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Clinical Competence in Evaluating the Consistent Use of the Criteria for Post-Acute Levels of Care Guideline

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Abstract

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MSN, Walden University, 2017

BSN, Midwestern State University, 2012

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Ineffectual transitions in the post-acute level of care stage have resulted in suboptimal patient care, delaying the recovery process and worsening health problems. Addressing ineffective patient care transitions in post-acute care within nursing practice is imperative in assuring patient safety, continuity of care, and quality of health care services. Improper care coordination during the discharge process has been shown in the inconsistent application of The Criteria for Post-Acute Levels of Care Guideline at the Southwestern Hospital. The important gap in practice was the level of discrepancy between the required guideline and the consistent use of the guideline, which showed that there was a lack of adherence in applying the guideline in the hospital setting. The practice-focused question highlighted whether the health care team was consistently applying The Criteria for Post-Acute Levels of Care Guideline and appraising if patients were being placed in the appropriate discharge setting. The methodology applied a before-and-after approach to evaluate how consistently The Post-Acute Levels of Care were used. The conceptual framework used to coordinate this project was the Transitional Care Model. Three months each of retrospective and prospective patient data (post-discharge setting, class of insurance, out-of-pocket payment (OPP) days, discharges, length of stay (LOS) ratio, and average geometric length of stay (GMLOS), were compared and analyzed, showing adherence to the guideline resulted in improvement in patient care transitions during the post-acute discharge phase This doctoral QI project endorsed positive social change fostering better collaboration amongst the healthcare team in guiding the appropriate and consistent use of the guideline.

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Dedication

This doctoral educational project is dedicated to my husband, father, mother, and brother for their consistent support and prayers throughout the many days and, at times, sleepless nights I dedicated to completing this DNP project. To my friends, thank you for understanding my doctoral journey and encouraging me to keep pressing through. I greatly appreciate you all.

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Table of Contents

List of Tables iii

List of Figures iv

Section 1: Nature of the Project 1

Introduction 1

Problem Statement 2

Purpose Statement 4

Nature of the Doctoral Project 6

Significance 9

Summary 11

Section 2: Background and Context 13

Introduction 13

Concepts, Models, and Theories 13

Definition of Terms 16

Relevance to Nursing Practice 16

Local Background and Context 19

Locally Used Terms Relevant to Understanding the Doctoral Project 21

Role of the DNP Student 22

Role of the Project Team 24

Summary 25

Section 3: Collection and Analysis of Evidence 27

Introduction 27

Practice-Focused Question....27
Sources of Evidence....28
Evidence Generated for the Doctoral Project....31
Participants....31
Procedures....31
Protections....32
Analysis and Synthesis....32
Summary....33
Section 4: Findings and Recommendations....35
Introduction....35
Findings and Implications....36
Recommendations....46
Contribution of the Doctoral Project Team....47
Strengths and Limitations of the Project....48
Section 5: Dissemination Plan....50
Analysis of Self....51
Practitioner....51
Scholar....51
Project Manager....52
Summary....52
References....53

List of Tables

Table 1. De-identified Retrospective Data Collected 37

Table 2. De-identified Prospective Data Collected..... 38

Table 3. De-identified Retrospective Data Obtained..... 39

Table 4. De-identified Prospective Data Obtained 40

Table 5. De-identified Retrospective Data Obtained..... 41

Table 6. De-identified Prospective Data Obtained 41

Table 7. De-identified Retrospective Data Obtained..... 43

Table 8. De-identified Prospective Data Obtained 43

Table 9. De-identified Retrospective and Prospective Data Obtained 45

List of Figures

Figure 1. The Nine Components of the TCM 14

Section 1: Nature of the Project

Introduction

Post-acute levels of care refer to an array of services offered to patients whose medical conditions and management have become hemodynamically stable enough following a course of hospital stay for them to prepare for discharge. These services include home health, skilled nursing facility, inpatient rehabilitation, residential nursing home, and long-term care facility. An essential component of post-acute care includes efficient coordination with clear roles and responsibilities to facilitate patients' return to the community with the needed healthcare services and continuity of care. In contrast, inefficient transitions during the post-acute level of care process have accounted for undesirable patient health outcomes and delays in patient care. The breakdown in the patient transition process, as well as the unproductive transfer of information between the health care team, creates misunderstanding and in turn contributes to poor coordination of services and inadequate discharge planning and evaluation.

The hospital of study, which is in the southwestern United States also is experiencing challenges in the post-acute level of care. The challenges include patients not being transitioned to the appropriate level of care on discharge, lack of coordination amongst health staff, loopholes in information when it came to the patient's post-discharge needs, patients' medical conditions not being managed at discharge, and patient noncompliance. The hospital then implemented The Post-Acute Levels of Care Guideline to address these issues. Alcusky et al. (2018) noted that a thorough understanding of the comparative outcomes within and between settings of post-acute levels of care through

characterizing the relationship between the different sites and health outcomes, as well as evaluating the association between facility-level factors is important in the rapidly evolving policy climate. This Quality Improvement (QI) project focuses on the evaluation of the application and effectiveness of the Post-Acute Levels of Care Criteria Guideline in the patient's transitional and discharge processes. The use of the Post-Acute Levels of Care Criteria Guideline will assist the health care team to appropriately learn the guideline to assess patient-specific post-acute care level needs for post-disease recovery, better coordination and communication among team members, improvement in discharge processes, and patient continuity of care and compliance. Section 1 includes the problem statement, purpose, nature of the doctoral project, significance, and summary.

Problem Statement

The healthcare team at the hospital has overseen post-acute levels of care with a hands-off attitude and is not appropriately applying the Criteria for Post-Acute Levels of Care Guideline, which has contributed to inconsistencies in the patients' discharge process. Issues that have escalated in the hospital organization from improper evaluation of post-acute levels of care for patients include delay in the continuity of care, lack of coordination efforts, noncompliance with medications, cost-related problems, not receiving the right education post-discharge, and over-extended hospital stays. Weekly, at least one patient is readmitted to the medical ward due to the need to be re-evaluated for the correct post-acute level of care, which implies that a minimum of four patients need reassessment monthly. It is estimated that the proportion of readmissions that are preventable ranges from 15 to 45% (Pugh et al., 2021). In addition, it has been observed

that some of the patients have had an overextended stay of 3 to 5 days. There is also a growing consensus regarding the need for improved transition of care interventions to reduce preventable readmissions (Pugh et al., 2021). Due to the inefficiency in the application of The Criteria for Post-Acute Levels of Care Guideline, a QI initiative was started that incorporated an educational component to enhance the healthcare team's knowledge and understanding of the Criteria for Post-Acute Levels of Care Guideline. It is unknown if the healthcare team is consistently applying the guideline, thus, the QI project will evaluate the efficacy of the healthcare team's use of The Post-Acute Levels of Care Criteria Guideline during the patient's post-hospital discharge stage.

The relevance of the doctoral project is the necessity to assess and evaluate the effectiveness of the implementation of the Criteria for Post-Acute Level of Care Guideline. The increase in the number of patient cases requiring reassessments for the right level of post-acute care was the impetus for staff education of the guideline and its subsequent implementation. This QI project will evaluate if the health care team properly assessed patients for the right post-acute level of care upon discharge, which entails evaluating if a patient met the requirement for home health, skilled nursing facility, assisted living, inpatient rehabilitation, or long-term acute care as shown by the documentation in the patient's electronic medical record (EMR). Identifying and addressing patients' needs after hospitalization can improve health, and minimize hospital reutilization (Jones et al., 2022).

The doctoral project is significant for nursing practice as it is anticipated there will be improved outcomes, fewer patient adverse events, and better teamwork and

communication amongst the health care team. If the guideline is being correctly used, patients will be discharged to the most medically appropriate setting based on their post-acute level of care needs. Appropriate placement for patients during the transitional phase of discharge plays an essential role in expanding patients' accessibility to safe nursing practice and care. Healthcare transition efforts are based on the framework of nursing practice and involve the elements of nursing actions and outcomes evaluation that are evidence-based, and responsive to the needs of patients and their families (Grady et al., 2021).

Purpose Statement

The meaningful gap that drove the QI initiative in the hospital setting is the level of discrepancy between the required guideline and the consistent use of the guideline which indicates that there is a lack of proper adherence in applying the guideline in this hospital setting. This has resulted in patients being readmitted to the hospital and needed to be re-evaluated to be transferred to the right facility setting for continuity of care. Some of the settings recognized untreated medical conditions which concerned these facilities resulting in readmissions to the hospital. One in four hospitalized Medicare beneficiaries makes the complicated transition to skilled nursing facilities (SNFs) for post-acute care, with 25% of these patients being readmitted to the hospital, and just over half returning to the community by 100 days following hospital discharge (Valverde et al., 2021).

The different barriers that have led to the gap in practice include poor communication, incomplete report of patient information, insufficient education on

medications and treatment to the patients and their families, limited accessibility to resources and follow-ups, and having a hands-off approach within the healthcare staff. The division of accountability, however, between the health care team and the post-acute level care settings was not effectively understood with a lack of clarity about the roles during the care transition. The intention to improve coordination during the patient transition in this hospital organization is substantial, thus, evaluation of the healthcare team's use of The Criteria for Post- Acute Levels of Care Guideline to determine if patients are discharged to the medically appropriate setting for continued management and treatment is essential.

The guiding practice-focused question for this QI doctoral project is as follows: Is the health care team consistently applying The Criteria for Post-Acute Levels of Care Guideline when assessing the patient for the most medically appropriate placement settings at discharge based on the patient's post-acute level of care needs? The health care team includes registered nurses, nurse practitioners, physician assistants, physicians, unit directors, and case managers who will integrate the patient's post-acute level of care requirements and collaborate in the use of The Criteria for Post-Acute Levels of Care guideline to adequately assess the patient for the suitable level of care setting. The intent of this QI project is to evaluate if The Criteria for Post-Acute Levels of Care guidelines by the healthcare team are consistently used at discharge to determine the most medically appropriate placement based on the patient's post-acute level of care needs.

The incongruence in practice is the health care team not professionally applying The Criteria for Post-Acute Levels of Care guidelines when assessing patients for post-

acute level of care services. The goal of this doctoral project was to appraise if patients are being appropriately placed in the correct discharge facility and setting based on the healthcare team's effective usage of the guideline so that patients can avoid readmissions and hospitalizations and reach their optimal baseline health. The importance of the application of the guideline is to provide clear goals, avoid unnecessary hospitalization and enhance independence and autonomy, integrate comprehensive assessments, have clear cognitive and physical functional recovery therapeutic regimens, clear service time limits to avoid confusion with long-term care, and joint implementation of the acute care hospital and post-acute level of care settings (Wang et al., 2019). The gap of inefficient application in the evaluation of post-acute levels of care for patients will be addressed through the doctoral project and then bridging and closing the practice gap through the adoption of best practice in the use of The Criteria for Post-Acute Levels of Care guideline in support of effectual care transitions.

Nature of the Doctoral Project

This DNP project was carried out in a Southwestern Hospital in the United States. General observations at this hospital and as reported elsewhere (Li et al, 2021), were that unplanned readmissions were a result of poorly managed care transitions, resulting in poorer patient experience, elevated risks of hospital-acquired conditions and injury, and more than $25 billion annually in healthcare costs. The database used for the literature search was obtained from the National Library of Medicine. Other database sources that were used include CINAHL, Embase, MEDLINE, ProQuest Nursing and Allied Health Database, PubMed, and TRIP databases. Additional sources of information and evidence

include the Agency for Healthcare Research, Guidelines from Healthy People 2030, and The National Institute of Health. The search terms and Boolean operators used include *post-acute levels of care, the transition of care, discharge management, case management, post-acute level of care and home health, post-acute level of care and inpatient rehabilitation,* and *post-acute level of care and skilled nursing facility*. The inclusion criteria consist of studies that have been published in the last 5 years, peer reviewed articles, transitional care in the hospital setting, and the different discharge settings of post-acute care. The exclusion criteria entail qualitative studies, peer reviewed articles in a different language other than English, and studies published more than 5 years ago.

A before and after approach was used, along with the Quality Improvement manual by Walden University. Retrospective data were obtained for 3 months before the educational intervention was provided. The data were provided by the manager of case management from the electronic medical record (EMR). The data collected included the number of patients assessed by the health care team in each placement location setting, title of healthcare team member that placed the patient, number of patients wrongly placed and sent to another placement location, patients denied placement by insurance, patients with insurance, class of insurance, patients unfunded, patients that stayed over the geometric length of stay and percentage of patient accounts that were denied, accepted, and pending. The data were provided on a USB drive and uploaded into an Excel file saved to a personal laptop that was password protected. The laptop containing the data used for the project analysis was stored in a locked private office.

Prospective data were obtained over a period of 3 months after the educational component on the Post-Acute Level of Care criteria guideline intervention was given. The data were provided by the manager of case management from the EMR. The data collected included the number of patients assessed by the health care team in each placement location setting, title of healthcare team member that placed the patient, number of patients wrongly placed and sent to another placement location, patients denied placement by insurance, patients with insurance, class of insurance, patients unfunded, patients that stayed over the geometric length of stay, and percentage of patient accounts that were denied, accepted, and pending. The data were provided on a USB drive and uploaded into an Excel file saved to a personal laptop that was password protected. The laptop containing the data used for the project analysis was stored in a locked private office.

The gap in practice that was addressed is the inconsistency of the use of The Criteria for Post-Acute Levels of Care Guideline and the high rate of readmissions due to improper patient discharge placement. In the evaluation of the effectiveness of the guideline, the findings from the estimated data analysis reflect consistency in appropriate placement for patient's post-discharge. Consistency in the use of The Criteria for Post Acute Levels of care is projected to decrease the number of readmissions and promote a better discharge process that will bridge the gap and promote safer practice for patients transitioning out of the hospital. The relationship between consistent evaluation of post-acute levels of care and lower hospital readmissions is attributed to proper care coordination among specialty support services and more frequent higher intensity

rehabilitation, which has led to improved functioning in mobility and activities of daily living (Lee et al., 2019).

Significance

The stakeholders for the project include patients, patient families, the healthcare team, and the hospital organization. Addressing the improper evaluation of post-acute levels of care for patients in the hospital setting and the impact and influence it will have on the stakeholders is imperative to achieve coordinated care, inclusive communication, and transitions with positive outcomes during the discharge process (Williams et al., 2021). It is important that the stakeholders engage in the discharge and post-level care process through their involvement, investment, and efforts. The engagement of stakeholders will promote a space to establish credibility, ensure clarity, display accountability, and consistent support for this quality improvement project. The influence on patients will ensure their role in advocating for themselves during the post-acute level of the care process. Families serve as a dedicated support system in seeking out more knowledge and information that will best serve the patient. The healthcare team will be able to see their impact in implementing decisions with the potential to positively influence the continuity of care for patients. The hospital organization will be impacted in its quest and aim to promote best health practices collectively for patients and the community at large.

The potential contribution of the project to nursing practice is recognizing that appropriately transitioning patients to the most suitable level of post-acute care is an essential aspect of disease management and health promotion. Evaluating the staff's

consistent use of the guideline presents an aspect of nursing care that promotes delivery of change, and challenging system processes to improve patient outcomes. A health care system that focuses on assessing the consistent use of the guideline can aid towards making sure patients are being discharged to the proper level of care, which enhances healthcare delivery. A guideline that can serve as a basis to direct the health care team in consistently evaluating patients towards proper placement at discharge, is a step towards promoting continuity of care, proper coordination amid the health care team, health compliance, and efficient hospitalizations. Furthermore, attention is directed towards applying the guideline consistently in preventing readmissions and over-extended hospital stays. Standardized protocols are considered successful when they address the needs of 80% of patients through timely identification of key risk factors and a health staff team with the capacity and expertise to engage best practice recommendations during the transition from hospitalization to post-acute levels of care (Austin et al., 2021).

This QI project has the potential for transferability to other hospital settings to encourage evidence-based outcomes for the patient population and health care team to enhance coordination as patients transition between different post-acute levels of care for post-illness recovery. The importance of proper patient placement at discharge can be seen in different hospital settings such as community hospitals, district hospitals, and free hospitals with the aimed goal for patients to have the needed health care services for continuity of care. Post-acute care in different hospital settings all work towards creating clear goals to avoid unnecessary hospitalization and enhance independence and autonomy through integrated comprehensive assessments, clear cognitive and physical functional

recovery therapeutic regimens, and clear service time limits to avoid confusion with long-term care (Wang et al., 2019).

Potential implications for positive social change will be reflected through this QI project, in how the health care team is able to improve in their effective and consistent approach when evaluating the facilitation of careful transition of patients from one level of care to the next. The importance of social change is to promote the importance of justice, knowledge, servanthood, and collaboration for the healthcare consumer. The implication is that there will be a demonstration of ownership, responsibility, and accountability with the staff in enhancing the transition of care process for the care of the patient as it reflects the hospital organization (Earl et al., 2020). The healthcare team will see a social impact in accurately assessing patients for post-acute care with the ability to promote advocacy, system processes, and compliance incorporated within the hospital organization.

Summary

Section 1 emphasized the practice problem involving assessing patients for post-acute levels of care during the discharge process leading to this QI evaluation doctoral project. The problem is the healthcare team not properly applying the Criteria for Post-Acute Levels of Care Guideline to appropriately transition patients to their post-acute level of care setting when medically cleared from the hospital. This QI project was designed to evaluate the effectiveness of the health care team's consistency in using The Post-Acute Levels of Care Criteria Guideline to ensure the patients are transitioned to the most medically appropriate placement setting. The influence of the doctoral project on

nursing practice is for patients to be appropriately transitioned to their respective discharge settings and patient outcomes enhanced, while also showing organizational improvement in collaboration within the healthcare team and hospital system. Furthermore, assessment of the appropriate patient post-acute level of care placement, and the aim to provide systematized care has been recognized and encouraged in published literature. Retrospective and prospective data were collected to evaluate the effectiveness of the use of The Post-Acute Levels of Care Criteria Guideline and the most appropriate post discharge setting for the patient. In Section 2, the concepts, models, and theories relevant to nursing practice, local background and context, the role of the DNP student, and the role of the project team will be discussed.

Section 2: Background and Context

Introduction

At the intended project site, the health care team has not been efficiently assessing patients to the right post-acute level of care at discharge. The intent of this project was to evaluate the efficacy of the healthcare team's competence in applying The Post-Acute Levels of Care Criteria Guideline during the patient's post-hospital discharge stage. The practice-focused question is as follows: Is the health care team consistently applying The Criteria for Post-Acute Levels of Care Guideline to effectively assess the patient for the most medically appropriate placement settings at discharge based on the patient's post-acute level of care needs? Section 2 consists of the concepts, models, and theories, relevance to nursing practice, local background and context, the role of the DNP student, and the role of the Project Team.

Concepts, Models, and Theories

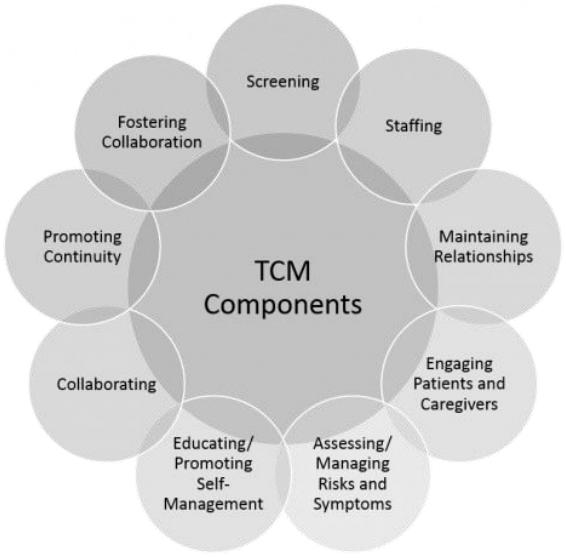
The model that guided the QI project is the transitional care model (TCM). The TCM is a provider-led, team-centered, and case management approach shown to enhance the outcome of patients with complex medical and social needs throughout the transition phase from acute hospital to post-discharge level of care (Naylor et al, 2018). The model acknowledges that patients typically encounter challenges during the critical period between acute hospital and post-discharge level of care; thus, there is a need for comprehensive support to necessitate an efficient transition. The TCM, used as a multi-component, nurse-led intervention has been evaluated in the U.S. and has consistently shown to decrease the number of hospitalization readmissions, the number of days

hospitalized, and decrease costs and improve patient-reported outcomes (Morkisch et al., 2020). The use of the TCM has reliably been demonstrated to improve patient care experiences during acute care events, assess and manage chronic conditions, promote patient compliance, provide consistent communication, collaborate with all team members, and efficient coordination of health care and community-based services.

The nine core components of the TCM include (i) screening, (ii) staffing, (iii) maintaining relationships, (iv) engaging patients and caregivers, (v) assessing and managing risks and symptoms, (vi) educating and promoting self-management, (vii) collaborating, (viii) promoting continuity, and (ix) fostering coordination (Morkisch et al., 2020). The model and the nine components are illustrated below in Figure 1.

Figure 1

The Nine Components of the TCM



The first component of screening is considered a standardized protocol to focus on the hospitalized patients prone to poor outcomes. The second stage of staffing entails the healthcare team known to deliver and coordinate the post-acute level of care services. The third and fourth component, which comprise maintaining relationships and engaging patients and caregivers, promotes sustaining a relationship with the patient and family which is important when navigating the transition of the care process. The fifth component of assessing and managing risk and symptoms aims to assess each patient's or caregiver's transitional care (TC) needs, develops a comprehensive TC plan, use medication management, and uses symptoms management (Naylor et al., 2018). Education and promoting self-management, the sixth component prepares patients, families, and caregivers to recognize and respond with an emergency plan, when worsening symptoms occurs. This component includes everyone in the discharge process and promotes advocacy. Collaboration, the seventh component, facilitates a consensus on the plan of care so that follow-ups are done, and patients are monitored, and thus promoting continuity, which is the eighth component. The ninth stage, fostering coordination, enhances communication and connections between healthcare and community-based practitioners (Naylor et al., 2018).

Developed in 1981 at the University of Pennsylvania's School of Nursing by a team led by Dr. Mary Naylor, the TCM is a nurse-led intervention designed to improve the outcomes of chronically ill older adults who transition from hospital to home and are at risk of readmission based on the following factors: one or more chronic illnesses, more than one hospital visit within the last 6 months, multiple prescribed medications to treat

multiple conditions and living alone (Hall et al., 2020). The model is applied through personalized, multidisciplinary, and evidence-based processes to decrease 30-to-60-day hospital readmissions. In addition to lowering the number of readmissions, the TCM supports the patient, family, and caregivers to manage and advocate for their medical conditions. The model has been recently adapted and assessed with other populations, including individuals who are eligible for Medicaid and patients with psychiatric diagnoses in addition to chronic and other comorbidities (Hall et al., 2020).

Definition of Terms

Post-acute level of care: A series of services provided to patients whose conditions had stabilized following acute hospitalization to facilitate their return to the community; these services could include medical treatment, nursing care, rehabilitation, and residential care (Wang et al., 2019).

Discharge process: Discharge planning is the process of transitioning a patient from one level of care to the next (Patel & Benchmann, 2023).

Transition of care: A set of actions aimed to ensure the coordination and continuity of care in the patient transfer between different sectors or health services (Acosta et al., 2018)

Relevance to Nursing Practice

In the field of nursing practice, there has been a longstanding challenge in ensuring appropriate care and placement for patients following discharge. Historically, healthcare systems have faced difficulties in evaluating and determining the most suitable post-discharge care options for patients. Improper transition of care and placement has

led to suboptimal outcomes, increased healthcare costs, and limited resources. Recognizing the need for focused research and practice in efficiently evaluating patients for the right post-acute level of care, the emerging field of post-acute levels of care has gained prominence within nursing clinical research. Scholars and practitioners have increasingly directed their attention towards understanding and improving the post-acute care continuum.

This specific doctoral project aligns with the broader problem by aiming to contribute to the body of knowledge regarding the diverse levels of care needed and the challenges associated with evaluating the appropriate placement of patients post-discharge. To provide a comprehensive understanding of the context, a thorough narrative review spanning a period of twenty-one years was conducted by Betz (2021), focusing on post-acute levels of care. The pioneering efforts in the field revealed seminal findings regarding nursing research and practice related to post-acute care. Notably, 12 out of the 43 studies included in the review were published by nurses, underscoring the growing involvement of nursing professionals in investigating the needs and patient care within the post-acute setting. By addressing the historical challenges and knowledge gaps in nursing practice, this doctoral project contributes to the ongoing development and advancement of post-acute levels of care. It aims to enhance nursing practice by providing insights into improving patient outcomes, optimizing resource allocation, and promoting evidence-based decision-making in the post-discharge phase.

Enhancing post-acute levels of care for hospitalized patients is a high priority among hospital organizations and healthcare systems in the United States. New

guidelines by the Centers for Medicare and Medicaid Services (CMS) reveal that 30-day readmission rates are now seen as a direct correlation and measurement of quality of care, and it is estimated that hospital readmissions cost the United States health system $17.4 billion annually (Baldwin, 2018). Hospital organizations are at risk for fiscal penalties for readmission rates higher than national benchmarks and have been mandated to build advanced methods towards enhancing the post-hospital discharge stage and transition of care to decrease delayed care and readmissions. The impact and influence of an interprofessional healthcare team are essential to the improvement of the transition of care process as patients are discharged to their post-hospital settings. The present state of nursing practice in post-acute levels of care includes fragmentation in patient care, inconsistent use of regulations, lack of patient advocacy and involvement, and limited outcome measures (Miller et al., 2019). Improving interdisciplinary coordination and communication, enhancing standardized practices, incorporating patient and caregivers, measuring outcomes efficiently, and encouraging self-management will lead to better patient outcomes and experiences.

The increasing importance of interprofessional collaborative practice has been recognized in enhancing the transitions of care for patients in chronic illness populations. A study conducted at the University of North Carolina's posthospital follow-up clinic demonstrated significant improvements in readmission rates and transitions of care by implementing an interprofessional care team model (Baldwin, 2018). The collaborative health care team composed of a physician, pharmacist and social worker worked towards limiting and decreasing the number of readmissions by two-thirds. In addition, a report in

the New England Journal of Medicine found that only 50% of hospitalized Medicare patients receive outpatient follow-up within 30 days of discharge, highlighting the need for interprofessional care teams to bridge the essential gap of inconsistent patient care transition post discharge (Baldwin, 2018).

The doctoral project aimed to fill the gap in practice by evaluating the healthcare team's consistent use of the Post-Acute Levels of Care Guideline to appropriately place patients in their post-discharge setting. Having the knowledge and basis gained through the consistent application of the guideline promotes effective communication, enhances participation in decision-making regarding patient care transitions, and increases respect among the health care team. The potential of the guideline being consistently used by the healthcare team in improving care management within transitions of care and lowering hospital readmissions is paramount to the advancement of nursing practice.

Local Background and Context

The southwestern US hospital is a 327-bed facility that provides comprehensive acute medical care services. To ensure smooth transitions of care following a patient's hospitalization, a dedicated healthcare team is employed. The health care team facilitates the post-acute level of care transition by assisting patients in determining the most appropriate setting for their discharge. The settings may include the patient's home, home setting with home health services, inpatient rehabilitation, a skilled nursing facility, an assisted living setting, or a long-term acute care facility. Upon discharge, some patients, because of their complex medical conditions, are homebound and need continuous therapy and/or skilled nursing care that includes wound care, intravenous antibiotic

therapy, and medication management. The patients in question exhibit medical conditions necessitating intensive rehabilitation, which may involve 15 hours of therapy per week over a continuous 7-day period. Due to the complexity of their medical condition, patients who go to inpatient rehabilitation require continuous supervision and coordinated care within the healthcare team. An increase in therapy time was associated with positive outcomes such as return home, functional recovery, and a shorter length of stay whereas a decrease of therapy time was associated with return to hospital or death (Tijsen et al., 2019).

The Criteria for Post-Acute Levels of Care guideline is already constructed in the hospital facility. The healthcare team inconsistently uses The Criteria for Post-Acute Levels of Care guideline when assessing the patient for the most appropriate level of care upon discharge in the context of seeing improved performance and quality improvement amongst the health staff. The lack of standardized processes, poor multidisciplinary communication, and fragmented communication across settings can lead to chaotic and challenging transitions, poor patient outcomes, and feelings of futility and dissatisfaction among providers (Hudon et al., 2022). Post-hospital care transitions for patients in the acute hospital setting have been paramount to the process of ensuring continuity of care and an efficient home and facility at discharge, which is why consistent usage of the Post-Acute Levels of Care guideline in assessing patients in the discharge process is imperative.

Locally Used Terms Relevant to Understanding the Doctoral Project

Post-acute level of care: A series of services provided to patients whose conditions had stabilized following acute hospitalization to facilitate their return to the community; these services could include medical treatment, nursing care, rehabilitation, and residential care (Wang et al., 2019).

Discharge process: Discharge planning is the process of transitioning a patient from one level of care to the next (Patel & Benchmann, 2023).

Home Health: Provides skilled nursing care, physical therapy, functional and language therapy, social work services, and other healthcare services to patients at home (Wang et al., 2019).

Skilled Nursing Facility: A particular type of nursing home that provide short-term skilled nursing care and rehabilitation services, such as physical and occupational therapy and speech-language pathology services, to patients following a stay in an acute-care hospital (Gu et al., 2019).

Inpatient Rehabilitation: Rehabilitation treatment to patients requiring at least 3 hours of rehabilitation each day because of disabilities and functional impairments resulting from acute illness; such patients have an average of 12 days of hospitalization (Wang et al., 2019).

Long Term Care Hospital: Established within hospitals or existing independently to meet the needs of complex patients who have left the acute instability stage but still have multiple comorbidities or multiple care needs and require hospitalization and assistance from a medical team (Wang et al., 2019).

Transition of care: A set of actions aimed to ensure the coordination and continuity of care in the patient transfer between different sectors or health services (Acosta et al., 2018)

Differences in the utilization of post-acute level of care services occur across the United States. In the face of an aging population, post-acute care organization and delivery remains a legislative priority (Alcusky et al., 2018). State health departments play an important role regarding healthcare practices and evaluating the consistent use of the guideline can incorporate alignment with state specific policies and regulations. The June 2018 Medicare Payment Advisory Commission (MedPAC) Report to Congress recognizes four post-acute levels of care provider types of inpatient rehabilitation facilities, skilled nursing facilities, home health agencies, and long-term care hospitals (Dean et al., 2021). Geographic variation in the utilization of post-acute level of care services exists within the US where patients residing in certain provinces use these services more often than those living in other regions. Factors that drive differences in using a post-acute level of care services include the availability of post-acute levels of care facilities, patient characteristics and clinical diagnoses and severity, provider availability, and current reimbursement programs (Dean et al., 2021).

Role of the DNP Student

My professional role is a Family Nurse Practitioner, and I work in an acute care hospital as a hospitalist with a specialization in internal medicine. I manage and treat both acute and chronic disease conditions, primarily in the adult population. As an advanced practice nurse, my position is to establish and maintain trusting relationships with older

adults and their families and caregivers throughout the acute care episode, engage them in designing and implementing plans of care, assess and manage their symptoms and risks, prepare them for self-management, promote communication and collaboration with all team members, and assure coordination of health and community-based services (Naylor et al., 2018). As a provider, I am well-integrated alongside the healthcare team in the evaluation and coordination process of transitioning patients from one level of care to another. When a patient is readmitted back to the hospital, I work closely with the health staff to identify how services were coordinated before the initial discharge, any loopholes in patient care management and treatment, or inefficient discharge planning.

My role in the doctoral project was as project leader. As project leader, I collaborated with registered nurses, nurse practitioners, physician assistants, physicians, unit directors, and case managers to execute evidence-based practice. The manager of case management at the hospital and I collaborated on collecting the retrospective and prospective deidentified data and assessing the trends on how consistently The Criteria for Post Acute Level of Care Guideline was being applied by the healthcare professionals. The deidentified data included the number of patients assessed by the health care team in each placement location setting, title of healthcare team member that placed the patient, number of patients wrongly placed and sent to another placement location, patients denied placement by insurance, patients with insurance, patients unfunded, and patients that stayed over the geometric length of stay. My motivation for the doctoral project was inspired by seeing the same patients I managed and treated a few weeks prior, come back to the hospital needing to be re-evaluated for a different level of

care and location. The constant need to identify loopholes from lack of communication to poor coordination initiated the need for this doctoral project. In addition, the application of The Criteria for Post Acute Levels of Care guideline was not made accessible to everyone involved in the patient care plan. By actively acknowledging and addressing the lack of consistent access to the guideline, I can contribute to providing equitable and patient-centered care. I required continuous self-reflection, education, and a commitment to continuous improvement to reduce bias. It is imperative to assess for and understand the vulnerability of patients during care transitions and adopt best practices to successful care transitions (Campagna et al., 2019).

Role of the Project Team

The manager of case management worked closely to ensure efficient communication and coordination within the healthcare team and will intervene effectively as a liaison between the case management team and other stakeholders involved in this doctoral project. Case management, owing to its focus on coordination, is inherently rooted in multi-disciplinary communication and teamwork and must facilitate communication among various disciplines to develop a plan of care that is inclusive of the many fields that are typically involved in the care of a patient (Giardino & De Jesus, 2021). I collaborated with the manager of case management in gathering applicable data linked to the consistent application of The Criteria for Post-Acute Levels of Care Guideline. The manager of case management and I worked toward identifying trends in the data that contributed to the entire evaluation of the guideline's implementation. With their contextual insight and expertise in patient processes and transitions, the manager of

case management assisted in identifying gaps in patient care management and loopholes in the discharge planning process that may take place during transitions of care. The input from the manager of case management aided in acknowledging opportunities for progress, guarantee compliance with standards, and facilitate efficient collaboration among the healthcare staff.

Summary

Evaluation of the consistent use of The Criteria for Post Acute Levels of Care Guideline during assessment and placement of patients at the hospital, was responsible for this QI project. This project involved evaluating the gaps identified in patient care treatment, as patients transition from one level of care to the next, as well as the consistent and effective use of The Criteria for Post Acute Levels of Care Guideline by the healthcare professionals. The transitional care model (TCM) served as a foundational tool to assist in guiding the DNP project through the nine core components to improve the health outcomes of patients during the post-discharge level phase of care. Observations of patients being readmitted to the hospital to be reevaluated for the appropriate level of care drove the need to rectify inefficiencies in coordination, communication, and overall discharge planning. As project leader, I worked with the healthcare team to implement evidence-based practice applying the guideline. Through my leadership efforts and with collaboration from the healthcare team, the doctoral project sought to bring a commitment to enhancing patient care transitions and quality improvement during the assessment of diverse levels of care in the healthcare setting.

Section 3 will include the practice-focused question, sources of evidence, and the analysis and synthesis of the doctoral project.

Section 3: Collection and Analysis of Evidence

Introduction

There is an increasing need within healthcare practice for efficient and effective care coordination during the transition period from the time the patient is discharged from the hospital and when they are placed in a post-acute care facility. Healthcare professionals are therefore required to pay close attention and make improvements that guarantee smooth transitions, quality care, and safe outcomes for patients in post-acute care placements. The purpose of this project was to evaluate if The Criteria for Post Acute Levels of Care Guideline was being consistently utilized in healthcare practice. The site for the doctoral nursing project was located at a southwestern US acute care facility. Patients being discharged from this acute care setting to different post-acute settings have medical complexities that require intense rehabilitation and continuous supervision. The healthcare team showed inconsistency in the application of the guideline which has led to discrepancies in continuity of care and patient outcomes. By evaluating how consistently The Criteria for Post Acute Levels of Care Guideline are used, areas of improvement in meeting the health management needs of this adult population can be identified. Section 3 will discuss the practice-focused question, sources of evidence, and analysis and synthesis.

Practice-Focused Question

The local problem identified in the hospital setting is the lack of consistency in applying The Criteria for Post Acute Levels of Care Guideline during the transition period from this acute hospital setting to a placement setting post-discharge. Not

consistently applying the guideline has led to improper coordinated care, a risk of patient complications, and a higher number of readmissions. The level of inconsistency in applying the guideline by the health care team shows a gap in practice during the discharge process and placement of patients. A successful discharge outcome incorporates an interprofessional approach from the health care team to foster continuity of care and the transition of patient from hospital to post-discharge (Lobchuk et al., 2021). The guiding practice-focused question for this QI doctoral project is as follows: Is the health care team consistently applying The Criteria for Post-Acute Levels of Care Guideline when assessing the patient for the most medically appropriate placement settings at discharge based on the patient's post-acute level of care needs?

The purpose of this doctoral QI project was to evaluate the consistency of the use of The Criteria for Post Acute Levels of Care Guideline by the healthcare team in appropriately placing patients in the proper setting and facility at discharge. Discharge planning forms an integral part of an effective discharge care plan in adults with complex needs and its efficiency is reflected in the quality of care the patient receives and a reduced rate of readmissions (Rameli & Rajendran, 2022). The purpose was to deliver evidence-based practice and the intention to enhance the health staff's adherence to the guideline, creating an avenue for efficient decision-making in the placement of patients in their correct settings, and advancing patient outcomes in the post-acute care setting.

Sources of Evidence

A literature search was done using the National Library of Medicine, CINAHL, Embase, MEDLINE, ProQuest Nursing and Allied Health Database, PubMed, and TRIP

databases. The Agency for Healthcare Research, Guidelines from Healthy People 2030, and The National Institute of Health were also searched for pertinent information. The search terms and Boolean operators used were *post-acute levels of care, the transition of care, discharge management, case management, post-acute levels of care and home health, post-acute levels of care and inpatient rehabilitation*, and *post-acute levels of care and skilled nursing facility*. The inclusion criteria using the above search terms consisted of studies and peer-reviewed articles that were published between 2017 and 2023, transitional care in the hospital setting, and the different discharge settings of post-acute care. The exclusion criteria used were qualitative studies, peer-reviewed articles in a different language other than English, and studies published earlier than and before 2017.

The sources of evidence play an important role in ensuring efficiency in consistently applying The Criteria for Post-Acute Levels of Care Guideline for evaluating patients for the appropriate level of post-acute care. One relation between the different sources of evidence and the purpose of consistently applying the guideline is that standardization criteria and protocol were used to assess the patients' post-acute care needs. The sources of evidence established consistent and evidence-based approaches to evaluate patient conditions, functional status, and support systems, which guide healthcare in making informed decisions. Patient-centered outcome research provides an opportunity for researchers to partner with patients, families, clinicians, delivery systems leaders, and other stakeholders to assess outcomes that are meaningful and important to patients and caregivers and enhance the relevance of research findings for end users (Parry et al., 2021). By referencing credible sources of evidence, healthcare staff can

parallel their evaluation practices with updated research and sufficiently available evidence. There is growing evidence of the effectiveness of transitional care interventions in bridging the care gap during transitions from hospital to home and other health care settings with current evidence on the transitions of such patients with serious illnesses transitioning to a discharge setting that provides proper health outcomes (Caggianelli et al., 2023). The sources of evidence also provide a mutual understanding and language, fostering effective communication and collaboration among the health staff team, leading to more consistent and coordinated care decisions. Prior research has explored the efficacy and effectiveness of interventions to enhance communication and foster care continuity, utilizing elements such as home visits, multidisciplinary teams, a single point of contact, patient education on self-management, tailored discharge care planning and phone calls, and medication reconciliation and management (Parry et al., 2021). In addition, continuously referring to and updating the sources of evidence aids in enhancing the consistency of use of the guideline and the quality of care implemented to patients in the post-discharge setting.

The collection of different sources of evidence analyzed helped in determining factors to consider when assessing patients' needs and making placement decisions. Collection and analysis of different sources of evidence directly helped in embracing a shared understanding and better decision-making among the healthcare team. The Care Coordination and Transition Management Core Curriculum developed by the American Academy of Ambulatory Care Nursing, has been an excellent competency-based resource. It has been utilized to guide nurses in new care coordination and transition

management roles establishing evidence-based practices and encouraging nurses through competency, to improve patient outcomes (Harkness, 2020).

Evidence Generated for the Doctoral Project

Participants

The participants include about 60 registered nurses, five nurse practitioners, four physicians, four unit directors, and four case managers. Registered nurses are BSN prepared and have worked there for 2 to 5 years. Nurse practitioners are advanced practice registered nurses who have attained their master's or doctoral degree and have worked there for 2 to 10 years. The physicians are board-certified medical doctors and have worked there for more than 5 years. Unit directors are BSN or MSN prepared, manage and direct health staff within the unit floor and hospital and have worked there for more than 5 years. The case managers are BSN and MSN prepared, work to coordinate, and manage the continued care of patients and have worked there for 2 to 5 years. Each team member plays an essential part in the process of assessing patients for the most medically suitable placement setting post discharge, dependent on their post-acute level of care requirements. By including these diverse healthcare staff, the evaluation process covers the interdisciplinary and collaborative efforts involved in a thorough approach to the post-acute care needs of patients.

Procedures

The doctoral project is a QI Evaluation and will apply a before-and-after approach to evaluate how consistently The Post-Acute Levels of Care Criteria Guideline has been used. Retrospective data were obtained for 3 months before the educational intervention

was provided. The data were provided by the manager of case management from the electronic medical record (EMR). The data collected included the number of patients assessed by the health care team in each placement location setting, title of healthcare team member that placed the patient, number of patients wrongly placed and sent to another placement location, patients denied placement by insurance, patients with insurance, class of insurance, patients unfunded, patients that stayed over the geometric length of stay, and percentage of patient accounts that were denied, accepted, and pending. The data were provided by the manager of case management from the electronic medical record (EMR) in a USB drive, and I uploaded the information into an Excel file saved to my personal laptop that was password protected. The laptop that was also used for the analysis was kept in a locked private office.

Protections

The Walden University Institutional Review Board (IRB) approved the project before it was initiated. Human subjects were protected by ensuring that the data collected were deidentified with no specific descriptors of the participants. Deidentified retrospective and prospective data were collected 3 months before and after an educational intervention that was conducted outside the scope of the project. The data were stored in an Excel file saved to a password protected personal computer, which was kept in a private, locked office.

Analysis and Synthesis

The deidentified data were provided on a USB drive and uploaded into an Excel file saved to a personal laptop that was password protected. The project question was as

follows: Is the health care team consistently applying The Criteria for Post-Acute Levels of Care Guideline when assessing the patient for the most medically appropriate placement settings at discharge based on the patient's post-acute level of care needs? The expected outcome of the project was to evaluate if the healthcare team was demonstrating consistent application of the guideline when assessing and placing patients for post-acute care compared to the period when they were not applying the guideline. The data regarding Length of Stay (LOS) ratio, Average Geometric Length of stay (GMLOS), number of discharges and out of pocket payment (Opp) days of patients placed, and obtained 3 months (June, July, and August 2022) prior to when the healthcare team was exposed to the guideline and 3 months (October, November, and December 2022) after the healthcare team was exposed to the guideline were compared and analyzed using descriptive statistics. It was determined from the results how the consistent use of the guidelines resulted in any improvements in the post-acute care placement of patients.

Summary

The doctoral QI project was aimed at evaluating if the healthcare team at the Southwestern US hospital is consistently applying The Criteria for Post-Acute Levels of Care Guideline when assessing patients during the transitional period post-discharge. The doctoral QI question is as follows: Is the health care team consistently applying The Criteria for Post-Acute Levels of Care Guideline when assessing the patient for the most medically appropriate placement settings at discharge based on the patient's post-acute level of care needs? The sources of evidence include The National Library of Medicine, CINAHL, Embase, MEDLINE, ProQuest Nursing and Allied Health Database, PubMed,

TRIP, The Agency for Healthcare Research, Guidelines from Healthy People 2030, and The National Institute of Health. The doctoral project applied a before-and-after approach. The retrospective and prospective data collection included the number of patients assessed by the health care team in each placement location setting, title of healthcare team member that placed the patient, number of patients wrongly placed and sent to another placement location, patients denied placement by insurance, patients with insurance, patients unfunded, and patients that stayed over the geometric length of stay. Descriptive statistics were used to analyze the data. Section 4 will include the findings, implications, recommendations, contribution of the doctoral project team, and the strengths and limitations of the project.

Section 4: Findings and Recommendations

Introduction

Inefficient transitions through the post-acute level of care process have caused shortcomings observed at a Southwestern US hospital as patients are being moved from the acute care facility to post-discharge settings. Within the facility, inefficient transitions have been observed through inadequate collaboration between the healthcare team, fragmented care from ineffective coordination causing interferences in the continuity of care, and delayed patient care transitions. The ineffectiveness of patients being placed in the most efficient discharge setting raised local concerns about The Criteria for Post-Acute Levels of Care Guideline being consistently applied at the hospital. The gap in nursing practice was the incongruity in the consistent application of the guideline in this hospital setting during the discharge process and placement of patients. The local problem and gap in practice led to the practice-focused question: Is the health care team consistently applying The Criteria for Post-Acute Levels of Care Guideline when assessing the patient for the most medically appropriate placement settings at discharge based on the patient's post-acute level of care needs? The purpose of the doctoral project was to evaluate if The Criteria for Post-Acute Levels of Care Guideline is being consistently used at the time of patient discharge. The aim was to appraise patients' appropriate placement in the correct discharge facility based on the healthcare team's consistent and effective use of the guideline.

The sources of evidence for this doctoral project were attained from the literature search using the National Library of Medicine, CINAHL, Embase, MEDLINE, ProQuest

Nursing and Allied Health Database, PubMed, TRIP databases, The Agency for Healthcare Research, Guidelines from Healthy People 2030, and The National Institute of Health. The search terms and Boolean operators applied included *post-acute levels of care, the transition of care, discharge management, case management, post-acute levels of care and home health, post-acute levels of care and inpatient rehabilitation,* and *post-acute levels of care and skilled nursing facility*. The inclusion criteria using the above search terms consisted of studies and peer-reviewed articles that were published between 2017 and 2023, transitional care in the hospital setting, and the different discharge settings of post-acute care. The exclusion criteria used were qualitative studies, peer-reviewed articles in a different language other than English, and studies published earlier than and before 2017.

Findings and Implications

Retrospective data were collected from June to August 2022 prior to when the guideline was introduced. The data were obtained by the manager of case management from the electronic medical record (EMR) and provided on a USB drive. I uploaded the data into an Excel file saved to my personal laptop that is password protected. The laptop used for the analysis was kept in a locked private office. The data collected included the number of patients assessed by the healthcare team in each placement location setting, title of healthcare team member who placed the patient, number of patients wrongly placed and sent to another placement location, patients denied placement by insurance, patients with insurance, class of insurance, patients unfunded, patients who stayed over the geometric length of stay and percentage of patient accounts that were accepted,

declined, and pending. This QI project evaluated the consistent use of The Criteria for Post-Acute Levels of Care Guideline during the appropriate placement of patients to their respective discharge facilities. Across the post discharge settings of home health, skilled nursing facility, inpatient rehabilitation and long-term care hospital, home health had the majority of patients assessed, denied placement by insurance, were insured, unfunded and overstayed the average GMLOS (Table 1). The long-term care hospital had the lowest values for all parameters, and both the skilled nursing facility and long-term care hospital had no unfunded patients. Physicians were identified as the only healthcare team member and no data were provided for patients who were wrongly placed.

Table 1

De-identified Retrospective Data Collected

Post Discharge Settings	Number of Patients Assessed	Title of Healthcare Team Member	Number of Patients Wrongly Placed	Number of Patients Denied Placement by Insurance	Number of Patients with Insurance	Number of Patients Unfunded	Number of Patients Who Overstayed the Average GMLOS
Home Health	352	PHYSICIAN	-	98	285	4	144
Skilled Nursing Facility	125	PHYSICIAN	-	32	93	0	40
Inpatient Rehabilitation	101	PHYSICIAN	-	40	70	2	33
Long Term Care Hospital	11	PHYSICIAN	-	1	8	0	3

Prospective data were collected from October to December 2022 after the guideline was introduced (Table 2). Across the post discharge settings of home health, skilled nursing facility, inpatient rehabilitation and long-term care hospital, home health also had the majority of patients assessed, denied placement by insurance, were insured, unfunded and overstayed the average GMLOS. The long-term care hospital had the lowest values for all parameters and also had no patients who were denied insurance or

unfunded. Physicians were identified as the only healthcare team members, and no data were provided for patients who were wrongly placed.

Table 2

De-identified Prospective Data Collected

Post Discharge Settings	Number of Patients Assessed	Title of Healthcare Team Member	Number of Patients Wrongly Placed	Number of Patients Denied Placement by Insurance	Number of Patients with Insurance	Number of Patients Unfunded	Number of Patients Who Overstayed the Average GMLOS
Home Health	346	PHYSICIAN	-	85	251	3	144
Skilled Nursing Facility	102	PHYSICIAN	-	24	77	1	41
Inpatient Rehabilitation	103	PHYSICIAN	-	22	76	2	43
Long Term Care Hospital	10	PHYSICIAN	-	0	4	0	4

Comparing both the retrospective and prospective data, it can be observed that irrespective of the post discharge setting, the range of values for the number of patients assessed, those denied based on insurance, those with insurance, and those unfunded were lower after The Criteria for Post-Acute Level of Care Guideline was consistently followed. In the case of the number of patients staying beyond the average GMLOS the highest value observed belonged to the home health facility (144), which was the same for both the retrospective and prospective data. For other facilities, skilled nursing, inpatient rehabilitation and long-term care hospital, the number of patients staying beyond the average GMLOS were higher for the prospective data as compared to the retrospective data.

Table 3 shows the summarized retrospective de-identified data representing the Out-of-Pocket Payment (OPP) Days, number of patient discharges, the patient's length of stay ratio and the average Geometric length of stay for the different post discharge settings considered. Across the post discharge settings of home health, skilled nursing

facility, inpatient rehabilitation and long-term care hospital, home health had the highest values for OPP Days and Discharges, while long-term care hospital showed the lowest values for both parameters. The home health facility also showed the lowest values for LOS ratio, average GMLOS, while the skilled nursing facility showed the highest LOS ratio, and the long-term care hospital showed the highest average GMLOS.

Table 3

De-identified Retrospective Data Obtained

Post Discharge Settings	OPP Days	Discharges	LOS Ratio	Avg. GMLOS
Home Health	859.20	352	1.6	4.23
Skilled Nursing Facility	842.20	125	2.4	4.89
Inpatient Rehabilitation	521.40	101	2.1	4.56
Long Term Care Hospital	100.30	11	1.9	9.88

Table 4 summarizes the prospective de-identified data representing OPP Days, number of patient discharges, the patient's length of stay ratio, and the average GMLOS for the different post discharge settings considered. Across the post discharge settings of home health, skilled nursing facility, inpatient rehabilitation and long-term care hospital, home health had the highest values for OPP Days and Discharges, while long-term care hospital showed the lowest values for both parameters. The home health facility also showed the lowest values for LOS ratio and average GMLOS compared to the other facilities. The skilled nursing facility showed the highest LOS ratio, and the long-term care hospital showed the highest average GMLOS.

Table 4

De-identified Prospective Data Obtained

Post Discharge Settings	OPP Days	Discharges	LOS Ratio	Avg. GMLOS
Home Health	961.40	346	1.6	4.51
Skilled Nursing Facility	763.70	102	2.6	4.80
Inpatient Rehabilitation	598.60	103	2.2	4.96
Long Term Care Hospital	78.30	10	1.9	8.27

When comparing the retrospective and prospective data, it can be observed that the OPP Days and average GMLOS increased for the home health and inpatient rehabilitation facilities but decreased for skilled nursing facility and long-term care hospital. In the case of discharges, apart from inpatient rehabilitation facility, prospective data values decreased compared to retrospective data. The use of the guideline did not appear to result in a clear pattern nor significant change in the LOS ratio values after it was implemented.

Table 5 shows the retrospective de-identified data collected representing the OPP Days, number of patient discharges, the patient's length of stay ratio and the average GMLOS for the different Class of Insurance used by the patients. Across the different classes of Insurance used by the patients, the medical necessity guideline (Mng) Care Medicare had the highest value for OPP Days and Discharges with the no insurance Self-Pay and Charity group showing the lowest values. Exchanges showed the lowest LOS ratio value, while Health Maintenance Organization (HMO)/Prospective Payment System (PPS)/Commercial showed the highest LOS value. Exchanges showed the highest average GMLOS, and the no insurance Self-Pay and Charity group showed the lowest average GMLOS value.

Table 5

De-identified Retrospective Data Obtained

Class of Insurance	OPP Days	Discharges	LOS Ratio	Avg. GMLOS
Mng Care Medicare (FC 12)	1,222.90	300	1.9	4.38
Medicare-PPS (FC 1)	455.20	138	1.7	4.86
HMO/PPO/Commercial (FC 5,7,8,13)	270.90	42	2.3	4.93
All Other (FC 2,4,6,10,11)	134.40	41	1.8	4.28
Mng Care Medicaid (FC 9)	132.50	44	1.7	4.28
Exchanges (FC 14)	35.10	15	1.5	5.06
Self-Pay and Charity (FC 15,99)	27.10	6	2.2	3.82

Table 6 shows the summarized prospective de-identified data collected representing the OPP Days, number of patient discharges, the patient's length of stay ratio and the average GMLOS for the different Class of Insurance used by the patients. Across the different classes of Insurance used by the patients, the Mng Care Medicare had the highest value for OPP Days and Discharges with the no insurance Self-Pay and Charity group showing the lowest values. Exchanges showed the lowest LOS ratio value, and the no insurance Self-Pay and Charity group showed the highest LOS value. The no insurance Self-Pay and Charity group also exhibited the highest average GMLOS value while the All Other showed the lowest average GMLOS value.

Table 6

De-identified Prospective Data Obtained

Class of Insurance	OPP Days	Discharges	LOS Ratio	Avg. GMLOS
Mng Care Medicare (FC 12)	1,285.80	267	2.0	4.69
Medicare-PPS (FC 1)	478.40	144	1.7	4.72
HMO/PPO/Commercial (FC 5,7,8,13)	206.70	50	1.8	4.87
All Other (FC 2,4,6,10,11)	136.40	34	2.0	4.08
Mng Care Medicaid (FC 9)	194.60	39	2.0	4.98
Exchanges (FC 14)	50.60	21	1.5	4.97
Self-Pay and Charity (FC 15,99)	49.50	6	2.6	5.08

When comparing the retrospective and prospective data, the OPP Days of the prospective data except for HMO/PPO/Commercial class of insurance, were higher than

those of the retrospective data. The increase in the OPP days seen in the prospective data for class of insurance can be attributed to more cautious placement of patients in the use of the guideline. Discharges increased for Medicare-PPS, HMO/PPO/Commercial, and Exchanges class of insurance, decreased for HMO/PPO/Commercial, All Other, Mng Care Medicaid class of insurance but remained the same for Self-Pay and Charity. In general, and for almost all the insurance classes, LOS Ratio and Avg GMLOS from the prospective data correspondingly decreased when discharges increased and increased when discharges decreased, implying that the consistent use of the guideline led overall to reducing the LOS ratio and avg GMLOS of patients. However, for the Exchanges insurance class, LOS Ratio remained unchanged for both the retrospective and prospective data.

Table 7 shows the de-identified retrospective percentage of patient accounts that were accepted, declined, and placed on pending across all networks for the various post discharge settings considered. Across the post discharge settings of home health, skilled nursing facility, inpatient rehabilitation and long-term care hospital, the home health facility had the highest percentage of patient accounts accepted and the non-affiliated inpatient rehabilitation facility had the lowest percentage of patient accounts accepted. The affiliated inpatient rehabilitation had the highest percentage of patient accounts declined and the long-term care hospital facility had the lowest percentage of patient accounts declined. The non-affiliated inpatient Rehabilitation facility exhibited the highest percentage of patient accounts pending, while home health and the affiliated inpatient rehabilitation facility had the lowest percentage of patient accounts pending.

Table 7

De-identified Retrospective Data Obtained

Post Discharge Settings	% Patient Accounts Accepted to All Networks	% Patient Accounts Declined to All Networks	% Patient Accounts Pending to All Networks
Home Health	66	23	12
Skilled Nursing Facility	59	20	21
Inpatient Rehabilitation (Affiliated Facility)	56	32	12
Inpatient Rehabilitation (Non-Affiliated Facility)	27	16	57
Long Term Care Hospital	47	6	47

Tables 8 presents the prospective percentage of patient accounts that were accepted, declined and those put on pending across all networks for the various post discharge settings considered. Across the post discharge settings of home health, skilled nursing facility, inpatient rehabilitation and long-term care hospital, the home health facility had the highest percentage of patient accounts accepted and the non-affiliated inpatient rehabilitation had the lowest percentage of patient accounts accepted. Home health had the highest percentage of patient accounts declined and long-term care hospital facility had no patient account declined. The non-affiliated inpatient rehabilitation exhibited the highest percentage of patient accounts pending, while the affiliated inpatient rehabilitation had the lowest percentage of patient accounts pending value.

Table 8

De-identified Prospective Data Obtained

Post Discharge Settings	% Patient Accounts Accepted to All Networks	% Patient Accounts Declined to All Networks	% Patient Accounts Pending to All Networks
Home Health	62	21	17
Skilled Nursing Facility	59	18	22
Inpatient Rehabilitation (Affiliated Facility)	74	20	6
Inpatient Rehabilitation (Non-Affiliated Facility)	3	6	91
Long Term Care Hospital	29	0	71

When comparing the data from tables 7 and 8, the percentage of Patient Accounts accepted to all networks decreased for the prospective data in relation to the retrospective data for home health, non-affiliated inpatient rehabilitation, and long-term care hospital. The percentage of Patient Accounts accepted to all networks remained unchanged for skilled nursing facility and increased for the affiliated inpatient rehabilitation. The percentage of Patient Accounts declined to all networks, decreased for the prospective compared to the retrospective data irrespective of the post discharge Setting, with the lowest declines occurring for the non-affiliated inpatient rehabilitation and long-term care hospital. Thus, consistent use of the guideline is showing improvement in reducing the number of patients being declined. For those with percentage of Patient Accounts Pending to All Networks, there was an observed slight increase for prospective data compared to retrospective data collected in the case of home health and skilled nursing facilities, a more dramatic increase for the non- affiliated inpatient rehabilitation and long-term care hospital, while on the contrary for the affiliated inpatient rehabilitation, there was a decrease.

Reviewing the prospective data, there appears to be an interesting interplay between the affiliated inpatient rehabilitation and the non-affiliated inpatient rehabilitation. The affiliated inpatient rehabilitation facility experienced a marked increase in the percentage of Patient Accounts Accepted to All Networks and with a corresponding reduction in those declined and pending. On the contrary, the non-affiliated inpatient rehabilitation facility experienced a high reduction in the percentage of Patient Accounts Accepted and Declined, with a correspondingly high percentage of

Patient Accounts pending. The use of the guideline clearly does seem to have a positive impact on the interaction of the percentage of Patient Accounts Accepted, Declined and Pending, depending on the post discharge setting the patient will be placed.

A further analysis of the Number of Patient Accounts Declined to All Networks based on a number of criteria employed in the process of assessing the patients is shown in Table 9 for both the retrospective and prospective data collected. The comparison of the data shows a consistent reduction in the number of Patient Accounts Declined to All Networks in the case of prospective data in relation to the retrospective data, irrespective of the criteria used to decline. It does appear, therefore, that the use of the guideline provides some consistency in its use, especially in determining the number of patient accounts to be accepted, declined, or put on pending status.

Table 9

De-identified Retrospective and Prospective Data Obtained

Criteria for Patient Account Decline to All Networks	Retrospective (# of Patient Accounts Declined to All Networks)	Prospective (# of Patient Accounts Declined to All Networks)
Hospital Cancellation	39	32
Payer Not Accepted	63	57
Out of Service Area	23	18
Insurance Denial	20	13
Patient Too Complex	6	3
Discharged To Another Facility	4	1

Implications deduced from the findings show that from an individual level, each member of the health care team can see that consistently applying the guideline is shown to result in improvement during the post-acute discharge phase as seen and analyzed in Tables 7 and 8, where for most of the insurance classes, LOS Ratio and Avg GMLOS correspondingly decreased when discharges increased and increased when discharges

decreased. These findings can support community-wide education as patients in this particular community need to be rightfully placed in the appropriate level of care at discharge which is seen in Tables 5 and 6. From an organizational and institutional level, the trend seen particularly from Table 9 showed a consistent reduction in the number of Patient Accounts Declined to All Networks in the case of prospective data in relation to the retrospective data, which in turn, shows the impact and influence of the guideline in less patient insurance denials. Less patient insurance network denials enhance continuity of care for the patient and overall healthcare delivery within the hospital organization. From the data findings, there is also good potential to drive social change in fostering better collaboration amongst the healthcare team in guiding the appropriate and consistent use of the guideline.

Recommendations

The consistent use of The Criteria for Post-Acute Levels of Care Guideline was an enhancement to the evaluation of post-discharge continuity of care. In the retrospective data collection, the education on the guideline, which was outside the scope of the QI project, was not provided for the healthcare team to apply in assessing patients for the post-acute level of care process. The first recommendation is to consistently evaluate each patient in their respective discharge setting by applying The Criteria for Post-Acute Levels of Care Guideline for continuity of patient care. The QI project established an understanding of the significance of effectively applying the guideline to ensure compliance with the guideline's measure criteria.

The second recommendation is for the healthcare team to incorporate the guideline as part of discharge planning in the acute care hospital. Interdisciplinary collaboration and communication should be fostered amongst the healthcare staff to understand the importance of applying the guideline, as well as continuous monitoring of adherence to the guideline. Frequent performance evaluations can be implemented to make sure the guideline is being used appropriately and to address any inconsistencies. Moving onward, the QI project will enhance the healthcare staff's competence in the application of the guideline thereby bringing nursing practice in the hospital organization to the appropriate level of care.

Contribution of the Doctoral Project Team

The manager of case management worked attentively to guarantee effective collaboration within the healthcare team and intervened as a liaison between the case management team and other stakeholders involved in the doctoral project. I collaborated with the manager of case management to attain and acquire the appropriate data linked to the consistent application of The Criteria for Post-Acute Levels of Care Guideline. The manager of case management and I recognized trends in the data that contributed to the entire evaluation of the guideline's implementation. The manager of case management also provided gaps seen in patient care management and loopholes in the discharge planning process that took place during transitions of care. Team processes within healthcare is important as it is associated with the quality and safety of care delivery systems and contribute to solving large societal challenges (Rosen, et al., 2018). The knowledge and insight from the manager of case management aided in recognizing

opportunities for progress, guaranteed compliance with standards, and facilitated efficient collaboration among the healthcare staff. To extend this DNP project, presenting the project findings at a nursing conference will grant the opportunity for insights to be shared along with connecting and networking with other nursing professionals who hold the same interest. Presenting at a conference provides opportunities to share new discoveries, cutting-edge techniques, and inspiring research within a field of study (Corwin et al., 2018).

Strengths and Limitations of the Project

The primary strength of this project was that the healthcare team showed general improvement in applying the guideline more consistently for assessing patients to their placement setting at discharge. Clinical practice guidelines have long been used to inform best clinical practice by compiling the latest, high-quality evidence on the diagnosis, treatment, and management of serious acute and chronic illnesses (Dempsey et al., 2022). There was a clear indication of compliance with the guideline as shown by the decrease in the number of patients denied by insurance and the LOS Ratio and Avg GMLOS decreasing when discharges increased and increasing when discharges decreased for almost all the insurance networks. The guideline increased the healthcare team's knowledge base during the transition phase of the post-acute level of care.

One limitation of this doctoral QI project was that the only healthcare team member who was provided and shown in placing the patient was the physician. The data could have been more meaningful if other healthcare team members such as nurse practitioners and physician assistants, who assessed patients for post-acute level of care

phase were included in the data collection. A second limitation of the QI project was that the number of patients wrongly placed was not provided. Access to attaining data related to the number of patients wrongly placed would have covered all relevant aspects as well as provided a more in-depth analysis of the QI doctoral project.

Section 5: Dissemination Plan

The findings from this DNP project will first be presented to the Chief Medical Officer at the acute care hospital. If accepted by the Chief Medical Officer, I will then ask for approval to share the findings with the registered nurses, nurse practitioners, physician assistants, physicians, unit directors, and case managers at the hospital, to urge and motivate them to be consistent in applying The Criteria for Post-Acute Levels of Care Guideline and to ensure more improved and streamlined post-acute care transitions. Evidence-based quality improvement (EBQI) is one of a growing number of strategies used to enhance QI initiative impacts in clinical practice (Hempel, et al., 2022). The healthcare team will be encouraged to advocate the significance and importance of consistently applying the guideline to assist new and existing health staff in understanding and implementing the guideline within their work and practice.

The DNP project outcomes will be shared within the Walden University ProQuest library database according to the requirements and regulations of the university. I will share the findings with the sister hospital of this acute care hospital, within the same healthcare company organization. I will share my findings with healthcare professionals outside the community by hosting web-based seminars. EBQI aims to integrate scientific evidence and methods into the QI process while maintaining a focus on team-based innovation and problem-solving within real-world settings (Hempel et al., 2022). If permitted, I would also like to submit my findings of the project to the American Hospital Association: Accelerating Health Equity Conference for presentation.

Analysis of Self

Practitioner

The finalization of the DNP project has granted me the opportunity to acquire and develop skills. As I reflect on my role as a practitioner, I have not always approached my management or care and practice with an evidence-based practice approach; however, throughout the project, my understanding and experience in employing evidence-based practice has increased. My ability to engage better with the interdisciplinary healthcare team has also improved. I emphasize the importance of having a hands-on approach when coordinating care with the health staff. Healthcare teams that practice collaboratively, enhance the delivery of person-centered care, and improve patient and system outcomes (McLaney et al., 2022).

Scholar

As a scholar, I experienced growth in delivering interventions supported by factual and efficient literature reviews. A healthcare professional's inclination and ability to interpret and integrate research evidence is key to what it means to be a scholarly practitioner (Zaccagnini et al., 2020). Furthermore, executing this DNP project has given me better insight and contributed to my knowledge base on transition management during the post-acute care phase. I have also developed a continuous commitment to expertise in practice through consistent learning, partaking in evidence-driven decision-making, and promoting scholarship and knowledge translation in the healthcare setting.

Project Manager

The position of a project manager is to utilize the information, resources, and tools needed to execute interventions to meet the project needs. According to Smith and Johnson (2019), as transformation in healthcare is necessary, projects are common in healthcare organizations for innovation, problem-solving, and change. As project manager, I was able to develop and organize the project plan, which entailed outlining the scope and the resources needed for efficient execution. Coordinating efforts with the manager of case management was imperative as I was able to leverage more knowledge and strengthen the project impact in promoting overall post-acute care delivery. Scheduling the time to meet with the manager of case management posed the biggest challenge; however, we were able to make it work meeting our timeline.

Summary

In culmination, the DNP project underlined the significance of ensuring the consistent use of The Criteria for Post-Acute Levels of Care Guideline within the hospital setting. The project has emphasized the importance of coordination among the health staff, patient-centered care, and evidence-based practice to enhance the value of transitions in care during the post-acute period. The result and outcome of this project showed that adherence to the guideline serves as a beacon to aid the healthcare team in fostering proper care transitions and quality post-acute care delivery. The DNP project will assist in improving the overall healthcare experience by placing patient safety and needs at the forefront through the consistent application of the guideline.

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