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Staff Education on Discharge Planning for a County Crisis Stabilization Unit

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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
the review committee have been made.

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Walden University
2025

Executive Summary: Staff Education Project

Staff Education on Discharge Planning for a County Crisis Stabilization Unit

by

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Summary

This Doctor of Nursing Practice project was a staff education initiative designed to address the practice problem of insufficient staff knowledge related to discharge planning for homeless individuals experiencing mental health crises. This project examined whether enhanced staff training could improve staff knowledge of discharge planning, with the aim of ensuring more equitable and inclusive care. By strengthening staff understanding, the training sought to reduce gaps in discharge planning and provide homeless patients with mental health conditions more consistent access to resources, safer care transitions, and greater continuity of treatment compared to standard procedures. Addressing this knowledge gap is essential, as research shows that education targeted at staff can significantly improve patient outcomes during care transitions.

The participants included eight registered nurses and two case managers directly involved in discharge planning. Each participant completed a pre-education knowledge assessment before the educational session and a post-educational assessment after the educational session. The structured educational session included a PowerPoint presentation. Descriptive statistics were used to analyze the results. The average pre-education assessment score was 36%, whereas the average post-education score increased to 87%, resulting in a 51 percentage point gain in the education score for knowledge.

This project highlights the impact of targeted staff education to improve transitional care planning and discharge processes for individuals experiencing mental health crises. Recommendations include implementing the training during onboarding and offering annual refreshers to maintain competency. Overall, improved staff

proficiency among all discharge staff contributes to safer transitions and better long-term outcomes for vulnerable patients served by this organization.

Background

The Crisis Stabilization Unit (CSU), which was the target site of this Doctor of Nursing Practice (DNP) project, serves a high-acuity population, including individuals experiencing homelessness and co-occurring psychiatric and substance use disorders in the southern part of the United States. A gap in provider knowledge and inconsistent discharge practices contributed to suboptimal patient transitions and readmissions at the CSU. Literature supports that structured staff education improves care transitions and reduces preventable hospital utilization (Joo & Liu, 2021; Li et al., 2021). Effective transitional care is essential for reducing avoidable hospital readmissions and improving patient outcomes, especially for populations with complex psychosocial needs. The lack of knowledge among healthcare providers regarding community-based resources and discharge coordination has been identified as a persistent barrier to optimal care transitions (Fakha et al., 2021; Hewner et al., 2020). According to Parry et al. (2021), patient-centered approaches to transitional care must include educating healthcare providers on how to support vulnerable individuals through coordinated discharge processes.

Transitional care initiatives have demonstrated statistically significant impacts on health system performance. Tyler et al. (2023) found that interventions focused on comprehensive discharge education and follow-up planning can reduce emergency department visits and rehospitalization. These findings underscore the necessity of structured training for frontline providers who support patient transitions from acute

settings to community-based services. As noted by Campagna et al. (2019), improving care transitions through targeted education and structured planning can drive better patient outcomes and reduce care fragmentation across healthcare systems. This DNP project responded to a demonstrated need for enhanced transitional care training within the CSU practice. The project aimed to support CSU staff in overcoming knowledge gaps by equipping them with the tools necessary to engage effectively in discharge planning and reduce recidivism among individuals experiencing homelessness and mental health instability.

Staff Education Project Development

The staff education initiative was developed using the Analysis, Design, Development, Implementation, and Evaluation (ADDIE) model, a widely recognized instructional framework that supports the creation of effective, learner-centered education grounded in adult learning principles (Luo et al., 2024). The project began with an analysis CSU practices, followed by a search of current literature to guide the development of this evidence-based educational project. The focus was to build an educational session to close the identified knowledge gap in transitional care planning for homeless individuals among the CSU staff. Using the literature as a guide, a targeted education initiative was designed and developed in collaboration with CSU staff.

Evidence, Strength, and Translation of Literature Review

A comprehensive literature review was conducted using PubMed and CINAHL databases to explore the role of staff education in improving transitional care outcomes. The review focused on recent studies that evaluated the effectiveness of transitional care models, community-based resource coordination, and discharge planning practices,

particularly in vulnerable populations. Ten studies were analyzed to guide the development of this project.

The findings revealed strong evidence supporting the impact of structured transitional care interventions on reducing readmissions and improving patient outcomes (Fønss Rasmussen et al., 2021; Tyler et al., 2023). Studies by Joo and Liu (2021) and Li et al. (2021, 2022) confirmed that nurse-led and interprofessional discharge education significantly improves continuity of care. Furthermore, Parry et al. (2021) emphasized that patient-centered discharge planning tailored to social needs fosters equitable health outcomes, especially for individuals with unstable housing or psychiatric comorbidities.

Campagna et al. (2019) highlighted that targeted educational programs for staff facilitate smoother care transitions by improving knowledge, confidence, and communication across disciplines. Hewner et al. (2020) described how transitional care models for high-risk populations can reduce fragmented care and support sustainable discharge practices when staff are properly trained. Additionally, Fakha et al. (2021) identified factors influencing the success of these innovations, noting that staff engagement and preparedness were critical.

Overall, seven of the reviewed studies were classified as Level I evidence, two as Level II, and one as Level III. The consistency of findings offers robust support for implementing evidence-based training to enhance discharge planning. The strength and reliability of this body of literature underscore the need to translate these findings into organizational practice, reinforcing the value of continuous staff development and structured discharge planning to improve care for high-risk populations.

Educational Program Development

The education initiative was delivered in person over two sessions and included a multiple-choice questionnaire administered before and after the presentation to assess knowledge acquisition (see Appendix A) and a PowerPoint presentation (see Appendix B). Evaluation of post-test results provided immediate feedback on the effectiveness of the training in improving staff understanding. The training was delivered in two small group sessions on different days, conducted on-site during regular shift hours. Each session consisted of a 15-minute in-person PowerPoint presentation that addressed key components of transitional care, interdisciplinary collaboration, and available community services.

Evaluation Tools

Each participant completed a 10-item multiple-choice pre-education questionnaire to establish baseline knowledge. A pre-test multiple-choice questionnaire was given each day before the presentation. A 10-item multiple-choice post-educational assessment, with questions from the pre-test multiple-choice questionnaire rearranged to minimize recall bias, to evaluate knowledge acquisition.

The five knowledge domains assessed were: Domain 1, Goals and Benefits of Transitional Care (Q1, Q2, Q3); Domain 2, Roles and Responsibilities in Transitional Care (Q4, Q5); Domain 3, Interprofessional Collaboration and Community Integration (Q6, Q9); Domain 4, Educational Support and Resource Utilization (Q8, Q10); and Domain 5, Continuity and Safety in Patient Transitions (Q7).

Results

Descriptive statistics were used to analyze the data. A total of 10 staff members (eight registered nurses and two case managers) participated in the education sessions. All participants completed both pre- and post-education assessments. The average pre-education assessment score was 36%. The average post-education score increased to 87%, resulting in a 51 percentage point gain in knowledge. Analysis of the results showed consistent score increases across all five knowledge domains and among all participant roles.

Pre-test scores showed moderate variability by domain, with the lowest average observed in Roles and Responsibilities (25%) and the highest in Education and Resources (45%). These findings suggest varying baseline knowledge levels across content areas, highlighting specific domains where knowledge gaps existed before the intervention.

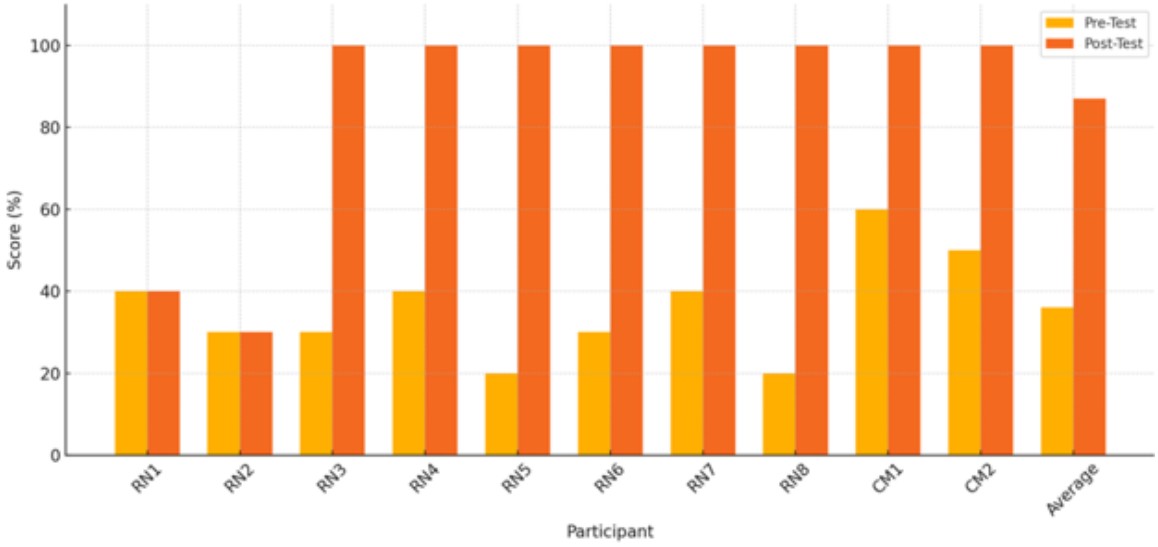
Pre-test scores among the eight nurses ranged from 20% to 40%, with an average score of 31.25%, indicating limited baseline knowledge. Following the educational intervention, post-test scores improved significantly, with six of the eight nurses achieving 100%. The average post-test score rose to 83.75%, reflecting a 52.5 percentage point increase.

Pre-test scores for the two case managers were 60% for CM1 and 50% for CM2, indicating moderate baseline knowledge. Following the educational intervention, both achieved 100% on the post-test. This improvement reflects a significant knowledge gain of 40 to 50 percentage points, demonstrating the effectiveness of the training in enhancing case managers' understanding of discharge planning and transitional care.

Figure 1 displays the pre- and post-education scores for all participants. There was some pre-test score variability, with low scores of 20% to as high as 60% (average 36%); however, most post-test scores reached 100%, except for RN1 and RN2 (average 87%). The change in pre- to post-test scores illustrates the overall effectiveness of the training in enhancing staff.

Figure 1

Pre- and Post-Education Scores for All Participants



Limitations

This project had several limitations. First, the small sample size of 10 participants, limits the ability to extend results to broader populations or other healthcare settings. Although the results showed consistent improvement across all knowledge categories; a larger and more diverse sample could better validate the effectiveness of the educational intervention. The project did not collect qualitative data such as participant feedback or

open-ended responses, which could have provided more nuanced insight into how the training impacted staff perceptions, confidence, and understanding.

Differences in baseline knowledge and transitional care experience between nurses and case managers also represent a limitation. Although results were stratified by role, the project did not control individual familiarity with community-based discharge planning or prior exposure to transitional care protocols. These factors likely influenced the degree of knowledge gain. Finally, the initiative was confined to a single crisis stabilization unit without any long-term follow-up to determine whether knowledge gains translated into sustained practice change or improved patient outcomes. Future studies should incorporate longitudinal tracking and multi-site implementation to better evaluate the durability and broader applicability of staff education efforts in transitional care planning.

Impact on Organization

This project has relevance beyond the immediate site. The structured educational intervention demonstrated measurable improvement in staff knowledge. Given the scalability of the intervention, similar educational programs can be adopted. Integrating such training into standard orientation and ongoing professional development, organizations can promote best practices that improve care transitions and provide community resources. The project also supports health equity by equipping frontline staff with the tools needed to address the complex needs of marginalized populations, ultimately leading to more efficient and equitable care delivery.

Recommendations

The project highlights several opportunities for organizational improvement and advancement in healthcare delivery. A key recommendation is to expand the training into a recurring professional development module for all new hires and incumbent staff, ideally incorporated into the orientation process. Additionally, transitioning the training content to an e-learning format would allow flexible access for facilities operating around the clock, ensuring consistency and reach across all shifts. In alignment with the ADDIE model, future iterations of the training should be informed by post-intervention data. Specifically, areas where knowledge scores remained below the 75% threshold, namely Categories 3, 4, and 5, should be prioritized for revision. Enhancing the clarity, depth, or delivery methods for these sections could help close the remaining knowledge gaps and achieve greater educational outcomes.

Another critical recommendation is to expand the number of participants in future implementations. While the initial results among ten participants were promising, evaluating the training's effectiveness across a larger cohort will provide a more comprehensive understanding of its impact. Even if future participants are included through a voluntary process, targeting those most directly involved in discharge planning will be important, but should not be the sole target for future implementations. Additional data could help to validate findings, identify patterns across diverse roles, and guide further refinements to the training.

Developing structured mentorship programs would further support knowledge retention, particularly by pairing less experienced staff with seasoned professionals. Follow-up assessments and qualitative interviews are also recommended to evaluate

long-term knowledge retention and identify emerging educational needs not easily captured using a quantitative measure. Disseminating the findings through internal quality reports, academic presentations, or peer-reviewed publications could foster a culture of continuous improvement and influence broader practice standards.

This project holds potential for promoting positive social change, diversity, equity, and inclusion. By engaging staff regardless of experience level, the intervention ensured equitable access to professional development. Strengthening staff knowledge in transitional care enables them to deliver more inclusive, person-centered services to marginalized groups, supporting more equitable health outcomes and fewer disparities by equipping providers with the tools to address social determinants of health through informed discharge planning. This project contributes to the creation of safer, more inclusive healthcare environments while promoting long-term systemic improvements in care delivery.

Conclusions

This project demonstrated that targeted staff education can improve staff knowledge related to discharge planning and transitional care for individuals experiencing homelessness and mental health instability. The structured intervention led to a measurable increase in staff knowledge, reinforcing evidence from the literature that highlights the value of educational initiatives in supporting care transitions (Campagna et al., 2019; Joo & Liu, 2021). Consistent with findings from Tyler et al. (2023) and Fønss Rasmussen et al. (2021), this project illustrates how training programs that improves knowledge may reduce fragmented care and promote patient-centered outcomes. The results suggest that even a brief, focused educational intervention can foster improved

clinical practices that ultimately support health equity for vulnerable populations. The project further contributes to the growing body of evidence advocating for structured discharge planning education, as seen in the work of Li et al. (2022) and Parry et al. (2021). Integrating this intervention into staff onboarding and offering periodic refresher sessions could sustain the gains achieved and continue to enhance workforce readiness. By addressing social determinants of health and equipping providers with tools for inclusive and collaborative care planning, the project supports positive social change and contributes to more equitable healthcare delivery systems.

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Appendix A

Pre/Post Knowledge Check Questionnaire

Pre-knowledge check questions

1. What is the primary goal of transitional care?

a) To reduce healthcare costs for hospitals.

b) To support patients after discharge and ensure continuity of care.

c) To increase the length of stay in healthcare facilities.

d) To improve the communication between hospital administrators and patients.

Answer: b) To support patients after discharge and ensure continuity of care.

2. Which of the following is a key benefit of transitional care?

a) It prevents the need for patient follow-ups.

b) It helps manage mental health and substance use conditions post-discharge.

c) It focuses solely on improving physical health.

d) It eliminates the need for community-based resources.

Answer: b) It helps manage mental health and substance use conditions post-discharge.

3. How does transitional care improve the quality of life for patients?

a) By reducing their hospital stay duration.

b) By ensuring collaboration with community organizations to provide housing solutions and treatment.

c) By eliminating the need for any post-discharge care.

d) By offering free healthcare services indefinitely.

Answer: b) By ensuring collaboration with community organizations to provide housing solutions and treatment.

4. What is one of the primary responsibilities of case management in transitional care?

a) Administering medication to patients post-discharge.

b) Creating individualized discharge plans and coordinating with healthcare providers.

c) Monitoring patients remotely through telehealth services.

d) Offering emotional support to patients during hospital stays.

Answer: b) Creating individualized discharge plans and coordinating with healthcare providers.

5. What role do nursing staff play in transitional care?

a) Developing individualized discharge plans.

b) Educating patients on managing post-discharge care and reinforcing the importance of transitional care.

c) Coordinating with healthcare providers on patient needs.

d) Managing patient finances after discharge.

Answer: b) Educating patients on managing post-discharge care and reinforcing the importance of transitional care.

6. How can case management and nursing staff work together to improve transitions?

a) By focusing only on the medical aspects of care.

b) By addressing barriers to care, reducing readmissions, and ensuring patient safety.

c) By referring patients to community services without collaborating on follow-up care.

d) By conducting follow-up calls once every six months.

Answer: b) By addressing barriers to care, reducing readmissions, and ensuring patient safety.

7. Why is it important to align resources with existing community services in transitional care?

a) It makes it more difficult for staff to access necessary resources.

b) It streamlines the care process and promotes seamless integration of services into discharge planning, enhancing continuity of care in the community.

c) It increases the cost of patient care services.

d) It limits the types of resources available for patient care.

Answer: b) It streamlines the care process and promotes seamless integration of services into discharge planning, enhancing continuity of care in the community.

8. What is one key resource type mentioned for supporting staff in transitional care?

a) Printed guides with community service contact information.

b) Personal healthcare plans for patients only.

c) Digital apps that replace face-to-face communication.

d) Medication administration charts for patients.

Answer: a) Printed guides with community service contact information.

9. Which of the following is a long-term benefit of strengthening connections to community services for patients?

a) Reducing the overall healthcare budget.

b) Providing stability to patients' lives and enhancing staff confidence in care delivery.

c) Increasing patient dependence on healthcare providers.

d) Limiting access to long-term healthcare services.

Answer: b) Providing stability to patients' lives and enhancing staff confidence in care delivery.

10. How does ongoing education contribute to the success of transitional care initiatives?

a) It reduces the need for patient follow-ups.

b) It reinforces the importance of community services and refines educational approaches based on staff feedback.

c) It eliminates the role of community services in patient care.

d) It focuses solely on physical health needs, disregarding mental health.

Answer: b) It reinforces the importance of community services and refines educational approaches based on staff feedback.

Post-knowledge check questions

1. What is one of the primary responsibilities of case management in transitional care?

a) Administering medication to patients post-discharge.

b) Creating individualized discharge plans and coordinating with healthcare providers.

c) Monitoring patients remotely through telehealth services.

d) Offering emotional support to patients during hospital stays.

Answer: b) Creating individualized discharge plans and coordinating with healthcare providers.

2. How does transitional care improve the quality of life for patients?

a) By reducing their hospital stay duration.

b) By ensuring collaboration with community organizations to provide housing solutions and treatment.

c) By eliminating the need for any post-discharge care.

d) By offering free healthcare services indefinitely.

Answer: b) By ensuring collaboration with community organizations to provide housing solutions and treatment.

3. What is the primary goal of transitional care?

a) To reduce healthcare costs for hospitals.

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c) To increase the length of stay in healthcare facilities.

d) To improve the communication between hospital administrators and patients.

Answer: b) To support patients after discharge and ensure continuity of care.

4. Which of the following is a long-term benefit of strengthening connections to community services for patients?

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c) Increasing patient dependence on healthcare providers.

d) Limiting access to long-term healthcare services.

Answer: b) Providing stability to patients' lives and enhancing staff confidence in care delivery.

5. How can case management and nursing staff work together to improve transitions?

a) By focusing only on the medical aspects of care.

b) By addressing barriers to care, reducing readmissions, and ensuring patient safety.

c) By referring patients to community services without collaborating on follow-up care.

d) By conducting follow-up calls once every six months.

Answer: b) By addressing barriers to care, reducing readmissions, and ensuring patient safety.

6. What role do nursing staff play in transitional care?

a) Developing individualized discharge plans.

b) Educating patients on managing post-discharge care and reinforcing the importance of transitional care.

c) Coordinating with healthcare providers on patient needs.

d) Managing patient finances after discharge.

Answer: b) Educating patients on managing post-discharge care and reinforcing the importance of transitional care.

7. Why is it important to align educational materials with existing resources?

a) It makes it more difficult for staff to learn new information.

b) It streamlines the learning process for staff and promotes easy integration of new information into discharge planning.

c) It increases the cost of staff training programs.

d) It limits the types of resources that can be used for patient care.

Answer: b) It streamlines the learning process for staff and promotes easy integration of new information into discharge planning.

8. Which of the following is a key resource type mentioned for supporting staff in transitional care?

a) Printed guides with community service contact information.

b) Personal healthcare plans for patients only.

c) Digital apps that replace face-to-face communication.

d) Medication administration charts for patients.

Answer: a) Printed guides with community service contact information.

9. How does ongoing education contribute to the success of transitional care initiatives?

a) It reduces the need for patient follow-ups.

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c) It eliminates the role of community services in patient care.

d) It focuses solely on physical health needs, disregarding mental health.

Answer: b) It reinforces the importance of community services and refines educational approaches based on staff feedback.

10. Which of the following is a key benefit of transitional care?

a) It prevents the need for patient follow-ups.

b) It helps manage mental health and substance use conditions post-discharge.

c) It focuses solely on improving physical health.

d) It eliminates the need for community-based resources.

Answer: b) It helps manage mental health and substance use conditions post-discharge.

Appendix B

Staff Education Presentation Slides

Gap in Practice or Problem and Project Question

Gap in Practice or Problem:

Staff not providing all possible resources regarding transitional care and support services to expand the range of options available during discharge planning.

Project Question:

Can effective staff training improve the transition of care and support services' knowledge and application of transition of care practices?

Why is This Project Needed

This project aims to increase staff knowledge of community aftercare services to better support patients during discharge from the Crisis Stabilization Unit (CSU).

It enhances staff understanding of how structured aftercare, including medication support, housing referrals, and behavioral health follow-up, can reduce relapse and improve patient outcomes.

By addressing gaps in discharge planning and aftercare coordination, this project can help reduce readmission rates and lower healthcare costs associated with untreated mental health and substance use conditions.

Evidence From Literature Review

The findings revealed strong evidence supporting the impact of structured transitional care interventions on reducing readmissions and improving patient outcomes (Fønss Rasmussen et al., 2021; Tyler et al., 2023).

Studies by Joo and Liu (2021) and Li et al. (2021, 2022) confirmed that nurse-led and interprofessional discharge education significantly improves continuity of care. Furthermore, Parry et al. (2021) emphasized that patient-centered discharge planning tailored to social needs fosters equitable health outcomes, especially for individuals with unstable housing or psychiatric comorbidities.

Evidence From Literature Review - Continued

Campagna et al. (2019) highlighted that targeted educational programs for staff facilitate smoother care transitions by improving knowledge, confidence, and communication across disciplines.

Hewner et al. (2020) described how transitional care models for high-risk populations can reduce fragmented care and support sustainable discharge practices when staff are properly trained.

Additionally, Fakha et al. (2021) identified factors influencing the success of these innovations, noting that staff engagement and preparedness were critical.

Evidence From Literature Review - Continued

Overall, seven of the reviewed studies were classified as Level I evidence (randomized controlled trials or systematic reviews), two as Level II (quasi-experimental), and one as Level III (non-experimental).

The consistency of findings across these studies offers robust support for implementing evidence-based training to enhance discharge planning. The strength and reliability of this body of literature underscore the need to translate these findings into organizational practice, reinforcing the value of continuous staff development and structured discharge planning to improve care for high-risk populations.

Teaching Methodology

The approach for the staff education project is the ADDIE Model, a structured framework used in instructional design to guide the creation of effective education and training programs. It consists of five phases: Analysis, Design, Development, Implementation, and Evaluation, which help ensure learning experiences are clear, targeted, and outcome-driven (Luo et al., 2024).

How ADDIE was Applied:

Analysis:

Identified a knowledge gap in discharge planning and aftercare coordination among CSU staff.

Teaching Methodology – Continued

Design:

Created educational objectives focused on aftercare benefits, strategies, and interprofessional roles.

Development:

Developed training materials, including a PowerPoint presentation, pre- and post-test multiple-choice questionnaires.

Teaching Methodology – Continued

Implementation:

Two 15-minute in-person PowerPoint presentations were delivered on separate days to staff at the Crisis Stabilization Unit (CSU). A pre-test was given before each presentation, and a post-test was administered immediately after each presentation.

Evaluation:

Used pre- and post-tests to measure knowledge gained and effectiveness of the educational initiative.

Educational Process

A 10-question multiple-choice questionnaire was administered before the educational initiative to assess staff's baseline knowledge.

Staff educational PowerPoint presentation.

The same set of multiple-choice questions, rearranged in order, was used in a post-test following the training to evaluate knowledge gained through the staff education project.

The Importance of Community Aftercare for CSU Patients

Promotes Continuity of Care

Reduces Relapse & Readmissions

Supports Vulnerable Populations

Strengthens Patient Outcomes

Empowers Staff

Practical Tools and Strategies for Connecting Patients to Community Support

Resource Handouts:

Provide printed guides with contact information for housing programs, outpatient behavioral health, MAT services, and peer support groups.

Warm Handoffs:

Directly communicate with aftercare providers before discharge to ensure smooth transitions and appointment scheduling.

Practical Tools and Strategies for Connecting Patients to Community Support - Continued

Bridge Prescriptions:

Coordinate short-term medications and pharmacy access, especially for patients without insurance or stable housing.

Multidisciplinary Planning:

Involve nurses, case management, and providers early in discharge planning to create comprehensive aftercare plans.

Practical Tools and Strategies for Connecting Patients to Community Support - Continued

Culturally Sensitive Approaches:

Integrate trauma-informed care principles to build trust and reduce stigma in aftercare engagement.

Core Elements of Transitional Care:

Discharge planning that includes medication management, mental health support, and housing solutions

Warm handoffs to behavioral health and community providers
Follow-up appointment scheduling before discharge

Key Components of Transitional Care and Interdisciplinary Collaboration- Continued

Interdisciplinary Collaboration:

Registered Nurses:

Monitor symptoms, educate patients, discharge meds, and importance of transitional services

Case managers:

Coordinate housing, transportation, Insurance, and transitional care services

Key Components of Transitional Care and Interdisciplinary Collaboration- Continued

Community Resources Utilized:

- Outpatient behavioral health services
- Medication-Assisted Treatment (MAT) programs
- Transitional housing and shelter systems
- Peer support, mobile outreach, and case management

Why Patients Need Transitional Discharge Planning

Promotes Patient Engagement:

Community aftercare and behavioral health services help clients take an active role in managing their health and recovery.

Builds Structure and Accountability:

Discharge plans that include scheduled appointments, housing referrals, substance use disorder (SUD) programs, and medication management foster stability and confidence.

The Wide Impact of Strong Transitional Care

Supports the Entire Healthcare System

Enhances Interagency Collaboration with local law enforcement and community partners for safer, more streamlined care.

Reduces Strain on Emergency Services

Promotes Ethical, High-Quality Care

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