphasize the improvement of whole organizational quality and thereby processes and outcomes. This distinction is subtle, yet important if viewed as another step toward an appreciation for systemic thinking. Indeed, one of the key shifts from an exclusive QA paradigm to a more inclusive PI paradigm, is systems thinking.

Returning to a familiar theme, the 1996 Accreditation Manual offers two Dimensions of Performance: 1.) Doing the right things, and 2.) Doing the right things well (JCAHO, 1996). The standards under the function of PI include: planning, designing, measuring, assessing and improving (JCAHO, 1996). It should be noted, there are 14 sub standards under measuring, 12 sub standards under assessing, one substandard under planning, one substandard under improving, and zero sub standards under designing. At first glance one is led into believing the dirth of sub standards under planning, designing, and improving is an indication of the relative value the JCAHO places on the more quantifiable measuring and assessing. However, the lack of detailed guidelines may be more benevolently understood as the JCAHO providing adequate flexibility for individual organizations to address their idiosyncratic needs/wants regarding PI. Regardless of motivations, the JCAHO has left considerable room for creative expressions of PI planning, designing and improving.

The JCAHO recognizes delivery of healthcare does not exclusively happen within organizational departments (e.g., medical records, mental health, lab, registration, etc.). Rather, service to patients happens both within and across departments. As stated under the intent of the first PI standard, planning, "Too often, PI efforts are isolated within specific
departments, units, or professions. Collaboration on PI activities enables an organization to plan and provide systematic and organization wide improvement” (JCAHO, 1996, p. 246.)

As such, a central distinction advocated by the JCAHO is to move the emphasis of PI efforts from structure (i.e., within departments) to function (i.e., both within and among departments). The shift from emphasizing structure to emphasizing function provides segue for the discussion of systems theory.

**Systems Theory and Change**

Systems theory as a conceptual frame for learning, thinking, and talking about organizational change is both aesthetically and pragmatically appropriate. Systems thinking has profound implications for program evaluation, where the parts are often evaluated in terms of strengths, weaknesses and impacts with little regard for how the parts are embedded in, and interdependent with, the whole program (Patton, 1990). As demonstrated above, quality in healthcare has evolved from monitoring individual performance in parts (i.e., QA), to improving process performance involving systems of interdependent people (i.e., TQM/CQI), to the current emphasis on improving entire organizational performance (i.e., PI). It is crucial to recognize whole organizational improvement includes not only working with processes, but also relationships between people and processes.

Contemporary quality improvement necessitates cultural change in healthcare organizations (Barnette & Clendenen, 1996; Batalden & Stoltz, 1993; Benson, 1994; Berman, 1995; Berwick, 1989; Caldwell, 1993; Cesarone, 1993; Kaluzny & McLaughlin, 1992; Lewis, 1993; McGuire & Longo, 1993; Sluyter, 1996; QRB, 1993). Systems theory
can help us describe organizations (Senge, 1990). Specifically, positive/negative feedback, interdependence, and self-reference are mentioned below as useful ideas.

Feedback

Quality improvement initiatives signal change, such change is understood and juxtaposed against the backdrop of organization cultural stability. Organizations are essentially human systems, or groups of people working together interdependently. Information in such systems takes the form of communication among system members. Communication in organizations can have the effect of encouraging change in systems or discouraging change in systems. Positive feedback (i.e., change promoting information) is always tempered or balanced with negative feedback (i.e., change inhibiting information) (Becvar & Becvar, 1988; Keeney, 1983). Positive and negative feedback are first order systemic ideas which by definition are interpretive distinctions. In other words, when an observer classifies communication as either positive or negative feedback, the observer is reifying the observed communication at a particular order of abstraction (Keeney, 1983). Communication among organization members can be understood as promoting change in the system, or positive feedback, or promoting stability in the system, or negative feedback (Senge, 1990).

Interdependence

The JCAHO has steadily gained appreciation for organizational interdependence. Their emphasis on function over structure is evidence of this appreciation. "Thus, from a systems perspective, meaning is derived from the relation between individuals and elements as each
defines the other” (Becvar & Becvar, 1988, p. 62). Acknowledging the interconnected relationships between people and processes as well as people to people, signals a paradigmatic shift toward systems thinking. Such a shift necessitates acknowledgment that the whole is greater than the sum of its parts.

Guiding an organization effectively toward continual improvement depends on the organization leaders’ developing, basing their leadership on, and communicating to everyone knowledge of the organization as a system of production, that is, a group of interdependent people, items, processes, products and services that have a common purpose or aim (Batalden & Stoltz, 1993, p. 426).

Quality improvement changes do not happen in a vacuum, they happen in a context of interrelationship, or culture.

Self - Reference

The observer is always part of the observed. Embracing the inseparability of observer and observed necessarily moves us from first order systemic thinking to second order systemic thinking (Becvar & Becvar, 1988). Holding this premise, one may no longer simply observe and/or research systems, such as organizations, without also influencing that which is researched. Consequently, the ethical observer must account for their biases in the process of research. This business of interacting with systems is a complicated matter. As such, one must acknowledge and be responsible for the distinctions drawn in the course of conducting research. Responsibility of this nature necessitates disclosure of assumptions which influence interpretations throughout the research process.
Organizational Change

"Interventions designed to offer people more opportunities to perform well, tend to invade the culture of an organization" (Carr, 1994, p. 36). People in organizations have been disillusioned by quality efforts. The "program of the month," which was somebody else's idea, often leaves staff persons beat-up and burnt out, and patients receiving unnecessarily compromised services. The disillusionment is often characterized as organization cultural cynicism. Such cynicism is maximized when change is implemented without the close consultation and involvement of staff persons (Covey, 1990; Senge, 1990). "The single best validated principle in the literature on management of change is that people who will have to live with the results of change need to be deeply involved in designing and implementing new processes. Unfortunately, they rarely are" (Backer, 1995, p. 352). The respective difference between "involvement" and "non-involvement" is analogous to the difference between "commitment to our changes" and "compliance to your changes" (Covey, 1990). Genuine involvement with change regarding quality improvement may be the best inoculation against cultural cynicism.

A healthcare organization culture characterized by involvement and commitment to improvement, is a culture constantly in development. Vigilance and integrity to consensually agreed upon organizational principles, or shared vision, is ongoing work (Senge, 1990). Proceeding cautiously, respectfully and yet confidently is the suggested course for building such a culture capable of managing complex and challenging changes (Covey, 1990).
Quality Improvement in Mental Healthcare

The Joint Commission on Accreditation of Hospitals began offering accreditation to mental healthcare organizations in 1970 (Roberts et al., 1987). Formalized effort to enhance the quality of care in mental health services is a comparatively recent initiative. Only recently was there a first national conference on TQM in Mental Health, May 4-5 1995 (Sluyter & Berman, 1996). The second national conference may need to change its venue to keep current with the appropriate vernacular of Behavioral Healthcare Accreditation as dictated by the JCAHO's January/February, 1996 issue of their newsletter.

Quality improvement in healthcare and mental healthcare, is being pursued for the same, or similar reasons. "The issue of quality is as compelling in mental health services as it is for healthcare in general, especially in light of the growth of privatization, capitated payment systems, and managed care networks" (Sluyter & Berman, 1996, p. 5-6). Just as healthcare has borrowed concepts and tools from industry to facilitate the evolution of quality improvement, so to may mental healthcare learn from the experiences of healthcare quality improvement efforts. The January 1996 issue of the JCAHO's journal on quality improvement is entirely dedicated to quality improvement in mental healthcare. Several themes are highlighted as key issues for consideration when implementing quality improvement efforts:

- Quality improvement is hard work;
- Serious attention to leadership style and organizational culture is needed for success;
- Learning is continuous;
• There must be a "compelling reason" to become involved in quality improvement; and
• All stakeholders must be involved and committed to improvement efforts (Sluyter, 1996; Sluyter & Berman, 1996).

In reviewing the literature on quality improvement in mental healthcare, a sense of urgency is either implied or exclaimed, "The need for mental healthcare to reinvent itself is not a spurious one, it is an urgent one. Many mental healthcare professionals, particularly those working in public settings, do not yet realize that we are entering a period of fundamental, rather than incremental change" (Chowanec, 1996, p. 19). Although the need to begin meaningful quality improvement efforts may be urgent, rushing in to change, before working to evaluate, seems unwise. Rather, there is broad support for taking time to discern what the right things are to do, before trying to do things right.

Leadership involvement is cited over and over again as crucial to the successful implementation of quality improvement tools along with organization cultural commitment (Barnette & Clendenen, 1996; Chowanec, 1996; Elliott, 1996; Hyde & Vermillion, 1996; McFarland, Harmann, Lhotak, & Wieselthier, 1996; Sluyter, 1996; Sluyter & Berman, 1996). If top management is consistently, enthusiastically and visibly involved with quality improvement efforts, then the cultural context should be favorable to staff commitment.

Emphasizing the role and responsibility of leadership regarding quality improvement, Batalden and Stoltz (1993) summarize, "A central obligation for top leaders is to create conceptual space within which healthcare professionals can redesign their own work for the improvement of healthcare" (p. 438).
CHAPTER 3

METHODOLOGY

Assumptions for a Qualitative Design

In research the phenomena of inquiry needs to drive methodological choices. Quantitative methods are highly refined and efficient processes of reductionism. Such methods are driven by assumptions of a tangible social reality. "Physical, temporal and social reality all exist, and with sufficient time and reasonably good principles of investigation, inquiry can converge on those realities" (Lincoln & Guba, 1985, p. 82). Especially in regard to social realities, convergence and reductionistic assumptions are questionable. Assumptions of an unchanging social world is in direct contrast to qualitative and interpretive assumptions that the social world is always being constructed (Marshall & Rossman, 1995).

Qualitative methods adhere to assumptions congruent to systems theory and social constructionist epistemology (Joanning & Keoughan, 1997; Wulff, 1994). Further connecting systems theory with qualitative methods, Patton (1990) offers three broad points of consideration:

1. A systems perspective is becoming increasingly important in dealing with and understanding real-world complexities, viewing things as whole entities embedded in context and still larger wholes;

2. Some approaches to systems research lead directly to and depend heavily on qualitative inquiry; and
3. A systems orientation can be very helpful in making sense out of qualitative data (p. 78 & 79).

To maximize learning about organizations as human systems, methods employed must "get at" the unique understandings people have of their experiences. "Like systems theory, qualitative research emphasizes social context, multiple perspectives, complexity, individual differences, circular causality, recursion, and holism" (Moon, Dillon, & Sprenkle, 1990, p. 364). Changes in organizations are manifestations of human systems changes. Such changes are dynamic and emergent indicating the appropriateness of fit with qualitative methods (Joanning & Keoughan, 1997). Further, Patton (1990) clearly advocates the "particularly appropriate use for qualitative methods" regarding process studies and process evaluations, formative evaluations for program improvement and focusing on program quality or quality of life (p. 141). Qualitative research is based on several assumptions regarding the nature of the knower, the knowledge, and how research can relate to that knowledge (Lincoln & Guba, 1985). Some of these assumptions are listed below:

- Acknowledgment of multiple realities;
- Research generates knowledge vs. verifying knowledge;
- Recursiveness among knowers and what is known;
- Research is flexible and emergent as the study unfolds;
- Knowledge is accepted as subjective vs. objective;
- Research remains socially contextualized;
• The researcher is the instrument of inquiry, thus necessitating constant self-reflection; and
• Knowledge is accepted as a social construction (Gergen, 1985; Goetze & LeCompte, 1994; Lincoln & Guba, 1985; Moon et al., 1990, 1991; Patton, 1990).

Researcher Descriptions

Primary Researcher Role and Assumptions

The role of the primary researcher was to understand the whole of what the participants had to say. Understanding in this sense is akin to the German verstehen, referring to the unique human capacity to make sense of the world (Patton, 1990). The researcher is accountable to describe their own experiences and assumptions which in part co-construct the interpretive results of the study. In qualitative inquiry the researcher is the instrument of learning (Lincoln & Guba, 1985). Learning during the course of the research was expected, and adjustments in the design were anticipated. Researcher decisions regarding the emergence of the design are best understood in the context of knowing who the researcher is.

The primary researcher is a 31 year old white male. He is single has never been married and has no children. The researcher’s family of origin consists of two parents and one older brother who is married and has two children. All nuclear family members reside in the upper midwest, are Lutheran and espouse a mixture of German, Norwegian and Scottish heritage. Given the emergent emphasis on staff and administration relationship issues in the study, it is important to note the researcher’s father has been and continues to be a high ranking executive at a major US based corporation. The researcher has had informal access for a
number of years to various organizational leaders and managers. Researcher familiarity with
administrative persons needs to be acknowledged as a likely influential bias.

The researcher holds a B.A. in Psychology and Religion from a liberal arts college and
an M.S. in Marriage and Family Therapy from a state university. Attending Iowa State
University (ISU) as a doctoral student in Human Development and Family Studies, the
researcher has a specialization in Marriage and Family Therapy. It should be noted the ISU
specialization program is fully accredited by the Commission on Accreditation for Marriage
and Family Therapy Education. The researcher completed a one year clinical internship with
the Adolescent Services department at the medical center under study. Remaining at the
medical center and concluding the internship, the primary researcher attained full time
employment as a Mental Health Therapist in the Adult Services department. May of 1997
marked the end of the second full year of employment at the medical center. Prior to
internship the researcher had four years of clinical experience and as of June 1995 attained
Licensure as a Marriage and Family Therapist. The researcher has numerous experiences
facilitating group therapy and assisting other doctoral level researchers conducting focus
groups.

"Research embodies assumptions regarding the way the world is and how it operates.
We cannot get away from assumptions, nor should we" (Wulff, 1994, p. 25 & 26). To
provide the reader with clear information regarding the researcher, several personal
assumptions were important to articulate. The following assumptions reflect some of the
researchers native experience, principles and informal theories.
• Staff have intrinsic expertise about organizational functioning and about what needs to happen for improvement.

• In order for staff to be committed to changes, they must experience greater levels of involvement with designing changes.

• Staff will experience interventive benefits from involvement in the focus groups.

• Cultural change in organizations takes time, supportive leadership and sustained focus.

• Qualitative methods allow participants to teach the researcher about what is important to research.

Co-Researcher

The co-researcher is a 27 year old white male. He is married has no children and was raised in the upper midwest. Like the primary researcher, the co-researcher attends Iowa State University as a doctoral student in Human Development and Family Studies, with a specialization in Marriage and Family Therapy. The co-researcher completed a clinical internship with the Adolescent Services department at the medical center under study. Further, he had been employed for one year with the Adult Services department at the same medical center. In total the co-researcher has approximately four years of clinical experience. In addition to co-facilitating group interviews, the co-researcher served as a continuous peer debriefer challenging the primary researcher’s conclusions and judgments throughout the study. Finally, the co-researcher has considerable experience facilitating group therapy and assisting other doctoral level researchers conducting focus groups.
Observer Role and Descriptions

Three separate individuals served as focus group observers. Their role was to observe the focus groups in whatever fashion they found valuable. Considerable flexibility was given to observers to perform the role in accord with their own strengths. In addition to observation they also monitored audio recording equipment for unanticipated problems (there were none) and changed tapes when necessary. Further, the observers took part in the formal debriefing sessions immediately following every focus group. As such, the co-researchers would take half an hour to discuss the interview with the observer. All peer debriefing sessions were audio recorded.

The first primary observer is a white male, married and approximately 40 years of age. He was designated “primary” as he observed seven out of ten focus groups. This observer is a doctoral student at Iowa State University in the Human Development and Family Studies program with a specialization in Marriage and Family Therapy. He has considerable clinical experience and knowledge of qualitative methods. Further, this observer was completing his internship with the Adolescent Services department at the medical center under study.

The second observer is a white female, married and approximately 30 years of age. She witnessed three out of ten focus groups. She is a doctoral student at Iowa State University in the Human Development and Family Studies program with a specialization in Marriage and Family Therapy. This observer has considerable clinical experience and knowledge of qualitative methods. Finally, she conducted interviews with the co-researchers in support of her own research interests.
The third observer is a white female, married and approximately 45 years of age. She witnessed only one focus group with staff persons. She had wanted to participate further, but was unable due to schedule conflicts. This observer has earned a Ph.D. from Iowa State University in Human Development and Family Studies with a specialization in Marriage and Family Therapy. She is a Licensed Marriage and Family Therapist with considerable clinical experience as well as qualitative research experience.

Dependability Process Auditor

The dependability auditor is a white female, married and approximately 35 years of age. She has earned a Ph.D. from Iowa State University in Human Development and Family Studies with a specialization in Marriage and Family Therapy. She is a Licensed Marriage and Family Therapist with considerable clinical experience and expertise using qualitative research methods. Her role was to assist the primary researcher in reviewing and refining the analysis. At various stages the results were shared with the auditor as a means to bolster triangulation and dependability.

The most important task for the auditor was to review the data and offer her critique regarding the appropriateness of fit between the emerging themes and the participant’s information. The auditor was given summaries of focus group transcripts including tentative, initial themes as well as copies of focus group transcripts. She was specifically asked to review only the summaries for her opinion regarding congruity between initial theme headings and the transcript segments used to substantiate the headings. The transcripts were provided as a courtesy if the auditor wished to read any particular transcript segment in the
original context. For the present research the auditor took extra time to read the transcripts in entirety, thus enhancing the dependability of the results.

**Consultant**

The consultant is a white female, married and approximately 45 years of age. She has earned a Ph.D. from Iowa State University in Human Development and Family Studies with a specialization in Marriage and Family Therapy. She is a Licensed Marriage and Family Therapist with considerable clinical and management experience as well as expertise using qualitative research methods. Specifically helpful for the present research was the consultant's experience in working with healthcare delivery systems in a hospital setting. Further, she is the President of a consulting firm specializing in human systems assessment, intervention and training.

By comparison to the dependability auditor, the consultant was more broadly involved with the study from the early stages of design through the last stages of discerning the results. Her role was to examine relevant research materials (e.g., transcripts, summaries, field notes, etc.) to review and critique the overall trustworthiness of the methods and results. Nearing the final drafting stages, the document was reviewed one last time and the consultant signed a letter indicating her conclusions (see Appendix A).

**Site Description**

The medical center is classified as a small (200 licensed bed capacity), urban (city population over 100,000), county funded healthcare provider. Further, out of 27,851 inpatient days for the 1994-1995 fiscal year, 15,066 of those days were classified under
mental health. Also, out of 202,409 ambulatory care visits for the same period, 42,845 were classified under Psychiatric Outpatient (Newsletter, 1996). The patients served by the mental health organization are predominantly Caucasian and of low social economic status. Further, the vast majority of the mental health patients do not carry insurance and are funded through county, state and/or federal resources.

All interviews were conducted on site at the medical center. The context in which the interviews were conducted is a medium sized group room located in close proximity to the mental health area with easy access to handicap exits and rest rooms. The capacity of the group room is approximately 15 - 20 adults comfortably. The group room is well lit with natural and incandescent lighting. The group room is adjoined by a smaller observation room also well lit with natural and incandescent lighting. Both the group room and the observation room were scheduled well in advance to secure a reservation. The means of observation is provided with a large one way mirror. Further, the group room is equipped with extremely sensitive microphones which feed to speakers located in the adjoining observation room. Finally, also located in the observation room, a dual cassette tape deck is connected for audio recording capability.

Sample

Participant Recruitment

“All sampling is done with some purpose in mind” (Lincoln & Guba, 1985, p. 199). The purpose guiding recruitment was to learn staff perceptions regarding mental healthcare service provision and how the process might improve. Further, given the desire to learn
about a function which is segmented and carried out by participants with differing responsibilities and perspectives, a maximum variation procedure was appropriate (Lincoln & Guba, 1985).

The researcher recruited staff to participate based largely on pre-study exploratory work and native understanding of adult outpatient mental health service provision. The jugular issue was to attain adequate diversity of roles all having a part in providing services.

Pre-study exploratory work started with the researcher attending to staff frustrations regarding the complexity of service provision. The researcher expressed his interests in facilitating multi-disciplinary staff meetings with the goal of better understanding the process of providing services. It was thought better understanding might yield a cleaner, less complicated system, and in turn less frustration for patients and staff. The initial meetings were very educational. The researcher quickly learned how mental health service provision in unavoidably complicated. There are a great number of variable contingencies that complicate the process.

The early recognition of a complicated system made clear the need to include representative staff persons from each role involved in service provision. The researcher's native knowledge of the organization allowed rapid discernment of appropriate potential participants.

Each participant was approached individually and invited to participate in the study. The researcher often called ahead to ascertain a convenient “10 or 15 minutes to talk.” The researcher met personally with each participant and provided a copy of the project overview
and informed consent (see Appendix B). Allowing ample opportunity to read the project overview, the researcher took whatever time necessary to answer questions and/or address concerns. When a staff person agreed to participate, they were asked to commit three (3) focus groups to their schedule. They were also informed of the emergent characteristic of the research and the possibility that individual interviews and/or other groups may be added. Further, they were informed patients would be involved in the interviews and conjoint patient/staff groups would be conducted. Finally, benefits and risks of participation were discussed.

Upon agreement to participate, each staff person was asked if they knew anyone else who might be available and important to include. As the study progressed participants occasionally suggested inviting other staff persons. When possible the researcher followed through with staff suggestions and a few additional participants joined the groups.

Participant Descriptions

The participants were all full time employees of the medical center. Twelve staff participated in the study and all but one staff participated in focus groups. Due to emergent information from the focus groups, one staff person, a psychiatrist, was interviewed individually on just one occasion. The descriptions that follow consist mainly of role and/or position descriptions. Each staff participant was assigned a code number ranging from Staff (S1) - Staff (S12). Codes were assigned in the order of participation beginning with introductions at the first staff only focus group and continuing as new staff joined the study.
Staff attendance ranged from a minimum of one to at most six focus groups. A group of five staff attended five focus groups while other participant attendance varied (see Table 1).

Staff one (S1) is out of the Registration Department and holds the position Coordinator. Staff one is a white female approximately 40 years of age. She has been employed at the research site for approximately 10 years. The Coordinator is under the direct supervision of the Director of Registration. She is responsible for the overall management of the registration functions and staff. The Coordinator is responsible for ensuring that patients are registered in a timely, efficient and courteous manner. She is responsible for ensuring that the information gathered by the Registration Representatives is as complete and as accurate as possible. The Coordinator establishes and maintains registration staffing schedules covering mental health and main registration during hours of operation. She develops customer service policies and protocols for patient contact.

Staff two (S2) is out of the Registration Department and holds the position Mental Health Representative, Inpatient. Staff two is a white female approximately 40 years of age. She has been employed at the research site for approximately 2.5 years. Although currently holding the inpatient registration position, this staff person worked as the outpatient registration representative for nearly 2 years and shortly before the research began was reassigned to the inpatient unit. The Mental Health Representative is under direct supervision of the Registration Coordinator. She is responsible in assisting patients and/or their representatives with insurance information, locating outside resources for
Table 1. **Staff Interview Attendance.** Column one (Staff Code) indicates the total number of staff persons interviewed in either group and/or individual format. Other column headings indicate either Staff, Conjoint (patient/staff) or individual (Ind.) formats with exact dates.

<table>
<thead>
<tr>
<th>Staff Code</th>
<th>Staff Group One 10-03-96</th>
<th>Staff Group Two 10-17-96</th>
<th>Staff Group Three 10-31-96</th>
<th>Conjoint Group One 11-14-96</th>
<th>Conjoint Group Two 12-05-96</th>
<th>Ind. 12-10-96</th>
<th>Ind. 12-12-96</th>
<th>Conjoint Group Three 03-13-97</th>
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<td>Staff 1</td>
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- * Indicates those interviews which were transcribed for analysis.
- * Indicates staff who completed and returned Thematic Statement Surveys.
payment and determining a payment schedule on the balance of the patient’s account. The Mental Health Representative works closely with third party payers, physicians, social services personnel, therapists, the Department of Human Services and the courts.

Staff three (S3) is out of the Department of Managed Care and holds the position Managed Care Outpatient Coordinator (MCOC). Staff three is a white female approximately 40 years of age. She has been employed at the research site for approximately 10 years holding different positions. She has held her current position for approximately 1 year. The MCOC is under the direct supervision of the Director of Managed Care. She is responsible for outpatient managed care. The MCOC routinely works with physicians and therapists to ensure expedient, customer friendly outpatient services. In conjunction with the Clinical Case Manager and the Director of Managed Care, she is responsible for providing and monitoring information and setting up systems around managed care functions, and for participating in actively diagnosing and solving managed care systems problems.

Staff four (S4) is out of the Department of Managed Care and holds the position Managed Care Analyst. Staff four is a white male approximately 25 years of age. He has been employed at the research site for approximately 2 years. The Managed Care Analyst is under the direct supervision of the Director of Managed Care. He is responsible for the coordination of managed care processes and procedures as they relate to Medical Information Systems, Patient Accounting, generating appropriate charges and program development medical center wide. The Analyst assists department directors with the implementation and maintenance phases of managed care system development. He coordinates administrative
processes and procedures for managed care as they relate to individual departments. The Analyst assists the Director of Managed Care with contractual analysis of managed care agreements including generating reports on obligations from both the medical center as well as the managed care organization. He is responsible for the development and educational aspects of information systems and services for the Division of Patient and Family Services. The Analyst coordinates statistical and productivity reporting as well as evaluation mechanisms for the Division.

Staff five (S5) is out of the Division of Patient and Family Services and holds the position Program Secretary. Staff five is a Hispanic female approximately 45 years of age. She has been employed at the research site for approximately 2.5 years. The Program Secretary is under the direct supervision of the Director of Mental Health Treatment. She performs various secretarial and administrative functions for program coordinators, psychiatrists and psychotherapists. The secretary performs receptionist duties, schedules patients and processes routine and special needs documentation.

Staff six (S6) is out of the Mental Health Treatment Department and holds the position Adult Outpatient Services Psychotherapist. Staff six is a white female approximately 45 years of age. She has been employed at the research site for approximately 5 years. The Psychotherapist is professionally responsible to the Director of Mental Health Treatment. The purpose of the position is to provide clinical services to adult outpatients and inpatients using a variety of psychotherapeutic and assessment modalities. Her clinical service includes
conducting intake history assessments, maintaining current documentation and cultivating working relationships with community referral sources.

Staff seven (S7) is out of the Mental Health Treatment Department and holds the position Psychologist. Staff seven is a white female approximately 45 years of age. She has been employed at the research site for approximately 1.5 years. The Psychologist is professionally responsible to the Director of Mental Health Treatment under the supervision of the Coordinator of Psychological Services. The purpose of the position is to provide clinical service to adult outpatients and inpatients using a variety of psychotherapeutic and assessment modalities. Her clinical service includes conducting psychological evaluations, maintaining current documentation and cultivating working relationships with community referral sources.

Staff eight (S8) is out of the Department of Managed Care and holds the position Managed Care Technician. Staff eight is a white female approximately 25 years of age. She has been employed at the research site for approximately 1.5 years. The Managed Care Technician is under the direct supervision of the Director of Managed Care. She is the first contact person for all managed care referrals. The Technician is responsible for triage of all managed care patients to the appropriate clinical and/or administrative resources. She is responsible for coordinating with the registration department all ambulatory managed care intakes. The Technician is also the first contact person for managed care phone calls. She is responsible to ensure all managed care phone calls are answered in a timely manner during regular working hours. The Technician is responsible for initiating appropriate paperwork,
securing appropriate authorizations and for coordinating or scheduling patient intakes and/or initial outpatient visits. She is responsible for ensuring that charges going to the billing department coincide with authorized visits.

Staff nine (S9) is out of the Department of Mental Health Treatment and holds the position Adult Outpatient Program Coordinator. Staff nine is a white male approximately 45 years of age. He has been employed at the research site for approximately 6 years. The Program Coordinator is professionally responsible to the Director of Mental Health Treatment. He is responsible for the administrative and clinical functioning of the program. The purpose of this position is to supervise the work of staff psychotherapists. The Coordinator will also function as a psychotherapist in the mental health outpatient program and maintain a minimum patient caseload. He is responsible for program development and accountability. Further, the Coordinator is responsible for establishing, reviewing and revising as appropriate, program policies, procedures and philosophy. He is also to maintain contact with relevant medical center staff and community agencies. The Coordinator is responsible for ensuring quality assurance and evaluation systems are developed, implemented, reviewed and revised as appropriate.

Staff ten (S10) is out of the Registration Department and holds the position Director of Registration. Staff ten is a white female approximately 55 years of age. She has been employed at the research site for approximately 20 years. The Director of Registration reports directly to the medical center Chief Financial Officer. She is responsible for the daily operation of the Registration Department. The Director develops policies and procedures so
they are congruent with the overall mission of the hospital. She implements and manages new and existing programs to improve services and increase revenue. The Director develops short and long range departmental goals and objectives consistent with the medical center goals and objectives. She develops the departmental annual expense budget, monitors results and makes adjustments ensuring pre-established limits are not exceeded. The Director is responsible for defining and implementing structural changes within the department to achieve optimal efficiency.

Staff eleven (S11) is out of the Registration Department and holds the position Outpatient Mental Health Registration Representative. Staff eleven is a white male approximately 28 years of age. He has been employed at the research site for approximately 1 year. The Outpatient Registration Representative is under the direct supervision of the Registration Coordinator. He arranges for efficient and orderly registration of outpatients by collecting all pertinent information to determine the financial responsibility of the patient for services. He assists patients in identifying relevant financial resources that will allow the patient to meet their financial obligations. The Outpatient Registration Representative is held accountable for maintaining a positive public image and collaborative relationships with all medical staff, therapists and patients.

Staff twelve (S12) is out of the Department of Psychiatry and holds the position Psychiatrist. Staff twelve is a white male approximately 55 years of age. He has been employed at the research site for approximately 12 years. The Psychiatrist has supervision responsibilities for clinical staff, including some nurses and therapists. He has access to the
upper administration team. The Psychiatrist is professionally accountable to the Medical Director. He is responsible to treat both outpatients and inpatients. Clinical duties include performing psychiatric evaluations, ongoing outpatient treatment and leading routine multidisciplinary rounds. The Psychiatrist also maintains medical education responsibilities actively participating in the medical education programs at the medical center. He provides general medical center psychiatric consultation services for patients in rotation with other psychiatric staff.

Procedure

Access

Gummesson (1991) states, “The ability of a researcher or a consultant to carry out work on a project is intimately tied up with the availability of data and information that can provide a basis for analysis and conclusions (emphasis added)” (p. 11). Accessibility to data and information was analogous to “getting permission” to begin the project/research. Three levels of access were relevant to the current research: physical, information and personal.

Physical access refers to the researcher having direct contact with the phenomena of interest. Access at this level is analogous to “getting in the front door.” Attaining physical access for the present research was uncomplicated as the researcher is employed on site.

Information access refers to issues of data collection. Several layers of administrative permission were necessary prior to collecting information. The researcher and co-researcher conjointly negotiated the entire process of administrative permission. Initially, “brainstorming” discussions with the researcher’s direct supervisor led to more formal
exploration of research possibilities. The researcher then scheduled a consultation with the Department Director for Adult Outpatient Mental Health Services. During the consultation, several issues were addressed including logistical concerns, e.g., release time for staff participants, approximate time frame, costs, etc. Beyond addressing logistical matters, the Department Director gave permission to proceed and suggested further consultation with the Director of Medical Information Management (MIM). The MIM consultation was essential as the Director currently oversees all performance improvement activities at the medical center. The MIM Director was extremely supportive and helpful in guiding the research design, in fact she wanted the researchers to do focus groups with several departments throughout the medical center.

With the scope of the research restricted to adult mental health outpatient services and with all the necessary layers of administrative permission addressed, a proposal to the medical center human subjects review was constructed and submitted (see Appendix C). On August 27, 1996 a memorandum of support and approval was issued by the Medical Director on behalf of medical center human subject review (see Appendix D). Finally, information access was attained through a series of focus group interviews, two individual interviews and written feedback in the form of group summaries and surveys constructed from the experience and language of staff and patients.

Personal access refers to the emotional and relationship issues endemic to research with human systems. The researcher should emphasize understanding, even empathy, for the participants in order to gain access into their world (Marshall & Rossman, 1995).
Gummesson (1991) states, “Access refers to the ability to get close to the object of study, to really be able to find out what is happening” (p. 21). Being native to the system under study provided advantages regarding personal access. The researcher was known to all staff participants allowing an apparent rapid development of rapport and comfort with the interview process. “The quality of the information obtained during an interview is largely dependent on the interviewer” (emphasis original) (Patton, 1990, p. 279). Beyond varying degrees of familiarity with staff participants, the researcher was also knowledgeable of important current issues within the site environment. On several occasions during the focus group interviews, staff shared sensitive information with the caveat they did not want it repeated (the reader will not find this information included in the study). Staff disclosures of such a sensitive nature indicated a high degree of trust in the researcher and the research process.

**Interview Questions**

“We cannot observe how people have organized the world and the meanings they attach to what goes on in the world. We have to ask people questions about those things. The purpose of interviewing, then, is to allow us to enter into the other person’s perspective” (Patton, 1990, p. 278). The researcher sought first and foremost to create a safe space for participant discussion. “The most important aspect of the interviewer’s approach concerns conveying an attitude of acceptance, that the participant’s information is valuable and useful” (Marshall & Rossman, 1995, p. 80). The ground rules of confidentiality were explained at
the outset along with reassurances the interviews were intended to generate information for improvement, rather than finding fault.

Having assembled knowledgeable participants, the researcher worked closely with the co-researcher to "pre-script" as few questions as possible.

Typically, qualitative in-depth interviews are much more like conversations than formal events with predetermined response categories. The researcher explores a few general topics to help uncover the participant's meaning perspective, but otherwise respects how the participant frames and structures the responses. This, in fact, is an assumption fundamental to qualitative research, the participant's perspective on the phenomenon of interest should unfold as the participant views it, not as the researcher views it. (Marshall & Rossman, 1995, p. 80)

Pre-scripted questions tended to reflect curiosity about evaluating current processes of service provision and/or suggestions for improvement. Otherwise, some questions emerged from the group discussion and other questions were geared toward evaluating the research process and focus groups. The reader will note introductory codes in parenthesis indicating the question to have come from a particular staff only (st) or conjoint patient/staff (ct) group. A partial listing of questions is provided below:

- (st-1-p.9) I want to know how you describe your role in providing services to adult mental health outpatients?
- (st-1-p.12) As if you were talking to a fifth grader, what do you do at the hospital?
- (st-1-p.25) Hearing about what other people do, did anybody learn anything new?
• (st-1-p.30) How well do you think other staff understand the “domino theory” (i.e., the interconnectedness of staff roles)?

• (st-1-p.38) I would like to hear from everybody from your own perspective, when I say performance improvement, what does that mean to you?

• (st-2-p.3) When I say performance improvement and when you think about the role you serve in helping to provide adult outpatient mental health services, what comes to mind?

• (st-2-p.9) What gets in the way of patients giving us important information?

• (st-2-p.13) What do you need from the system in order to do your job better?

• (st-2-p.15) What do you think our patients think we need to improve our performance?

• (st-2-p.17) If we were to ask patients, “how are we doing” what do you think they would say?

• (st-2-p.19) Is there a sense that mental health services are “second fiddle”?

• (st-2-p.23) What gets in the way of staff helping each other?

• (st-2-p.24) If you could change one thing about the way you work, right now, from your own perspective you think would make things better, what would it be?

• (st-2-p.29) What has it been like to sit in the focus group today?

• (st-3-p.16) What is it that staff could do to take better care of themselves?

• (st-3-p.17) If you had the opportunity to restructure the organization, what are some very concrete kinds of things that you might suggest?

• (st-3-p.21) If we all know the things needed to improve, how come it does not seem to get done?
• (st-3-p.23) What would you like us (co-researchers) to do with the information from the groups?

• (ct-l-p.3) What would you like to have happen in today’s meeting?

• (ct-l-p.10) Thinking about improving adult outpatient mental health services, things would be better if _____?

• (ct-l-p.18) If you had one opportunity to talk with the hospital CEO to tell him one thing you would like to see different, what would you tell him?

• (ct-l-p.25) Have you ever had the opportunity to sit and listen to patients talk about these kinds of issues before today?

• (st-2-p.15) How could we take this information that we have gathered and put some of it to good use?

Staff Focus Group Interviewing

The researchers conjointly facilitated all focus groups. The group interview format was selected for several reasons. As a participant observer in the research setting, the author was aware of the interdependency among staff persons. Services are provided with the cooperation of many staff operating out of different departments, and the JCAHO has recognized the utility of organizing improvement activities around the functioning of staff as well as within departmental boundaries (JCAHO, 1996). Focus groups were also utilized due to the creative synergy often experienced through group process (Yalom, 1985). Senge (1990) refers to group discussions as, “special conversations that begin to have a life of their own, taking us in directions we could never have imagined nor planned in advance” (p. 239).
Finally, the group format was economical with regard to time and money. Staff persons have very busy schedules and pulling them together at one time, consistently and over the lunch hour was very productive.

An exhaustive attempt was made to schedule staff for all interviews in advance to promote continuity and attribute a sense of “follow through” to the research. The researcher was responsible for negotiating schedule conflicts among staff participants. If participants could not, or choose not to attend groups, then the researcher attempted to schedule individual interviews. Only one individual interview was conducted due to a participant missing a focus group.

All staff only focus groups were conducted over lunch time for participant convenience and were limited to one and a half hours in duration. Lunch was provided courtesy of the medical center catering service and usually consisted of sandwiches, a side dish, chips, cookies, ice tea, lemonade and coffee (both caffeinated and decaffeinated). It is important to note the cost of providing the lunches was covered by the medical center under authorization from the Mental Health Department Director.

Prior to staff focus groups the researchers met to discuss the agenda and pre-script as few questions as possible. In order to adequately address the questions posed by the study, a method of interviewing evolved that dictated only one or two questions would be introduced by the researchers. The scripted one or two questions came to be known as “clipboard” questions given both researchers used clipboards to hold their field notes during interviews.
Finding balance between the pre-scripted clipboard questions and the questions emergent from group discussion proved to be challenging.

At the outset of the staff groups the observer, or observers were introduced and participants were given opportunity to ask questions. These introductions proceeded rapidly and relatively few questions were asked. At the first group the ground rules for group discussion and research were reviewed and emphasis was placed on preserving participant confidentiality. If participants had not reviewed the project overview and informed consent when being recruited for the study, then ample time was allowed to review the consent and sign off (see Appendix B). The participants were given opportunity to ask questions or state concerns about the audio recording equipment, rationale and/or process. Participants never requested not being taped and on only a few occasions did staff request information not be repeated on paper or outside of the group. Participants were reminded the tapes would be transcribed by an individual living in a different community who has no connection to the research site and would be destroyed in one year. As highly trained clinicians, both researchers were sensitive to staff requests for anonymity and often repeated the expectations of confidentiality.

The following descriptions help to define both General Procedural guidelines and some of the specific procedures differentiating Staff Groups One, Two and Three.
General Procedure

- Lunch was ordered approximately one week in advance of the group dates.

- Several days prior to the groups, staff were contacted informally by the researcher and reminded of the group time, place and free lunch.

- On group days the co-researchers met early in the morning to discuss the agenda and prescribe some clipboard questions. As the number of groups progressed the information from each group was more and more influential on the development of clipboard questions.

- The researchers met briefly with the observers to share the clipboard questions and discuss the limited agenda for the group.

- The researchers conducted a final equipment check to assure no problems with recording equipment, no shortage of pens or paper for field notes and all tapes were properly and clearly labeled. In addition to the equipment, the researcher cleaned up the group room, arranged chairs in a circle and set the room up for the catered lunch.

- The researchers welcomed participants with informal discussion, handed them name tags and invited them to help themselves to lunch.

- As the staff ate the researchers shared information, reviewed ground rules and continued informal discussion. Evidenced by the considerable laughter which was commonplace when groups started, the style of informal discussion seemed to put participants at ease.

- Groups were ended promptly after one and a half hours in order to convey respect for participant schedules and use of time.
• The researchers took a short break (approximately 5 minutes), switched tapes and recorded peer debriefing discussions with both researchers and the observer(s). The peer debriefing sessions lasted for half an hour.

• Typically, within one or two days of the group interview, tapes were hand delivered to the transcriptionist at Iowa State University. Turn around time for the researchers to receive the transcripts varied.

• The researchers reviewed tapes regularly to discern initial salient themes needing further exploration at subsequent groups.

• The review process was essentially the first round of analysis and culminated in the researcher preparing summaries of each group for participant review (for example, see Appendix E). Having reviewed the summaries and made any editorial contributions, the staff signed the summaries and returned to the researcher.

Staff Group One

• During this first group considerable time was devoted toward reviewing the intent of the research and discussing confidentiality.

• If each participant had not already reviewed and signed the informed consent, opportunity was provided to do so.

• All appropriate researcher, observer and participant introductions were made.

• Participants were asked the following initial question, “I want to know how you describe your role in providing services to adult mental health outpatients?” Beyond the initial question other open ended questions and discussion ensued.
Staff Group Two

- The researchers reviewed notes and tapes from the first round of patient groups as well as reviewing the first staff group materials. Initial salient themes were identified and fed into the pre-scripted questions for the second staff focus group.
- Two new staff joined the group and necessitated appropriate introductions.
- Following introductions the researchers posed the question, “When I say performance improvement and when you think about the role you serve in helping to provide adult outpatient mental health services, what comes to mind?” Staff were asked other open ended questions and discussion ensued.
- At the group conclusion, staff were informed of a summary that would be mailed to them regarding both the first and second groups. The staff were asked to review the summary, correct any misunderstandings, add important information and return via medical center internal mail or personally.

Staff Group Three

- Having received all the staff summaries from groups one and two, and having reviewed all available notes, tapes and transcripts, the researchers refined the initial themes needing further exploration. Salient themes were identified and fed into the pre-scripted questions for the third staff focus group.
- One new staff person joined the group and necessitated appropriate introductions.
- Staff were given summaries from the previous patient groups and allowed adequate time to review.
• Discussion opened with the researchers inviting reactions to the patient summaries and asking the question, "If you had the opportunity to restructure the organization, what are some very concrete kinds of things that you might suggest?"

• At the group conclusion, staff were reminded the next round of focus groups would be attended by both patients and staff. Further, the staff were asked permission to share the summaries from the previous staff only groups with the patients. All staff gave their verbal consent to share summaries with patients.

Conjoint Patient/Staff Focus Group Interviewing

On November 14, 1996 the first conjoint patient/staff focus group was conducted. The researcher had no need to choose which staff would participate with the conjoint groups. Rather, given schedule difficulties staff participation was self selected. The following procedural outlines help to define Conjoint Patient/Staff Groups One, Two and Three.

Conjoint Group One

• Six staff attended the first conjoint group.

• Prior to the group starting the researchers followed all general procedures discussed above. Such procedures included: confirming the catering service, preparing the equipment, arranging the group room, briefing the observer(s), reviewing previous group tapes and transcripts and pre-scripting questions.

• Prior to the group, staff had been given copies of patient summaries to review and discuss.
• Upon arriving, patients and staff were greeted by the researchers, invited to help themselves to lunch and engaged in pleasant conversation.

• The formal beginning of the group was demarcated by introductions including each participant stating their expectations from the group.

• Following introductions, the researchers had decided during their pre-group meeting to employ an “inner/outer circle” group format. As such, the patients were given first opportunity to respond to the question, “Thinking about improving adult outpatient mental health services, things would be better if _______?” While the patients responded to the question and had discussion, the staff had been “invited to just listen, no talking, just listen.” Patients were given 15 - 20 minutes to talk.

• Staff then were given opportunity to talk and respond to the question, “What did you learn when listening to the patients?” During this time the patients were invited to “just listen.” Staff were given approximately 20 minutes to talk.

• The discussion was opened up for all participants.

• The group was concluded after one and a half hours and another group was scheduled.

• The debriefing procedure outlined above was followed.

Conjoint Group Two

• Seven staff attended the second conjoint group.

• Prior to the group starting the researchers followed all general procedures discussed above. Such procedures included: confirming the catering service, preparing the
equipment, arranging the group room, briefing the observer(s), reviewing previous group
tapes and transcripts and pre-scripting questions.

- Participants were again greeted, offered lunch and engaged in polite conversation.

- The researchers imposed considerably less structure allowing the participants to reflect and discuss any issues remaining from the first conjoint group.

- As discussion proceeded the following question was asked, "How could we (researchers) take this information that we have gathered and put some of it to good use?" Participants agreed the information should be presented to upper administration and perhaps the psychiatrists.

- The group was concluded after one and a half hours and another group was tentatively scheduled for approximately late February 1997.

- The debriefing procedure outlined above was followed.

Conjoint Group Three

- Four staff attended the third conjoint group.

- Prior to the group starting the researchers followed all general procedures discussed above. Such procedures included: ordering pizza to celebrate the last group, preparing the equipment, arranging the group room, briefing the observer(s), reviewing previous group tapes and transcripts and pre-scripting questions.

- In addition to the general procedures, the researchers had constructed Thematic Statement Surveys to be completed by participants.
• One survey was developed collaboratively by both researchers derived from the transcripts of conjoint groups one and two. Several weeks prior to the third conjoint group, the project consultant and major professor reviewed the emerging themes and suggested the researchers construct a survey grounded in the language of the participants for use during the final conjoint group. Reviewing the conjoint transcripts page by page, the researchers cross checked their summaries and tentative final themes. Based on the rich triangulation of information, the Conjoint Patient/Staff Thematic Statements Survey was constructed and completed by both patients and staff during the interview (see Appendix F). The survey was intended to serve as a first step toward a more sophisticated quantitative measure as well as an additional source of member checking documentation. Approximately half an hour was devoted to open discussion and reactions to the survey.

• The patients and staff then split up and reconvened in separate rooms.

• The other survey was constructed from the transcripts of the three staff only groups. Working independently, the primary researcher reviewed the staff only focus group transcripts and cross checked them with summaries and tentative final themes. The most salient issues indicated by the triangulated information were included in the Staff Thematic Statements Survey (see Appendix G). Staff persons needed approximately 15 minutes to complete the survey. The remainder of the group was used to process the survey and/or any other residual issues from previous groups.
• The staff group was concluded after one and a half hours and staff were thanked for their
time and participation. No other groups were scheduled.

• The debriefing procedure outlined above was followed.

Staff Individual Interviews

Two individual staff interviews were conducted between the second and third conjoint
patient/staff focus groups. The date, rationale and salient information from each interview is
summarized below.

The first interview was conducted on 12-10-96 and lasted one hour. A psychiatrist
was interviewed in response to the group information highlighting the necessity of involving
psychiatrists in the improvement process. The psychiatrist was not aware of the research
project and yet when informed he was very interested in the process and outcome.

The psychiatrist commented extensively regarding the current organizational culture not
being conducive to Continuous Quality Improvement (CQI), “In no way do we have a CQI
kind of culture.” He recollected some history regarding quality improvement efforts at the
medical center, “approximately five years ago, with different administrative people, there
was a big push for CQI.” Evidently, lack of organizational administrative support is the
reason such efforts have not maintained momentum. In addition to poor administrative
follow through, the psychiatrist stated his opinion about the lack of fit between psychiatric
training and the principles of CQI. He recognized CQI cultures to de-emphasize
organizational hierarchy, encourage teamwork and flatten out administrative structure and
functioning. “The medical profession is very hierarchical, in general docs are pretty individualistic and not very avid team players, unless they are the chief.”

The second interview was conducted on 12 - 12 - 96 and lasted one hour. The interview was with a coordinator/therapist for adult mental health services. This staff person had been participating in focus groups and due to missing the first conjoint patient/staff focus group elected to be interviewed individually.

The coordinator commented extensively about his “skepticism” regarding upper level administration competence and character. Further, he suggested the current skepticism is pervasive with mental health staff due to several recent incidents and some historical patterns, “upper administration makes major decisions based on partial, irrelevant and sometimes inaccurate data.” The effects of such poor decision making are, “staff looking for other jobs, high turnover and the clients thinking twice about coming here — the patients think the system is crazier than they are.” The coordinator was clearly concerned about the direction of the organization, “the lower an organization’s self esteem gets, the shorter its life span.” He responded, “probably not” to the following question, “if you were an investor, and you knew everything you know about this organization, would you invest your money and buy stock?” Finally, he offered some feedback regarding the research process itself, “people are talking about real issues and administration should value this information.” Further, “you guys (the researchers) are getting in-depth responses, your giving people a chance to talk and not just bitch, you have a good balance of structure and freedom in the groups.”
The above information is not duplicated in the results section for several reasons. First, the interviews were not transcribed. Second, the information is largely supportive of the themes derived from the focus groups and therefore would have been redundant. Rather, the information is better perceived as another member check opportunity furthering the trustworthiness of the results.

**Analysis**

**Development of an Organizing System**

The process of data analysis is eclectic, there is no “right way” (Tesch, 1990). Analysis began informally even before the first data collection. As a participant observer employed at the research site, the bias of common experience with staff persons was unavoidable. However, it is important to recognize such bias as a potential strength of data collection and analysis. As a means to account for native biases, it was important to expose the analysis process through continuous discussion with the co-researcher, the observers and the dependability auditor.

Patton (1990) suggests several strategies for analyzing interview data, the initial decision is to analyze by case analysis or cross-case analysis. “Beginning with cross-case analysis means grouping together answers from different people to common questions or analyzing different perspectives on central issues” (Patton, 1990, p. 376). Attaining multiple perspectives simultaneously through group interviews indicated cross-case analysis to be most appropriate. Further regarding interpretational qualitative analysis Tesch (1990) suggests the following **Steps for Developing an Organizing System**.
• Get a sense of the whole by immersing yourself in the data as it comes in.

• Review the data asking yourself, "What is this about?" Do not think about the substance of the information, but rather its underlying meaning.

• Cluster the data, or select a manageable portion for consideration. This is the process of de-contextualizing the data and the formation of an emerging organizing system.

• Arrange the clustered data into themes and create a list of these initial themes.

• Expose the list of initial themes to the data and determine if new themes emerge or if initial themes need adjustment. Continually refine your organizing system based on emerging data and/or theory.

• Determine the most descriptive wording for the emerging themes and look to reduce the total list of themes by grouping similar or related areas.

• Re-contextualize your data according to coherent themes that represent categories of meaning in relationship to the original data.

The analysis process is extremely challenging work necessitating both persistence and creativity. "Identifying salient themes, recurring ideas or language, and patterns of belief that link people and settings together is the most intellectually challenging phase of data analysis and one that can integrate the entire endeavor. Through questioning the data and reflecting on the conceptual framework, the researcher engages the ideas and the data in significant intellectual work” (Marshall & Rossman, 1995, p. 114). The following steps describe the analysis process utilized for the present research.
• All focus groups were audio taped and the tapes were duplicated for use during transcription and as a precaution against lost tapes.

• To enhance participant confidentiality, the researchers contracted with a transcriptionist not at all connected to the participants or research site.

• The tapes were hand delivered to the transcriptionist usually within a few days of the interview.

• While tapes were being transcribed the researcher listened several times to the duplicate tapes and took field notes. These secondary field notes were compared to the primary field notes taken during the actual group interview. Through this comparison a sense of contextually dependent importance emerged. Some issues seemed to be important to participants regardless of circumstances or mood, while other issues seemed to be “topics of the day.”

• With the transcripts back in the researcher’s hands, the audio tapes were again reviewed for comparison to the transcripts. Any misquoted text was justified to the tape. As tapes were compared with the transcripts any gross analogical phenomena (e.g., voice tone, laughter, significant silence) was noted.

• Repeated exposure to the transcripts and tapes immersed the researcher in the data. The co-researcher also reviewed the data. Observer debriefing notes and tapes were reviewed; thereby, assisting the primary researcher’s decision making process for further text analysis.
Idea segments were identified as the text was read and re-read. These segments were indicated by underlining or highlighting the text. The criteria by which idea segments were defined, are two fold:

1. Text which was important to the researchers, or related to research questions.
2. Text which was important to the participants, based on their direct report, analogical indications, repeated occurrence and/or broad group consensus.

Staying grounded in the language of participants, common idea segments were synthesized. These synthesis statements eventually yielded initial themes.

The initial themes were exposed to participants in the form of group summaries (see Appendix E). Summaries were constructed primarily from repeated review of the interview transcripts; however, the transcripts were also cross checked with field notes taken during the interview and secondary field notes taken off the tapes. This step constituted the first formal member check. Participant feedback regarding the summaries as accurate, not accurate, or to what degree accurate was incorporated into ongoing theme development.

Using the feedback from participants, the summaries and supporting transcript narrative segments were condensed to computer documents. The documents were then printed for greater ease of comparison and physical grouping.

The printed documents were read, re-read and compared to the original transcripts. Additional narrative text was assimilated into the developing themes when appropriate.
The emerging themes were grouped logically into related categories. These categories were written on a large dry erase board for ease of alteration depending on continuous comparison to initial summaries, documents and/or transcripts. Throughout this process the researcher articulated rules for inclusion, i.e., within themes, and exclusion, i.e., between themes. An example of rules for inclusion would be, “All of these statements have to do with the relationship between staff and administration.” An example of rules for exclusion would be, “These statements have to do with staff being frustrated with administrative decision making; whereas, these statements are about staff perceptions of administration not listening to their concerns.”

The categories were delivered to the dependability auditor for review. The auditor had full copies of transcripts for comparison and met with the researcher on several occasions to discuss the developing themes.

Accounting for the auditor feedback, final themes were developed from the categories.

The final themes were then subjected to final member check documentation, co-researcher review and participant feedback from the last focus group.

Regarding final member check documentation, the researchers collaboratively analyzed the conjoint group transcripts and created “statements” corresponding to the developing themes. These “thematic statements” were presented in the form of a survey utilizing a seven point Likert scale ranging from strongly disagree to strongly agree. The thematic statements developed conjointly are labeled the Conjoint Patient/Staff Thematic Statements Survey (see Appendix F).
Working individually, the researcher compared the final themes to the transcripts one last time and derived "statements" based on staff only groups one, two and three. The statements often reflected the verbatim language of the participants and were presented in the form of a survey utilizing a seven point Likert scale ranging from strongly disagree to strongly agree. The resulting member check document was labeled the Staff Thematic Statements Survey (see Appendix G).

Both surveys were presented to the participants of the third conjoint patient/staff focus group. In addition, the researcher mailed surveys to all staff participants who attended at least two focus groups but were not in attendance at the third conjoint group. Total staff completing and returning the staff survey was eight (8) with only one staff person not returning the survey.

With returned surveys in hand, the final themes were adjusted one last time.

Last, the consultant completed a review of all pertinent materials and submitted a letter of verification (see Appendix A).

Indicators of Rigor/Trustworthiness

Trustworthiness is the central issue of concern when considering qualitative research. "The basic issue in relation to trustworthiness is simple: How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of?" (Lincoln & Guba, 1985, p. 290). The present research utilized a variety of methods to support the study's trustworthiness. Designing a study in which multiple cases, multiple participants, or more than one data gathering method are used can
greatly strengthen the study's usefulness for other settings (Marshall & Rossman, 1995). The following indicators of rigor account for the trustworthiness and usefulness of the present research.

**Credibility**

The notion of credibility asks about the match between the presented realities of the participants and those realities re-presented by the researchers. This indicator addressed how well the researcher portrayed the experience expressed by the participants. The following steps were taken to enhance the credibility of the research:

- Peer debriefing tests the growing insights and interpretations of the researchers via constantly exposing their thinking to peer review and scrutiny. Given the collaborative nature of the project, the researchers jointly conducted all interviews and thus constantly debriefed each other regarding salient information. Also, the observer(s) both informally and formally discussed growing impressions with the co-researchers following every interview. These steps were taken to expose isolated thoughts about the data and to challenge each other's perceptions regarding important themes.

- Triangulation of data involved using a variety of methods and people to collect the data. Different collection methods (e.g., audio tape, field notes and audit trail journaling) emphasized the cross checking of data and interpretations. As interpretations of data were being formed, constantly looking at the information in new and/or different ways challenged such interpretations.
• Member checking was a powerful way to establish credibility. By analyzing transcripts and preparing documents which attempted to re-present what was learned/heard during an interview, then presenting that document to the participants, researcher interpretations were again challenged. In addition to submitting the group data summaries for participant review, the emerging themes were also addressed with two staff participants in individual interviews.

**Dependability**

This indicator deals with the notion of consistency. In essence, there needs to be a method to the collection and analysis procedures, and the method must be clearly stated and available for inspection and critique. In the present research, dependability was addressed by the following steps:

- Triangulation, as mentioned above, was accomplished by converging multiple methods of data collection (e.g., audio tapes, field notes, audit trail, observer notes, etc.) and multiple researchers (e.g., the co-researchers, observers and auditor).
- An audit trail was kept as a detailed record depicting the process of the research and the decision making of the researchers. Long before the research was taking on formal aspects, the researchers were having discussions with a variety of persons regarding appropriate research questions, methodological issues and potential difficulties with conducting focus groups. These discussions were often recorded in steno notebooks and the practice of recording particulars of such discussions along with lasting impressions or afterthoughts was maintained throughout the study.
• Dependability audits consisted of an auditor, versed in qualitative methods, reviewing data collection processes, transcripts and summaries to determine if they were clear, understandable, sound, acceptable and logically led to the final themes.

**Transferability**

This indicator deals with the fit of the present research to other contexts. Rather than seeking generalizability via inferential methods, the issue is one of applicability or fit. The researcher describes the study rationale, process, context, results etc. to the point where others might read and decide if the study would be useful in other settings. Regarding the present research, transferability was addressed by the following:

- A thick description of the context and circumstances out of which the research was derived and conducted was included in the final text. Such a description necessarily included detailed information describing the research context, participants, researchers and other sources of influential bias.

- Purposive sampling is utilized when some purpose drives the decisions about participant recruitment. A very clear statement regarding the interests of the researcher to learn about quality improvement in a mental healthcare setting from multi-disciplinary staff persons was important. Further, the rationale supporting maximum variation sampling was also helpful.

**Confirmability**

This indicator is the final criteria of rigor for qualitative research. As such, an examination of the data and process to ensure they are firmly rooted, or grounded, in the
participants experience was the key to establishing confirmability. In this research, confirmability was addressed by the following:

- Triangulation was a broadly applied and very effective manner to enhance the overall trustworthiness of the data, including confirmability. By using multiple methods and researchers triangulation of data and interpretation was accomplished.
CHAPTER 4

OUTCOME OF STUDY

Results

Qualitative data analysis is a process employed to reduce expansive text and holistic observation and description, in such a way it becomes distilled to its essentials rather than simply diminished in volume (Tesch, 1990). The process of discerning meaningful themes was an attempt to describe the salient experience of the participants. Patton (1990) states, "Description must be carefully separated from interpretation ... description comes first" (p. 375). Themes emerged as the analysis was conducted in a chronological sequence. As transcripts, field notes, and audio tapes were reviewed from the first interview to the last, the salient aspects of the participant’s experience emerged. The use of qualitative methodology provides a clearer understanding of the context, or culture, in which research is occurring (Joanning & Keoughan, 1997).

The following themes are designated either emergent, imposed or some combination of both. Emergent themes are those that were generated from the synergistic efforts of the participants through group discussion. Imposed themes are those that were primarily responses to researcher scripted questions. Some themes seemed to manifest both emergent and imposed origins. Further, themes are substantiated by a mixture of narrative text as well as relevant items taken from the Staff Thematic Statements Survey (see Appendix G). Rather than following a consistent order from theme to theme, the survey items were appropriately integrated with narrative text.
Reflecting the sentiments of all informants, a patient stated the following during the second conjoint patient/staff focus group:

(ct-2-p.25) "(patient to researcher) Well, when you do your report, number one I assume that once you actually start putting this stuff into a form to be shared with whoever is overseeing your work, you are going to get rid of some of the redundancy, you are going to clarify some things a little bit and I don’t think there is going to be names next to a particular comment. But, I don’t see how we can accomplish anything if this information isn’t shared.”

It is appropriate to give the reader some basic instructions to facilitate clear understanding of the following thematic presentation. Each narrative transcript segment (like the one above) will be “introduced” by a particular code format. Note the following example, (st-1-p.34) indicating the transcript segment can be traced back to staff transcript number 1, on page 34. The (st-1,2 or 3) code format will indicate transcript segments to have originated in the corresponding staff only focus groups. Otherwise, to indicate transcript segments coming from conjoint patient/staff focus groups 1 or 2, the code format (ct-1 or 2) will be utilized.

Following the code introductions, additional information may be enclosed in parenthesis. The additional information was intended to further contextualize the transcript segments. The information most often delineates among the researcher, staff persons and/or patients as well as describing some segments as an exchange between two or more participants.
Finally, eight staff persons completed and returned the staff thematic statements survey. As the survey items are integrated into the results, staff responses are indicated as Response Frequencies (RF) located just above the scale. The corresponding number of staff are enclosed in parenthesis directly above their chosen response.

Two guiding criteria shaped the final appearance of the themes. These criteria are evidenced by the following two questions:

1. Regarding adult outpatient mental health service provision, do the themes help to evaluate performance?

2. Regarding adult outpatient mental health service provision, do the themes help to improve performance?

The evaluation/improvement criteria reflected the pragmatic applicability of the study. The following six themes contain information which either evaluates and/or suggests improvement for the provision of adult outpatient mental health services.

1. Understanding the entire process of service provision, depends on which roles staff occupy.

2. Focus groups are helpful as they validate participants, enhance understanding of staff interdependency and emphasize the need for effective communication.

3. Staff perceive upper administration as non-supportive and out of touch with their needs and concerns.

4. Other than serving patients better, staff perceive “performance improvement” as ambiguous and/or not relevant.
5. Staff recognize the complexity of change as an emotional process resulting in frustration, isolation and compromised quality of service to patients.

6. Attaining important information for quality service is compromised by both the unique challenges inherent with mental healthcare and the frustrating complexity of the system.

Themes

1. Understanding the entire process of service provision, depends on which roles staff occupy.

Staff persons understand service provision from different perspectives or roles. This theme is an imposed theme as it reflects staff responses to the a priori question:

(st-1-p.9) "(researcher) I want to know how you describe your role in providing services to adult mental health outpatients?"

To facilitate group participation this first question was attached to the introductions, or “getting to know you,” phase of the group interviews.

Staff responses varied regarding role description. They tended to see their roles as serving patients and/or dealing with information. Three out of ten (3/10) staff persons indicated an emphasis on direct patient care.

(st-1-p.23) "(therapist) I have two main jobs, one is outpatient counseling or therapy with clients and the other is to do what we call mental health intakes with the client."

(st-1-p.24) "(psychologist) I provide psychological services to adult outpatients. That means I do a couple of different things. I do therapy with individuals and I do
some group therapy, the other piece I do is evaluation, or assessment, which is testing different aspects of how someone’s brain or personality works so we can identify areas they might have trouble with.”

(st-2-p.1 & 2) “(coordinator) I am one of the coordinators in adult outpatient services. I do individual and group therapy and I supervise therapists.”

By contrast, other staff persons viewed their role as dealing with information and communicating such information. Within this group of staff persons who saw their role as primarily dealing with information, there are two further distinctions. One group involves considerable direct patient contact, where the emphasis is on collecting accurate information about patients and then communicating such information effectively. The other group emphasizes further processing the information, which again necessitates effective communication, yet does not involve considerable direct patient contact.

Four out of ten (4/10) staff persons indicated an emphasis on the handling of information and included direct patient contact.

(st-1-p.11 & 13) “(registration clerk) I deal with people who are here to get help, because if they are here once they will probably be here more often. I try to take care of the patient, financially.”

(st-1-p21) “(secretary) My role is getting the patient ready to see their therapist and/or doctor. I try to make sure the chart is there so when the patient sees the provider, that information is available. Or, if it is a first time patient, I make sure the forms are filled out and they are sent to registration. I am the start of the process,
getting the patient name, insurance, who they were referred by and getting all that
documented and then sent on to registration."

(st-2-p.1) "(client care specialist) I schedule the mental health adult outpatient
intakes, initial first visits and emergency psychiatric visits. I get client pre-
authorizations from insurance companies."

(ct-2-p.8) "(registration clerk) I am starting in outpatient registration. I think I am
going to learn a lot of things as to what my role should be and I guess I see it as kind
of a customer service type of position."

Still seeing themselves as dealing primarily with information, three out of ten (3/10)
staff persons indicated a lack of direct patient contact.

(st-1-p.14 & 15) "(outpatient care coordinator) I get our therapists and doctors
credentialed with insurance companies, they want to make sure there are qualified
people seeing their clients. Basically, I guess you would say its on paper introducing
the doctor or therapist to the insurance company."

(st-1-p.9 & 10) "(registration supervisor) How I see my role is to make sure the
registration staff is informed, so that we don’t bankrupt a patient while they are
trying to go through therapy. I see my role as training the staff that works with
registering these patients, getting them informed with the programs that are available
out there to help pay for those services."

(st-1-p.15 & 18) "(managed care analyst) What my job entails is a lot of non patient
contact. I don’t deal with patients face to face, I do a lot of the administrative duties
which include behind the scenes making stuff work. I am making sure we get the
flow from the registration to the financial side, making sure that information gets
appropriately over there."

Further substantiating the influence of role variation, items 1. and 2. on the Thematic
Statements survey are noted. Item 1. addresses role definition as a function of serving
patients, whereas item 2. addresses the distinct perspectives regarding quality
improvement between patient contact and non patient contact staff. The survey items are
listed below with corresponding response frequencies (RF) located above the scale:

1. **Staff understand their role, or what they do, only as a function of serving patients.**
   
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2. **Staff who have direct day to day contact with patients, compared with staff who do not have direct day to day contact with patients, see how to improve the quality of service differently.**

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Item 1. seems to substantiate the variation of perspective regarding role definition. As
indicated with narrative data, exclusively serving patients is not a uniformly held ideal.

Item 2. suggests consensus regarding the influence of roles on designing improvement
efforts. A strong majority of staff respondents agree, variation in role impacts strategy on
how to improve.
Acknowledging the variation in roles is important as staff may evaluate and make judgments about improvement, depending on their differing perspectives. The following exchange exemplifies the impact of understanding service provision from different roles.

(st-2-p.5) "(managed care staff to secretary) I think the one thing that would be more helpful is, and it is not just one person, it is all different therapists, they all have different ways of tracking their visits for insurance and a lot of times patients call me and they want to know if they are responsible on how many visits they have left. Then sometimes they are pre-registered and their insurance can change since when they get put in (to the computer) and then they get different insurance. Well, if patients are already in the system then the (registration) slip is already there the next day isn’t it? So patients don’t even see registration. Does that make sense? Isn’t that how it goes for the secretaries?"

(st-2-p.6) "(secretary responds) It doesn’t happen that way. Many times registration slips aren’t there and I don’t know why. I guess, what I’ve been told is they are not there because they aren’t in the system. We haven’t put it in the computer so...I don’t know."

There is discussion back and forth between managed care staff and the secretary regarding scheduling and registration issues. It seems they “understand” the process of tracking patient authorizations, registering patients, pre-registering patients, attaining patient charts from medical records, and inputting patient insurance/demographic information into the computer system (assuming for registration) in different ways. They
seem to understand these processes from their own perspective/role and they see it differently. Therefore, their present communication is dominated with efforts to inform each other of “the way it is,” in other words they are “straightening each other out.” This is an example of Covey’s (1989) “dialogue of the deaf,” people aren’t really learning from each other and communication breaks down. Breakdowns in the process of service provision will stem from such misunderstandings. Staff encounter day to day problems which must be solved on the spot. As such, staff persons develop idiosyncratic methods of dealing with problems. In other words, staff develop grassroots, partial solutions to system problems. Such solutions take the form of behavior based on partial understanding, i.e., misunderstanding. When idiosyncratic solution behaviors are enacted within a highly interdependent system, other staff persons must “deal with” or “react to” those behaviors. Sometimes this series of actions and reactions does not create a problem, sometimes it does. This behavioral pattern seems to exemplify the principle, “action stems from understanding, or often misunderstanding.”

2. Focus groups are helpful as they validate participants, enhance understanding of staff interdependency and emphasize the need for effective communication.

Staff persons recognize several valuable or helpful outcomes from involvement with the focus groups. This theme is in part imposed as the researcher intended to elicit feedback regarding the usefulness of the focus groups; however, the theme is also emergent as informants generated insights not explicitly anticipated by the researcher.
Introducing the theme and evidencing the apparent investment in the focus group process, staff respond candidly to what seemed like a flippant question regarding dwindling attendance at the outset of the third staff only focus group.

(st-3-p.1) "(researcher to group) I want to ask you guys about dwindling attendance, what do you think about that?"

(st-3-p.1) "(staff) I think it sucks!"

(st-3-p.1) "(staff) We made a commitment to be here, and I take that seriously. So that is a good word for it. I wasn’t going to be quite that direct thank you. It also is angering to me because I did block it out of my schedule and took it seriously and I don’t feel other people are.”

(st-3-p.2) "(staff) It is natural in my corner of the world, so ... typical in my area not to show up for things they are supposed to. It is irritating.”

(st-3-p.2) "(staff) It is natural in my area of the world with clients, and we complain about clients not showing up!”

This brief yet energetic discussion seems to indicate staff persons receive some message when their colleagues don’t attend. It is unclear what the message is, yet the emotional response seems to be frustration and/or anger.

The remainder of this theme will be presented in three parts: Validation of Participants, Understanding of Interdependency and Effective Communication.
Validation of Participants. Participants, both staff and patients, articulated a sense of value from their involvement in the group process. Toward the end of the second staff only focus group, the researcher imposed the following question.

(st-2-p.29) "(researcher to group) I just want to ask one last question, what has it been like to sit in here today?"

(st-2-p.29) "(staff) I don't know why, but I think today was a better use of time than the last one."

Unfortunately, given the rapid pace of responses to the question, further elaboration regarding the difference between the first focus group and the second focus group did not happen. As the responses continued, they reflected a sense of consensus as well as cynicism.

(st-2-p.29) "(staff) I think today basically we all agree that it is the system. You know that we need to improve the system. Everybody agrees on that."

(st-2-p.30) "(staff) I love coming here. I got a lot of input on what people think and how we can improve. Is it going to work, is it going to improve? For me, from my perspective, I can't see it. At least we understand everybody's position."

(st-2-p.30) "(staff) I felt like it was a good use of time, but I think that sitting here listening to everyone and thinking about it ... I think I should go behind the (secretary's) desk and help, so that we help each other and then maybe with the strength of us all, someone else will listen. You know the higher ups that make the decisions will, we can get them to listen."
Further evidence regarding the validation of participants emerged as the conjoint patient/staff focus groups were conducted. An often experienced benefit of group participation is "universality" or the awareness that one is not alone with one's own opinions or views (Yalom, 1985).

(ct-1-p.22) "(staff) It was real interesting that a lot of their (patient's) opinions are the same opinions I have had for quite a while. It was kind of uncanny almost. I thought those opinions were just my own and no one else's, you know. I have worked here a while so I guess, unfortunately, when you have been here a long time, you start to accept things."

Shortly after the above statement, the researcher asked the following question.

(ct-2-p.25) "(researcher to staff) Have you ever had the opportunity to sit and listen to patients talk about these kinds of things before today?"

(ct-2-p.25) "(around the circle, all staff respond) No."

Toward the conclusion of the second conjoint patient/staff focus group, participants share some comments reflecting validation and encouragement.

(ct-2-p.29) "(patient) I think there is a certain amount of hope in what has been discussed and suggestions, frustrations have been voiced. Whether or not there are huge changes made, I think that would be unrealistic. But there is hope that at least some of these concerns will fall upon interested ears. It may not happen immediately, but I think there are some people out there willing to hear what is said and keep that in mind over a long term rather than, 'yea, great, that is interesting but
we don't have time.' There are people who are going to keep it in mind. For me hope springs eternal, some days more so than others. So I think at some level we have had an important impact."

"(staff) What struck me when we met last time was the likeness of the concerns between the two sides, but rarely do we hear that. There is not affirmation from our clients on a scale like this very often. Nor do we get an opportunity as staff to talk with clients on this scale. On one to one we might hear something but in terms of over all concerns ... Also, what struck me is there should be some kind of regular forum for that. Why do we have to wait until there is a huge problem. Why isn't it done every six months so that things don't turn into huge problems. That is one of the things that struck me."

"(patient) I really enjoyed doing this (focus groups). I feel you are actually counting, you are not just a number, you are actually a person and someone cares about you. You (staff) care about us (patients), we care about you. We are trying to work together."

"(staff) We have some fine gentlemen here who are willing to go on our behalf and say, 'hey, we have this stuff.' I think it is a natural progression. I mean we are all saying that we are happy that somebody is asking us these questions. So wouldn't the natural step then be to share the pertinent information. Because we have done all this talking and interaction and it will be printed, they will present their papers and then not much else can be done."
(ct-2-p.31) "(patient) Thanks for remembering, keeping the humanity here. Because it is very encouraging and comforting that people really do care. So thanks to all of you (staff). I think the two of you (co-researchers) have done an excellent job in how you have handled this. Your thoughts on it, the directions you are going and your openness to exploring different avenues. Thank you for that."

Understanding of Interdependency. Currently, regular staff meetings occur within departments only, making the operating structure of the organization prohibitive of interdepartmental coordination. Nevertheless, staff persons intuitively understood the close connectedness and inter-relatedness of their roles.

(st-1-p.30) "(staff person commenting on the understanding of organizational functioning) There is a big vehicle somewhere that they understand, but they don't understand how we are getting acquainted in this focus group."

(st-1-p.25) "(staff) I don't think I understood that each of us did quite as much as we do. I don't think I understood how much there was to each individual job that each person does in this room."

(st-1-p.25) "(staff) You just don't understand what their (other staff persons) role is, what all they have to do and why they are all so busy."

(st-1-p.26) "(staff) I am surprised at how our roles link."

(st-1-p.26) "(staff) Yea, I can see where there is like a chain."
(st-2-p.31) "(staff) I think it is good that we have the different departments here so that we can all communicate like how registration works and how busy (the secretaries) are and I think that is good."

(st-1-p.29 & 30) "(staff) Say we each have a domino, that’s part of the whole scenario. I can let my domino fall down and tumble everybody else, or I can help registration’s domino stand up by the information I provide. So, I think at any one time and how we do our own particular piece, makes them toggle or keeps the system up. I have to be aware that my domino effects everybody else’s and I have to be responsible. I can’t only be responsible for my own domino."

(st-1-p.29) "(staff) If one thing falls out, then they all ... it doesn’t matter if the therapist does everything right, it doesn’t matter if the secretary does everything right, it doesn’t matter if registration, if I goof up ... it’s all a wash."

(ct-2-p.4) "(staff) I think the most important thing that I got from the meeting is the realization that we are all connected. How we come together, how we effect each other or other departments. How we are able to help the patient solve some of the problems that come through our department, by just knowing what other people do."

Demonstrated by responses on a relevant item off the Thematic Statements survey, focus groups were helpful for staff understanding of role interdependency.

3. Focus groups with staff who serve different roles, are helpful to gain further appreciation and understanding of how staff roles are connected with each other.

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Finally, not only did focus groups enhance staff understanding of role interdependency, the groups also facilitated greater appreciation for each others’ roles.

(st-1-p.46 & 47) “(staff) It is interesting to me, and you (to registration staff person) said this a number of times in the hour and twenty five minutes that we have been talking and it is not an angle that ... it managed to escape me. I saw our purpose in having registration as protecting the hospital’s longevity so we can continue to get paid for today’s services, so we can continue to provide them tomorrow. I understand that is still part of the picture, the piece I missed was the piece about how that also assists patients in avoiding indebtedness they can’t hope to impact. I never saw that piece of it so I am really glad you brought that up and emphasized it a number of times because it has helped me understand.”

Effective Communication. There is a strong realization regarding the interdependency of everyone’s role, i.e., how they each depend on each other in order to provide services. The emerging emphasis is clearly on articulating and coming to consensus on how they are all connected and need to communicate effectively.

(st-1-p.33) “(staff) Communication is a big barrier in an institution this size, it isn’t a fault, I don’t think, it is just a barrier. We may have four people in this institution capturing all the same information. So, it is just going to be a communication issue and hopefully if there are areas that still need help and stuff we will recognize that through communication.”
Given the size of the organization and subsequent role variation, the inherent difficulty of effectively communicating is substantiated by the following Thematic Statements survey item.

15. It is difficult to communicate effectively when staff are understanding the process of providing services from different roles, or perspectives.

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In addition to differing perspectives, the pace of day to day operations present further challenges to effective communication.

(st-l-p.30 & 31) "(staff) It starts from the time you open that door until the time you walk out that door, it is rush, rush, rush, we are all rushed. I’m rushed to get the patient done and out, the secretary is rushed to get the patient started and gone, so we are rushed from the time we come in the morning, until the time we go home. We don’t stop and do this sort of thing (talk in focus groups) with each other, so we don’t realize how we all effect each other until you really just sit down and just look at it. We are all one big family really, and if we take the time to communicate more, I think we learn a lot."

The need to communicate effectively is clearly established and recognized by both staff and patients. In fact, on separate occasions a staff person and a patient identify the importance of involving the psychiatrists in better communication practices.

(st-l-p.36) "(staff) I think it is a wonderful idea, I mean I would like to see maybe a monthly, bimonthly, or some kind of communication group between ... right down
from Dr. (a psychiatrist) on down to me. You know, we could sit in the same room and say, ‘well, you know, I had a problem this month with this ...’ iron it out, I think we really need that.”

(ct-2-p.3) “(patient) For the past three weeks I have been thinking a lot about what we did here last time we were together. I really think it is great that the staff and just some of us common people can get together. We have the same problems. We can work this information together. One of the main problems that I see coming across between you folks and the psychiatrists, that is where I think the main breakdown is. I really feel that is where we need more communication, the psychiatrists need to become more involved with you.”

The focus groups help to emphasize the need for effective communication. The following narrative exchange and Thematic Statements survey items, point to the interventive effect and unanimous agreement regarding the value of the focus groups.

(ct-2-p.4 & 5) “(researcher to staff) I want to ask you a quick question. You mentioned you have asked different patients about their experience in registration, have you always asked patients that, or did you just start doing that since these groups?”

(ct-2-p.4 & 5) “(staff responding) I just started. Most of the time before, they came out and told me why they hated to go. But, since we had this meeting you know, I have just kinda wondered what other patients thought. So, when they would come through I would say, ‘well just tell me why you don’t like to go to registration?’.”
If “intervention” is defined as new behavior flowing from new insight, then it would appear the staff person is behaving differently as a result of focus group involvement. The relevant survey items substantiate the value of the focus groups and conclude this theme presentation.

4. Focus groups help staff to understand how information flows through the system.
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   Strongly Disagree Somewhat Neutral Somewhat Agree Strongly Agree
   Disagree Agree Agree Agree

5. Focus groups help staff to understand how important it is to communicate effectively.
   (RF) 1 2 3 4 5 6 7
   Strongly Disagree Somewhat Neutral Somewhat Agree Strongly Agree
   Disagree Agree Agree Agree

6. Focus groups help staff to understand how communication with each other either works well, and/or breaks down in our system.
   (RF) 1 2 3 4 5 6 7
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   Disagree Agree Agree Agree

3. Staff perceive upper administration as non-supportive and out of touch with their needs and concerns.

As staff were invited to discuss their roles and how they work together, they responded with what it feels like to do their work. This theme was emergent as staff began to comment about their frustrations in the work environment.

At the outset of the focus group process, staff recognized the absence of upper administrative representation. Beyond the acknowledgment of such an absence, staff initially indicated a need to talk about issues without administrative presence.
"(staff) I think this type of focus group is very good because you keep away from some of the administrative types ... people get intimidated by that, I know I do."

There was the apparent understanding that administration has different concerns compared to staff persons who "do all the work."

"(staff) I am just sitting here looking around at everybody, we have what I would say is no upper management here. We have middle management here, that I think do all the work. I mean we get in the nuts and bolts and get our hands dirty and we have to do with the daily operations and know what is going on. But, once you get to the upper echelon, they have to worry about the other factors and might not know, I mean the only way to find a good process is by making some bad decisions."

Staff sense administrative persons are out of touch with what they do on a day to day basis. The comment, "I mean the only way to find a good process is by making some bad decisions," seems to accept, excuse and expect a continued lack of understanding and coordination between "doing the work staff persons" and "decision making administrators."

Evidenced by the following survey item and narrative, there is concern about administrative neglect being due to stigma and/or fear of mental health services.

20. Staff perceive the administration to view AOMH services as unimportant, or "second fiddle."

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(st-2-p.19) “(staff) Oh yea, I think mental health gets by passed a lot, and mental health carries the ball of this hospital, you know and they (administration) have to realize that. They need to realize that, but it is not their favorite thing.”

(st-2-p.19) “(staff) That is pretty scary. It is pretty scary. I think, all of us who work in or with mental health need to recognize that not everyone shares the same enthusiasm for mental health that we do. Many people are frightened by the idea of mental illness in whatever form it takes so that anything associated with mental health treatment carries an aura of something frightening with it in their view. I mean, its an interesting observation to me that we don’t often in our end of the building see very many people swinging through who aren’t somehow working in that end of the building. Maybe it is just because geographically we are sort of stuck out there in the northwest corner of the hospital, I don’t know, but it is a curious observation to me. I don’t know what to make of it.”

(st-2-p.20) “(staff) Well, there are administrators who aren’t allied with either medical or mental health, who administer all of it, who we never see.”

The following survey items and narrative further indicate some consensus regarding administration being out of touch with staff needs and concerns. Due to the perceived lack of administrative support, staff are concerned about their own resourcefulness, emotional and financial consequences and compromised quality of service to patients.

9. Staff who work with patients directly on a day to day basis, feel more work responsibilities are being put on them without their input.

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11. Staff perceive upper administration to be out of touch with their needs and concerns regarding change with Adult Mental Health Services.

(RF) 1 2 3 4 5 6 7
Strongly Disagree Somewhat Neutral Somewhat Agree Strongly Agree
Disagree

22. If administration does not support and care for the staff, there will be no human resources within the building to offer patients.

(RF) 1 2 3 4 5 6 7
Strongly Disagree Somewhat Neutral Somewhat Agree Strongly Agree
Disagree

"(staff) If we don’t support and care for the staff there will be no resources within the building to offer to the patients who walk in. I am talking more about the atmosphere. It doesn’t feel terribly supportive to me and I am speaking in very general terms. I realize that staff, both support staff and professional staff, whatever flavor of staff you want to talk about, we all need to feel supported in what we do, and valued. I am not talking about more money in the paycheck necessarily.

What I am talking about is something highly intangible but worth at least as much as what comes in my paycheck every two weeks. That is a sense of feeling valued and feeling supported by the hospital as an institution. That is what seems to generate the energy in many people to continue to be able to come in every morning five days a week or seven days a week and keep giving to the patient, being compassionate with the patient, leaving the door open for the patient, saying ‘good morning’ to the patient and to the other staff. You can’t measure this stuff, but we are lacking in it in my opinion and we need it."
(staff person questioning another staff) What could happen that would give you the opposite impression. That you are getting support from administration? What would tell you that?"

(staff person responding to the above question) Well, I think there are probably a number of places, a number of things that could convey that message. But one that I'd really like to see happen soon is clearer more open flow of back and forth communication between those of us who deliver services directly dealing with patients, and those who operate the upper levels of this administration. I don't see very much of that kind of contact.”

(staff) Administration has to feel that way and we were told we had to get patients registered in 90 seconds. I told them I would start running the Rawhide theme for registration. You know that is how they wanted to treat people.”

(staff) There seems to be sort of... our organizational environment and attitude seems to be, 'let's get by with as few support staff as possible' to cut costs you know. What I think is what that does is loses us more money than we save.”

(staff) What is the concern? What are the main concerns at the top administration in this hospital? I mean my speculation is they are concerned about money, pure and simple.”

(staff) I agree with you, I don't think that we have the staff to do what needs to be done and therefore I don't see the quality that mental health is up to
the standard that it should be. You need the staff in order to get it done what needs to be done. You make more money in the end.”

(st-3-p.18) “(staff) I have patients tell me what they think that if we had, if people were paid better, or paid more, or whatever, I don’t know how they know, but they know. That people would stay longer, and that our area needs more help, I mean the patients say it right out.”

Staff recognize an apparent incongruity between hospital public image and the actual practices of the organization. Such incongruity coupled with a non responsive administration yields mistrust and frustration.

(st-3-p.21) “(staff) We as a hospital, I have heard this theme over and over in the years I have been here, want to upgrade our image. We want to be like other places in the community. How many other places in the community do you go for an appointment and part of the system isn’t open because they don’t have staff to cover it? I have not been to one.”

(st-2-p.23) “(staff) It’s not that you don’t want to help somebody, the work load, the frustration, the system is not working. The demands being put on people, when they, the people making the decisions, are not wanting to listen, it is just like they say, stuff rolls down hill, still ... someone has to listen.”

(st-3-p.22) “(staff) I think that has to come from administration on down. They are going to have to care for the people coming into this institution, and I don’t see that caring at all.”
(st-3-p.24) "(staff) I want the CEO to come down and work in my area for a day is what I want. I want him to come down and see, I mean it is never going to happen, I don't think, but they need to come down here and do what we do."

(st-3-p.24) "(staff) I don't see administration as being actively, or I don't even want to use the word interested, but I don't see them as thinking of those patients. I just, I don't know. There still has to be that concern for the patient. You have to care. You have to care."

(st-2-p.17) "(staff) Oh, I think our patients are very frustrated. They would say we need more help, they would say less steps to get where they want to go. We need to find people who are going to stay and making it worthwhile for them to stay. See, my personal opinion is they need to call god down from the mountain and put him in our positions and let him see what it is like and then let him go, 'oh, O.K.' They just sit around a big oval table and go, 'yee, these stats say that, yep, that is what we are going to do.'"

In addition to staff concerns regarding administrative support, patient feedback was also important. The following question, responses and additional narrative demonstrate patient ideas about improving outpatient mental health services.

(ct-1-p.18) "(researcher to patients) If you had one chance to talk to the CEO of the hospital, or the Board of Trustees, if you had one opportunity to talk with them and tell them one thing you would like to see different from a patient perspective, about
how outpatient adult mental healthcare is run, what would be your one suggestion to them?"

(ct-1-p.19) "(patient) I would first ask the CEO for some of his credentials, then I would ask him, 'do you give a darn?' I would analyze the CEO, then I would tell him to get his butt up to the legislative department and do what needs to be done and go down to Principal and the rest of the insurance companies and do what needs to be done and I don't mean playing golf with them."

(ct-1-p.19 & 20) "(patient) OK, if I were to go to the CEO, over all I would tell him I am pleased very much with the counselors, the therapists, the secretaries and through the registration process they are really trying, but they do need more help to smooth the process out."

(ct-2-p.13 & 14) "(patient) I think what happens a lot of times people up here think they have a lot of the answers and they implement things, they think, 'this is going to be great.' But in fact, what they end up doing is making things more difficult or less clear or whatever. Some of them are open to hearing why it is not working, but a lot of them say, 'O.K., this is what we need to do.' Bing, bam that is it, and it creates a more difficult working atmosphere and it complicates and slows down the processes. I think it comes down to are they going to listen and are they willing to say, 'yes, there may be an easier way, a clearer way, a simpler way.' But it gets back to everybody has to have some input and if you don't listen to their input then there is a lot of wasted time."
Evidenced by the above narrative, patients recognized similar issues regarding questionable administrative support. Staff resonated with the sentiments shared by patients.

(ct-l-p.24 & 25) "(staff) Hearing the patients reiterate our own feelings ... I mean we’ve got the staff and we’ve got the clients and we’ve got the same interests at heart. It was just like voicing my own concerns and everybody says exactly, I mean if I could just open up my mouth, they were speaking for me. I mean I felt the same thing, I have heard the same thing. I am seeing what they are going through it is just a matter, you know, sometimes the communication may fall on deaf ears."

(ct-l-p.22) "(staff) Well, basically what I learned is what I have been trying to say all along that we need more help. You know, there are just too many things going on for us to take the time to listen or give special attention to some of the problems the patients have. I can’t give them the time they deserve because I am trying to take care of everybody at the same time. So, we need more help. I have said that since the day I started, and I am still at square one. I have gone to the top and I have said what I needed to say and as far as I am concerned, it has fallen on deaf ears."

(ct-l-p.23) "(staff) I have learned that when the patients speak out, that they (administration) tend to listen a little more around here versus employees. They (administration) are listening to what patients are saying and I don’t know ... I have told people, the secretaries have told people and the therapists have told people you know, ‘the patients don’t like this ...’ and I think when the patients speak out, I think
that they tend to listen a little bit more than when we do, because when we do, they just take it as we are a just bitches!"

There was further evidence regarding staff mistrust of administration. Even if needs and concerns are conveyed to administration, and the message is heard, there is still anxiety about how the message will be interpreted.

(CT-2, p.5 & 6) "(staff) Then the other thing that struck me is we are missing a layer here. We are missing several layers. We can talk, we cannot make the decisions and make the changes and so the psychiatrists are one of those layers. The other is higher administrative levels that will be making the decisions and how they will interpret what these concerns have been and then how they will interpret what the solution should be, and then as I started thinking, that could be frightening. Because I don't know how they will interpret what we have said and how they will interpret what our clients say and I think that becomes vastly different sometimes from what we actually meant, and the solutions that are somewhat fabricated from those assumptions or those interpretations and then they are colored by that level of administration that holds the purse strings and the staffing and all of that, it can get real wild, so that is my anxiety speech."

Finally, in spite of perceived administration shortcomings, the following narratives indicated staff are trying to maintain a focused and proactive posture.

(ST-2, p.25 & 26) "(staff) I am wondering if we can identify what can we do ourselves to make things work better? That is not to say we give up trying to you
know get some response, some appropriate response from administration, but in the mean time if it is true that we are all kind of pulling back from each other because we are getting pressured, you get pressure from the administration, you know if something is not in the chart, it is your fault. If you feel like the finger is being pointed at you, unfairly, then your tendency is to get very impatient and intolerant, and just kind of hunker down and do your own thing. We can’t wait for the finger pointing above us to just stop before we have to realize what is going on and quit reacting that way and do something different.”

(ct-2-p.16) “(staff) We keep saying the administrative layer is missing. But if they don’t know what is bothering us and we don’t tell them, then we are not being responsible in trying to go on and make this do something. Do you know what I mean? I don’t think higher ups sit and say, ‘lets make this decision and make their lives miserable.’ You know I don’t think that is their intent. I think sometimes it is a communication issue you know. I mean I can’t imagine, I don’t know anybody that works here that I think sits down and says lets make their lives miserable. I think that they need to know.”

(st-3-p.23) “(staff) Keep our focus where it needs to be, which is acknowledging problems but trying to do the best we can with what we have got. How do we deal with our own attributes and with our tendency to at times isolate from each other and not communicate and point fingers you know and act out our frustrations and so on. We need to really be aware of that and work to overcome that. I think also, we are
not in a position to make the types of decisions that we are saying need to be made. So, the people that are, need to know and we can’t control whether they take it seriously or do anything about it or do what we asked but I think that it is an opportunity. I mean you guys (co-researchers) are basically doing a free consultation for the medical center (MC), you know.”

(staff) Yea, I’ve got something to say. it is pretty easy for me to slip back into what used to be pretty much my world view which was ‘nothing ever changes, nothing gets better.’ So basically it didn’t matter what I did or said, I had no impact. Well, very slowly, on small scales over time, I figured out I was wrong about that. So, even if I spoke up, took a risk, opened my mouth, and nothing changed, at least I had not participated in perpetuating the problem. Because by not talking, by not speaking up, that is what I was doing, I was helping what didn’t work continue not to work. Then what we are doing by not sitting back and saying, ‘let somebody else do this’ is we are refusing to support problems. The problems are there, you can’t have an organization of this size without major problems. It is like a big dinosaur, it doesn’t know quite what the other end of itself is doing and that may always be the case. But, I think we can improve information flow from one end of the dinosaur to the other and if we can do that then we refuse to participate in maintaining the problems.”
4. Other than serving patients better, staff perceive "performance improvement" as ambiguous and/or not relevant.

Near the conclusion of the first staff only focus group, this theme was imposed as staff persons responded to the following question.

(st-l-p.38) "(researcher) I would like to hear from everybody, from your own perspective, when I say 'performance improvement,' what does that mean to you?"

The responses to this question reflected a strong desire to serve the patient better. It would appear staff concepts of performance improvement only minimally stir reflection and/or comment about being better served themselves.

(st-l-p.38) "(staff) It means we serve the client in the most efficient manner that we can."

(st-l-p.38 & 39) "(staff) A perfect example of what we are doing at the MC right now in performance improvement is exactly what we are doing in registration. We are looking at the performance of that department, or the registration process, and looking at it trying to streamline it and look at the flow, the information flow, in order to improve upon it. Making it not only easier for the registration personnel, we are looking at it from a client friendliness atmosphere, making it quicker to get into therapy."

(st-l-p.44) "(staff) I would be a lot more effective, more experienced and be able to figure out more quickly what a useful response might be to a patient. I mean that is performance improvement, to provide better service to my patients."
I agree, being able to better serve that client with what they need help, to help solve their problems, to help them get through a crisis. I also think performance improvement in mental health is assisting that client to be able to better negotiate the system, and I think that is what this is about.”

The thing I could probably add to that is we need more help. There are times we have patients lined up just waiting to be waited upon and by the time we get to some of them, I mean, they are ready for the crisis team (a 24 hour mental health crisis response team).”

Performance improvement lets you make it easier for the patient to get through, to be patient friendly, and to be able to clarify to the patient that we are here to help them with their finances, we are not just worried about the money.”

The following survey item reflects some consensus among staff regarding the ambiguity about “performance improvement.”

13. The terminology “Performance Improvement” is somewhat ambiguous, and lacks significant meaning to staff.

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Beyond serving patients better, it would appear most staff agree “performance improvement” lacks conceptual clarity and may not be meaningful.

During the second staff only focus group, essentially the same question is asked. It should be noted the membership of the second group included two new participants.

However, two staff who were present during the first group were now absent.
(researcher) When I say ‘performance improvement’ and when you think about the role you serve in helping to provide adult outpatient mental health services, what comes to mind? What do you think of?

Responses:

(staff) (laughing) I have no idea, (more seriously) I think of ways I can improve my performance, provide better service to my patients perhaps be more efficient, effective.”

(staff) Two things come to mind with that phrase, ‘performance improvement.’ One is meetings where we listen to people report statistics on their programs, that is the technical part of it and it is not very interesting and a lot of times, it doesn’t seem all that relevant. But, theoretically, our performance improvement activities, that is the things we monitor in our procedures and outcome measures, really do have some relevance to what we do and what is important to the patients, and that is the other thing I think about. I think about what can not only I be doing to improve my performance, but what can our department do to improve what we provide?

(staff) It is more a question of relevance. It is ... the things that we are keeping track of and counting and keeping statistics about, do those really measure anything that has to do with what we do, what is important to the patient?

(staff) Our performance improvement committee and the whole structure of performance improvement in the hospital comes down from on high, you know it
is through the ... what is the hospital credentialling ... JCC? ... the joint commission, and they have certain expectations and you have to fit into their way of doing things.

And so it has been in the last couple of years a real adjustment, what used to be called 'quality assurance' to now be called 'performance improvement' and changing formats and so on. So since that is kind of a top down kind of thing, it always raises the question of well, what relevance does that have from the patients perspective?"

Finally, there is considerable variation in response to the following survey item regarding the relevance of statistical reports improving the quality of services.

14. Improving the quality of services for staff and patients has little to do with statistical reports.

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Although the majority of staff respondents at least somewhat agree that statistical reports have little to do with improving service quality, the ratio is not dramatic. Further, although theoretical, a reasonable interpretation of the varied item responses might be found in the earlier discussion regarding role variation. Specifically, variation in staff roles influence the understanding of service provision and how to improve, including the use of statistical reports.

5. **Staff recognize the complexity of change as an emotional process resulting in frustration, isolation and compromised quality of service to patients.**

Arguably any conversation about evaluation and/or improvement in a work setting might inherently provoke discussions about change. However, the researcher scripted no
a priori questions regarding change and therefore the theme is emergent.

Staff discuss change in both general emotional terms as well as more specific current circumstances and potential consequences. During the first staff only group, the discussion of change is connected with technology and efficiency.

(st-1-p.32) "(staff) Change is an obstacle everywhere. The MC is going to be going through some big changes in the next five years, and they are starting already. They have started with the implementation of the computer systems and stuff. Just from the littlest thing like moving the mailbox where you put the charts makes people... they get in a habit, they just do it this way. They are accustomed to it, they are like, 'why change it, it worked before?' But we are trying to make it more efficient."

(st-1-p.33) "(staff) Not having enough help or assistance to perform the duties efficiently, or effectively, that is just coming with the down sizing, the restructuring, reorganizing of the corporate everything, all companies are doing that. Like we just went through our cutbacks and we felt it very heavily in mental health and I don’t think we are going to see a change away from that and hopefully with these computer systems we may... well, I hope these systems are going to alleviate some of the work other people are doing."

There is some interesting commentary above about the relationship between people and technology. It is interesting to note a computer systems person trying to solve problems of "not enough help" by suggesting some "system is going to alleviate some of the work other people are doing." What about alleviating not only work, but also positions and/or
livelihoods? The issue here is the balance between efficiency on the one hand and technologically displaced employees on the other hand (Rifkin, 1995). If quality and efficiency equal, or are perceived to equal job loss, then quality efforts will not work. Rather, such efforts might be understandably sabotaged at the grassroots level by those who may lose their jobs, or by those who may lose their colleagues. Nevertheless, evidenced by the following survey item responses, staff largely agree technological support should enhance the quality of their work lives.

12. Staff think greater technological support, i.e. computers and efficient software, will make significant improvement in the quality of their work lives.

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Near the end of the first staff only group, and in response to the above narrative comments, a staff person introduces less tangible considerations regarding change.

(st-1-p.47) "(staff) At some point I would like to address some of the things said today about the changes that are coming or beginning and that are in the foreseeable future. Not the specific changes, but rather the temperament surrounding the change."

This particular staff person continued to articulate concern regarding the complexity and emotional aspects of change throughout the focus group process.

(st-2-p.22) "(staff) I think that underneath all of the mechanics, all the logistics of getting somebody through our system so they can get to where they can get what they need ... I think underneath all of that is an emotional layer that the staff are
trying to deal with and that includes myself and everybody else to one extent or another. We are failing to address that piece. We are trying to do the upper layers and fix them, when in fact that is not where we need to be working in my opinion. I think we need to be addressing that lower emotional layer attending to that and if we are successful there, the success will drift upward and we will fix the logistics, we will fix the mechanics of getting people through the system to where they can get what they need.”

(staff) I see our system, outside the hospital and within the hospital, becoming increasingly complex to a point where it is really difficult to digest the whole thing and make sense of the piece you have to weave your way through. Which I think causes us to feel less able to advance through one day to the next getting things done that we need to get done. Not just at the workplace but in our individual lives. I think when people feel like they can no longer manage well in a situation, they hunker down and they pull into themselves and they try to restrict their activities to a realm that still is comprehensible, or they feel some sense of being able to manage. My opinion is that there is this under current through staff of feeling like there is not much that we can manage because it is so complicated. There is nothing from our individual perspectives that we could do to simplify it or make it more understandable. So we kind of pull in and go, ‘Oh, I’m just gonna stay in this little spot that I am familiar with and at least I know what to do here and I can manage the pieces here and I am feeling scared to venture beyond that because once I
get out beyond this certain limit, it is like I am in chaos-land and I don't know what
to do, and I can't have an impact.' I honestly think there are an awful lot of people
who are feeling that.”

(st-3-p.27 & 28) “(staff) Unless we're willing to face the fact that change is scary,
and unsettling, and you never know quite how it is going to turn out ... In other
words, unless we deal with the emotional part of change, we won't be able to do the
practical pieces of it very well. We will just be trying to hang on.”

(ct-2-p.8) “(staff) I left the last joint meeting with a sense of frustration. I think that
we recognize problems and would like to change things but I have some responses
about change. First of all, I am not sure we know where to start and a part of that is
that the people who could start some things are not directly involved here, and I wish
they were. The other piece of it is, I feel like we are still missing a deeper layer of
something that is a piece of our various problems. My feeling is we are missing
whatever sort of emotional undercurrent drives the problems. Typically something
scares me about making change. I don't know what it is but I think that is what we
are seeing here. As an institution something scares us about making change, and we
are not addressing that, and no changes will be permanent and lasting and global
until we address how scary it is to make changes.”

It should be noted all staff agreed with much of what is re-stated above. The following
survey item further conveys the staff consensus.
10. Staff have strong feelings about change in their work lives.

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Some of the “emotional layer” is frustration. Given the current circumstances, staff notice the isolating consequences of frustration as well as the impact on quality service provision.

(st-2-p.20) “(staff) I am here to try to make her job easier, and his job easier and your job easier, that is what we are here for, we are all a team. I mean we all work for the same hospital, but it just seems like it breaks down because there is ... you know people are frustrated. Patients are frustrated and if we are frustrated, you can’t cover it up every day. So when they sense that frustration, they are going to be frustrated to.”

(st-2-p.21) “(staff) I also think that sense of frustration then pulls people away. Rather than sometimes pulling them together, that sense of frustration pulls them, then I am going to do what I need to do and I am staying out of everybody else’s domain or business. I’ve got enough frustration of my own so I am not going to worry about that frustration and ... it is counter productive.”

(st-3-p.16) “(staff) That is what we learned from last time. We have all stopped talking. You can tell we are all stressed because we don’t talk. We just hide in our own little world. Do what we have to do, and go home.”

Finally, evidenced by the following survey item and narrative, staff distress impacts the quality of mental health service provision.
21. High distress in the work environment compromises the quality of AOMH services.

(st-3-p.22) "(staff) I think we have exceptional people here. I think they work here because they want to mostly. They can only give so much too. There is a certain amount they can give in a day, then you have to ... you are going to shut down."

(st-3-p.19 & 20) "(staff) One of the registration clerks in mental health one time said not only in mental health, but in family health center, they felt like they were herding these patients through like cattle. That is what the patient feels, the patient does not feel that friendly Hy-Vee smile, you know. They really don't."

(st-3-p.19) "(staff) When we are stressed, or you are busy ... I don't work directly with patients any more, but when I worked at the clinic, I know that they (patients) knew. They could perceive that because when you are going, 'O.K.' and 'thanks.' You know you are the assembly line kind of thing, and I don't know if other people are under the same pressures. You have to tell yourself, 'I need to say how are you today' because you are trying to keep up and not have the person waiting on hold on the phone upset because they have been on hold for fifteen minutes you know. I think they can perceive that, and depending on what kind of day you are having too. Some days are harder."

(st-3-p.16) "(staff) Generally, people (patients) feel like they are treated O.K., but they see that the staff are under stress because you can't hide that indefinitely. You
know the secretaries and registration clerks are stressed and so are the therapists and sometimes that comes through.”

(st-3-p.17) “(staff) How we feel effects how well we can serve the client.”

6. **Attaining important information for quality service is compromised by both the unique challenges inherent with mental healthcare and the frustrating complexity of our system.**

This theme is emergent as staff informed the researcher regarding the importance of accurate information. It is clear many staff either have difficulty attaining information and/or experience distress and diminished production capability when working with inaccurate information (Covey, 1989). The net result of such difficulties are both frustrated staff and compromised quality of service for patients.

The following survey item and narrative statements substantiate the importance of attaining accurate information and indicate some issues of concern.

7. **Getting accurate information** from, or about the patients helps to **reduce distress** among staff and patients.

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(st-2-p.9) “(researcher) What gets in the way of patients informing us?”

(st-2-p.9) “(staff) They don’t ask, in mental health with our type of patient, you need to ask them. You need to prod them.”

(st-2-p.10) “(staff) We do several things I think. We ask more, we have someone here in the facility that will help fill out current title nineteen papers. We have the
Iowa City desk to help with other financial kinds of assistance. We have inpatient people that try and get people hooked up with financial assistance before they become outpatients. I think there is a variety of things we do.”

(st-2-p.12) “(staff) I think it makes a lot of difference the way collections ask. I mean it makes a lot of difference in the tone that she used to ask a question. I don’t know anything about mental health registration but when I worked up front in the department of ... well registration was up there (indicating the front of the MC) and it was amazing when different people worked that round desk registering patients, how some people have a much better rapport with people and how some people had patients exploding at them all day long. You know, it seemed as though some people were able to get the information more easily.”

(st-3-p.14) “(staff) So what happens then, because many of these people don’t have other resources besides our county, if we don’t provide the support to capture that money, we don’t get paid. So are we farther ahead to provide the support, pay for staff to be able to get the information so that we can then get the money, or do we cut off our nose to spite our face so to speak.”

Several issues regarding information gathering are mentioned above: how our system already assists patients, attitude of staff or rapport with patients, adequate staff to do the job and the financial consequences if the job isn’t done.

In the following narrative staff elaborate on both the nature of our mental health patients and our current system of mental healthcare delivery. Specifically, staff make
several comments comparing patients who receive mental healthcare to patients who receive medical care. Further, staff also note several differences comparing mental health to medical care service provision.

(st-3-p.7 & 8) "(staff) With many of our mental health patients, the part of them that is in need of care is the part with which they manage to get through the world. In other words, their brain. When a person is a medical patient, often times they are able to think, to represent themselves and reason is not impaired the way it will be if they had acquired a mental illness instead of a physical illness. Those disorders that seem to be most debilitating to one’s motivation are typically the kinds of things that are chronic and will remain with somebody for the balance of their life and impair them in fighting their way through whatever system."

(st-3-p.7) "(staff) I think our whole system is hard to get through. I do think our mental health patients have a harder time because they are in many cases more chronic. They are disenfranchised from the system more than the medical and I think they need different kinds of things to help them through the system. I don’t know, I also think they have a hard time in medical because there are medical personnel who don’t want to work with mental health clients. I think there are different needs to help mental health clients get through the system."

(st-1-p.41 & 42) "(staff) I think one thing I like to observe, is that on the medical side, outcome of a procedure has less to do with patient participation then it does on the mental health side. I can beat my brains against a patient’s issues for months and
unless the patient takes action, hopefully on the basis of the support I provide in an appointment, nothing will change because I can not change that patient. Nor can any other therapist that I have ever known. The patient is the change agent, they are his or her own change agent. All I can do is support, suggest, guide, enlighten, question, challenge, and yada - yada - yada -- but I can not do the changing for him or her.”

(st-1-p.39 & 40) “(staff) Compared to medical ... a gallbladder is a gallbladder. Mental health is ... you’ve got a DRG for a gallbladder and you have got Blue Cross and you get paid for it. There are different services within mental health, I mean in terms of the different levels, testing, psychiatry, therapy, inpatient, outpatient, you know, and that is why the trouble. Very complicated.”

(st-3-p.7) “(staff) There is a different type of motivation that fuels following through for medical clients, in terms of, ‘I got pain, I want to get it fixed, it is going to be fixed, I have to have surgery, so I have to follow through.’ Mental health patients don’t seem to have that type of motivation.”

Staff make several comments regarding the chronic nature of some mental healthcare problems. As such, both patients who struggle with chronic problems and in general most mental health patients will have repeated exposure to our system of service provision.

(st-3-p.7) “(staff) I think that mental healthcare clients have to come here much more frequently than most other patients and when they encounter the same old
problems every time, it is a real burden for them. It is not the same as it is for other patients.”

(st-3-p.8 & 9) “(staff) People being chronic, they will be coming back and coming back. Some of those chronic disorders tend to alter the brain in such a way that it is not lack of will, it is part of the brain that manages the will that is just not working the way it ought to. It is a symptom of the disease rather than a response to the disease. That alone makes it difficult to maneuver a complicated system whether it is ours, DHS, trying to get their food stamps, or trying to get less expensive housing. Whatever it is that they are trying to do, everyday survival is tough under those conditions.”

(st-3-p.11) “(staff) It is just the inherent nature of the mental health population, one aspect being the nature of their problems often involve their motivation, their capacity to understand, and that sort of thing. It makes it difficult for them to negotiate the process like other patients might be able. The other thing is that because of the chronicity and intensity of the problem, they come back more frequently and for longer periods of time. So, if there is a problem in the process, they encounter it every time they come and it gets to be more burdensome for them than for some other patients who don’t have to come as often.”

(st-3-p.12) “(staff) That is a good point because I never thought about those patients coming more often, mental health is a lot different. Some of the patients we can’t even get into disability till they start mental health and see a therapist and we find out
if they are eligible for disability. So, it is a longer process getting the payer source for them, and their bills are a lot higher.”

(st-3-p.19) “(staff) Yea, I think any time you are trying to complete paperwork initiated by a bureaucracy, you have the potential for confusion. We are asking folks to complete that kind of stuff and understand what it is that is required in terms of information. These are folks who are having trouble figuring out day to day kinds of things like doing the laundry, cooking a meal, do I need a shower today, and so we are asking a lot. A lot is being asked of them before they can get the help they need. It seems a little backwards.”

Staff comment on both the assumed limited capacities of mental health patients as well as the frustrating complexity of our current system of service provision. The following survey item and extensive narrative conclude this theme.

19. Staff recognize AOMH services are growing increasingly complex and difficult to understand for themselves as well as patients.

(RF) 1 2 3 4 5 6 7
Strength Disagree Somewhat Neutral Somewhat Agree Strongly
Disagree Agree Agree

(st-1-p.39) “(staff) Outpatient mental health, that portion of registration has been pushed off because it is so ... it has it’s own identity from the medical side of the house, it really does. It is a different monster, you have to know the insurance, it is a lot more detailed in the verification.”

(st-2-p.17) “(staff) It is an issue, because this client may only want medication, they know what they want they may have even been on the medication before, but they
need a new provider because they have lost title nineteen or they have lost their insurance. But in order to get that, Prozac or Wellbutrin, or whatever it is, they have to go through all these other things, they become frustrated.”

(ct-1-p.23) “(staff) As I listen to a little of everything the patients are saying, their frustrations are the same as my frustrations. I mean I have experienced them, I have tried to help different clients through that maze and been frustrated along with them whether it is registration or insurance issues or psychiatrists not returning phone calls and those kinds of things. They are just shadows of my own frustrations. I think we all feel them, it is a major problem.”

(ct-2-p.3) “(patient) Well, I think for me it is just knowing that staff, regardless of what level they are at, do understand that especially when you are talking outpatient or inpatient psyche., there are a lot of emotions and stuff. Sometimes it is harder to deal with the small daily frustrations that happen and it is reassuring the staff are also aware of how difficult that can be. They may not be able to do a lot about it, but they are aware of it and they will do what they can.”

(st-2-p.16) “(staff) One of the things I have had discussion with several clients is an easier way to get through the system. It takes too long to get what they need. They have to go through too many people and they may really like the therapist they are seeing, or they may really like the primary care provider they are seeing, but they get frustrated with having to do all the other stuff it takes to get them there. Then, when that system is breaking down and when one of those pieces is pulled out, it is even
more frustrating. Like having to call one place to get the appointment and having voice mail, never getting to a person but having to have the voice mail and somebody call them back and I have had clients playing in terms of a tennis match with calls going back and forth. Then coming and having registration closed, you know so there is nobody in registration. Maybe trying to check in with the secretaries and they are busy answering four phone calls plus three other clients standing in line, it is difficult for them.”

(staff) We have done for years these client surveys and they are not very scientifically valid probably but I think they have a real positive bias. Without variation they come back very positive about therapy services. That is, the patients who respond to these things always say they really think their therapist is great, the services are great, the secretaries are great, everybody is great, but you will get comments about, ‘I am frustrated with this or that part of the process’ or ‘it takes too long and why do I have to go to registration every time?’ I have been here awhile and it goes in cycles. Every few months when there is turnover in registration we will hit another trough where things just don’t go well for quite a while and then it will kind of right itself for a while when somebody is doing well in registration, but then it will fall over again. We seem to be hitting on registration a lot here but I think that is such a key thing because it is a necessary part of what we do, but it seems to get in the way of what we do so much. I just think if the hospital could understand the importance of putting enough resources into registration, to make it
easier for patients, that it would make it easier for everybody. It would make it a lot
easier for therapists to do their job, and I think we would all be much more
productive as a result."
CHAPTER 5

DISCUSSION

Not everything that counts can be counted and not everything that can be counted counts.

—A. Einstein (Goolishian & Anderson, 1992, p.5)

Established practices of improving quality in processes and/or systems has substantiated that improvement is about more than numbers and thresholds (Deming, 1982; Senge, 1990). Nor is improvement solely about better systems; rather, improvement is about bettering the system. “You cannot continuously improve interdependent systems and processes until you progressively perfect interdependent, interpersonal relationships” (Covey, 1990, p. 267). The organizational culture, including human relationship issues, has significant importance to staff regarding the provision of quality mental healthcare services. As clearly indicated by the results of the study, human systems issues including relationships, emotions, culture and communication are the “right things” in need of attention (Joanning & Keoughan, 1997).

The results of the research provided descriptions of staff experiences, evaluations and ideas regarding improvement in the system under study. Essentially, participants taught the researcher about the important issues needing further attention. Staff involvement in designing quality is crucial to the success of improvement efforts. “According to Bateson, any organizational transition is best understood not as a shift in the rate of production or in the flow of energy in the organization but rather as a change in the relationships among members of the system or organization” (Bergquist, 1993, p. 120).
The discussion will recontextualize the results by adding the researcher’s interpretations and connecting salient themes with existing literature from quality improvement resources in healthcare and mental healthcare, organizational consulting and marriage and family therapy. The remaining sections discuss the evolving context of the organization, suggestions for the organization under study, implications and limitations. These sections will be presented in the following order:

- Pre-study Context
- Systems and Organizational Change
- Improving the Culture
- Recent Events
- Recommendations for the Medical Center
- Developing the Process
- Implications for Marriage and Family Therapists
- Limitations of the Study

**Pre-study Context**

The pre-study context is intended to more fully inform the reader of important contextual circumstances relevant to the research. The section is denoted as “pre-study” given the information is in regard to events happening before the research was conducted.

Several months prior to the actual study, the researcher was aware of cultural issues effecting his own performance and the performance of his colleagues. Through a variety of informal discussions with other staff persons and sensitivity to interactional patterns serving
as prognostic indicators of system health or dysfunction, the researcher grew concerned about
the continued functioning of adult outpatient mental health services. This growing concern
coupled with more formal discussions with the researcher’s direct supervisor and a desire to
do applied research lead to the present study.

Mental healthcare in general has been and continues to undergo tremendous change
(Chowanec, 1996). The Medical Center’s (MC) mental health services are not immune from
such changes. A particular series of events continues to influence the MC culture
surrounding mental healthcare service delivery. The events highlight administrative decision
making regarding crisis issues. Specifically, a problem with Medicare reimbursement and
the possibility of staff termination is described below.

Medicare Review

Beginning in approximately May of 1996 the MC faced serious problems regarding
appropriate documentation for Medicare patients receiving mental health services. Given the
MC is the county provider serving a population with low socioeconomic circumstances, the
elderly poor and disabled persons, considerable revenue is generated via Medicare
reimbursement. As such, the MC is accountable to Medicare documentation requirements
and review. Medicare reviewers were performing medical record audits of patients receiving
mental healthcare and were finding numerous inadequacies. Efforts were made within
departments to “clean up their own house” in hopes the glitches in the process might then
become more transparent. Steps to improve therapist documentation included routine (i.e.,
weekly) audits resulting in a published and distributed list of missing documentation
complete with the patient’s name and date of service. Each provider was given a list and was expected to appropriately remedy problems. From the perspective of the researcher the efforts were labor intensive, anxiety provoking and yet productive and the problems should have been on the decline.

Evidently the problems were more serious than staff were aware of and/or the solution wasn’t working or not working fast enough. On July 9, 1996 a policy was issued by the Executive Director of the medical center (see Appendix H). Essentially the policy held providers solely accountable for medical chart deficiencies, and implemented a protocol for termination. The protocol became known among staff as the “3 strikes and you’re out rule.”

The rule and the manner in which the rule was established and implemented exacted considerable distress on providers and support persons. Virtually all staff discussion both formally in meetings and informally in hall ways and behind closed doors, was devoted to emotionally and psychologically processing the rule and its implications. During one staff meeting in particular there was considerable open and divergent discussion about how and if providers ought to respond to the rule. Staff expressed alarm, sadness, anger and anxiety about the circumstances, yet some staff wanted to ignore the rule and hope it would just go away, a coping strategy analogous to the “no talk rule” typical of dysfunctional families (Becvar & Becvar, 1988; Trepper & Barrett, 1989). Instead, staff decided to ask for clarification from administration regarding some of the specifics of the rule and await more information before a conclusive response. The only clarifying information ever returned to staff amounted to “the rule will probably never be used.” Eventually, only informal
discussions about the rule continued, the crisis passed, no further formal discussion was facilitated, no one was terminated and the rule went away.

The impact of the rule and of the way the rule was handled, or not handled, continues to influence the culture of the organization. Evidenced by lingering critical remarks, staff trust of administrative leadership was compromised and has not yet recovered.

**Systems and Organizational Change**

The following section is divided in two parts. Changing the viewing addresses the significance of staff developing new perspectives about the system and their functioning in the system. Changing the doing addresses the need for staff to develop new communication practices to more effectively function as a system.

**Changing the Viewing**

"Systems thinking is a conceptual framework, a body of knowledge and tools that has been developed over the past fifty years, to make full patterns clearer, and to help us see how to change them effectively" (Senge, 1990, p. 7). A systemic understanding of change in organizations is crucial to the success of quality improvement efforts. When staff define their emotional experience of the system as "isolating and frustrating" the rich support available in human systems is clearly not being mobilized.

The present system is reactive in character, it does not learn from itself nor does it improve (Senge, 1990). One of the hallmarks of a reactive system is the often heard refrain, "we don't have enough time." It takes time to build the trust necessary to improve human system functioning and thereby improve the quality of life experienced by staff and patients.
Further, reactive systems are consumed by survival needs and do very little investing in future opportunities for improvement. Such constant pressure to survive, to keep the proverbial head above water, leaves staff feeling burnt out and hopeless regarding the possibilities for positive change.

A fundamental premise regarding change in human systems is that participants recognize their membership in the system and the depth of their interdependency (Cecchin, 1987; Deming, 1982; Hoffman, 1981; Senge, 1990; Watzlawick, Weakland & Fisch, 1974). As staff discussed their roles early in the focus group process they experienced a new awareness of their systemic interconnectedness. The recognition was happening at a new level of abstraction (Burr, 1991; Keeney, 1983). Keeney (1983) refers to this level as the description of interaction which, "does not focus on isolated bits of action, but on chains or sequences of action that are exhibited by interacting individuals or groups" (p. 42). The staff could understand their part of the process but could not appreciate their impact on other parts of the process.

Staff had an uneducated and unsophisticated suspicion regarding their influence on each other but did not view the depth of their interdependence. The result of such partial understanding of the whole often leads to problems arising from non-systemic learning (Senge, 1990). As demonstrated under the description of theme one in the results chapter, staff currently behave in the system based on the following tacit principle, "solutions to problems are bound to local knowledge of the system." Local knowledge of the system is context bound and does not account for the parts of the whole nor the whole which is more
than the sum of the parts. Gharajedaghi and Ackoff (1985) refer to such partial and disjointed considerations of the whole to be ineffective:

Because the effects of the behavior of the parts of a system are interdependent, it can be shown that if each part taken separately is made to perform as efficiently as possible, the system as a whole will not function as effectively as possible. For example, if we select from all the automobiles available the best carburetor, the best distributor, and so on for each part required for an automobile, and then try to assemble them, we will not even obtain an automobile, let alone the best one, because the parts will not fit together. The performance of a system is not the sum of the independent effects of its parts; it is the product of their interactions. Therefore, effective management of a system requires managing the interactions of its parts, not the actions of its parts taken separately (p. 23-24).

Staff understood their part of the system and were beginning to develop appreciation for the other parts of the system, as well as the whole. However, staff continue to enact idiosyncratic partial solutions to system problems. Each department and each individual staff person strives for their own optimal efficiency and effectiveness. Staff have routinely worked to improve quality in autonomous ways. The motivation for such segmented strategies for improvement is both inherent to the system as well as individuals in the system. There are currently no standing procedures or processes encouraging staff who work in different sub-systems to collaborate more fully.
Staff recognized that changing the system will include hard work, time, administrative leadership and whole organizational commitment. Improvement efforts at only one level of the organization will not work due to systemic forces toward stability. "To effect change of a cybernetic system, requires an understanding of the change of change -- change of how a system's habitual process of change leads to its stability" (Keeney & Ross, 1983, p. 377). If a system fundamentally does nothing to change the way it sees itself, i.e., if a system does not become self-referential, then habitual solution behavior becomes part of and sustains the problem.

Staff identified the need for a new kind of change. The researcher asserts the new kind of change can be described as both first-order and second-order systemic change (Montgomery & Fewer, 1988). Change is a process which informs itself. A systemic concept of change typically includes the complementary action of change amplifying and change inhibiting information balanced in the form of homeostasis (Becvar & Becvar, 1988). Homeostasis and related concepts used to describe information are most often associated with first-order change. In some ways first-order change is characterized as "more of the same" and not qualitatively different from previous conditions. First-order change is useful but limited by the mechanistic metaphor which provides its roots.

Second-order change transcends the limits of first-order ideas. Dell (1982) states, "A system can not behave without altering itself" (p. 32). In this sense change is constant and recursive. The implied dualism with homeostatic forces of change and stability are recast as limitations of the mechanistic metaphor. Taking the place of homeostasis Dell offers the
concepts of “coherence and discontinuous change” (1982). Coherence implies a congruent interdependence of functioning in which all parts of the system fit together (Dell, 1982). Discontinuity in coherent systems may be equated with second order change. Although Dell argues discontinuous change at the intrapersonal level is attained only through death of the individual, “multi-individual interactional systems are capable of true discontinuous change” (p. 34). The whole of the multi-individual interactional system is qualitatively distinct from the parts of the system. “Coherence as an interactional system is fundamentally different from the coherence that constitutes the individual living members who constitute that system” (Dell, 1982, p. 34). The coherence of the system under study is characterized by habitual patterns of problem resolution based on partial and inadequate information. Staff have indicated their desire for a new system characterized by unprecedented interactional behavior, hence second-order change.

Changing the Doing

The provision of adult outpatient mental health services is a systemic phenomenon. Staff are highly interdependent but largely unaware of the extent of their mutual influence. In order to change and improve, the system must communicate in new ways and become more richly cross joined (Hoffman, 1981).

Currently, staff are organized within departmental structures, or sub-systems, making effective communication complicated and uncertain. The resourcefulness of system members is constrained by current operational procedures, cultural morays and communication practices. The system is too poorly cross joined (Hoffman, 1981). Being too poorly cross
joined results in system members being out of touch with their interdependency. As such, communication is delayed and often breaks down thus allowing for pejorative attributions of other system members. "Virtually all organizations and the feedback systems within them experience some form of delay. Delays in communication not only prevent information from being received in a timely manner, which can create instability and breakdown. Delays often are misinterpreted. They are frequently attributed to inefficiency, incompetence or malevolence" (Bergquist, 1993, p. 134). The net result of such dynamics are mistrust and/or fear of the actions taken by other system members who do not understand all parts of the system.

Improvement efforts always affect real or perceived change in a system. Juran (1964) recognized, "Changes are a form of threat to the status, habits, beliefs, etc., of the people involved. They have a 'way of life' which is important to them, and which they will defend against invasion" (p. 141). Enhanced communication in organizations may require change that can often be complicated, difficult and fearful. "Fear serves as a silent thief, often robbing healthcare organizations of precious energy for improvement" (Batalden & Stoltz, 1996, p. 432). If fear dominates the system, changes in communication practices leading to enhanced quality will not take hold. "The prime requisite for achievement of any aim, including quality, is joy in work. This will require change. When everyone has a part in the change, fear of change will vanish" (Deming, 1995, p. 163). Staff participating in the study had involvement by informing the design of improvement. They taught the researcher about the right things to address in the process of improving performance. The key to staff
commitment regarding organizational changes brought about by performance improvement is involvement in the design of such changes, otherwise staff will do little more than comply with administrative expectations (Covey, 1989; Senge, 1990). Clearly, one crucial “right thing” is improving the communication among upper administration, staff and patients.

Staff expressed clear sentiments regarding the state of communication between various layers in the organization. They are in the position of having to guess about upper administrative decisions and are often unsatisfied with the outcomes. Communication in systems takes the form of feedback loops between members of the system. Typically, communication loops are characterized as either positive or negative feedback (Hoffman, 1981). When a system acts, it frequently receives information about how well it is behaving or how well it behaved. Within system’s language, positive feedback is information signaling deviation from previous states. If unchecked or not balanced, positive loops may result in the evolution of the system. Negative feedback acts in such a way as to minimize the effect of deviation information and maintain system stability. Positive and negative feedback loops are complementary processes maintaining the overall stability of the system (Keeney, 1983). When feedback loops are minimized very little individual or system learning takes place. In effect, system members remain isolated and poorly cross joined.

A core assumption is that staff will behave according to how they frame, define and/or punctuate the situations in which they are actors (Bogdan, 1984). If staff continue to perceive the system in partial or incomplete ways, then improvement is not likely. Improving communication under such circumstances requires a systems perspective. Unless
staff recognize their interconnectedness, they may see no reason to spend the time and energy to improve communication.

**Improving the Culture**

The following section builds on staff evaluations of the culture in which they currently provide mental health services.

Regarding the influence of organizational culture on quality improvement, Dennis FitzGerald, M.D. the CEO of St. Vincent Hospital in Massachusetts states, “The biggest barrier that we’ve experienced is culture. It is really a very, very powerful thing. By culture I mean, simply, the way we do things around here. It can be a plus, it can be a negative, but whatever it is, I guarantee you it is very, very strong” (JCAHO, 1993, p. 160). Understanding the culture of an organization is elusive work because the culture is always being created and recreated. Knowledge of the organizational culture is a social construction evolving from the ongoing discussions and interpretations of all organizational members and those served by the organization (Berger & Luckmann, 1966). Improving the culture will require new ways of communicating among members of the system.

The social constructionist view of culture happens through a process of communication. Culture is co-created consensually through social interaction and sustained conversation (Gergen, 1985; Hoffman, 1990; Real, 1990). Culture is a social construction composed of many voices. Staff recognize the current culture to be dominated by the voice of administration to the degree other voices are subjugated and marginalized (Parry, 1991; White & Epston, 1990). As administration maintains an unyielding and non collaborative
position of authority, they isolate themselves from the creative energies of the staff. The net result of such isolation is compromised service to patients and failed efforts to implement performance improvement activities.

Results clearly indicated staff criticisms of the current MC culture and expressed cynicism with regard to performance improvement. Garrison Keillor skillfully articulates cynicism regarding quality improvement language, "The words holistic, leadership, process, quality and commitment crop up everywhere -- sentences like, 'The commitment to quality is a holistic value structure throughout the leadership process that is accessed dynamically through all functions of the organization from the bottom up.' Sentences that, the moment you hear them, they're gone, like gas" (1996, p. 100). In order for quality efforts to sustain themselves, staff cynicism must be addressed and a commitment from the organization leadership must be evident and genuine. Organization leadership must set the stage for a culture supportive of improving the quality of life for staff and patients (Arnold, 1993; Batalden & Stoltz, 1993; Berwick, 1989; Berwick, 1994; Boss & Golembiewski, 1995).

Diane Cesarone the Director of Quality Improvement for the JCAHO states, "One might, therefore, view the regular evaluation of staff perception of the corporate culture and values personification as one critical element of an organization's overall process for measuring its performance, quality and value" (1993, p. 47). The current culture is typified by staff who are spending their creative energies doing survival activities. In order to survive or maintain their employment, most staff persons are spending the vast majority of their work time
strategizing how they can manipulate methods of evaluation based on numerical ranking, e.g., productivity ratings.

Staff currently perceive their voice to be the most marginalized, behind even the voices of patients. This sentiment is evidenced by the remarks noted in the results chapter indicating staff view patients as having the voice which gets listened to. By contrast, when staff voice concerns regarding operations or cultural issues, they believe they are either placated or written off as just “bitching.” People working in such cultures with little or no security are caught in a bind. Many can not afford to go without work and are too frightened by the shifting vicissitudes of the current mental healthcare industry. Living in organizational cultures typified by such conditions is analogous to the food in most bachelor’s refrigerators, not quite good enough to eat but not quite bad enough to throw away (Senge, 1990).

Staff, like patients, must be treated as if they are volunteers. You can buy someone’s hands but not their heart, you can buy someone’s back but not their mind (Covey, 1990). Creativity in a culture must come from involved committed staff persons wanting to improve what they do. Staff must be motivated and supported by a culture conducive to safe, productive and satisfying changes. The needs of the organization must be important to staff. Trust and security in organizational cultures are essential if staff are to remain interested in, much less committed to, improvement efforts.
**Recent Developments**

The recent developments section provides information which further substantiates many of the themes articulated in the results chapter. The information is included to bring the reader up to date regarding important developments which have influenced the researcher and the potential usefulness of the research for the site under study.

Recently, a series of events contributed to further mistrust of administration. On April 22, 1997 a satellite clinic of the MC was informed of their impending closure and the subsequent layoffs of two therapists, one coordinator and a clerical person. The announcement was made and the laid off staff persons were instructed to not discuss the closure. Rumors of the closure and layoffs spread throughout the mental health department within hours. Within two days of the apparent closure, administration withdrew the action and reported the situation was under review, no decisions were made.

In the midst of speculation regarding the on again/off again closure, staff at the medical center learned on April 23, 1997 that a consulting firm from Boston Massachusetts would be reviewing productivity expectations, staffing and other facets of outpatient mental health services. The atmosphere was extremely tense as staff persons were very concerned about job loss. The consultants were to spend two or three days interviewing staff persons and reviewing records, then making recommendations to upper administration. The consultants were scheduled to arrive and begin on May 12, 1997.

The consulting firm sent two people who were M.S.W. trained and very experienced mental healthcare professionals and administrators. A considerable amount of their time was
devoted to interviewing coordinators, and other supervisory persons. The consultants reviewed records and spoke to representative staff persons who have a role in providing outpatient adult mental health services. Of particular note is the one hour group interview conducted with 19 therapists. During the interview, which the researcher attended, the consultants spoke for 45 minutes, fielded 7 questions from 4 different clinicians and repeatedly stated they wanted the therapists input regarding needed changes in the system.

As the researcher left the group interview discussed above, he asked several (3) staff therapists their opinions regarding the interview experience. Without exception staff stated skepticism and concern about the pending recommendations. The therapists viewed the interview as placation rather than opportunity for input.

The Director requested this researcher to share results from the present research with her and with the possibility of sharing the results with the consultants. The researcher was hesitant to do so given the uncertainty of how the results may be used to the detriment of the participant staff persons.

It is important to note the researcher's native response to the consultation and the request to share the results with the administration via the consultants. The researcher is bound by the context of the research site and the emotional events which develop the organizational culture (Keoughan & Joanning, 1996). Further discussion of the native researcher experience is included in the later section on developing the process.


**Recommendations for the Medical Center**

The results of the research are to be returned to the system in accordance with the wishes of the participants. Considerable time and effort has gone into the development of information intended to inform performance improvement activity at the MC. All participants, staff and patients, expressed their desire for the information to be shared with upper administration.

"A central obligation for top leadership is to create conceptual space within which healthcare professionals can redesign their own work for the improvement of healthcare” (Batalden & Stoltz, 1996, p. 438). The MC leadership will receive the following recommendations:

- Administrative leaders need to become more involved with staff. Such involvement should take the form of attending departmental meetings regularly without a predetermined agenda. Rather, administrators need to connect with, listen to and learn from their staff.

- Administrators need to demonstrate understanding of staff roles and responsibilities. Staff request a routine presence of the Executive Director in and around their work area to familiarize himself with the people and processes of adult outpatient mental health services.

- In addition to learning from outside consultants, administration needs to learn from the expertise of their own staff as inside consultants.
Developing the Process

Staff Focus Groups as Interventive

Staff are not familiar with any concerted effort to evaluate the system and invite their opinions regarding ideas for improvement. Focus groups put in place a process more richly cross joining the system. The focus groups enhanced the cybernetic looping in the system by evoking new ways of communicating. Qualitatively distinct from existing patterns of communication, focus groups prompted the system to begin learning (Senge, 1990).

Setting the context for safe discussion was a crucial first step. By adopting a genuine stance of not-knowing or curiosity, a stable and non-threatening invitation to talk was issued to participants (Anderson & Goolishian, 1988; Cecchin, 1987). When asked about what they do, staff tended to reveal a great deal more. As such, staff talked about how they feel in addition to describing what they do.

Senge (1990) makes note of a distinction between two forms of communication in groups, dialogue and discussion. Both are valuable sources of learning and yet adhere to different rules of conduct/behavior. Discussion is a convergent process entailing conversation and/or debate toward a conclusion with certainty. That is, discussion focuses on appropriate outcomes, some idea eventually wins out over less appropriate options. Dialogue is a diverse process subscribing to a different set of premises. More like the collaborative process of therapeutic conversation, dialogue permits mutual consideration of various perspectives simultaneously. There is no clear winner from the process of dialogue. Senge (1990) outlines three critical components of dialogue: 1) all participants must suspend their
assumptions, 2) all participants must regard one another as colleagues, and 3) there must be a facilitator who holds the context of dialogue. Connecting therapeutic elements (e.g., sensitivity to rapport, theory of change grounded in metaphors of influence rather than control, maintaining a position of not-knowing or curiosity, etc.) along with the components of dialogue make for a powerfully validating process.

Staff clearly articulated the interventive effect of their own participation with the focus groups. Even if observable changes were not immediately evident, staff felt empowered to participate and were genuinely appreciative of the value placed on their perspectives. Staff had a unique opportunity to communicate and learn from other system members at a depth previously not experienced. The result of such communication and learning is enhanced performance. Benefits of more richly cross joining include shifting the system from reactive to responsive. The value of the process is a broader and deeper assessment of system needs and wants regarding specific changes, and the less tangible but just as influential and important cultural changes.

Conjoint Patient/Staff Focus Groups

Even before staff and patients met for the first conjoint focus group they had opportunity to see what each other was saying. Summaries of the individual staff and patient focus groups were prepared by the researchers, adjusted by the participants and then shared. This method of cross-informing was intended to work with and present the information in a manageable fashion. Further, the sharing of information on paper greatly minimizes the opportunities for analogical communication and thus mis-interpretation and pejorative
judgments. The researchers also elected to maintain some control over the emergent design of the study.

The research offers a source of legitimacy to otherwise marginalized voices. In this sense following the lead of feminist scholarship (Goodrich, 1991) the subjugated voices of staff and patients were cross joined. The result is a more responsive system, better able to anticipate the needs of both patients and staff. The unique benefits of the process result in the development of grassroots improvement efforts grounded in the experience, language and expertise of participants.

As the experiences of staff working in the system and patients being served by the system came together, various isomorphic relationship patterns emerged. As such, dynamics between patients and staff were similar to dynamics between staff and administration. Both patients and staff shared their surprise at how close their opinions were of the system. It was clear that addressing both specific practical concerns and cultural issues was important.

Processes are always “speaking” the responsibility of those seeking to make improvement is to listen (Batalden & Stoltz, 1996). Communication becomes effortless when a richly cross joined system clarifies the roles of all interdependent system members. Such a system is characterized by high mutual understanding, high trust and high quality.

Implications for Marriage and Family Therapists

Marriage and family therapists are striving to effectively utilize their skills both in and beyond the rapidly changing marketplace of mental healthcare. Therapists are finding the traditional methods of providing services growing more competitive and less reliable.
Largely due to the advent of managed mental healthcare, marriage and family therapists are struggling to attain third party reimbursement. Insurance carriers and managed care companies are competing to deliver mental healthcare benefits for lower costs and under more restrictive circumstances. All mental health professionals, marriage and family therapists included, are re-educating themselves to provide services under such circumstances. Staying ahead of the curve is growing more and more difficult. The mental healthcare industry is at a time of second-order change, with outcomes unpredictable.

The present research suggests opportunities for marriage and family therapists to expand their practice and work with organizational systems. To remain valuable, therapists must adapt. Stephen Covey (1990) states the shelf life of knowledge in today’s fast paced information society is approximately two years, maybe less. Marriage and family therapists have skill and knowledge broadly applicable to systems beyond the four walls of the home. Unique knowledge and experience dealing with and in human systems allows the marriage and family therapist to assist human system dilemmas in various contexts (Joanning & Keoughan, 1997; Keoughan & Joanning, 1996). Specifically, marriage and family therapists are adept at effectively joining groups of people, clarifying and assessing system problems, negotiating multiple perspectives, defining attainable goals and mobilizing pre-existing resources for change. Family therapy theory is rich with complexity regarding understanding and facilitating processes of change in human systems.

Marriage and family therapists are highly trained conversationalists who utilize the unique human capacity for empathy to thoroughly understand the systems with which they
work (Goolishian & Anderson, 1992). As mental health professionals, marriage and family therapists are uniquely well trained to track the complexity of mental healthcare systems and respond effectively.

**Limitations of the Study**

"Qualitative inquiry cultivates the most useful of all human capacities, the capacity to learn from others" (Patton, 1990, p. 7). The researcher made strident attempts to soundly address the trustworthiness of the data and results of the study. Even so, various issues need to be briefly discussed as potentially limiting the credibility and transferability of the research.

- The researcher’s native status at the site under study provides both pros, previously mentioned throughout the study, as well as cons. The researcher had developed relationships through working with many of the staff over a period of 1 - 2 years prior to the study. Further, all staff were aware of the researcher holding a therapist position at the MC. With the best of intentions, staff may have skewed their responses to researcher questions in order to accommodate the researcher’s supposed opinions or position in the organization. Also, with the knowledge of continued contact with the researcher following the study, participants may have consciously or sub-consciously adjusted their responses.

- It is important to note the researcher holds no supervisory role at the medical center. Therefore, no staff were formally compromised in regard to hierarchical considerations. However, some staff are in a supportive role to the researcher thus informally
subordinating them and possibly compromising their responsiveness to research questions.

- Purposeful sampling limited the range of staff eligible for participation. Only a small number of staff perform the roles required to address the evaluation of adult outpatient mental health service provision. The participants were essentially hand-picked by the researcher leaving open the possibility the researcher anticipated who may provide certain responses in harmony with the researcher's own opinions. Additionally, the staff sample was composed of white men and women with the exception of one Hispanic woman. The sample racial homogeneity restricts the potential richness of perspective otherwise attainable from greater diversity.

- The group format has numerous challenges which may have altered staff responses to research questions and discussion. Some participant voices were likely marginalized by virtue of differences within the staff group along lines of education, experience and degree of comfort in group settings. In regard to interpersonal differences within groups, Creswell (1994) states, "not all people are equally articulate and perceptive" (p. 150).

- Decisions regarding data collection and analysis were closely self monitored, shared often with the co-researcher and recorded in audit trail documentation (Lincoln & Guba, 1985). However, the researcher acknowledges periods of time during the research when closer records could have been maintained.

Convergent problems have a solution: "the more intelligently you study them, the more the answers converge." Divergent problems have no "correct" solution. The more they are studied by people with knowledge and intelligence the more they "come up with answers which contradict one another." The difficulty lies not with the experts, but in the nature of the problem itself (p. 283).

Due to the self-reflexive nature of human researchers studying human phenomena, the possibilities for conclusions are expansive and divergent.
June 28, 1997

To: Members of the Dissertation Committees
   for Jeffrey Angera and Jeffrey Kerber

From: Patricia Keoughan, Ph.D., President, Human Systems Consultants

Re: Audit of Angera and Kerber Dissertations

This memo is to inform the Committees that I have reviewed both Mr. Angera's and Mr. Kerber's dissertations and found them to be methodologically sound. I have been involved with their dissertations since they began. I originally consulted with them regarding their initial research questions and proposed methodology. I also joined them in meeting with administrators of the medical center to explain the project and solicit the hospital's cooperation. I have meet regularly with Mr. Angera and Kerber as the project has developed. My involvement has been largely consultative. We have discussed a variety of methodological issues such as who to interview, how to interview, number of informants to sample, specific questions to ask, how to handle logistical issues which have emerged, how to analyze data collected, how to interpret the data, and issues to explore in the final discussion section of the dissertations.

Throughout this project I have found both Mr. Angera and Kerber to proceed in an ethical and professional manner. They have been very attentive to my suggestions and eager to conduct a thorough and competent study. I have been especially impressed by the sensitivity they have shown to their informants and the care they have exercised in analyzing their data. In sum, I find their studies to be of high quality and illustrative of competent consulting.
APPENDIX B
STAFF OVERVIEW AND CONSENT

To: Patient and Family Services Staff

From: Jeff Angera, M.S., Mental Health Therapist
Jeff Kerber, M.S., Mental Health Therapist

RE: Research

Dear Participant:

This letter is intended to fully inform you of the proposed research and how you may choose to be involved. The following sections will adequately detail: a.) rationale for the project, b.) overview of the entire project, c.) what you may expect to experience if you choose to be involved, and finally d.) a request, for those interested, to sign the informed consent statement at the conclusion of this letter. It is important you know both the Medical Center and Iowa State University Human Subjects committees have evaluated and approved this project.

Rationale. Our interest lies in the success of the Performance Improvement initiative which is in the early phases of implementation at the Medical Center (MC). Mandated by the 1996 JCAHO reaccreditation standards, Performance Improvement is the cornerstone of all core functions identified for health care organizations. The success of Performance Improvement hinges largely upon careful attention to the planning and design phases of improvement efforts. Meaningful involvement of staff will likely enhance ownership and greater commitment to Performance Improvement changes. As stated by Backer (1995), "The single best validated principle in the literature on management of change is that the people who will have to live with the results of change need to be deeply involved in designing and implementing new processes. Unfortunately, they rarely are." This research is an attempt to examine and develop sound and meaningful methods to improve the quality of mental health service provision at the MC.

Overview. This study is qualitative in nature and makes use of data derived from transcript analysis taken from audio taped focus group interviews. It must be clear, this research will examine all facets of service provision except confidential information expressed within the confines of the therapeutic relationship. Rather, we intend to explore patient and staff evaluations regarding the provision of mental health services. Beginning in September of 1996, two focus groups with adult mental health outpatients and/or their families will be conducted by both researchers conjointly. Each patient focus group will meet a minimum of two times for approximately one and a half hours and will consist of eight to twelve participants. Concurrently, a focus group with eight to twelve multidisciplinary staff persons will be conducted by both researchers conjointly. The staff focus group, again approximately one and a half hour in duration, will meet a minimum of three times. Information from the patient/patient family focus groups will be shared with the
staff focus group thereby beginning an exchange of information between patients and staff. Such an exchange will culminate with the formation of a combined patient/staff group. This combined group may well serve the MC as a valuable consultant to ongoing Performance Improvement efforts. All focus groups are projected to be completed within a three month window. However, the focus group schedule will be dependent on logistical considerations and the emergent design characteristics of qualitative research.

**What you may expect.** This research is not intended to cause any discomfort to or deception of participants. If you should choose to participate you will first and foremost expect to review, discuss, and sign the informed consent statement at the conclusion of this letter. Further, you have the right to be informed of some potential benefits and risks due to your involvement with this research:

- **Benefits** may include the opportunity to directly influence changes in the way the MC provides mental health services. Such changes would be intended to improve service delivery systems, i.e., changes allowing us to work smarter and better. Working smarter may be evidenced by less redundancy of paperwork, improved communication systems among departments, and more efficient responsiveness to emerging developments in service delivery. This research will provide valuable information regarding the strengths and weaknesses of current MC procedures.

- **Risks** may include the sharing of critical information in a group context. In sharing such information there may be political concerns. However, it is important to remember the goal of the project is to improve, not find fault. If participants strongly oppose group participation, appropriate accommodations will be made to conduct individual interviews. It should be stressed confidentiality of group discussion is included on all Informed Consent documentation. As such, group participants will be strongly encouraged to refrain from discussing group member identities and/or input outside of the group context. Nevertheless, participants will be reminded confidentiality is never 100% guaranteed.

You will be asked a variety of questions concerning your unique vantage and evaluation of mental health service delivery. All interviews will be audio taped in group room two. In addition to audio taping there will be a third researcher observing either behind a one way mirror or in the room taking extensive notes. The audio tapes will then be transcribed by personnel outside of the MC system. Audio tapes will be destroyed within one year from time of taping.

**Informed Consent.** I have read and understand the above information. I understand my participation is voluntary and I may withdraw at any time without prejudice or penalty.

Date & Signature of Participant: ___________________________ Date & Signature of Witness: ___________________________
APPENDIX C
MEDICAL CENTER PROPOSAL
Patient and Staff Evaluations of Mental Health Service Provision and
Organizational Readiness for Change:
Implications for Performance Improvement

Proposal for Research
Jeffrey Angera, M.S. & Jeffrey Kerber, M.S., L.M.F.T.
Research for completion of Ph.D. in Human Development
& Family Studies, Specialization in Marriage & Family Therapy
Iowa State University, Ames Iowa
Supervising Professor: Harvey Joanning, Ph.D.

Purpose of the Study
Our interest lies in the success of the Performance Improvement initiative which is in the early phases of implementation at the Medical Center (MC). Mandated by the 1996 JCAHO reaccreditation standards, Performance Improvement is the cornerstone of all core functions identified for health care organizations. The success of Performance Improvement hinges largely upon careful attention to the planning and design phases of improvement efforts. This research is an attempt to examine and develop methods to improve the quality of mental health service provision at the MC. It must be stressed the study will examine all facets of service provision except confidential information expressed within the confines of the therapeutic relationship. Rather, this research will explore patient and staff evaluations regarding the provision of mental health services. Focus groups with both patients and staff will yield data regarding current perceptions of service provision as well as suggestions for change. Patient focus groups and a multidisciplinary staff focus group, will exchange and process evaluative information leading to the development of a combined team. Such a team, consisting of both patients and staff, may well serve the MC as a valuable consultant to ongoing Performance Improvement efforts.

Research Design
Qualitative methods will be utilized for data collection. Two focus groups with adult mental health outpatients and/or their families will be conducted by both researchers conjointly. Each patient focus group will meet a minimum of two times for approximately one and a half hours and will consist of eight to twelve participants. Concurrently, a focus group with eight to twelve staff persons will be conducted by both researchers conjointly. The staff focus group will meet a minimum of three times for approximately one and a half hours. Information from the patient/patient family focus groups will be shared with the staff focus group thereby beginning an exchange of information between patients and staff. Such an exchange will culminate with the formation of a combined patient/staff group/team. All focus groups are projected to be completed within a three month window beginning in September, 1996. However, the
focus group schedule will be dependent on logistical considerations and emergent design characteristics of qualitative research.

Data Analysis

The data will consist of transcript narrative taken from audio taped interviews and researcher field notes. Transcripts will be analyzed using the Developmental Research Sequence established by James P. Spradley (1979). This method of analysis is advantageous as it allows description of social phenomena without statistical data reduction that may obscure meaningful distinctions. In addition, analyses will ensure all descriptors of patient and staff identities will be kept anonymous so as to protect the confidentiality of participant responses.

Potential Benefits

The proposed study has a number of potential benefits for the Division of Patient and Family Services and Adult Outpatient Mental Health Services. First, the research will make efforts to understand and address patient and staff evaluations of service provision; thus, providing valuable information regarding the strengths and weaknesses of current MC procedures. This information will be shared with staff in order to generate improvement strategies leading to better quality patient care. Second, the invitation for meaningful patient collaboration with improvement efforts conveys a message that the MC seeks and values patient involvement. In turn, the meaningful involvement of staff will likely enhance ownership and greater commitment to Performance Improvement changes. As stated by Backer (1995), “The single best validated principle in the literature on management of change is that the people who will have to live with the results of change need to be deeply involved in designing and implementing new processes. Unfortunately, they rarely are.” Third, this project will foster a collaborative effort between MC and Iowa State University researchers. Finally, if this exploratory project proves useful, the procedures used in this research may be tailored to assist the development of Performance Improvement initiatives associated with other core medical center functions.

Potential Risks

This research is not intended to cause any discomfort or deception of participants. Patient informants will be invited to participate through an informational letter detailing specifics which clearly define the parameters of the study (See Appendix A). These letters will be available through individual therapy staff as well as in common areas of the outpatient mental health department. Staff persons will be informed and invited to participate through formal presentations at regularly scheduled staff meetings. All participants will be provided an Informed Consent letter in addition to the complete project description (See Appendix B). For all informants in this study, participation is completely voluntary and no incentives will be offered.

This research promotes the evolution of ideas in the group context. However, if informants strongly oppose group participation, appropriate accommodations will be made to conduct individual interviews. It should be stressed confidentiality of group discussion is included on all Informed Consent documentation. As such, group
participants will be strongly encouraged to refrain from discussing group member identities and/or input outside of the group context. Nevertheless, participants will be reminded confidentiality is never 100% guaranteed.

Confidentiality and Consent

During analysis, personal identifiers will be used only to differentiate among informant responses on transcriptions from audio taped focus groups. Each participant will be issued a code name and number (e.g., Patient #1 or Staff #5). There is no follow-up phase planned; thus, the inclusion of names with the data will not be necessary. It should be noted each participant will be required to review and sign Informed Consent documentation which will be kept separate from all data (See Appendices B & C). For a complete description of the Informed Consent and Descriptive documents, please see the attached letters.

Conclusion

We appreciate the consideration of this proposed research. It is our belief this research will address some of the recommendations suggested by the recently published Community Focus Groups conducted by the Community Relations and Development Department at the MC. If you have any questions and/or concerns please contact either Jeff Angera, M.S., or Jeff Kerber, M.S. Thank you.
Dear Outpatient Mental Health Patients:

The Medical Center is committed to providing the best possible services. The Medical Center Outpatient Mental Health Services is striving to ensure that we are in line with this mission. However, due to the great numbers of patients we serve at times it is difficult to evaluate if we are doing our best in the eyes of our patients and their families.

In an effort to hear the voice of our patients and their families, we are asking for volunteers to participate in two focus groups. The aim of the focus groups is to ask patients and their family members to evaluate their experience with our outpatient services to help us improve what we do in order to best meet your needs. Our primary interest is not specifically what happens between you and your therapist or psychiatrist. Rather, we want to understand how you evaluate all the “nuts and bolts” of Outpatient Mental Health. For instance, this could include the first time you made contact with outpatient mental health to set up an appointment, register for services, to your last contact with our billing department. We know each patient has different situations and we would like to hear your experience.

The requirements for your participation are minimal. As stated earlier, you will be asked to participate in two focus groups led by two facilitators who are therapists on the staff. These focus groups will last approximately 1 & 1/2 hours and will begin in mid-September. To ensure we do not miss any of your valuable input we will be taking notes, audiotaping the discussions, and later transcribing them to determine common themes of experience. Though we will be taping your responses we will not identify your name. All responses will be completely confidential. The questions will not address sensitive issues between you and your therapist, but as stated earlier, will ask about your experience with Outpatient Services as a whole. In addition, refreshments will be provided after your participation.

If you are interested please inform one of our secretarial staff (xxx-xxxx), your therapist, or contact Jeff Angera (xxx-xxxxx) or Jeff Kerber (xxx-xxxxx). We ask that you leave your name, phone number and/or address where you can be contacted. You will be contacted as soon as possible.

We strongly encourage your participation. You can make a difference in improving the services you receive. We look forward to hearing from you!

Sincerely,

Jeff Angera

Jeff Kerber
To: Patient and Family Services Staff

From: Jeff Angera, M.S., Mental Health Therapist
      Jeff Kerber, M.S., Mental Health Therapist

RE: Research

Dear Participant:

This letter is intended to fully inform you of the proposed research and how you may choose to be involved. The following sections will adequately detail: a.) rationale for the project, b.) overview of the entire project, c.) what you may expect to experience if you choose to be involved, and finally d.) a request, for those interested, to sign the informed consent statement at the conclusion of this letter. It is important you know both the Medical Center and Iowa State University Human Subjects committees have evaluated and approved this project.

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be shared with the staff focus group thereby beginning an exchange of information between patients and staff. Such an exchange will culminate with the formation of a combined patient/staff group. This combined group may well serve the MC as a valuable consultant to ongoing Performance Improvement efforts. All focus groups are projected to be completed within a three month window. However, the focus group schedule will be dependent on logistical considerations and the emergent design characteristics of qualitative research.

**What you may expect.** This research is not intended to cause any discomfort to or deception of participants. If you should choose to participate you will first and foremost expect to review, discuss, and sign the informed consent statement at the conclusion of this letter. Further, you have the right to be informed of some potential benefits and risks due to your involvement with this research:

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- **Risks** may include the sharing of critical information in a group context. In sharing such information there may be political concerns. However, it is important to remember the goal of the project is to improve, not find fault. If participants strongly oppose group participation, appropriate accommodations will be made to conduct individual interviews. It should be stressed confidentiality of group discussion is included on all Informed Consent documentation. As such, group participants will be strongly encouraged to refrain from discussing group member identities and/or input outside of the group context. Nevertheless, participants will be reminded confidentiality is never 100% guaranteed.

You will be asked a variety of questions concerning your unique vantage and evaluation of mental health service delivery. All interviews will be audio taped in group room two. In addition to audio taping there will be a third researcher observing either behind a one way mirror or in the room taking extensive notes. The audio tapes will then be transcribed by personnel outside of the MC system. Audio tapes will be destroyed within one year from time of taping.

**Informed Consent.** I have read and understand the above information. I understand my participation is voluntary and I may withdraw at any time without prejudice or penalty.

Date & Signature of Participant:  
Date & Signature of Witness:  
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7/9/97 JA/JK
Appendix C
Patient Informed Consent

Dear Participant:

The following project is designed to gather your evaluations and experiences of receiving outpatient mental health services at the Medical Center. In collaboration with Iowa State University researchers, the Medical Center outpatient mental health is attempting to evaluate its services and make necessary improvements to provide the best care possible. The information that you and your fellow patients/family members provide will be shared with a group of mental health staff persons. In addition, representatives of your group will be asked and/or may volunteer to join the staff group to attempt to generate appropriate courses of action. As you have been previously informed, each focus group will take approximately 1-1/2 hours and will be approximately three weeks apart. Further, to ensure none of the valuable information you provide is lost, the focus groups will be audio taped, notes will be taken, and later transcribed for analyses.

It is hoped that the information you provide will enable the Medical Center to continue providing services you think are satisfactory and make changes where necessary. In all, it is hoped your participation will allow the Medical Center to provide the best possible services for patients. This project is not designed to cause any discomfort; however, if you do feel that you do not want to continue to participate at any time throughout the focus groups you may choose to quit without any repercussions. Though we prefer you participate in a group setting, if you are completely uncomfortable the facilitators will provide the option of an individual interview. If you do experience any difficulties, both facilitators are staff therapists and will take appropriate measures to provide services if necessary. Further, your responses will be taken very seriously and therefore it is asked you to be as honest and open as possible.

In order to protect the confidentiality of each persons responses, it is asked that all information stays within the confines of this group. In addition, the facilitators will code and analyze the information provided in such a way to ensure that no participants names will be identified. Audio tapes will be destroyed within one year from time of taping.

If you have any questions throughout the project please feel free to discuss them with the facilitators, the Director of Adult Outpatient Mental Health xxx-xxxx, or Dr. Harvey Joanning (Iowa State University Professor and supervisor of the project) 294-5215.

I have read and understand the above information. I understand my participation is voluntary and that I may withdraw at any time without prejudice to me.

Signature of Participant and Witness:

__________________________________________  Date: ______________________________

7/9/97 JA/JK
MEMORANDUM

TO: Mental Health Director
FROM: Medical Director
DATE: August 27, 1996
RE: Research

The proposal you submitted on behalf of Jeff Angera and Jeff Kerber is supported and approved as a study for our Patient and Staff Evaluations of Mental Health Service Provision and Organizational Readiness for Change: Implications for Performance Improvement and we understand this study is to complete their doctoral degrees at Iowa State University.

We would ask that we receive timely updates and progress reports on this report for our "Human Subjects Research" notebook.
APPENDIX E
STAFF GROUP SUMMARY

Summary: Staff Group One.

So we begin with some introductory comments, including review of informed consent, invitation to eat, and discussion of some ground rules. Thanks for your time and participation.

Initial question posed to each informant was, (you will pardon my language, “informant,” this is the appropriate term for the type of research I’m doing) “I want to know how you describe your role in providing the services to adult mental health out-patients?”

Your summarized responses:

Supervisor Registration. “I see my role as training staff that works with registering patients, getting them informed with the programs available out there to help pay.” “Making sure the registration staff is informed, more worried about the financial aspect...” “...we don’t bankrupt a patient while they are trying to go through therapy.”

Registration Clerk, in-patient. “I register in-patients, try to get all the information in place for when they become out-patients.” Communication with other registration clerks and her supervisor is a big part of what she does. She also problem solves on her own or in communication with others. Here the initial question changed, “As if I’m a fifth grader, tell me what you do?” Brady continues, “I register people who are admitted to the hospital and make sure they have financial coverage, i.e., insurance, to pay for their services.”

Out-patient Coordinator for Managed Care. “I just started this job so I’m still learning what I do.” “I get our therapists and doctors credentialed with insurance companies.” “I guess you would say it’s on paper introducing the doctor or therapist to the insurance company.” She added some description of what is involved with the credentialling, “going through our provider’s history, checking their licensure.

Managed Care Analyst. “I don’t deal with patients face to face, I do a lot of the administrative duties which include behind the scenes making the stuff work.” He accesses different national data banks to learn about the appropriate charges for our therapist or doctor services. “I make the applicable charges flow across to the insurance companies in the format they want to see.” This “flow” includes understanding “codes” which fit our services with the insurance company expectations. “We try to regionalize our charges to make sure our health care is affordable.” “It is like the inner workings of an engine, making sure the information gets appropriately from registration to the financial side.” He helps different computer systems communicate so the financial side has the appropriate
information from registration to create a bill. He also works with "denials, which means we did not get the correct information on the bill they (insurance companies) wanted to see."

Adult Mental Health Out-patient Secretary. "Basically my role is getting the patient ready to see their therapist and/or doctor." "I am the start of the process (of getting information)." "Getting the patient ready" entails gathering information, making sure appropriate forms are filled out, getting the charts, getting the patient appointment in the computer and the book.

Out-patient Therapist or Intake Specialist. "I have two main jobs, one is out-patient counseling the other is doing mental health intakes." She goes on to describe what is involved with doing an intake including: attaining social history, prior treatment history, or whether they've been on medication. She then gets that intake information to the therapist or doctor who will need it. "I assist clients in obtaining appointments." "I inform patients of community resources." She does whatever is needed to get the patient the appropriate services.

Adult Out-patient Assessment Specialist. "I provide psychological services to adult out-patients." "I do therapy with individuals and some groups." "I do evaluation or assessment." She does evaluation using testing procedures to help assessment for both psychological services and for medical services. "I'm done." She lets you know when she is finished talking.

Next question. "Hearing what other people do, did anybody learn anything new?"

Your summarized discussion/responses:
- Greater appreciation and understanding of the complexity and interdependency involved with providing services.
  - "I don't think I understood that each of us did quite as much as we do."
  - "You just don’t understand what their role is, what all they have to do and why they are all so busy."
  - "I am surprised at how they link."
  - "Yes, I can see where there is like a chain."
- Communication.
  - Communication seems to be vital to "information flow."
  - Rapid turnover of personnel in registration contributes to communication lines "breaking down."
  - Being too busy gets in the way of communication, "It starts from the time you open the door till the time you walk out the door, it is rush, rush, rush we are all rushed."
  - "We are all one big family really, and if we take the time to communicate more I think we learn a lot."
"I would like to see maybe a monthly or bi-monthly or some kind of communication group between right from the psychiatrists right down to me."

"I would say we have no upper management here, we have middle management here that I specifically think do all the work. I mean we get in the nuts and bolts and get our hands dirty and we have to do with daily operations and know what is going on."

"You know, understanding what everybody's roles are is real important."

Thought processes or beliefs influence communication, "Some therapists don't believe they need to know all of this or need to be involved and maybe that is the difference in training."

- **Information flow.**
  - Lots of different pieces for which we all share responsibility. "It doesn't matter if the therapist does everything right, it doesn't matter if Roberta does everything right, it doesn't matter if registration... if I goof up, it is all a wash."
  - The Domino Theory, "I have to be aware that my domino effects everybody else's." There was agreement among group members that other staff persons don't fully appreciate the Domino Theory, or interdependence of our roles, "There is a big vehicle somewhere that they understand, but they don't understand how we are getting acquainted in this focus group."
  - There is a process of communicating important information. Such a process is complicated and is difficult to define, "there is no definitive one point to start."
  - New computer systems and other technology should help, e.g., phone mail.
  - Redundancy of gathering information compromises efficiency, "We may have four people in this institution capturing all the same information."

- **Change.**
  - What has happened, what is happening, what needs to happen, and what do we want to happen?
  - "Everybody gets into a routine."
  - "Change is an obstacle everywhere. The MC is going to be going through some big changes in the next five years, and they are starting already."
  - One of the implications of "downsizing" is no real expectation of getting more people to help. Therefore, the secretarial plea for more help may only be responded to with computer systems, not people.
  - Toward the end of the group, "Chad said today changes are coming or beginning in the foreseeable future. I would like to come back to that, not the specific changes, rather the temperament surrounding the change."

**Next question.** (After Jeff K. has a potty break), "When I say performance improvement, what does that mean to you?"

**Your summarized discussion/responses:**

- "Serve the client in the most efficient manner that we can."
• Improving processes and information flow, "We are looking at the performance of the registration process, trying to streamline it and look at the flow. Making it not only easier for the registration personnel, also looking at it from a client friendliness atmosphere, making it quicker to get into therapy."

• Mental health has been neglected in the past. The current effort is difficult due to the inherent complexity of mental health services. Some of the complexity is due to the high degree of "patient participation" in treatment, "The patient is the change agent, he is his, or her, own change agent."

• "I would be a lot more effective, be able to figure out more quickly what a useful response might be to a patient."

• "To better help clients with their problems and to help them negotiate the system."

• "We need more help, there are times we have patients lined up just waiting to be waited upon and by the time we get to some of them, they are ready for the crisis team."

• "I have a problem sometimes when people say mental health patients are the patients having the hardest time getting through the system. I think our whole system is hard to get through."

• "Making the system patient friendly."

Group concludes at 1:30.

I have condensed 48 pages of transcript into the above summary, not a simple task. Thank you for taking the time to review this summary and for making comments in the margins, on the back, or wherever. If you have further comments and/or questions, please write them in the space provided below and on additional sheets if needed.

Comments/Questions:
The following statements are re-presentations of themes generated from the 11/14 and 12/5 focus groups. Please take time to read the following statements carefully and circle one response per statement that best fits your opinion. Thank you for your time and consideration!

1. The focus group format with patients and staff meeting together is helpful.

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2. It is helpful to start the focus groups clearly understanding everyone’s expectations.

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3. It is important the focus group process involves understanding how adult outpatient mental health (AOMH) currently functions.

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4. It is important the focus group process involves understanding how AOMH services could improve.

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5. It is important all participants experience equal power and voice during the focus groups.

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6. I prefer the focus group discussion to be organized and structured.

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7. The talker/listener format is effective.

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8. Service would be better if there were more secretarial and registration staff in AOMH.

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9. A patient advocate would be experienced with AOMH and act like a guide.

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10. A patient advocate would act like an interpreter helping patients communicate with providers.

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11. A patient advocate would provide ongoing feedback to administration regarding what is working and what is not working.

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12. Patients perceive AOMH positions with high turnover rate as stressful and devalued.

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13. Patients are concerned about rapid personnel turnover in AOMH registration.

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14. Patients recognize and acknowledge the difficulty of AOMH staff responsibilities, the need for technical support (software), the financial costs of improvement, and the stress on staff.

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15. Patients recognize and acknowledge the need for technical support (software) in AOMH.

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16. Patients recognize and acknowledge the financial costs of improving AOMH services.

1 Strongly Disagree 2 Disagree 3 Somewhat Disagree 4 Neutral 5 Somewhat Agree 6 Agree 7 Strongly Agree

17. Patients recognize and acknowledge the stress on AOMH staff.

1 Strongly Disagree 2 Disagree 3 Somewhat Disagree 4 Neutral 5 Somewhat Agree 6 Agree 7 Strongly Agree

18. Registration is not a problem when patients are pre-registered, review the registration sheet and sign off.

1 Strongly Disagree 2 Disagree 3 Somewhat Disagree 4 Neutral 5 Somewhat Agree 6 Agree 7 Strongly Agree

19. It is important patients see the MC leadership demonstrate caring and concern for the best interests of AOMH patient care.

1 Strongly Disagree 2 Disagree 3 Somewhat Disagree 4 Neutral 5 Somewhat Agree 6 Agree 7 Strongly Agree

20. AOMH staff view their observations and frustrations as largely parallel to those expressed by patients.

1 Strongly Disagree 2 Disagree 3 Somewhat Disagree 4 Neutral 5 Somewhat Agree 6 Agree 7 Strongly Agree

21. AOMH staff view themselves as having little power to influence change in the system.

1 Strongly Disagree 2 Disagree 3 Somewhat Disagree 4 Neutral 5 Somewhat Agree 6 Agree 7 Strongly Agree

22. AOMH staff participants recognize/acknowledge the financial costs of improvement.

1 Strongly Disagree 2 Disagree 3 Somewhat Disagree 4 Neutral 5 Somewhat Agree 6 Agree 7 Strongly Agree

23. Patients prefer the focus group format versus surveys for gathering information to improve AOMH service.

1 Strongly Disagree 2 Disagree 3 Somewhat Disagree 4 Neutral 5 Somewhat Agree 6 Agree 7 Strongly Agree
24.  AOMH staff recognize current improvement efforts as valuable and want them to continue.

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25.  It would be important for future focus groups in AOMH to include psychiatry representation.

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26.  Patients recognize a communication breakdown between psychiatrists and other AOMH staff.

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27.  The staff/patient focus groups provide new information to patients helping them negotiate the AOMH system.

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28.  Focus groups emphasize the interdependence of AOMH staff functioning.

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29.  As a result of these focus groups AOMH staff are more likely to ask patients about the quality of AOMH services.

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30.  It is helpful for focus group ground rules to allow for difference of opinion.

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31.  AOMH staff recognize the value of a regular group forum involving patient/staff interactions regarding patient concerns.

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32. AOMH staff expressed concern about how focus group information might be interpreted and acted on by upper administrative levels.

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33. AOMH staff acknowledge the need to recognize and value the emotional components of changes in an organization.

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34. AOMH staff sense the emotional components of organizational change are not being addressed at the MC.

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35. Patients and AOMH staff recognize the need for improvement efforts to include patient involvement.

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36. AOMH staff who will be effected by performance improvement efforts must be involved in the design of such efforts.

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37. Patients have stated a need for better information and direction about sources for financial assistance.

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38. AOMH staff and patients acknowledge and give consent to share focus group information with administration, psychiatry, registration, billing, secretarial, therapy, and managed care personnel.

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39. Although generally perceiving the focus groups as productive, there was concern that there would be no changes.

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40. Patients recognize that the focus group format communicated a sense of caring about their input.

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41. The focus group process would be useful in other parts of the hospital.

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42. I thought the above statements were clear and understandable.

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APPENDIX G
STAFF THEMATIC STATEMENTS SURVEY

STAFF THEMATIC STATEMENTS:
Adult Outpatient Mental Health (AOMH) Staff.

The following statements are re-presentations of themes generated from the staff focus groups. Please take time to read the following statements carefully and circle one response per statement best fitting your opinion. Thank you for your time and consideration!

1. Staff understand their role, or what they do, only as a function of serving patients.

   1 2 3 4 5 6 7
   Strongly Disagree Somewhat Neutral Somewhat Agree Strongly Agree
   Disagree Agree

2. Staff who have direct day to day contact with patients, compared with staff who do not have direct day to day contact with patients, see how to improve the quality of service differently.

   1 2 3 4 5 6 7
   Strongly Disagree Somewhat Neutral Somewhat Agree Strongly Agree
   Disagree Agree

3. Focus groups with staff who serve different roles, are helpful to gain further appreciation and understanding of how staff roles are connected with each other.

   1 2 3 4 5 6 7
   Strongly Disagree Somewhat Neutral Somewhat Agree Strongly Agree
   Disagree Agree

4. Focus groups help staff to understand how information flows through the system.

   1 2 3 4 5 6 7
   Strongly Disagree Somewhat Neutral Somewhat Agree Strongly Agree
   Disagree Agree

5. Focus groups help staff to understand how important it is to communicate effectively.

   1 2 3 4 5 6 7
   Strongly Disagree Somewhat Neutral Somewhat Agree Strongly Agree
   Disagree Agree
6. Focus groups help staff to understand how communication with each other either works well, and/or breaks down in our system.

1 2 3 4 5 6 7
Strongly Disagree  Disagree  Somewhat Neutral  Somewhat Agree  Agree  Strongly Agree

7. Getting accurate information from, or about, the patients helps to reduce distress among staff and patients.

1 2 3 4 5 6 7
Strongly Disagree  Disagree  Somewhat Neutral  Somewhat Agree  Agree  Strongly Agree

8. Communication breaks down more readily when there is high turnover in registration staff.

1 2 3 4 5 6 7
Strongly Disagree  Disagree  Somewhat Neutral  Somewhat Agree  Agree  Strongly Agree

9. Staff who work with patients directly on a day to day basis, feel more work responsibilities are being put on them without their input.

1 2 3 4 5 6 7
Strongly Disagree  Disagree  Somewhat Neutral  Somewhat Agree  Agree  Strongly Agree

10. Staff have strong feelings about change in their work lives.

1 2 3 4 5 6 7
Strongly Disagree  Disagree  Somewhat Neutral  Somewhat Agree  Agree  Strongly Agree

11. Staff perceive upper MC administration to be out of touch with their needs and concerns regarding change with Adult Mental Health Services.

1 2 3 4 5 6 7
Strongly Disagree  Disagree  Somewhat Neutral  Somewhat Agree  Agree  Strongly Agree

12. Staff think greater technological support, i.e. computers and efficient software, will make significant improvement in the quality of their work lives.

1 2 3 4 5 6 7
Strongly Disagree  Disagree  Somewhat Neutral  Somewhat Agree  Agree  Strongly Agree
13. The terminology "Performance Improvement" is somewhat ambiguous, and lacks significant meaning to staff.


14. Improving the quality of services for staff and patients has little to do with statistical reports.


15. It is difficult to communicate effectively when staff are understanding the process of providing services from different roles, or perspectives.


16. The quality of relationships between patients and staff effects the quality of services.


17. Repeatedly collecting the same information from patients sends a message that the MC is more concerned about collecting bills than serving the patient.


18. Clerical staff (secretaries and registration) feel they need more people to allow them to do their work as well as possible.


19. Staff recognize AOMH services are growing increasingly complex and difficult to understand for themselves as well as patients.

20. Staff perceive MC administration to view AOMH services as unimportant, or "second fiddle."

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21. High distress in the work environment compromises the quality of AOMH services.

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22. If administration does not support and care for the staff, there will be no human resources within the building to offer patients.

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23. Overall, I am satisfied working with MC Adult Outpatient Mental Health services.

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24. If I had the choice, I would work elsewhere.

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25. The staff focus group process should be utilized for other areas of the MC.

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Thank You.
The meeting was called to order in the xxxx conference room at 10:30 a.m.

Present: Thirteen upper administrative team members, including the executive director.

While progress has been made in our efforts to improve charting to the level dictated by the rules and regulations applicable to the Medicare program, we continue to experience problems. The past quarter saw us exceed the 10% error rate by nearly 6%. While we were eventually able to win a concession from the "reviewers", thereby lowering our rate to 9.6%, it was not without much effort, time and expense. Additionally, we continue to find charts which cannot be billed due to charting errors. Such errors cause us to lose revenue, revenue which is vitally important to the future existence of the Medical Center.

In response to the above, we find it necessary to institute the following:

1. Supervisory personnel and staff will be provided with a checklist, service specific; i.e., Outpatient Mental Health, Partial Hospitalization, Physician specific, etc., to assist them in their charting.

2. The supervisory personnel will be responsible for checking, DAILY, the charting of their staff. The charting will be done in accord with the Medicare standards and the check lists.

3. Charting errors will lead to one written warning; the second error will result in a three (3) day suspension, without pay. If charting errors are discovered subsequent to billing, the suspension will apply to both the individual responsible for the error and the supervisor responsible for checking the charting.

4. Following one suspension, should another be indicated, TERMINATION will be automatic.

5. Should any physician refuse to cooperate with the requirements of this program, or to properly record written orders, treatment plans, progress notes, etc., said physician shall be immediately brought to the attention of the Director of Psychiatry, Patient and Family Services Division Director, the Executive Director or the Medical Director. Said physician shall be immediately contacted, with any further delay or refusal to comply leading to their automatic suspension (or termination), and the re-assignment of the patient to a new physician.

I realize that these are extremely high standards, and that the consequences are severe, but so too is the severity of our problem and the cost of our failure to comply.

Thank you.

xxxxxx x. xxx
Executive Director
REFERENCES


