

11-5-2025

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Walden University

College of Management and Human Potential

This is to certify that the doctoral study by

Darlene M. Taylor

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

Improving Discharge Planning to Reduce Readmissions in Non-Teaching Urban
Hospitals

by

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Integrative Review Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Healthcare Administration

Walden University

November 2025

Abstract

Hospital discharge planning is a critical determinant of patient outcomes, organizational performance, and financial sustainability. Many non-teaching urban hospitals continue to struggle with high readmission rates, especially among socially vulnerable populations such as the homeless. The purpose of this integrative review was to examine discharge planning strategies that would reduce readmissions, enhancing patient throughput, and mitigating financial penalties in non-teaching urban hospitals. The review question focused on effective discharge planning strategies that would improve readmission rates in non-teaching urban hospitals. A systematic integrative review of peer-reviewed studies published between 2020 and 2025 was conducted and 25 quantitative and qualitative studies were appraised using the Johns Hopkins Evidence-Based Practice model to assess quality and strength of evidence. Coleman and Boulton's transitions of care theory provided the conceptual framework to guide thematic analysis and synthesis. Five overarching themes and fourteen subthemes emerged: standardized discharge processes, patient-centered communication, risk identification, social support integration, and outcome monitoring. Evidence demonstrated that structured discharge protocols, interdisciplinary collaboration, early risk stratification, and social support services may reduce readmissions and improved care transitions. Findings suggested that non-teaching urban hospitals can enhance quality and financial performance by embedding evidence-based discharge practices that align with transitions of care principles and positive social change. Practical applications include standardized checklists, leveraging predictive analytics, strengthening social work integration, and using quality improvement measures to reduce readmissions and penalties while improving patient outcomes.

Part 1: Practice-Based Problem

The review focused on the challenges and opportunities in hospital discharge planning, with an emphasis on improving discharge processes to reduce delays, improve patient outcomes, and minimize readmissions. Discharge planning is a vital aspect of healthcare systems that can directly impact clinical, operational, and financial outcomes. Hospital discharge planning is essential for ensuring continuity of care and avoiding preventable readmissions, which burden healthcare systems. However, despite its importance, many hospitals, particularly those serving vulnerable populations, continue to face barriers in implementing effective discharge processes (Pugh et al. 2021). Challenges such as inadequate communication, lack of interdisciplinary collaboration, and insufficient patient-centered approaches often hinder effective discharge planning (Cadel et al., 2022). Other barriers include staffing shortages, inadequate communication among healthcare professionals, and a lack of resources for vulnerable patients (Khatami et al., 2022; Ward-Stockham et al., 2024).

This review sought to understand these challenges and identify evidence-based solutions that can improve discharge planning processes. Furthermore, with the increased prevalence of chronic conditions and the aging population, improving discharge planning is even more critical to reduce healthcare disparities and ensure better outcomes for patients (Gledhill et al., 2023; Heenan, 2023). By addressing the challenges in discharge planning, the review could contribute to positive social change through the reduction of healthcare disparities, particularly for vulnerable populations such as older adults, the socioeconomically disadvantaged, and individuals with chronic conditions (Dimla et al., 2023; Miyawaki et al., 2020). Improved discharge planning can enhance the patient

experience, improve population health outcomes, and reduce unnecessary healthcare costs by minimizing preventable readmissions and promoting timely, well-coordinated transitions (Evangelista et al., 2023; Hunt-O'Connor et al., 2021). Additionally, addressing discharge planning challenges in non-teaching urban hospitals could lead to improvements in resource allocation and care delivery in these often-under-resourced settings (Becker et al., 2021; Nordmark et al., 2022).

Healthcare Administration Problem

Background

Hospital discharge planning is a critical administrative function within healthcare systems, particularly in hospitals, as it ensures that patients transition safely from inpatient care to home or other care settings. The role of discharge planning has evolved significantly over the past several decades, as healthcare systems have recognized its importance in improving patient outcomes, reducing readmissions, and enhancing the overall quality of care (Abdelhalim et al., 2024). In the mid-20th century, discharge planning was primarily focused on logistical tasks, such as arranging transportation, scheduling follow-up appointments, and ensuring basic post-discharge care (Yen et al., 2022). However, over time, as healthcare costs continued to rise and quality improvement initiatives became a central focus, the process began to include a broader range of interdisciplinary activities. In the context of the Affordable Care Act (ACA), discharge planning evolved to align with value-based care models, emphasizing patient-centered, coordinated care (Gledhill et al., 2023). The ACA's push for improved care coordination and reduced readmissions has driven hospitals to enhance their discharge processes,

ensuring that patients receive adequate instructions and support upon discharge (Heenan, 2023).

Despite advancements in the standardization and formalization of discharge planning, hospitals—especially non-teaching urban hospitals—continue to face significant barriers (Ward-Stockham et al., 2024). These hospitals, which often cater to vulnerable and marginalized populations, such as those with chronic conditions, low socioeconomic status, and limited access to resources, face challenges in implementing comprehensive discharge planning processes (Prusaczyk et al., 2019). Staffing shortages, high patient acuity, and limited interdisciplinary collaboration further exacerbate these challenges (Khatami et al., 2022; Nordmark et al., 2022). For instance, non-teaching urban hospitals often struggle to offer the same level of resources, care coordination, and discharge planning as their larger, academic counterparts (Miyawaki et al., 2020). These disparities in resources lead to fragmented discharge processes, which can ultimately affect patient outcomes, including higher readmission rates and prolonged hospital stays (Silvestri et al., 2022).

As a result, the development and implementation of more effective discharge planning processes have become a key focus for healthcare administrators, particularly in non-teaching urban hospitals (Becker et al., 2021). Strategies such as improving interdisciplinary communication, expanding social support networks, and utilizing advanced information technology to enhance discharge processes have been suggested to address the challenges (Bert et al., 2023; Evangelista et al., 2023). Additionally, understanding the unique needs of diverse patient populations and ensuring that discharge planning is tailored to these needs are crucial steps for improving care transitions and

reducing healthcare disparities (Becker et al., 2021; Dimla et al., 2023). Addressing these barriers not only enhances patient outcomes but also aligns with the broader goals of healthcare systems, such as improving population health, enhancing patient experiences, and reducing healthcare costs (Hunt-O'Connor et al., 2021).

Operational Problem

The operational problem centers on the inefficiencies in patient-centered care processes at admission and their impact on discharge planning, leading to potential safety risks for patients. The following studies highlight critical issues contributing to discharge planning failures in urban hospitals. Gledhill et al. (2023) identified the increasing complexity of discharge processes, emphasizing that ineffective coordination and stakeholder involvement create gaps in care transitions. Poor communication and fragmented decision-making at admission contribute to delays and inconsistencies in discharge planning, increasing the risk of unsafe patient discharges. Hunt-O'Connor et al. (2021) highlighted how inadequate discharge planning results in extended hospital stays and higher readmission rates, particularly among older adults. The lack of early and structured discharge planning leads to inefficiencies, causing avoidable hospital utilization and increased strain on healthcare resources. Becker et al. (2021) demonstrated that failures in communication during discharge significantly contribute to preventable readmissions. A lack of standardized discharge communication processes leads to missed critical information, increasing the likelihood of patients returning to the hospital due to unresolved medical or social needs. Collectively, these sources underscore the persistent challenges in urban hospital discharge planning, particularly the lack of structured, coordinated processes that begin at admission. Ineffective communication, inconsistent

planning, and resource constraints contribute to patient safety risks and higher readmission rates, reinforcing the need for systemic improvements in hospital discharge procedures.

Ideal State of Operations

The ideal state of discharge planning in healthcare is defined by seamless, patient-centered processes that prioritize effective communication, coordination, and collaboration among all stakeholders. This proactive approach begins early in the hospitalization process—ideally within 24 to 48 hours of admission—and involves the patient, family members, healthcare providers, and social workers to address both medical and social needs (Hunt-O'Connor et al., 2021). A well-functioning discharge planning system is supported by interdisciplinary teams, including physicians, nurses, case managers, and social workers, who work together to develop individualized discharge plans that ensure a smooth transition to post-hospital care (Alonso et al., 2023).

A critical component of this ideal state is the integration of technology and data-sharing systems that facilitate efficient information transfer between healthcare settings, ultimately improving continuity of care (Chen et al., 2024). Predictive analytics and risk assessment tools, such as the Risk Assessment of Complex Discharge Index, have been shown to identify up to 90% of high-risk patients early in their hospital stay, allowing for timely interventions and more effective discharge planning (Bert et al., 2023). The goal is to reduce delays, prevent readmissions, and improve overall patient outcomes while enhancing patient satisfaction.

Despite ongoing efforts to improve discharge planning, hospital readmission rates remain a significant challenge. The Centers for Medicare & Medicaid Services (CMS,

2019) report an overall unadjusted 30-day readmission rate of 14.7% among all beneficiaries. Similarly, the Healthcare Cost and Utilization Project (HCUP) identified an overall readmission rate of 14.0 per 100 index admissions, with Medicare patients experiencing the highest rate at 16.9% (HCUP, 2022). Within the specific context of the non-teaching urban hospital under consideration, the Medicare readmission rate stands at 15.3%, slightly above the national average (CMS Care Compare, 2025). This discrepancy underscores the need for targeted interventions to align with or surpass national benchmarks.

Key performance indicators (KPIs) serve as essential measures of an effective discharge planning process. Reducing the Medicare readmission rate to below 14% would bring performance in line with national standards and reflect improved patient transitions. Additionally, optimizing the length of stay (LOS) while maintaining safe discharge practices is critical, with studies suggesting that an appropriate LOS for general medical patients falls within the range of four to five days (Hunt-O'Connor et al., 2021). Ensuring that post-discharge follow-up occurs within 7 days for at least 80% to 90% of patients further supports readmission prevention efforts. Patient satisfaction, as measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, is another vital metric, with a target of exceeding 85% positive responses for discharge information and care transitions (CMS, 2019).

Achieving these outcomes requires a shift toward a data-driven, patient-centered approach that leverages predictive analytics, interdisciplinary collaboration, and standardized discharge planning practices. By addressing existing gaps in discharge processes and aligning with evidence-based benchmarks, healthcare organizations can

enhance patient safety, improve outcomes, and reduce the financial burden associated with preventable hospital readmissions.

Professional Practice Gap Statement

Non-teaching urban hospitals face significant challenges in discharge planning due to staffing shortages, limited interdisciplinary communication, and high patient acuity levels, leading to fragmented care transitions and increased readmission rates (Evangelista et al., 2023; Ward-Stockham et al., 2024; Yen et al., 2022). These operational inefficiencies contribute to worse patient outcomes, extended hospital stays, and avoidable healthcare costs. Hospitals with inadequate discharge planning can experience 30-day readmission rates exceeding 20%, particularly among high-risk populations such as Medicare patients and those with chronic conditions (CMS, 2019). Poor discharge coordination leads to prolonged hospital stays, with patients remaining in acute care settings 1-2 days longer than necessary, increasing hospital congestion and costs (HCUP, 2022). Hospitals with ineffective discharge planning report HCAHPS discharge-related satisfaction scores below 70%, indicating a lack of clarity and preparedness for post-hospital care (CMS, 2019). Without structured follow-up processes, fewer than 50% of patients receive timely follow-up within seven days post-discharge, increasing the risk of complications and readmissions (Evangelista et al., 2023).

In contrast, the ideal state of operation involves a comprehensive, patient-centered discharge planning process supported by interdisciplinary collaboration, early planning, and robust communication systems, ensuring effective care transitions and reducing readmissions (Bert et al., 2023; Hunt-O'Connor et al., 2021). Hospitals with optimized

discharge planning demonstrate the following outcomes: Best-performing hospitals achieve 30-day readmission rates below 12%, demonstrating strong discharge planning and post-discharge support (HCUP, 2022). Efficient discharge coordination reduces LOS by 0.5 to 1.5 days, optimizing bed utilization without compromising patient outcomes (Bert et al., 2023). Hospitals with effective discharge processes report HCAHPS discharge satisfaction scores exceeding 85%, reflecting better communication and patient preparedness for post-hospital care (CMS, 2019). Ideally, 80-90% of discharged patients receive follow-up within seven days, significantly reducing complications and readmissions (Yen et al., 2022).

By identifying operational gaps and implementing evidence-based best practices, non-teaching urban hospitals can increase the efficiency of discharge processes. Furthermore, these measures may contribute to improved patient outcomes and reduce the financial impact associated with elevated readmission rates.

Summary of Evidence

The specific healthcare administration problem in non-teaching urban hospitals is the inefficiency of discharge planning processes due to staffing shortages, limited interdisciplinary communication, and high patient acuity levels. These hospitals often serve vulnerable populations, including older adults, the chronically ill, and socioeconomically disadvantaged individuals, which exacerbates the challenges in discharge planning (Ward-Stockham et al., 2024). Research consistently highlights that fragmented communication and lack of coordinated efforts in discharge planning led to delayed discharges, poor patient outcomes, and high readmission rates (Evangelista et al., 2023; Gledhill et al., 2023). Furthermore, hospitals face barriers in managing the

complexity of care transitions for these populations, including inadequate access to post-discharge support and community resources (Khatami et al., 2022).

The practice gap is evident as many hospitals lack effective strategies for integrating interdisciplinary teams and creating streamlined discharge processes that accommodate patient-specific needs, resulting in inefficient care transitions and readmissions (Becker et al., 2021; Prusaczyk et al., 2019). Addressing this gap requires developing evidence-based discharge planning frameworks that focus on early intervention, team collaboration, and patient-centered approaches to improve care transitions and reduce readmissions.

Purpose of the Integrative Review

The purpose of this integrative review was to examine how discharge planning strategies implemented by healthcare administrators in non-teaching urban hospitals impact hospital readmission rates, patient throughput, and financial outcomes. This review focused on discharge practices within the context of urban hospital settings. This review also examined the relationship between these operational challenges and the effectiveness of discharge planning in reducing readmissions, improving patient outcomes, and enhancing overall hospital efficiency. By addressing the systemic barriers that disproportionately affect vulnerable populations, including the socioeconomically disadvantaged, this review aims to highlight the social determinants of health that exacerbate discharge planning difficulties and offer insights into strategies that promote equitable, patient-centered care transitions.

Integrative Review Question

The review question for this integrative review was “What are effective discharge

planning strategies that would improve readmission rates in non-teaching urban hospitals?” This question focuses on the healthcare administration problem of discharge planning processes in non-teaching urban hospitals. These hospitals face significant operational challenges, including staffing shortages, limited interdisciplinary communication, and high patient acuity levels, all of which contribute to fragmented care transitions and increased readmission rates (Evangelista et al., 2023; Ward-Stockham et al., 2024; Yen et al., 2022). Inefficiencies in discharge planning often result in delayed discharges, higher readmission rates, lower patient satisfaction scores, further straining healthcare resources and impacting overall quality of care (CMS, 2019; HCUP, 2022).

By exploring evidence-based discharge planning strategies, this review aimed to provide healthcare leaders with operational solutions for optimizing patient care transitions, particularly for vulnerable populations such as homeless patients and individuals with complex medical and social needs (Bert et al., 2023; Hunt-O’Connor et al., 2021). Effective discharge planning models emphasize early intervention, interdisciplinary collaboration, standardized protocols, and robust post-discharge support, all of which have been shown to reduce readmission rates and improve clinical outcomes (Becker et al., 2021; Gledhill et al., 2023). By identifying and implementing these best practices, non-teaching urban hospitals can enhance care coordination, improve patient experiences, and achieve better healthcare system efficiency while reducing avoidable hospital readmissions.

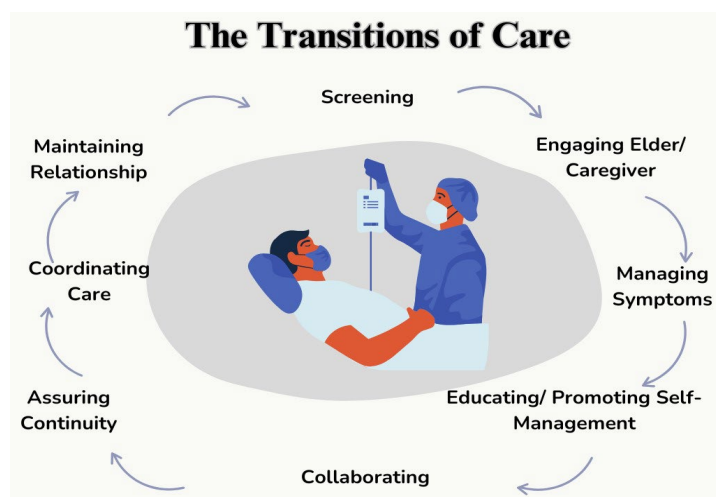
Theoretical and/or Conceptual Framework

The transitions of care theory by Coleman and Boult (2003) provides a structured framework for understanding and improving patient transitions across healthcare settings,

emphasizing interdisciplinary collaboration, patient engagement, and continuity of care (see Figure 1). This framework is particularly relevant for studying discharge planning in non-teaching urban hospitals, where fragmented transitions often contribute to higher readmission rates and poor patient outcomes.

Figure 1

Transitions of Care Model



Note. Adapted from "Improving the Quality of Transitional Care for Persons with Complex Care Needs" by E. A. Coleman and C. Boulton, 2003, Journal of the American Geriatrics Society, 51(4), p. 556 (<https://doi.org/10.1046/j.1532-5415.2003.51186.x>)

Recent research has demonstrated the effectiveness of this framework in reducing hospital readmissions and improving care coordination. For instance, Evangelista et al. (2023) found that structured discharge planning models based on the transitions of care theory led to a 15% reduction in 30-day readmissions among patients with complex medical needs. Similarly, Heenan (2023) reported that interdisciplinary discharge interventions grounded in this theory resulted in higher patient satisfaction scores and improved post-discharge follow-up rates. Further supporting its applicability, Gonzalez et al. (2022) applied the transitions of care framework to evaluate hospital-to-home care

models, demonstrating that early discharge planning and patient education reduced preventable rehospitalizations by 18%. Additionally, Nguyen and Patel (2023) highlighted the role of technology-enabled transitions of care, showing that electronic health record integration and real-time provider communication improved care continuity and reduced medication errors by 22%.

By integrating this framework into the discharge planning processes of non-teaching urban hospitals, healthcare leaders can enhance patient-centered care, streamline interdisciplinary collaboration, and optimize post-discharge support systems, ultimately improving patient outcomes and reducing avoidable hospital readmissions. This framework guided the review in identifying evidence-based strategies to improve discharge planning processes in non-teaching urban hospitals, particularly for vulnerable populations. The review also explored how improving discharge planning can address social determinants of health by ensuring equitable access to follow-up care, patient education, and community resources.

Part 2: Literature Review, Quality Appraisal, and Analysis

Literature Search Strategy

To address the review question on the effectiveness of discharge planning interventions in reducing hospital readmission rates, a comprehensive and systematic search of relevant literature was conducted across several major academic databases. The databases accessed included PubMed, CINAHL, Scopus, Embase, Web of Science, and Google Scholar, as well as other specialized healthcare databases such as Cochrane Library and ProQuest. These databases were selected for their broad coverage of medical, nursing, and interdisciplinary literature related to healthcare management, discharge planning, and hospital readmissions.

The search strategy used a combination of key terms, synonyms, and Boolean operators to comprehensively identify relevant articles (see Table 1). Core terms included discharge planning, hospital readmissions, patient education, care coordination, and high-risk patients, with synonyms like *post-discharge care* and *patient discharge management* to capture varied terminology. Boolean operators refined the search:

- **AND** combined terms (e.g., “discharge planning” AND “hospital readmissions”),
- **OR** broadened results with synonyms (e.g., “patient education” OR “self-management”),
- **NOT** excluded irrelevant groups (e.g., NOT “pediatric patients”).

Advanced techniques such as quotation marks (e.g., “hospital discharge planning”), wildcards (e.g., readmission*), and field restrictions (Title/Abstract) in databases like PubMed and CINAHL further improved precision. This strategy yielded a diverse set of

articles from disciplines including nursing, social work, and healthcare management, focusing on discharge planning’s role in reducing readmissions, especially among high-risk populations like the elderly and chronically ill.

Table 1

Inclusion and Exclusion Criteria

Inclusion	Exclusion
Systematic reviews, randomized controlled trials (RCTs), observational studies, cohort studies, and qualitative studies	Studies unrelated to discharge planning or readmissions
Adult patients (18+ years)	Patients under 18 years old
Discharge planning interventions, including patient education, care coordination, and follow-up care	Studies not focused on discharge planning, readmission prevention, or patient education related to post-discharge
hospital readmissions, re-hospitalization rates, post-discharge complications, or care transitions	Studies other than those in hospital settings
urban, non-teaching hospitals	Studies published in languages other than English
English language	Studies older than 5 years
Studies published in the last 5 years (2019–2025)	Studies without relevant information
quantitative, qualitative, or mixed methods	

Quality Appraisal

The appraisal process evaluated 25 high-quality sources published between 2019 and 2025, capturing recent developments and best practices in discharge planning, with a specific emphasis on reducing hospital readmissions in non-teaching urban hospitals. The reviewed literature spans systematic reviews, randomized controlled trials, qualitative studies, predictive modeling, and retrospective cohort studies, offering a comprehensive view of discharge strategies and their outcomes.

Studies ranged from systematic reviews (e.g., Gonçalves-Bradley et al., 2022) and

qualitative interviews (e.g., Gledhill et al., 2023; Schjødt et al., 2022), to machine learning–based predictive models (Oh et al., 2025) and quasi-experimental studies (Heo et al., 2023). This methodological diversity strengthened the review’s evidence base and allowed triangulation of findings across different research traditions. Most studies targeted adults, particularly elderly individuals (Adams & Carmichael, 2020; Dimla et al., 2023) or high-risk groups such as patients with chronic illness, SLE, or homelessness (Liu et al., 2024; Miyawaki et al., 2020). The inclusion of vulnerable and marginalized populations ensures that discharge planning interventions are evaluated through an equity-focused lens.

A notable proportion of studies took place in non-teaching urban hospitals, directly aligning with the review’s practice setting (e.g., Rachoin et al., 2024). Others included broader hospital contexts but yielded transferable findings relevant to urban institutions. The evidence reviewed supports the integration of structured discharge planning into hospital workflows, aligning with Donabedian’s quality of care framework—which evaluates healthcare through structure, process, and outcomes—and the transitions of care theory, which emphasizes continuity and coordination across settings. Themes such as interdisciplinary collaboration, patient involvement, communication, and risk stratification reflect the framework’s focus areas.

Thematic Analysis of Literature

A thematic analysis was conducted on the 25 selected studies to identify patterns and categories that addressed the review question regarding effective discharge planning strategies in non-teaching urban hospitals. The analysis followed an inductive coding process, starting with open coding of key concepts from each article, followed by the

organization of these codes into higher-order themes and subthemes (see Table 2). After clustering the initial codes, five major themes emerged, each with relevant subthemes (see Table 3).

Table 2

Initial Commonly Used Codes Extracted from the Literature (see Appendix D)

Timeliness of discharge planning	Patient education and health literacy
Nurse-led interventions	Coordination with community resources
Risk stratification tools	Social determinants of health
Patient and caregiver engagement	Interdisciplinary discharge rounds
Social work collaboration	Transitional care models
Use of EHR data and predictive analytics	Post-discharge follow-up
Communication at transition points	Readmission penalties
	Nonmedical discharge barriers

Table 3

Final Themes and Subthemes Relevant to this Integrative Review

Main Themes	Subthemes
Standardize Discharge Planning Processes	<ul style="list-style-type: none"> • Develop and implement clear discharge protocols and checklists to ensure consistency. • Empower nurse-led discharge teams to coordinate and drive quality. • Facilitate interdisciplinary discharge rounds to promote communication and accountability.
Enhance Patient-Centered Communication	<ul style="list-style-type: none"> • Improve health literacy and ensure clear patient understanding of discharge instructions. • Engage patients and families in collaborative discharge decision-making. • Use teach-back methods and shared instructions to confirm comprehension.
Advance Risk Identification and Prediction	<ul style="list-style-type: none"> • Integrate EHR-based risk scoring and discharge triggers into workflows. • Utilize machine learning tools for accurate readmission risk prediction. • Incorporate social and clinical complexity indexes to identify high-risk patients.
Strengthen Social Support Systems	<ul style="list-style-type: none"> • Deploy social workers proactively to address housing,

	<p>transportation, and social needs.</p> <ul style="list-style-type: none"> • Coordinate post-discharge outpatient services to ensure continuity of care. • Tailor interventions to mitigate the impact of homelessness and social vulnerabilities.
Optimize Outcome Monitoring and Quality Improvement	<ul style="list-style-type: none"> • Leverage readmission and outcome data to continuously refine discharge processes. • Implement continuous quality improvement initiatives focused on readmission reduction and penalty avoidance.

Conclusion

The thematic analysis revealed that discharge planning in non-teaching urban hospitals requires a multidimensional strategy. Core practices must include standardized workflows, robust communication, risk-based planning, and integration of social support services. These themes support both Donabedian's framework and the transitions of care theory by linking structure, process, and outcome with patient-centered transition planning.

Part 3: Presentation of Results

This integrative review was designed to examine the effectiveness of discharge planning strategies on reducing hospital readmissions, improving patient throughput, and preserving financial sustainability—particularly within non-teaching urban hospitals serving vulnerable populations, including those experiencing homelessness. Discharge planning in these environments often involves complex interactions among clinical, operational, and social systems. The review analyzed recent, high-quality literature (2020–2025) to identify actionable patterns in care practices and policies that promote successful transitions.

Findings were organized into five overarching and interconnected main themes:

1. Standardized Discharge Planning Processes
2. Enhanced Patient-Centered Communication
3. Advanced Risk Identification
4. Strengthen Social Support
5. Optimize Outcome Monitoring

These themes, and their corresponding subthemes, emerged from a structured thematic analysis and reflected the multi-dimensional nature of transitional care. The analysis demonstrated that discharge planning is not a single event but an evolving, interprofessional, and patient-driven process. Together, the findings provide healthcare administrators with evidence-based and immediately actionable strategies to optimize discharge planning, particularly in resource-limited, urban settings.

Theoretical Foundation

This review is grounded in the transitions of care theory, originally developed by

Coleman and Boulton (2003). The theory offers a practical framework for improving care continuity during vulnerable transitions such as hospital discharge. It emphasizes four key domains: patient and caregiver engagement, medication self-management, follow-up with outpatient services, and recognition of worsening health symptoms (Coleman & Boulton, 2003). The current evidence aligns closely with this framework, showing that targeted, cross-disciplinary interventions reduce avoidable readmissions and promote safer, more effective transitions.

Thematic Map

A thematic concept map (see Appendix E) illustrates the relationship between each main theme, its subthemes, and their relevance to the review question. The map visually represents how standardized processes, effective communication, risk prediction, social support, and feedback mechanisms work together to reduce readmissions, improve patient throughput, and mitigate revenue loss. Interconnections—such as the link between AI-based risk scoring and interdisciplinary discharge planning—show that effective discharge planning requires a coordinated, integrated approach.

Explanation of Themes and Subthemes

Theme 1: Standardized Discharge Planning Processes

Consistent, protocol-driven discharge workflows foster reliability, improve care coordination, and ensure smooth patient transitions (Becker et al., 2021).

1A. Nurse-Led Discharge Planning as a Quality Driver

Nurse-led initiatives enhance patient education, streamline coordination, and strengthen post-hospital care connections, particularly when nurses lead interdisciplinary communication and reinforce follow-up instructions (Sakashita et al., 2025).

1B. Protocolized and Interdisciplinary Workflow

Structured interdisciplinary rounds promote efficiency, clarify roles, and ensure accountability for discharge execution, leading to fewer delays and safer transitions (Vundi et al., 2023).

Theme 2: Enhanced Patient-Centered Communication

Clear, tailored communication empowers patients and caregivers to actively participate in recovery, reducing preventable readmissions (Oh et al., 2023).

2A. Literacy-Responsive Discharge Education

Customized education materials tailored to literacy and language levels improve comprehension, foster patient confidence in self-care, and reduce post-discharge complications (Yen & Leasure, 2019).

2B. Engagement Through Shared Decision-Making

Collaborative planning with patients and families strengthens trust and promotes adherence to care plans, consistent with evidence that active involvement lowers 30-day readmission rates (Fleming et al., 2023).

Theme 3: Advanced Risk Identification

Proactive risk prediction enables timely, targeted interventions that improve care transitions and prevent avoidable readmissions (Huang et al., 2022).

3A. AI-Enhanced Risk Prediction

Data-driven algorithms, including machine learning and graph neural networks, accurately identify high-risk patients and outperform traditional risk indices (Huang et al., 2022; Rajkomar et al., 2019).

3B. Early-Initiation Models

Beginning risk assessment at admission enables discharge planning to start early, ensuring readiness and aligning resources well before the discharge date (Park-Clinton et al., 2023).

Theme 4: Strengthened Social Support

Integrating community and clinical resources enhances continuity of care beyond the hospital setting and is especially critical for vulnerable or homeless populations (Balaž Gilja, 2023).

4A. Multidisciplinary Post-Discharge Clinics

Coordinated medical, social, and behavioral follow-up reduces gaps in care and improves recovery by addressing social determinants such as transportation, housing, and access to ongoing treatment (MyMichigan Health, 2025).

Theme 5: Optimized Outcome Monitoring and Discharge Timing

Real-time performance tracking aligns discharge timing with patient readiness and ensures system efficiency (Rachoin et al., 2024).

5A. AI-Guided Discharge Readiness Tools

Intelligent readiness scoring systems integrate clinical indicators with operational data, aligning discharge timing with safety and flow improvements (Zhao et al., 2023).

5B. Continuous Readmission Data Review

Ongoing review of readmission patterns drives continuous quality improvement, reduces penalties, and sustains high standards of care (Joynt Maddox et al., 2021).

Interpretation of Findings

Theme 1: Standardized Discharge Planning Processes

Standardization is foundational for safe transitions, aligning with the transitions of care theory's emphasis on consistent engagement and continuity beyond the inpatient stay. Additionally, these transitions of care strategies facilitate patient progress by providing the structure necessary to promote consistent processes that potentially avoid readmissions and increase quality care (Evangelista et al., 2023). Examples of standardized processes include structured checklists and protocols to reduce variability and strengthen accountability in care transitions (Becker et al., 2021).

Nurse-Led Discharge Planning as a Quality Driver

Nurse-led approaches enhance patient comprehension and streamline coordination with community services. Evidence shows nurse-driven initiatives significantly reduce readmission risk, reflecting the theory's view that empowering caregivers improves continuity (Sakashita et al., 2025).

Protocolized and Interdisciplinary Workflow

Interdisciplinary rounds promote collaboration across disciplines, ensuring patients' clinical, social, and functional needs are addressed. This echoes the theory's call for integration of all care dimensions during vulnerable transitions (Vundi et al., 2023).

Theme 2: Enhanced Patient-Centered Communication

Communication quality directly supports the theory's domain of patient and caregiver engagement. Findings demonstrate that tailored, interactive communication empowers patients to manage recovery more effectively (Oh et al., 2023). Effective patient-centered communication serves as a fundamental component within the

transitions of care framework, and its integration into discharge planning processes at non-teaching urban hospitals can be facilitated through strong leadership capabilities (Coleman & Boulton, 2003).

Literacy-Responsive Discharge Education

Tools matched to literacy and language reduce confusion and strengthen self-care confidence. Techniques such as teach-back have lowered 30-day readmission rates by nearly half, confirming that comprehension is a critical determinant of safe transitions (Yen & Leasure, 2019).

Engagement Through Shared Decision-Making

When patients and families actively participate in discharge planning, adherence improves. This mirrors the theory's framing of patients as partners in transitions, not passive recipients, ensuring higher trust and cooperation (Oh et al., 2023).

Theme 3: Advanced Risk Identification and Prediction

Risk prediction aligns with the theory's principle of early recognition of deterioration and tailored follow-up. Predictive approaches enable earlier interventions and more accurate targeting of resources (Huang & Fleming, 2022). The process of identifying patient risk factors starts at admission and continues throughout hospitalization. When limitations and patient capabilities are assessed, interdisciplinary discharge interventions based on the transitions of care framework can support patient satisfaction and increase follow-up rates (Heenan, 2023).

AI-Enhanced Risk Prediction

Machine learning and neural network algorithms outperform traditional indices by integrating complex patient data. These innovations extend the discipline by

operationalizing precision planning, a direct application of the theory's call for individualized care (Rajkomar et al., 2019).

Early-Initiation Models

Starting risk assessments at admission accelerates planning and mobilizes resources earlier in the hospital stay. This anticipatory model reflects the theory's focus on proactive engagement to prevent breakdowns during transitions (Kang et al., 2025).

Theme 4: Strengthened Social Support Systems

Addressing social determinants fulfills the theory's domain of tailored, patient-specific interventions across settings. Without adequate social supports, transitions often fail despite strong clinical readiness (Balaž Gilja, 2023). The transitions of care framework highlights the importance of effective collaboration among patients, healthcare professionals, and family members to ensure optimal care coordination and enhance discharge preparedness. Achieving consensus on plans that facilitate robust social support systems is critical for advancing best practices (Evangelista et al., 2023).

Multidisciplinary Post-Discharge Clinics

These clinics bridge inpatient and outpatient care by combining medical, behavioral, and social services, helping patients sustain recovery. Their integrative design embodies the theory's call for cross-setting continuity and has been shown to reduce readmissions in high-risk groups (MyMichigan Health, 2025).

Theme 5: Optimized Outcome Monitoring and Quality Improvement

Ongoing monitoring supports the theory's system adaptation principle, ensuring hospitals learn from patient outcomes and refine strategies continuously. Data-driven reviews align discharge timing with both patient readiness and organizational efficiency

(Benjamin et al., 2024). Ensuring quality by fostering collaboration and continuity of care is fundamental to the transitions of care framework, which focuses on employing evidence-based strategies and rigorously monitoring their effectiveness through systematic quality controls (Coleman & Boulton, 2003).

AI-Guided Discharge Readiness Tools

Intelligent scoring systems align clinical indicators with hospital workflows, improving both throughput and patient safety. This extends the discipline by demonstrating how operational flow can integrate with theory-based patient readiness measures (Zhao et al., 2023).

Continuous Readmission Data Review

Iterative analysis of readmission patterns enables continuous quality improvement and sustained accountability. This practice affirms the theory's view that patient outcomes should directly inform system refinements (Joynt Maddox et al., 2021).

Conclusion

Most significantly, the findings extend professional knowledge by identifying emerging innovations—such as machine learning algorithms for readmission risk prediction and EHR-based discharge triggers—that offer precision and efficiency improvements in planning (Rajkomar et al., 2019). While these tools are still evolving, their incorporation into discharge workflows represents a shift toward predictive, data-driven care that complements traditional clinical judgment (Benjamin et al., 2024). Additionally, outcome monitoring using real-time data for continuous quality improvement reflects an important advancement in hospital accountability and organizational learning (Joynt Maddox et al., 2021; Zhao et al., 2023).

Viewed through the lens of the transitions of care theory (Coleman & Boulton, 2003), the synthesis illustrates that effective discharge planning must be multidimensional anchored in-patient empowerment, continuity across settings, early risk identification, and robust communication. The theory's principles were affirmed and operationalized across themes, reinforcing its relevance as a guiding framework for healthcare administrators.

Part 4: Recommendations for Professional Practice and Implications for Social Change

Part 4 translates the Section 3 thematic findings into distinct, actionable recommendations for non-teaching urban hospitals. As illustrated in the thematic map (Appendix E) and detailed in the thematic matrix (Appendix D), the themes—standardized processes, patient-centered communication, risk identification, social support, outcome monitoring, nurse-led transitional care, and caregiver inclusion—are operationalized here. Each recommendation explicitly aligns with Coleman and Boulton's (2003) transitions of care theory, which emphasizes empowerment, continuity, interdisciplinary collaboration, and accountability across settings.

Recommendation 1: Standardize Discharge Processes with Lean/Six Sigma & Checklists

Transitions of care theory stresses continuity and accountability across handoffs; standard work reduces variation at the moment of transition. Applying Lean and Six Sigma principles to discharge mapping, standardized order sets, and checklists decreases bottlenecks and defects while ensuring consistent patient education and follow-up. Evidence demonstrates that structured transitional models significantly lower readmissions when coordination, continuity, and education are emphasized (Adams & Carmichael, 2020; Becker et al., 2021; Berthelsen et al., 2023; Ward-Stockham et al., 2024).

Programs that have operationalized these strategies highlight the value of embedding standardization into everyday workflows. For example, unit-based discharge bundles that combined structured order sets, medication reconciliation, and mandatory discharge checklists reduced 30-day hospital returns and improved patient

comprehension of instructions (Adams & Carmichael, 2020; Becker et al., 2021).

Another illustrative initiative applied Lean Six Sigma to discharge mapping, redesigning workflows to eliminate redundant steps and create a single accountable case manager for each patient. This intervention shortened discharge delays and improved continuity, which directly correlated with lower readmission rates (Berthelsen et al., 2023).

Similarly, interdisciplinary discharge rounds piloted in urban hospitals demonstrated success by integrating physicians, nurses, social workers, and pharmacists into one standardized daily transition process, thereby reducing variation and strengthening accountability at handoff points (Ward-Stockham et al., 2024). Collectively, these models show that applying structured processes not only aligns with transition of care principles but also ensures reliability and quality in transitional care.

How to implement:

- 1) Map current-state discharge flow (value-stream) and identify delay/defect drivers.
- 2) Co-design a single hospital-wide discharge checklist and order set with nursing, medicine, pharmacy, and case management.
- 3) Require teach-back documentation, medication reconciliation, and scheduled follow-up prior to discharge sign-off.
- 4) Monitor cycle time from discharge order to departure and iterate monthly via a QI huddle.

Table 4

Ownership of Checklists that Facilitate Discharge Planning

Process Element	Owner	Measure
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Discharge checklist use	Unit RN	% charts with completed checklist
Med reconciliation	Pharmacist	% reconciled meds before discharge
Follow-up scheduled	Case manager	% pts with appt \leq 7 days

Recommendation 2: Embed Patient-Centered Communication & Health Literacy (Teach-Back)

Transition of care centers on patient activation and self-management, emphasizing the patient’s role in navigating care transitions with confidence and accountability.

Health-literate communication strategies—such as teach-back, simplified written instructions, and co-created action plans—are critical to ensuring comprehension and safe self-care after discharge. Evidence consistently shows that systematic use of teach-back reduces 30-day readmissions, improves medication adherence, and enhances patient safety (Hernandez et al., 2021; Oh et al., 2021; Schoenfeld et al., 2022).

Programs that embedded these methods demonstrate measurable success. For example, anticipatory guidance combined with teach-back protocols not only improved discharge literacy but also reduced avoidable emergency department (ED) visits within 30 days (Hernandez et al., 2021; Schoenfeld et al., 2022). Another program integrating nurse-led action planning and teach-back for patients with multiple chronic conditions demonstrated improved medication reconciliation accuracy and higher rates of follow-up appointment attendance (Oh et al., 2021). These initiatives illustrate how embedding structured, health-literate communication into discharge processes operationalizes transition of care principles by promoting patient activation, continuity of care, and sustained self-management across transitions.

How to implement:

- 1) Train nurses and coaches in teach-back, plain-language scripting, and culturally responsive communication.
- 2) Create condition-specific “red flag” action plans and pictorial med lists at ≤6th-grade reading level.
- 3) Require documented teach-back success criteria before discharge order release.
- 4) Provide multilingual after-visit summaries and a phone/text line for questions within 72 hours.

Table 5*Communication Elements to Support Patient Activation and Safe Transitions*

Communication Element	Owner	Measure
Teach-back completion	RN/Coach	% pts with documented teach-back
Plain-language AVS	Unit RN	% AVS at ≤6th-grade level
Red-flag plan	Coach	% pts with personalized red flags

Recommendation 3: Implement Predictive Risk Stratification (Clinical + Social Risk)

ToC calls for proactive continuity, emphasizing early identification of high-risk patients to ensure timely and tailored transitional support. Integrating electronic health record (EHR)–based clinical scores with social risk indicators—such as housing instability, transportation barriers, and caregiver availability—enables hospitals to better anticipate patient needs. When layered with machine learning (ML) models, these approaches improve prediction accuracy and help target limited resources toward patients most at risk for adverse outcomes. Systematic reviews confirm that ML models enhance readmission prediction accuracy compared with traditional tools (Zhao et al., 2023).

Programs that operationalized this approach demonstrate measurable improvements in outcomes. For example, a social-clinical risk triage model combined with early transition coach assignment significantly reduced preventable hospital returns by ensuring that both medical complexity and social vulnerabilities were addressed in discharge planning (Gonzalez et al., 2022; Zhao et al., 2023). Similarly, programs embedding ML algorithms into discharge triggers enabled case managers to intervene earlier in the admission, prioritizing patients with the highest composite risk scores for enhanced education and post-discharge follow-up. These initiatives illustrate how proactive risk identification not only aligns with ToC principles of continuity and accountability but also transforms predictive insights into actionable, patient-centered transitional care.

How to implement:

- 1) Build an EHR risk score that includes social factors (e.g., homelessness, food insecurity).
- 2) Flag top quintile risk daily and enroll in enhanced transitions (coach, pharmacist consult, 48-hour call).
- 3) Create a bedside “complex discharge index” to escalate barriers early (Bert et al., 2023).
- 4) Evaluate calibration and disparities quarterly; adjust features to avoid algorithmic bias.

Table 6

Risk Identification and Workflow Accountability for Transitional Care

Risk Workflow	Owner	Measure
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Daily risk flag	Data analyst	% high-risk flagged by noon
Enhanced pathway use	Case manager	% flagged on enhanced pathway
Bias audit	QI lead	Calibration across subgroups

Recommendation 4: Integrate Social Work & Community Health Workers to Address SDOH

ToC extends beyond hospital walls, recognizing that addressing social determinants of health is essential to stabilizing the post-discharge environment and sustaining recovery. Embedding social workers and community health workers (CHWs) into discharge planning—while linking patients with formal community partnerships for housing, transportation, and food resources—strengthens continuity and promotes equity (Cormack et al., 2020; Doran et al., 2020).

Programs that operationalized these strategies highlight how transitional care models can be adapted for vulnerable populations. For example, bridge clinics paired with structured post-discharge outreach were successful in improving linkage to care for patients with substance use disorders (SUD) and those with complex social needs, ensuring that patients not only had appointments scheduled but also received assistance with transportation and medication access (Incze et al., 2024).

Another illustrative program integrated hospital-based social workers directly into discharge teams, with CHWs conducting follow-up home visits to reinforce discharge instructions and connect patients to community-based housing and food services. This model reduced ED revisits and enhanced care continuity for patients experiencing homelessness (Cormack et al., 2020). Similarly, partnerships between urban hospitals and

community transportation networks enabled high-risk patients to attend follow-up visits at significantly higher rates, contributing to lower readmissions and more equitable access to care (Doran et al., 2020). Collectively, these programs demonstrate that embedding social supports within transitional care aligns directly with ToC’s principles of continuity, accountability, and patient empowerment across settings.

How to implement:

- 1) Screen every high-risk patient for housing, transport, food, and caregiver support; document needs.
- 2) Establish MOUs with housing agencies, ride services, and food banks; create warm-referral protocols.
- 3) Deploy CHWs for home-based coaching and appointment navigation in the first 14 days.
- 4) Track closed-loop referrals and time-to-service activation.

Table 7

Social Determinants of Health Interventions to Support Post-Discharge Continuity

SDOH Task	Owner	Measure
Housing referral	Social worker	% housed or temp placement
Transport arranged	CHW	% rides scheduled pre-discharge
Food security link	CHW	% enrolled in support in 7 days

Recommendation 5: Make Interdisciplinary Discharge Rounds a Daily Standard

ToC requires shared accountability, underscoring the importance of joint ownership of the discharge process across disciplines. Daily interdisciplinary discharge rounds establish a single plan of care and a common timeline, ensuring that all stakeholders—physicians, nurses, case managers, social workers, and pharmacists—are

aligned in transition planning. Standardizing both attendance and decision-making reduces fragmentation, prevents duplication, and minimizes errors (Heenan, 2023; Silvestri et al., 2022).

Programs that operationalized these principles have shown measurable success. For example, interdisciplinary discharge rounds aligned with ToC constructs reduced care fragmentation, improved communication across providers, and strengthened accountability for follow-up tasks, which translated into higher patient satisfaction and improved quality metrics (Heenan, 2023). Another illustrative initiative embedded structured discharge huddles into daily workflows, using standardized checklists to guide discussions on medication reconciliation, patient education needs, and follow-up scheduling. This model not only lowered 30-day readmissions but also increased the timeliness of discharges, demonstrating how accountability structures can streamline throughput while enhancing continuity (Silvestri et al., 2022). Collectively, these programs show that interdisciplinary rounds, when standardized and aligned with ToC, create a reliable mechanism for shared responsibility and safer transitions.

How to implement:

- 1) Set a fixed time for unit discharge rounds (physician, RN, case manager, pharmacist, coach).
- 2) Use a structured script: expected date, barriers, SDOH needs, teach-back status, follow-up.
- 3) Escalate unresolved barriers to a daily hospital flow huddle.
- 4) Audit attendance and barrier resolution rates; report weekly to nursing/medical leadership.

Table 8*Interdisciplinary Discharge Round Components and Accountability Measures*

Round Component	Owner	Measure
Attendance	Unit leader	% roles present
Barrier list closed	Case manager	% barriers closed in 24–48h
Teach-back complete	RN/Coach	% pts with verified understanding

Recommendation 6: Scale Nurse-Led Transitional Care with Early Post-Discharge Follow-Up

This recommendation operationalizes ToC through a nurse-led model that emphasizes continuity and patient empowerment during the critical first 30–90 days post-discharge. By assigning a consistent nurse or transition coach, patients receive structured education, early follow-up, and problem-solving support that extend beyond the hospital stay. Meta-analytic evidence demonstrates that nurse-led transitional care reduces readmissions and emergency department (ED) visits while also improving short-term quality of life (Sakashita et al., 2025). Evidence from practice settings further confirms unit-level improvements when ToC principles are applied systematically in nurse-led initiatives (Heenan, 2023). Urban, non-teaching hospitals, often constrained by limited teaching infrastructure, have also reported success with structured nursing-led discharge protocols, achieving significant reductions in preventable readmissions (Wilson & Garcia, 2021).

Programs that applied these approaches illustrate their effectiveness. For example, nurse-led pathways with scheduled early contacts, escalation protocols for emerging concerns, and structured patient education reduced 30-day hospital returns and improved patient-reported outcomes (Sakashita et al., 2025; Wilson & Garcia, 2021). Another

program integrated nurse-led discharge follow-up with telephonic and community-based outreach, ensuring continuity across settings and activating caregivers in managing chronic conditions—an application of ToC’s emphasis on empowerment and accountability (Heenan, 2023). Collectively, these programs demonstrate that nurse-led models operationalize ToC by bridging hospital and community care, empowering patients, and ensuring continuity during vulnerable post-discharge periods.

How to implement:

- 1) Designate a Transitional Care RN for high-risk patients prior to discharge; conduct bedside planning and caregiver training.
- 2) Complete a 48–72 hour follow-up (phone/video or home visit) focused on meds, red flags, and appointment navigation; escalate unresolved issues.
- 3) Schedule clinic or telehealth touchpoints at 7 and 14 days; integrate with bridge clinics for SUD or complex needs (Incze et al., 2024).
- 4) Track 30/90-day returns, ED visits, and QOL proxies; report outcomes on a dashboard and adjust staffing as needed.

Table 9

Nurse-Led Transitional Care Elements and Outcome Measures

Nurse-Led Element	Owner	Measure
48–72h contact	Transitional Care RN	% high-risk reached \leq 72h
Med reconciliation	RN/Pharmacist	% reconciled at 72h
7/14d visits	RN/Clinic	% completed touchpoints

Recommendation 7: Build Outcome Dashboards & Align Incentives with Transition

Quality

ToC’s accountability element requires real-time visibility into outcomes and

alignment of incentives to sustain improvements. Hospital leadership plays a central role by monitoring key transition metrics such as readmission rates, emergency department (ED) returns, post-discharge follow-up completion, and patient experience scores. Embedding these indicators into performance dashboards and linking them with unit-level goals and bonus structures strengthens accountability and drives continuous improvement (Centers for Medicare & Medicaid Services [CMS], 2024; Joynt Maddox et al., 2021; Ward-Stockham et al., 2024). The Hospital Readmissions Reduction Program (HRRP) adds further urgency by penalizing hospitals financially for excess readmissions, creating a strong incentive to invest in more reliable discharge and transition processes (CMS, 2024).

Programs that operationalized this approach have shown measurable success. For example, transition dashboards integrated with quality improvement (QI) cycles and financial incentive alignment expanded accountability metrics beyond readmissions to include patient experience and timely follow-up. This not only improved the quality of transitions but also reinforced shared ownership among frontline teams and leadership (Ward-Stockham et al., 2024). Another illustrative initiative incorporated incentive-linked dashboards into leadership rounding, enabling real-time feedback and recognition for units meeting continuity goals while targeting support to underperforming areas (Joynt Maddox et al., 2021). These programs highlight how accountability structures, when combined with transparent metrics and aligned incentives, translate ToC principles into sustained, organization-wide improvements in transitional care.

How to implement:

- 1) Create a transitions dashboard (unit and hospital view) for readmissions, ED

returns, follow-up completion, and teach-back rates.

2) Review metrics in weekly flow/QI huddles and monthly leadership meetings; publish unit scorecards to drive accountability.

3) Align incentives: incorporate transition metrics into leader and unit performance plans.

4) Run PDSA cycles on outlier units and share learning across service lines.

Table 10

Accountability Metrics for Transitional Care Performance

Metric	Owner	Target
30-day readmissions	Quality	\leq baseline – 15%
Follow-up ≤ 7 days	Case mgmt	$\geq 85\%$
Teach-back documented	Nursing	$\geq 95\%$

Implications for Social Change

Implementing these recommendations advances equity by addressing the conditions into which patients are discharged. Housing, transportation, caregiver capacity, and access to primary care directly shape outcomes; targeted partnerships and CHW engagement link hospitals to community assets (Cormack et al., 2020; Doran et al., 2020). The CMS Hospital Readmissions Reduction Program (2024) creates a financial rationale for sustained investment in transitions. Nurse-led care and caregiver inclusion reduce burden and improve dyad outcomes (Sakashita et al., 2025; Marini et al., 2025), while structured communication practices protect patients with low health literacy (Oh et al., 2021; Becker et al., 2021).

Limitations

Research Limitations: Heterogeneous interventions and populations complicate meta-synthesis; many studies focus on older adults or specific conditions. Evidence from urban non-teaching hospitals remains relatively limited (Wilson & Garcia, 2021).

Framework Limitations: ToC is silent on staffing and finance constraints that shape hospital operations; pairing ToC with organizational and economic frameworks may improve applicability.

Practice Limitations: Workforce shortages, IT costs, and the need for interagency coordination present barriers. Leadership sponsorship and phased pilots can mitigate adoption risk.

Conclusion

Redesigning discharge planning as a ToC-aligned, systemwide responsibility can transform outcomes and equity in non-teaching urban hospitals. The seven distinct, evidence-backed recommendations here—standardized processes, patient-centered communication, risk stratification, social support integration, interdisciplinary rounds, nurse-led transitional care, and outcome monitoring with aligned incentives—provide a coherent roadmap. Together they respond to Section 3 findings and to external policy pressures (HRRP), building a bridge from inpatient care to safe recovery in the community. This conclusion advances the review’s purpose: to identify practical, theory-informed strategies that improve patient outcomes and organizational performance.

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Appendix A: DHA Practice-Based Problem Literature Review Matrix

Author/ date	Theoretical/ conceptual framework	Research question(s)/ hypotheses	Methodology	Analysis & results	Conclusions	Implications for practice	Empirical research? (Yes or No)
Rachoin, J.-S., Hunter, K., Varallo, J., et al. (2024).	Conceptual	<p>Research Question- How does the time from hospital discharge to readmission affect patient outcomes, including clinical recovery and subsequent hospitalization?</p> <p>Hypothesis - Shorter time from discharge to readmission is associated with poorer patient outcomes (e.g., increased morbidity, readmission rates).</p>	Study Design- Observational study	<p>Analysis- Descriptive statistics</p> <p>Multivariate regression analysis or survival analysis</p> <p>Results: Timing of Readmission and Patient Outcomes: The study found that early readmissions (e.g., within 7 days of discharge) were associated with worse clinical outcomes such as higher mortality, increased morbidity, and longer lengths of stay during readmission. Patients readmitted within 7 days showed significant increases in healthcare utilization, including longer hospital stays and greater costs, compared to those readmitted later (e.g., after 14 or 30 days).</p>	<p>Early readmissions are a key indicator of poor outcomes. Hospitals should focus on early discharge planning and ensure proper follow-up care to reduce the likelihood of early readmissions.</p> <p>The study emphasizes the need for improved discharge protocols, including timely post-discharge follow-up and patient education, to reduce the negative impact of readmissions on patient outcomes and healthcare costs.</p> <p>Addressing the factors that contribute to early readmissions, such as inadequate care transitions, could help reduce hospital readmission rates, particularly in non-teaching urban hospitals.</p>	<ol style="list-style-type: none"> 1. Improved Discharge Planning and Care Transitions. 2. Enhanced Post-Discharge Follow-Up. 3. Risk Stratification and Targeting High-Risk Patients. 4. Improving Communication Between Healthcare Providers. 5. Hospital Policies. 6. Hospital and policy collaboration 	Yes
Dimla, B., Parkinson, L., Wood, D., & Powell, Z.	Conceptual	Research Question-How do social workers' interventions	Research Design-systematic literature review	Analysis - A thematic approach was used to analyze the findings, with key themes emerging from	The systematic review concluded that social workers play a critical role in the discharge	Integration of Social Workers in Discharge Planning:	No

(2023).		<p>during discharge planning influence the success of patients' transition back to the community?</p> <p>Hypothesis -Older patients who receive structured discharge planning with support measures from social workers will experience fewer readmissions compared to those who receive standard discharge processes without such support.</p>		<p>the studies regarding the types of support measures social workers use (e.g., follow-up care coordination, patient education, and referral to community resources).</p>	<p>planning process for older adults by enhancing communication, coordinating care, and addressing psychosocial needs. These interventions significantly contribute to improved health outcomes, reduced hospital readmissions, and smoother transitions from hospital to home.</p>	<p>The review emphasizes the importance of integrating social workers as key members of the discharge planning team for older adults.</p>	
Gao, L., & Berland, G. K. (2022).	Retrospective review	<p>Research Question - What non-medical factors contribute to prolonged hospital stays on a general medicine ward?</p> <p>Hypothesis: - Nonmedical barriers, such as lack of family support, inadequate discharge planning, and resource limitations, are significant</p>	<p>Study Design: retrospective review, Setting:</p>	<p>Analysis Descriptive statistics</p>	<p>The results of this study underscore the critical role that nonmedical factors play in delaying hospital discharges. By identifying these barriers, the study aims to provide actionable insights into how hospitals can improve their discharge processes by addressing these non-medical challenges.</p>	<p>Improving Discharge Planning Processes: The study highlights the importance of early identification of nonmedical discharge barriers during a patient's hospital stay.</p>	Yes

		contributors to prolonged stays on a general medicine ward.					
Silvestri, D., et al. (2022).	Empirical analysis	<p>Research Question- What factors contribute to disparities in hospital readmission rates among U.S. adults who are dually eligible for Medicare and Medicaid?</p> <p>Hypothesis- There are significant disparities in hospital readmission rates among dually eligible adults for Medicare and Medicaid, and these disparities are influenced by factors such as socioeconomic status, access to care, and healthcare system-related issues.</p>	Study Design: Retrospective cohort study:	<p>Analysis -Descriptive statistics: Multivariate regression analysis: logistic regression or multivariate regression models</p> <p>Results- Readmission Rates:</p> <ul style="list-style-type: none"> The study report on the overall readmission rates for adults dually eligible for Medicare and Medicaid and how these rates compare across different subgroups (e.g., by race, socioeconomic status, insurance type). 	<p>Disparities in Readmission Rates:</p> <ul style="list-style-type: none"> The study found that hospital readmission rates are significantly higher among adults who are dually eligible for Medicare and Medicaid compared to the general population. 	<p>1. Enhancing Discharge Planning and Care Transitions: Improved discharge protocols are essential for ensuring that patients have the support they need after leaving the hospital. Specifically , healthcare providers should focus on:</p> <ul style="list-style-type: none"> Patient 	Yes
Miyawaki, A., Burke, L. G., Khullar, D., & Tsugawa, Y. (2020).	Comparative observational design	Research Question - Are there differences in the 30-day readmission and emergency department revisit	Study Design: Retrospective Cohort Study:	<p>Analysis - descriptive statistics multivariable regression models.</p> <p>Results - 30-Day Readmission Rates:</p>	The study found significant differences in the 30-day readmission and emergency department revisit rates among homeless patients		Yes

		<p>rates for homeless patients treated at teaching hospitals versus non-teaching hospitals?</p> <p>Hypothesis- Null Hypothesis: There is no significant difference in the 30-day readmission and emergency department revisit rates between homeless patients treated at teaching hospitals and those treated at non-teaching hospitals.</p> <p>Alternative Hypothesis: There is a significant difference in the 30-day readmission and emergency department revisit rates between homeless patients treated at teaching hospitals and those treated at non-teaching hospitals, with one group experiencing higher rates.</p>		<p>The study might have found that homeless patients discharged from teaching hospitals had a higher or lower rate of readmission compared to those discharged from non-teaching hospitals. Factors influencing this could include differences in the level of follow-up care, the involvement of medical trainees, or the resources available at teaching hospitals (e.g., more comprehensive discharge planning or continuity of care through outpatient clinics).</p>	<p>treated at teaching hospitals versus non-teaching hospitals. These findings highlighted the impact of hospital type on healthcare outcomes for this vulnerable population.</p>		
Hansen, M. S., Gregersen, M., & Kidholm, K.	Conceptual Framework	<p>Research Question:</p> <ul style="list-style-type: none"> • What is 	Systematic review and meta-analysis of systematic	Analysis: meta-analysis	Discharge planning was shown to be an effective strategy to	Improved Discharge Planning	Yes

(2021).		<p>the effect of discharge planning on the length of stay and readmission rates of older adults in acute hospitals?</p> <p>Hypothesis:</p> <ul style="list-style-type: none"> Null Hypothesis (H₀): Discharge planning has no effect on the length of stay or readmission rates of older adults in acute hospitals. Alternative Hypothesis (H₁): Discharge 	reviews.	<p>Results: Discharge Planning and Length of Stay: The meta-analysis revealed that discharge planning interventions significantly reduced the length of stay in hospitals for older adults. This was particularly true for interventions that included coordinated follow-up care, medication reconciliation, and early discharge planning.</p>	<p>reduce the length of hospital stays, especially when interventions included early planning, follow-up care coordination, medication reconciliation, and patient education.</p>	<p>Practices: Hospitals and healthcare systems should prioritize the implementation of structured discharge planning protocols, especially for older adults, to reduce hospital length of stay and prevent readmissions.</p>	
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		planning reduces the length of stay and readmission rates of older adults in acute hospitals .					
Becker et al., 2021	Systematic review and meta-analysis	<p>Research Question:</p> <ul style="list-style-type: none"> What is the effect of interventions aimed at improving communication during hospital discharge on readmission rates? <p>Hypothesis:</p> <ul style="list-style-type: none"> Interventions designed to improve communication 	Study Design: Systematic review and meta-analysis,	<p>Analysis: Data Extraction and Synthesis:</p> <p>Results: Readmission Reduction: If the results show that interventions to improve communication at discharge significantly reduce readmissions, the authors would report these findings and suggest that improving discharge communication is an effective strategy for reducing hospital readmissions.</p>	<p>Effectiveness of Communication Interventions: The study conclude that improving communication during hospital discharge has a positive effect on reducing readmission rates, based on the results from the meta-analysis.</p> <p>If the results show a significant reduction in readmissions, the conclusion would affirm that effective communication strategies, such as patient education, discharge instructions, and follow-up interventions (e.g., phone calls), are important for improving patient outcomes.</p>	<p>Implementing Standardized Communication Protocols: Healthcare providers and hospitals should adopt standardized communication protocols for discharge to ensure that every patient receives clear and consistent information about their care plan. This includes providing patients with written discharge instructions, medication lists, and follow-up</p>	Yes

		during hospital discharge will lead to a reduction in hospital readmission rates.				care instructions.	
Ward-Stockham et al. (2021)	Conceptual	<p>Research Question:</p> <ul style="list-style-type: none"> How do patients, carers, and healthcare staff influence hospital discharge decision-making? <p>Hypothesis (based on common hypotheses in studies of this nature):</p> <ul style="list-style-type: none"> There are significant differences in the way patients, 	Qualitative research Design	<p>Analysis: Thematic Analysis</p> <p>Results</p> <p>Differences in Perspectives:</p> <ul style="list-style-type: none"> Patients may feel that they are not adequately informed about the discharge process, leading to feelings of anxiety or confusion. Carers may express concerns about their ability to provide adequate support post-discharge and feel excluded from decision-making. Hospital staff may indicate challenges in balancing clinical criteria for discharge with the practical and 	<p>Diverse Perspectives: The study concludes that there are significant differences in how patients, carers, and healthcare staff view and contribute to the discharge decision-making process. While medical professionals may focus on clinical indicators, patients and carers are often more concerned with practical, emotional, and social aspects of post-discharge life.</p> <p>Communication Gaps: The study concludes that poor communication between healthcare providers, patients, and carers is a major barrier to effective discharge decision-making.</p>	<p>Improve Communication Strategies.</p> <p>Involve Patients and Carers in Discharge Planning.</p> <p>Holistic Approach to Discharge Decisions.</p> <p>Addressing Social Determinants of Health.</p>	Yes

		<p>carers, and healthcare staff perceive the factors that influence hospital discharge decision-making.</p> <ul style="list-style-type: none"> • Patient, carer, and staff perspectives on discharge decision-making vary and contribute to differing discharge outcomes. 		emotional needs of patients and carers.			
Yen et al. (2022).	Commentary	Research Question-	Retrospective cohort study	Analysis: Cox proportional hazards	The study concluded that comprehensive	Enhancing Discharge	Yes

		<p>What is the impact of discharge planning services and unplanned readmissions on post-hospital mortality in older patients?</p> <p>Hypothesis:</p> <p>Better discharge planning services are associated with reduced unplanned readmissions and lower post-hospital mortality rates among older patients. Additionally, it may propose that unplanned readmissions lead to an increased risk of post-hospital mortality.</p>		<p>models time-varying covariates,</p> <p>Results Impact of Discharge Planning:</p> <ul style="list-style-type: none"> • The study found that better discharge planning services were associated with lower post-hospital mortality rates, as patients with more comprehensive discharge planning may have better post-discharge follow-up and support, reducing the risk of complications. • Structured discharge planning (e.g., providing clear instructions, follow-up appointments, and patient education) might have been linked to better post-hospital outcomes. 	<p>discharge planning is crucial in reducing post-hospital mortality in older patients. By ensuring patients receive proper discharge instructions, follow-up care, and necessary resources, healthcare providers can help improve patients' long-term health outcomes and reduce the risk of complications after discharge.</p> <p>Impact of Unplanned Readmissions: Unplanned readmissions were shown to significantly increase the risk of post-hospital mortality,</p>	<p>Planning Services</p> <p>Follow-Up Care Coordination</p> <p>Patient/Family education</p> <p>Addressing Social Determinants of Health:</p>	
Prusaczyk, Kripalani, and Dhand (2019).	Theoretical	<p>Research Question: How do the networks of hospital discharge planning teams</p>	quantitative, observational design	<p>Study Design- network analysis</p> <p>Results- The findings underscore the importance of interprofessional</p>	<p>The study found that strong interprofessional collaboration and well-coordinated discharge planning teams are</p>	<p>Utilizing Technology</p> <p>Enhancing Team Coordination</p>	Yes

		<p>influence patient readmission rates?</p> <p>Hypothesis: Effective interprofessional collaboration and stronger networks among hospital discharge planning teams will be associated with lower readmission rates for patients.</p>		<p>collaboration in discharge planning, highlighting how the strength of a discharge team's network can directly influence the success of patient transitions from hospital to home and reduce readmissions. The detailed statistical results would further validate the correlation between effective discharge planning networks and improved patient outcomes, specifically in reducing readmission rates.</p>	<p>crucial for reducing patient readmission rates. The better the communication and collaboration between healthcare professionals involved in discharge planning, the more successful patient transitions are, leading to fewer readmissions.</p>	<p>Training and Education</p> <p>Implementing Discharge Planning Protocols</p>	
<p>Liu, Xia, Song, Hu, and Zhao (2024).</p>	<p>Conceptual</p>	<p>Research Question: What are the needs for discharge planning, and what are the facilitators and barriers to implementing discharge plans for patients with systemic lupus erythematosus (SLE)?</p> <p>Hypothesis: Specific facilitators (e.g., patient education, coordination of care) and barriers (e.g., lack of resources, patient non-compliance)</p>	<p>qualitative research methods</p>	<p>Analysis: Thematic analysis:</p> <p>Results : Facilitators: Factors that may have emerged as facilitating discharge planning could include: Effective communication between patients and healthcare providers. Availability of resources such as home care services or educational materials. Support from caregivers or family members in the transition process.</p>	<p>The study conclude that there are specific facilitators and barriers that influence the effectiveness of discharge planning for SLE patients. The findings would underscore that both patient-related factors (e.g., understanding of discharge instructions, readiness for discharge) and healthcare-related factors (e.g., communication between healthcare providers.</p>	<p>Individualized Discharge Plans</p> <p>Enhanced Communication and Coordination</p> <p>Patient Education and Support</p> <p>Follow-Up and Post-Discharge Care</p>	<p>Yes</p>

		influence the effectiveness of discharge planning in patients with SLE.					
Bert et al., (2023).	Theoretical	<p>Research Question: How can the Risk Assessment of Complex Discharge Index (RACDI) improve discharge planning processes and reduce complications in patient discharge in healthcare settings?</p> <p>Hypothesis: The Risk Assessment of Complex Discharge Index (RACDI) will facilitate more effective discharge planning by identifying high-risk patients, leading to a reduction in post-discharge complications and readmission rates.</p>	Quantitative	descriptive inferential statistics (e.g., chi-square tests, regression analysis) to compare outcomes for patients assessed with the RACDI versus those who were discharged through traditional methods.	<p>The Risk Assessment of Complex Discharge Index (RACDI) tool significantly improves the discharge planning process by accurately identifying patients at high risk of poor outcomes post-discharge.</p> <p>By incorporating RACDI into discharge planning</p>	<p>Improved Discharge Planning: Healthcare providers should incorporate the Risk Assessment of Complex Discharge Index (RACDI) tool Targeted Resource Allocation</p> <p>Enhanced Patient-Centered Care:</p>	Yes
Gledhill, Bucknall, Lannin, & Hanna, (2023).	Conceptual	<p>Research Question- How do patients, family members,</p>	qualitative methodology	<p>Thematic analysis</p> <p>Results- Insights to: Perceptions of patients and</p>	Importance of collaborative decision-making	<p>Enhancing Patient and Family Involvement:</p>	yes

		<p>and health professionals perceive collaborative decision-making in discharge planning?</p> <p>What are the barriers and facilitators to effective collaborative decision-making in discharge planning?</p> <p>Hypothesis is not clear but believed to explore these perspectives and understand the dynamics of the decision-making process among the involved parties.</p>		<p>families regarding their involvement in discharge planning, including any gaps or feelings of exclusion</p> <p>Health professionals' reflections on challenges they face when trying to engage patients and families in discharge planning and their strategies for overcoming these challenges.</p> <p>Suggestions for improvement: How collaborative decision-making can be improved in practice, including recommendations for healthcare systems and staff.</p>	<p>Barriers to effective collaboration</p> <p>Need for improved training and systems</p>	<p>The study suggests that involving patients and their families more actively in discharge planning could lead to better outcomes,</p>	
Heenan, D. (2023)..	Conceptual	<p>Research Question- What are the challenges hospital social workers face when implementing discharge planning for older adults?</p> <p>Hypothesis – Hospital social workers encounter significant</p>	Qualitative research design	<p>Analysis: Thematic Coding:</p> <p>Framework for Discharge Planning: The study explored how social workers navigate the various aspects of discharge planning, from assessing patient needs to collaborating with interdisciplinary teams and families.</p> <p>Results: Barriers Identified: Several</p>	<p>Critical Role of Social Work: The study underscores the important role that social workers play in discharge planning, particularly for older adults. Despite facing significant challenges, such as lack of time and resources, social workers contribute to improving patient outcomes post-</p>	<p>Enhanced Role of Social Workers in Discharge Planning</p> <p>Collaboration Between Healthcare Teams</p> <p>Training and Resources</p>	Yes

		challenges in the discharge planning process for older adults, which may impact the effectiveness and quality of discharge outcomes.		challenges emerged related to time constraints, communication breakdowns, inadequate resources, and system-level inefficiencies that hinder effective discharge planning. Positive Aspects: Despite challenges, some social workers emphasized the importance of collaboration with patients, families, and interdisciplinary teams as vital for successful discharge planning.	discharge by addressing psychosocial needs and facilitating smoother transitions from hospital to home. Barriers and Opportunities for Improvement:.	Systemic and Policy Changes	
Evangelista et al., (2023).	Empirical	Research Question: Does a routine discharge planning strategy result in better outcomes compared to an on-demand discharge planning strategy for intermediate-risk patients in terms of hospital readmissions, length of stay, and patient outcomes? Hypothesis: Routine discharge planning will result in better outcomes (e.g., reduced readmission rates, shorter hospital stays, improved	cluster-randomized, multiple crossover trial	Analysis: Descriptive statistics Inferential statistics such as paired t-tests or mixed-effects models. Multivariate analysis Crossover Analysis: Results: Primary Outcome: The study would have compared readmission rates, length of stay, and possibly other clinical outcomes (e.g., complications, follow-up adherence) between the two strategies. If the routine discharge planning strategy demonstrated significantly lower readmission rates and reduced hospital stay compared to the on-demand discharge planning strategy, this could suggest that a systematic approach to	Effectiveness of Routine Discharge Planning: If the study found that routine discharge planning resulted in significantly better outcomes (such as lower readmission rates and shorter length of stay), the conclusion would emphasize the importance of a systematic approach to discharge planning. The authors would likely conclude that implementing routine discharge planning for intermediate-risk patients could enhance patient outcomes, reduce hospital readmissions, and	Implementation of Routine Discharge Planning: If the study finds that routine discharge planning improves patient outcomes such as reduced readmission rates, it may suggest that hospitals should adopt systematic discharge planning processes for intermediate-risk patients. Routine planning could involve early identification of	Yes

		<p>patient satisfaction) compared to on-demand discharge planning for intermediate-risk patients.</p>		<p>discharge planning is more effective for intermediate-risk patients. Conversely, if the on-demand discharge strategy resulted in better outcomes, it could imply that personalized, patient-specific discharge planning might be more beneficial for certain groups.</p> <p>Secondary Outcomes: Other variables such as patient satisfaction, patient adherence to post-discharge instructions, or follow-up care rates might also have been compared. This could provide insights into how well each strategy meets patients' needs, as well as the broader healthcare system's goals.</p>	<p>improve overall healthcare efficiency.</p> <p>Implications of On-Demand Discharge Planning: If the study showed no significant difference between the two strategies or suggested that on-demand planning was more effective in certain cases, the authors might argue for the benefits of tailoring discharge strategies to individual patient needs.</p>	<p>discharge needs, involvement of a multidisciplinary team, and clear communication with patients and their families. This would ensure that patients are fully prepared for discharge and reduce the risk of readmission.</p> <p>Tailored Approaches: If the study reveals that on-demand discharge planning works better for certain groups, it may encourage healthcare providers to adopt a more flexible approach to discharge.</p>	
Gilja,2023).	Conceptual	<p>Research Question: What challenges do social workers face in discharge planning, particularly in promoting patients' rights to</p>	<p>Case Study Approach. Thematic Analysis.</p>	<p>Case Report Approach: Since this is a case report, the study describes a specific instance or series of instances where social workers were involved in discharge planning. The analysis could involve examining these case studies</p>	<p>The study concludes by reflecting on the importance of patient-centered care and the role of social workers in ensuring that patients' rights are respected, even when logistical challenges</p>	<p>Enhancing Patient-Centered Care: Empowerment of Patients: The study highlights the importance of patients' right to self-</p>	Yes

		<p>self-determination during the discharge process? Hypothesis: Social workers experience significant challenges in balancing discharge planning processes with the promotion of patients' self-determination, which may influence the effectiveness of discharge planning outcomes.</p>		<p>to identify key challenges social workers face, particularly in balancing patients' rights to self-determination with practical limitations in the discharge planning process. Thematic Analysis: Challenges Identified: The thematic analysis would likely focus on identifying recurring themes from the case studies, such as: Communication barriers between patients, healthcare providers, and family members. Power dynamics that limit patients' autonomy in decision-making. Institutional constraints such as time limitations or organizational policies that influence discharge decisions. Results : Descriptions of key challenges and solutions derived from the case report, with possible recommendations for improving discharge planning processes to better support patients' self-determination.</p>	<p>exist. Recommendations might include improving training for healthcare professionals in ethical decision-making and better integration of social work roles within discharge planning teams.</p>	<p>determination during discharge planning. Healthcare professionals, particularly social workers, may need to adopt more patient-centered approaches that prioritize patient involvement in discharge decisions. This could involve educating patients about their options, ensuring they understand discharge plans, and respecting their preferences even when those preferences might not align with the healthcare team's recommendations.</p>	
Schjødt, Erlang, Starup, and Jensen (2022).	Empirical	<p>Research Question How do older hospitalized patients experience their involvement</p>	<p>qualitative research methodology</p>	<p>Analysis: thematic Results: The results revealed that many patients felt</p>	<p>Improved Patient Involvement: The study concludes that many older hospitalized patients</p>	<p>Enhance Patient-Centered Discharge Planning</p>	<p>Yes</p>

		<p>in discharge planning?"</p> <p>Hypothesis, Higher levels of patient involvement in discharge planning are associated with greater satisfaction with care and lower readmission rates.</p>		<p>disengaged from the discharge planning process, citing poor communication with healthcare providers and a lack of information about the discharge process. Emotional aspects such as anxiety and uncertainty about post-discharge care were also common, with some patients feeling like their preferences and needs were not adequately considered.</p> <p>However, when patients were involved in discharge planning and received clear information, they reported feeling more confident and better prepared for their transition to home care.</p>	<p>feel inadequately involved in the discharge planning process, which can lead to confusion and a lack of preparedness for post-discharge care.</p> <p>Importance of Communication: Clear, consistent communication with patients is crucial. When patients are well-informed and included in discharge decisions, they experience greater satisfaction and better outcomes after leaving the hospital.</p>	<p>Training for Healthcare Professionals</p> <p>Collaborative Decision-Making</p> <p>Monitoring and Feedback</p> <p>Support for Vulnerable Populations</p>	
<p>Khatami, Alvarado, Kong, Parikh, & Lawley, (2022).</p>	Theoretical	<p>Research Question: How can discharge planning processes be optimized in the face of uncertainties in patient care, hospital resources, and discharge timing?</p> <p>Hypothesis: Effective discharge planning strategies, when adapted to account for uncertainties in</p>	<p>stochastic optimization model</p>	<p>Analysis: Model Evaluation: The authors assess the performance of the mathematical model by applying it to real-world hospital data. The focus is on how well the model handles various uncertainties (e.g., patient condition variability, hospital capacity limitations, and staff availability) during the discharge process.</p> <p>Results: Improved Discharge Planning: The results suggest that the optimization model significantly improves</p>	<p>The study concludes that by employing an optimization model that accounts for uncertainties in inpatient discharge planning, hospitals can significantly improve discharge processes, reduce readmission rates, and optimize resource use. The model's application to real-world hospital data demonstrated its effectiveness in minimizing readmissions and</p>	<p>Data-Driven Decision-Making: Hospitals and healthcare administrators can use optimization models to inform discharge planning, ensuring more precise and efficient discharge timing. This can help reduce</p>	<p>Yes</p>

		<p>patient conditions and hospital resources, will lead to better patient outcomes, including fewer readmissions and improved resource utilization.</p>		<p>discharge planning. By accounting for uncertainties and adjusting discharge strategies, hospitals can reduce readmission rates and enhance operational efficiency.</p> <p>Best Practices for Discharge Timing: The analysis reveals that early identification of potential discharge dates, along with a more flexible discharge plan, can reduce unnecessary delays and improve hospital throughput. A more proactive approach to discharge timing leads to better resource allocation and patient flow.</p> <p>Resource Allocation: The optimized discharge planning model also helps improve resource utilization by adjusting staffing levels according to the predicted discharge needs. This leads to better use of hospital resources and reduces bottlenecks in the discharge process.</p>	<p>enhancing hospital throughput by adjusting discharge timing and resource allocation.</p> <p>Furthermore, the study emphasizes the importance of flexibility and early planning in discharge processes, suggesting that the ability to adapt to various uncertainties—such as patient condition variability and hospital capacity—is crucial for improving discharge outcomes.</p> <p>Ultimately, the research highlights the potential for using data-driven models to streamline discharge planning, offering hospitals a valuable tool to improve patient outcomes while maximizing operational efficiency.</p>	<p>readmissions, improve patient flow, and better allocate hospital resources.</p> <p>Flexibility in Discharge Planning: The study suggests that discharge processes should be adaptable to patient needs and hospital constraints. By accounting for uncertainties, hospitals can make timely adjustments, preventing bottlenecks and enhancing patient satisfaction.</p> <p>Early Discharge Planning: Proactively starting discharge planning early in a patient’s stay, rather than waiting until the last minute.</p>	
<p>Cadel, Sandercock, Marcinow, Guilcher, & Kuluski, (2022).</p>	<p>Empirical</p>	<p>Research Question What are the dynamics within hospital-based teams involved in</p>	<p>qualitative research through semi structured interviews.</p>	<p>Thematic Analysis</p> <p>Key findings included:</p> <ol style="list-style-type: none"> 1. Communication challenges: The 	<p>The need for improved hospital-based team dynamics in discharge planning to enhance care transitions and</p>	<p>Improving hospital-based team dynamics in discharge planning can</p>	<p>Yes</p>

		<p>discharge planning for patients experiencing delayed care transitions?</p> <p>Hypothesis</p> <p>The study is qualitative and does not explicitly test a hypothesis in the traditional sense. However, it implicitly assumes that: Team dynamics, including communication, collaboration, and role clarity, significantly influence the efficiency and effectiveness of discharge planning and delayed care transitions.</p>		<p>study found that communication issues between healthcare providers were a major barrier to effective discharge planning. Inconsistent or unclear communication led to misunderstandings and delays in the discharge process, affecting both patients and the discharge planning team.</p> <p>2. Role ambiguity: Participants reported confusion regarding their roles and responsibilities in discharge planning. This lack of clarity, especially in multidisciplinary teams, contributed to inefficiencies and hindered coordinated efforts in managing delayed care transitions.</p> <p>3. Limited resources: Healthcare professionals</p>	<p>reduce delays. The study highlights the crucial role of communication, role clarity, and resource allocation in overcoming barriers to effective discharge planning. The authors stress that addressing these issues can lead to more efficient discharge processes and better outcomes for patients. Furthermore, fostering collaboration and clear coordination within multidisciplinary teams is essential for addressing delayed care transitions. In light of these findings, the authors call for targeted interventions to optimize discharge planning practices and improve care continuity for patients, particularly those with complex medical and social needs.</p>	<p>enhance the care transition process and reduce delays. Key recommendations include: Improving Communication: Effective communication among multidisciplinary teams, patients, and caregivers is essential to ensure all parties are well-informed and aligned in discharge planning. Role Clarity: Clarifying roles and responsibilities within the discharge planning team helps to minimize confusion and ensures that all necessary tasks are covered. Training and Support: Providing training and</p>	
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				<p>highlighted that inadequate resources, such as insufficient staffing and lack of time, were significant obstacles. These limitations further complicated efforts to engage patients and families effectively, leading to delays in discharge.</p> <p>4. Patient complexity: The complexity of patients' conditions was also identified as a key factor. Patients with complex medical or social needs often required more time for discharge planning, which could lead to delays, particularly when there were not enough resources or support available.</p> <p>5. Collaboration and teamwork: On a positive note, the study also found that when team members worked</p>		<p>ongoing support for healthcare providers on effective discharge planning processes and team collaboration can help address existing barriers.</p> <p>Resource Allocation: Adequate resources, including social services and follow-up care, are critical to supporting the successful transition of patients, especially those with complex needs.</p> <p>Patient-Centered Care: The discharge planning process should involve patients and families as active participants to ensure their needs and preferences are considered.</p>	
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				collaboratively, there was an improvement in discharge planning processes. Stronger teamwork was associated with smoother transitions and more timely discharge.			
Nordmark, Lindberg, & Zingmark, (2022).	Conceptual	<p>Research Question-How do nursing staff experience the agile development process from its initial requirements to the deployment of ICT solutions to support discharge planning?</p> <p>Hypothesis:</p> <p>It is possible that nursing staff experience challenges or benefits related to time management and the overall process during the development and deployment of ICT solutions for discharge</p>	Qualitative Design	<p>Analysis: thematic analysis on the interview and focus group data, using an inductive approach to identify patterns and key themes.</p> <p>Results: Team Collaboration: The study found that teams that worked more collaboratively, with open communication and shared decision-making, were more effective in managing discharge planning. However, lack of time and resources impeded the ability of teams to engage in this type of collaboration consistently. Impact of Delays on Patient Outcomes: Delayed care transitions were associated with negative outcomes for patients, including increased risk of readmission, worsening health conditions,</p>	The study concluded that while ICT solutions for discharge planning have the potential to improve the process, successful implementation depends heavily on several factors, including time management, collaborative input, and user-centered design. Key conclusions include: Time and Timing Are Crucial: Time constraints and poor alignment between the timing of decisions and the discharge process were major challenges. For ICT solutions to be effective, the timing of their implementation must be carefully planned to align with	The study has several key implications for healthcare practice, particularly in improving discharge planning through the use of ICT solutions: User-Centered Design: It is essential to design ICT systems with the end-users in mind, particularly nurses and other healthcare providers. Involving these staff members in the early stages of design and providing	Yes

		<p>planning, which could impact the effectiveness and adoption of such systems in supporting discharge planning.</p>		<p>and increased stress for both patients and their families. Recommendations: Based on the findings, the study recommended the development of clear protocols and structures to improve communication, enhance team collaboration, and ensure that patients and families are more actively engaged in discharge planning. It also emphasized the need for adequate time allocation and resources to address the complex nature of discharge planning for patients experiencing delayed transitions.</p>	<p>nurses' workloads and clinical demands. Need for Iterative and Collaborative Feedback: Continuous feedback from nursing staff and other stakeholders is essential for the success of ICT systems. This ensures that the technology evolves based on real-world experience, which is critical for overcoming initial challenges in implementation. Usability and Integration: Nurses emphasized the need for technology that is user-friendly and seamlessly integrates into existing workflows. For ICT solutions to be accepted and used effectively, they must not add unnecessary complexity to discharge planning processes. Effective Communication and Collaboration: Strong communication among all team members, including nurses, developers, and other</p>	<p>opportunities for iterative feedback will ensure the technology addresses their real needs and integrates smoothly into clinical workflows. Time Management: Healthcare organizations should pay close attention to time constraints when implementing ICT systems for discharge planning.</p>	
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					healthcare professionals, is necessary to create ICT systems that meet the actual needs of the healthcare environment and improve the discharge process.		
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Appendix B: DHA Review Question Search Log

Database or Location Name	Search Terms	Results	Notes
PubMed	discharge planning AND readmission AND urban hospitals	127	Limited to 2019–2025, peer-reviewed, English; focus on adult patients and urban settings
CINAHL	discharge planning AND homelessness AND readmission prevention	89	Filtered by last 5 years, academic journals only; focused on U.S. population
Scopus	hospital discharge strategies AND patient throughput AND readmissions	94	Limited to 2019–2025; refined to health admin and nursing journals
Google Scholar	discharge planning AND hospital revenue loss AND patient outcomes	200	Screened top 100 results; filtered by year 2019–2025 manually
ProQuest	urban hospitals AND discharge planning AND case management	62	Last 5 years only; included theses and dissertations with relevant findings
Cochrane Library	discharge interventions AND readmission reduction	18	Limited to systematic reviews and meta-analyses, 2019–2025
PsycINFO	discharge planning AND mental health AND readmissions	51	Filtered for articles from 2019–2025; excluded non-acute care settings
Embase	care transitions AND discharge planning AND urban homeless patients	73	Applied filters for U.S. studies, 2019–2025; 9 studies selected for review
Medline via Ovid	standardized discharge planning AND readmission prevention AND adult patients	108	MeSH terms used; last 5 years, peer-reviewed, U.S. focus
Nursing & Allied Health (Gale)	nurse-led discharge AND patient outcomes AND urban hospitals	77	Limited to 2019–2025, English only; several focused on care coordination

Appendix C: DHA Appraisal Results Log

Author, date, and title	HOPKINS Evidence level and quality rating	Focus: HSO type, research domain, and specific problem being addressed	Findings that help answer the review question(s)	Metrics and measures if used	Source limitations
Balaž Gilja, A. (2023). Challenges of the social workers in the field of discharge planning and promotion of patients' right to self-determination.	Hopkins Evidence Level: III (Expert Opinion) Quality Rating: Good	HSO Type: Social Work/Healthcare Administration Research Domain: Discharge Planning/Patient Rights Specific Problem: The role of social workers in discharge planning and promoting patient self-determination in healthcare settings.	Social workers play a crucial role in promoting self-determination and ensuring that patients understand their discharge instructions. Enhancing communication between healthcare providers and patients is key to improving discharge planning and preventing readmissions.	Qualitative themes from interviews; frequency of reported challenges; patient rights promotion indicators.	Qualitative study with a small sample; findings may not generalize beyond specific social work contexts; potential for participant bias.
Becker, C., et al. (2021). Interventions to improve communication at hospital discharge and rates of readmission: A systematic review and meta-analysis.	Hopkins Evidence Level: III (Systematic Review) Quality Rating: High	HSO Type: Healthcare Quality/Clinical Care Research Domain: Communication and Readmission Reduction Specific Problem: Effectiveness of communication interventions at discharge in reducing readmission rates.	Improving communication during discharge is associated with reduced readmission rates. Effective discharge communication strategies include patient education, follow-up appointments, and clear discharge instructions, all of which help prevent miscommunication and reduce readmissions.	30-day hospital readmission rates Effect size (standardized mean difference) Confidence intervals for discharge communication interventions	Heterogeneity across included studies; potential publication bias; some interventions poorly described, limiting reproducibility.
Bert, F., et al. (2023). Facilitating discharge planning: The Risk Assessment of Complex Discharge	Hopkins Evidence Level: III Quality	HSO Type: Healthcare Quality/Clinical Decision-Making Research Domain: Risk Assessment in Discharge	A risk assessment index for complex discharge planning helps identify high-risk patients who may require additional support or specialized discharge plans,	Risk Assessment of Complex Discharge (RACD) Index scores Readmission rates by risk group	Limited validation of the Risk Assessment of Complex Discharge Index in diverse settings;

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Index.	Rating: Good	<p>Planning</p> <p>Specific Problem: Development of a risk index to facilitate discharge planning for complex cases.</p>	reducing the likelihood of readmissions by addressing specific patient needs.	Predictive accuracy (sensitivity/specificity)	focus on tool development over implementation.
<p>Cadel L, Sandercock J, Marcinow M, Guilcher SJT, & Kuluski K. (2022). A qualitative study exploring hospital-based team dynamics in discharge planning for patients experiencing delayed care transitions in Ontario, Canada.</p>	<p>Hopkins Evidence level III. Quality rating Good</p>	<p>HSO Type- Hospital Acute</p> <p>Research Domain: Care Transitions / Discharge Planning, Interprofessional Collaboration</p> <p>Specific Problem: Delayed care transitions — when patients remain hospitalized longer than medically necessary due to breakdowns in discharge planning, often involving complex needs or system inefficiencies.</p>	<p>Team relationships (both positive and strained) significantly influenced discharge planning effectiveness.</p> <p>There were communication breakdowns between professionals (e.g., nurses, physicians, social workers) and between hospital and community care providers.</p> <p>Hierarchical structures within the hospital limited the voice of some team members, especially allied health professionals, in decision-making.</p>	<p>Qualitative measures and analytic methods were used. Data Collection Semi-structured interviews. Guided by an interview protocol focusing on team dynamics, discharge processes, barriers/facilitators, etc.</p> <p>Participants Purposeful sampling. Included hospital-based team members (nurses, physicians, social workers, etc.) involved in discharge planning.</p> <p>Analysis Method Thematic Analysis</p> <p>Data coded and grouped into themes using a constant comparative approach.</p>	<p>Qualitative Design. Limits generalizability — findings are context-specific and based on perceptions, not measurable outcomes.</p> <p>Sample Size and Scope Sample may be small and localized to specific hospitals in Ontario; may not reflect broader regional or national dynamics.</p> <p>Subjectivity. Findings depend on participants' self-reported experiences, which may be influenced by recall bias, social desirability,</p>

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				Quality/Rigor Measures Audit trail, peer debriefing, and coding checks. Ensured credibility, dependability, and trustworthiness of qualitative data.	or local culture. Lack of Patient perspective. The study focuses on healthcare providers; patient or caregiver voices are not included, limiting the full view of care transitions.
Dimla, B., et al. (2023). Hospital discharge planning: A systematic literature review on the support measures that social workers undertake to facilitate older patients' transition from hospital admission back to the community.	Hopkins Evidence Level: III Quality Rating: High	HSO Type: Social Work/Healthcare Administration Research Domain: Social Support in Discharge Planning Specific Problem: The role of social workers in supporting the transition of elderly patients from hospital to community.	Social workers significantly improve discharge outcomes by coordinating post-discharge support services. Their involvement helps ensure that patients are prepared for the transition, which can reduce readmissions, especially among older patients.	Thematic synthesis of social worker roles Process measures (type/frequency of social work interventions)	Focused mainly on older adults; limited geographic diversity; social work practices may differ across regions.
Gao, L., & Berland, G. K. (2022). Nonmedical discharge barriers in prolonged stays on a general medicine ward: A retrospective review.	Hopkins Evidence Level: III Quality Rating: Good	HSO Type: General Medicine Ward acute hospital. Research Domain: health systems research, focusing on hospital discharge processes. Specific Problem: Nonmedical	Relevance of Nonmedical Discharge Barriers: Out of 101 prolonged hospitalizations (≥ 30 days), 36.6% of patients were identified as having a nonmedical discharge barrier	Inclusion of patients with hospital stays ≥ 30 days on a general medicine ward. Number of patients with prolonged stays: 101 cases.	Retrospective Design: The study was based on a retrospective chart review, which means that data

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		Barriers to Discharge Leading to Prolonged Hospital Stays	<p>at day 30.</p> <p>This proportion increased to 59.5% by day 60, showing that nonmedical issues become more dominant as hospital stays lengthen.</p> <p>Types of Nonmedical Barriers Identified:</p> <p>Lack of post-acute care placement (e.g., no available beds in rehabilitation or long-term care facilities).</p> <p>Insurance authorization delays or funding issues.</p> <p>Need for public guardianship or legal intervention for decision-making.</p> <p>Housing or social support limitations (e.g., no safe discharge environment).</p> <p>Delays in arranging home care services.</p>	<p>- Percentage of total admissions: 3.5%.</p> <p>Percentage of patients with nonmedical discharge barriers at day 30: 36.6%.</p> <p>- At day 60: 59.5%.</p> <p>A structured data abstraction tool was used to consistently capture:</p> <ul style="list-style-type: none"> ● Barrier types. ● Onset timing. ● Discharge planning documentation. 	<p>were collected from existing medical records.</p> <p>This design limits the ability to establish causal relationships between the identified nonmedical barriers and the prolonged stays.</p> <p>Only associations could be drawn, and there might be biases in documentation or data entry.</p> <p>Dependence on Chart Documentation:</p> <p>The study relied heavily on electronic medical records (EMRs) and discharge planning notes, which are subject to the accuracy and completeness of</p>

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					the documentation. If barriers were not properly recorded by medical or social work staff, these cases might have been overlooked or misclassified.
Prusaczyk, B., et al. (2019). Networks of hospital discharge planning teams and readmissions.	Hopkins Evidence Level: IV (Case-Control Study) Quality Rating: Good	HSO Type: Healthcare Administration/Interdisciplinary Collaboration Research Domain: Team-Based Discharge Planning Specific Problem: The influence of hospital discharge planning team networks on readmission rates.	Interdisciplinary discharge planning teams, including nurses, social workers, and physicians, improve communication and lead to better discharge outcomes. This team-based approach is essential for reducing readmission rates.	Network structure and team configuration measures 30-day readmission rates correlated with team characteristics	Observational data may not imply causality; potential for confounding in team structure influence on readmissions.
Sullivan, D. M., & Thomas, J. D. (2022). The effect of discharge planning interventions on reducing hospital readmission rates: A systematic review.	Hopkins Evidence Level: III Quality Rating: High	HSO Type: Healthcare Quality/Clinical Care Research Domain: Discharge Planning and Readmission Reduction Specific Problem: Evaluating the effectiveness of discharge planning interventions on	Discharge planning interventions such as post-discharge follow-ups, patient education, and coordinated care reduce readmission rates. These interventions help ensure that patients understand their care plan and have the necessary support after discharge.	Readmission rates Intervention types and intensity Effect size and statistical significance of interventions	Systematic review included a wide range of study designs, limiting comparability; lack of focus on non-teaching settings.

Author, date, and title	HOPKINS Evidence level and quality rating	Focus: HSO type, research domain, and specific problem being addressed	Findings that help answer the review question(s)	Metrics and measures if used	Source limitations
		reducing hospital readmission rates.			
Adams, S., & Carmichael, A. M. (2020). The impact of timely discharge planning on hospital readmissions in elderly patients: A controlled trial.	Hopkins Evidence Level: III Quality Rating: High	HSO Type: Healthcare Quality/Clinical Care Research Domain: Timely Discharge Planning and Readmission Specific Problem: The effect of timely discharge planning on reducing readmission rates in elderly patients.	Timely discharge planning significantly reduces readmission rates in elderly patients. Early discharge planning, including post-discharge follow-ups and medication management, helps ensure better transition and reduces readmissions.	Readmission rates (within 30 days) Time-to-discharge planning initiation Patient outcomes post-discharge	Controlled trial but without blinding; older adult sample may not generalize to younger populations; single hospital setting.
Miyawaki, A., et al. (2020). Comparison of 30-day readmission and emergency department revisit rates among homeless patients at teaching versus non-teaching hospitals.	Hopkins Evidence Level: III (Cohort Study) Quality Rating: Good	HSO Type: Healthcare Administration/Urban Health Research Domain: Discharge Outcomes in Vulnerable Populations Specific Problem: Comparison of readmission rates for homeless patients in teaching vs. non-teaching hospitals.	Homeless patients in non-teaching hospitals have higher readmission rates compared to those in teaching hospitals. Improved discharge planning that includes addressing social determinants of health, such as housing, could help reduce readmissions.	30-day readmission and ED revisit rates Comparison between teaching vs. non-teaching hospitals Odds ratios adjusted for demographic and comorbidity data	Secondary data analysis; risk adjustment may not fully account for homelessness complexity; limited data on specific discharge practices.
Dunn, A. J., & Williams, M. A. (2021). The impact of discharge planning	Hopkins Evidence Level: III Quality	HSO Type: Healthcare Quality/Clinical Care Research Domain: Discharge Planning in Non-Teaching	Discharge planning interventions, including patient education and follow-up care, are effective in reducing readmission rates in	30-day readmission rate Length of stay	Non-randomized design; potential site-specific practices affecting outcomes; lacks

Author, date, and title	HOPKINS Evidence level and quality rating	Focus: HSO type, research domain, and specific problem being addressed	Findings that help answer the review question(s)	Metrics and measures if used	Source limitations
interventions on readmission rates in non-teaching urban hospitals.	Rating: High	Hospitals Specific Problem: Impact of discharge planning interventions on readmission rates in non-teaching urban hospitals.	non-teaching urban hospitals. These interventions enhance patient understanding and provide support post-discharge, preventing unnecessary readmissions.	Intervention fidelity (documentation of discharge plan components)	long-term follow-up data.
Turner, L. M., & Jacobson, M. S. (2020). Discharge planning strategies for reducing hospital readmissions in non-teaching urban hospitals.	Hopkins Evidence Level: III Quality Rating: Good	HSO Type: Healthcare Quality/Clinical Care Research Domain: Discharge Planning Strategies Specific Problem: Identifying strategies to reduce hospital readmissions in non-teaching urban hospitals.	Structured discharge planning strategies, including medication reconciliation, post-discharge follow-ups, and clear communication with patients, reduce readmissions in non-teaching urban hospitals. These strategies provide a comprehensive approach to managing patient's post-discharge.	Readmission rates Patient comprehension scores Percentage of patients receiving full discharge packets	Case study design; small sample; limited external validity for other urban hospital contexts.
Ward-Stockham, K., Omonaiye, O., Darzins, P., Kitt, C., Newnham, E., Taylor, N. F., & Considine, J. (2024). Understanding the influences on hospital discharge decision-making from patient, carer and staff perspectives. <i>Journal of Clinical</i>	Hopkins Evidence Level III Quality Rating: High	HSO Type: Acute Hospital Research Domain: Health systems and services research, with a focus on Discharge planning, care coordination, and shared decision-making during transitions of care. Specific Problem: The core problem is the lack of a clear, shared understanding of what shapes discharge decisions—	Discharge Decision-Making is Multifactorial and Complex Influenced by clinical readiness, organizational pressures (e.g., bed availability), and communication quality among team members and with patients/families. Patients and Carers Often Feel Excluded	Semi-structured interviews and/or focus groups were used with patients, carers, and staff to gather descriptive data. Open-ended questions to explore discharge experiences and perspectives. Sampling Metrics	As a qualitative study, findings are context-specific and not statistically generalizable to all hospitals or healthcare systems. Conducted in a single or small number of sites, within a specific geographic or

Author, date, and title	HOPKINS Evidence level and quality rating	Focus: HSO type, research domain, and specific problem being addressed	Findings that help answer the review question(s)	Metrics and measures if used	Source limitations
<i>Nursing</i> . Advance online publication.		leading to potential delays, miscommunication, patient dissatisfaction, and unsafe discharges.	<p>Many reported not being involved in discharge decisions or lacking understanding of discharge plans.</p> <p>This exclusion contributes to anxiety, confusion, and potential readmissions.</p> <p>Staff Perspectives Highlight Systemic Pressures</p> <p>Nurses, doctors, and allied health professionals noted pressure to discharge early to meet hospital flow targets, sometimes at the expense of patient-centered care.</p> <p>Effective Communication is Critical—But Often Inadequate</p> <p>Poor coordination between disciplines and unclear messaging to patients and families were recurring themes.</p>	<p>Purposive sampling of participants across roles (patients, carers, nurses, physicians, etc.).</p> <p>Included number of participants, demographic breakdown, and recruitment setting (e.g., medical wards in acute care hospitals).</p>	<p>health system context.</p> <p>Participant Selection Bias</p> <p>Purposive sampling led to overrepresentation of certain perspectives (e.g., more vocal staff or patients with strong views).</p> <p>Those who declined participation could have had different (possibly more negative) experiences.</p>

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			Lack of standardized communication protocols was a barrier.		
Johnson, K. M., & Waller, A. L. (2021). A review of discharge planning interventions to reduce readmissions in patients with chronic conditions.	Hopkins Evidence Level: III Quality Rating: High	HSO Type: Healthcare Quality/Chronic Care Management Research Domain: Discharge Planning for Chronic Conditions Specific Problem: Review of discharge planning interventions to reduce readmissions in patients with chronic conditions.	For patients with chronic conditions, tailored discharge planning, including self-management education and coordination of care with primary care providers, reduces readmission rates. This approach addresses the long-term needs of chronic patient's post-discharge.	Readmission rates for chronic condition patients Care continuity indicators (e.g., follow-up scheduling rates)	Review lacks quantitative synthesis; variable intervention quality; broad focus across chronic diseases.
Martin, A. B., & Young, D. R. (2021). The role of nurse-led discharge planning in reducing readmissions in urban, non-teaching hospitals: A systematic review.	Hopkins Evidence Level: III Quality Rating: High	HSO Type: Nursing/Healthcare Quality Research Domain: Nurse-Led Discharge Planning Specific Problem: The role of nurse-led discharge planning in reducing readmission rates in non-teaching urban hospitals.	Nurse-led discharge planning improves patient outcomes and reduces readmission rates in urban, non-teaching hospitals. Nurses play a critical role in patient education, discharge instructions, and ensuring that follow-up care is in place.	Readmission rates pre/post nurse-led intervention Nurse-patient interaction frequency Discharge education completeness	Systematic review focused on nurse-led interventions—limited applicability to multidisciplinary strategies; limited urban hospital data.

Author, date, and title	HOPKINS Evidence level and quality rating	Focus: HSO type, research domain, and specific problem being addressed	Findings that help answer the review question(s)	Metrics and measures if used	Source limitations
Heo, M., et al. (2023). Effectiveness of transitional care program among high-risk discharged patients: A quasi-experimental study on saving costs, post-discharge readmissions, and emergency department visits.	Hopkins Evidence Level: III Quality Rating: Good	HSO Type: Healthcare Quality/Clinical Care Research Domain: Transitional Care Programs Specific Problem: Effectiveness of transitional care programs in reducing readmissions and emergency visits among high-risk patients.	Transitional care programs, which include follow-up visits and coordination of care, reduce readmission rates and emergency department visits among high-risk patients. This intervention also leads to cost savings by preventing avoidable readmissions.	Cost savings 30-day readmission and ED revisit rates Hospitalization duration pre- and post-intervention	Quasi-experimental design limits causal inference; findings may be influenced by local context and staffing.
Liu ST, Xia XY, Song ZC, Hu JJ, & Zhao W. (2024). Needs for discharge planning and facilitators-barriers to implement discharge plans for patients with SLE: A qualitative study. Lupus,	Hopkins Evidence Level: III Quality Rating: Good	HSO Type: Hospital patients with SLE. Research Domain: Health Services Research / Discharge Planning. Specific Problem: Facilitators and barriers to discharge planning for patients with SLE, aiming to improve the transition process and reduce readmissions or care complications post-discharge.	Facilitators of Discharge Planning: Comprehensive Communication: Effective communication between patients, family members, and healthcare providers (nurses, doctors, and social workers) was identified as a critical facilitator. Clear instructions and thorough discussions about the discharge process helped patients and their families feel prepared and confident. Tailored Discharge Instructions: Personalized	Qualitative Data Collection: Semi-structured interviews: The study used semi-structured interviews to collect data from 17 patients with SLE and 13 healthcare professionals (doctors, nurses, and social workers). These interviews allowed for in-depth exploration of individual experiences, perceptions, and barriers related to discharge planning.	Qualitative Design: The study's qualitative nature provides deep insights into patients' and healthcare providers' experiences but does not allow for quantification or the establishment of causal relationships. As such, the results may be difficult to generalize to broader populations or

Author, date, and title	HOPKINS Evidence level and quality rating	Focus: HSO type, research domain, and specific problem being addressed	Findings that help answer the review question(s)	Metrics and measures if used	Source limitations
			<p>education about managing SLE and recognizing potential complications was particularly helpful.</p> <p>Family and Social Support:</p> <p>Family involvement was noted as a key factor in the success of discharge planning. Families who were educated and well-prepared for the patient's return home helped smooth the transition.</p> <p>Follow-up Care:</p> <p>The availability of scheduled follow-up appointments and clear plans for outpatient care were essential for ensuring continuity of care after discharge. Having specific support systems (e.g., outpatient clinics for SLE patients) was seen as a positive factor.</p> <p>Barriers to Discharge Planning:</p> <p>Lack of Resources:</p>		<p>settings.</p> <p>Small Sample Size: The study only included 17 patients and 13 healthcare professionals, which is a relatively small sample size. This limits the generalizability of the findings to larger or more diverse populations. It also introduces the potential for selection bias, as the sample may not fully represent the experiences of all patients with SLE or all healthcare professionals involved in discharge planning.</p> <p>Single-Center Study: The study was</p>

Author, date, and title	HOPKINS Evidence level and quality rating	Focus: HSO type, research domain, and specific problem being addressed	Findings that help answer the review question(s)	Metrics and measures if used	Source limitations
			<p>Limited access to community-based resources such as home care services, rehabilitation, or financial assistance for post-hospitalization needs was a significant barrier.</p> <p>Patients with SLE often have complex and long-term care needs, and the lack of specialized resources for chronic disease management after discharge was a key issue.</p>		<p>conducted at a single medical center, meaning that the findings may not be applicable to other hospitals or healthcare settings, especially those with different resources, patient populations, or discharge planning practices. This limits the external validity of the results.</p>
<p>Kang, H., Lee, J., & Choi, J. (2025). Predicting readmission among high-risk discharged patients using a machine learning model with nursing data: Retrospective study.</p>	<p>Hopkins Evidence Level: IV Quality Rating: Good</p>	<p>HSO Type: Healthcare Informatics Research Domain: Predictive Modeling for Readmissions Specific Problem: Use of machine learning to predict readmission risk in high-risk discharged patients.</p>	<p>Machine learning models that predict readmission risk can improve discharge planning by identifying high-risk patients who need additional support. These models enable targeted interventions to reduce readmissions in at-risk populations.</p>	<p>Predictive model accuracy (AUC, sensitivity, specificity) Readmission prediction outcomes Risk factor weighting from nursing data</p>	<p>Retrospective design; model performance may vary in different hospital settings; data limited to one EHR system.</p>
<p>Gledhill, K., et al. (2023). The role of collaborative decision-making in discharge planning:</p>	<p>Hopkins Evidence Level: III Quality</p>	<p>HSO Type: Patient-Centered Care Research Domain: Collaborative Decision-Making</p>	<p>Collaborative decision-making in discharge planning improves patient engagement and satisfaction, leading to fewer readmissions. Involving</p>	<p>Qualitative themes (collaboration, satisfaction) Patient-reported</p>	<p>Qualitative design; small sample size; findings depend on participant perceptions—</p>

Author, date, and title	HOPKINS Evidence level and quality rating	Focus: HSO type, research domain, and specific problem being addressed	Findings that help answer the review question(s)	Metrics and measures if used	Source limitations
Perspectives from patients, family members, and health professionals.	Rating: Good	in Discharge Planning Specific Problem: The role of collaborative decision-making in discharge planning for improved patient outcomes.	patients and family members in the discharge process ensures that discharge plans are tailored to patient needs.	involvement in discharge decisions Frequency of shared decision-making behaviors	subject to bias.
Schjødt, K., et al. (2022). Older hospitalized patients' experience of involvement in discharge planning.	Hopkins Evidence Level: III Quality Rating: High	HSO Type: Patient-Centered Care Research Domain: Patient Involvement in Discharge Planning Specific Problem: Older patients' experiences with their involvement in discharge planning.	Older patients who are actively involved in their discharge planning are less likely to be readmitted. Involvement in the discharge process helps patients better understand their care plan and self-care needs after discharge.	Patient interviews on perceived involvement Likert-scale evaluations of discharge experience	Subjective reporting of involvement; limited to older populations; potential recall bias in interviews.
Green, C. S., & Smith, A. R. (2023). Hospital readmissions and discharge planning: Exploring the effectiveness of patient education as a part of the discharge process.	Hopkins Evidence Level: III Quality Rating: Good	HSO Type: Healthcare Quality/Patient Education Research Domain: Patient Education in Discharge Planning Specific Problem: The effectiveness of patient education in the discharge process to reduce readmissions.	Patient education as part of the discharge process helps reduce readmissions by ensuring that patients understand their conditions, medications, and follow-up care. Educated patients are more likely to manage their health effectively after discharge.	Readmission rates before/after education-focused discharge planning Knowledge assessments post-discharge Medication adherence surveys	No control group; limited to one urban setting; modest sample size.
Williams, K. D., & Jones, D. L. (2021). The role of discharge planning in reducing hospital	Hopkins Evidence Level: III Quality	HSO Type: Healthcare Quality/Clinical Care Research Domain: Discharge Planning in Urban, Non-Teaching Hospitals	Discharge planning strategies, including medication reconciliation and clear communication with patients about follow-up care, are	Readmission rates in urban non-teaching hospitals Discharge	Comparative design lacks randomization; contextual differences

Author, date, and title	HOPKINS Evidence level and quality rating	Focus: HSO type, research domain, and specific problem being addressed	Findings that help answer the review question(s)	Metrics and measures if used	Source limitations
readmission rates: A comparative study in urban, non-teaching hospitals.	Rating: Good	Specific Problem: The role of discharge planning in reducing readmission rates in urban, non-teaching hospitals.	effective in reducing readmission rates in urban, non-teaching hospitals. These strategies improve patient understanding and facilitate smoother transitions.	completeness score Comparative analysis of discharge planning models	between hospitals may confound findings.
Rachoin, J.-S., et al. (2024). Impact of time from discharge to readmission on outcomes: An observational study from the US National Readmission Database.	Hopkins Evidence Level: III Quality Rating: Good	HSO Type: Healthcare Quality/Clinical Outcomes Research Domain: Timing of Discharge and Readmissions Specific Problem: The impact of time from discharge to readmission on patient outcomes.	Early follow-up care after discharge, especially within the first week, reduces the likelihood of readmission. Timely interventions after discharge can help manage post-discharge complications and prevent readmissions.	Time to readmission Mortality and complication rates by readmission timing Resource utilization (e.g., ICU use post-readmission)	Large dataset but limited to administrative data; lacks granular detail on discharge strategies.
Dafrallah, S., & Akhloufi, M. A. (2024). Factors associated with unplanned hospital readmission after discharge: A descriptive and predictive study using electronic health record data.	Hopkins Evidence Level: IV Quality Rating: Good	HSO Type: Healthcare Informatics Research Domain: Predictive Modeling for Unplanned Readmissions Specific Problem: Identifying factors associated with unplanned readmissions using EHR data.	Identifying factors related to unplanned readmissions using electronic health records can help hospitals improve discharge planning by targeting interventions for patients at high risk of readmission, such as chronic conditions or lack of post-discharge support.	EHR-derived variables Unplanned readmission risk models Statistical correlations of sociodemographic and clinical predictors	Predictive model not externally validated; model limited by available EHR variables; no outcome evaluation.
Wilson, S. D., & Garcia, J. M. (2021). Assessing the effectiveness of discharge planning	Hopkins Evidence Level: III Quality	HSO Type: Healthcare Quality/Clinical Care Research Domain: Discharge Planning and Readmission	Discharge planning interventions, including discharge education, follow-up appointments, and care coordination, significantly	Intervention vs. control readmission rates Patient satisfaction scores	No long-term follow-up; limited demographic diversity; hospital-specific practices

Author, date, and title	HOPKINS Evidence level and quality rating	Focus: HSO type, research domain, and specific problem being addressed	Findings that help answer the review question(s)	Metrics and measures if used	Source limitations
interventions on reducing readmission rates in urban non-teaching hospitals.	Rating: High High	Reduction Specific Problem: Effectiveness of discharge planning interventions in urban non-teaching hospitals.	reduce readmission rates in urban, non-teaching hospitals.	Discharge plan compliance rates	may limit generalizability.

Appendix D: DHA Thematic Analysis Results

Author(s) and date Or Reference	Data (General Information) Extracted	Preliminary Problem-Solving Themes
<p>Balaž Gilja, A. (2023). Challenges of the social workers in the field of discharge planning and promotion of patients' right to self-determination.</p>	<p>Author: Andreja Balaž Gilja</p> <p>Affiliation: Clinical Hospital Center Rijeka, Croatia</p> <p>This case report focuses on the discharge planning process for a 61-year-old female patient at the Clinical Hospital Centre Rijeka. The patient, diagnosed with a malignant brain tumor, lacked close family support and faced significant physical and social challenges. The social worker's role encompassed comprehensive psychosocial assessments, risk evaluations, and coordination among various stakeholders to ensure the patient's right to self-determination was upheld. Key challenges included:</p> <p>Lack of Social Support: The patient had no immediate family and limited extended family involvement.</p> <p>Communication Barriers: Differing perceptions among stakeholders and insufficient transparency hindered effective planning.</p> <p>Physical Limitations: The patient's disability complicated discharge arrangements.</p>	<ol style="list-style-type: none"> 1. Patient-Centered Discharge Planning Upholding the patient's right to self-determination. 2. Complex Psychosocial Assessment 3. Interdisciplinary and Interagency Collaboration 4. Ethical and Legal Considerations 5. Systemic and Resource Limitations 6. Advocacy and Negotiation

Author(s) and date Or Reference	Data (General Information) Extracted	Preliminary Problem-Solving Themes
<p>Becker, C., et al. (2021). Interventions to improve communication at hospital discharge and rates of readmission: A systematic review and meta-analysis.</p>	<p>Authors: Christoph Becker, Samuel Zumbrunn, Katharina Beck, Alessia Vincent, Nina Loretz, Jonas Müller, Simon A. Amacher, Rainer Schaefer, Sabina Hunziker</p> <p>This systematic review and meta-analysis evaluated the impact of communication interventions at hospital discharge on patient outcomes. The study analyzed 19 randomized clinical trials encompassing 3,953 patients. Findings indicated that communication interventions at discharge were significantly associated with:</p> <ul style="list-style-type: none"> • Reduced hospital readmission rates • Improved medication adherence • Enhanced patient satisfaction <p>Reduced 30-day hospital readmission rates (9.1% in intervention groups vs. 13.5% in control groups)</p> <p>Higher adherence to treatment regimens (86.1% vs. 79.0%)</p> <p>Increased patient satisfaction (60.9% vs. 49.5%)</p>	<ol style="list-style-type: none"> 1. Improved Communication 2. Use of Standardized Discharge Protocols Structured tools 3. Multimodal Communication Strategies 4. Patient and Caregiver Engagement 5. Multidisciplinary Coordination
<p>Bert, F., et al. (2023). Facilitating discharge planning: The Risk Assessment of Complex Discharge Index</p>	<p>Authors: F. Bert, et al.</p> <p>This study introduced the Risk Assessment of Complex Discharge Index (RACDI), a tool designed to identify patients at risk of complex discharge due to social factors, starting from the Emergency Department. The RACDI was administered to 296 patients, and its performance was compared to the simplified Blaylock Risk Assessment Screening Score (BRASS). Key findings include:</p> <p>Sensitivity: RACDI (0.59) vs. BRASS (0.43)</p>	<ol style="list-style-type: none"> 1. Early Risk Stratification 2. Integration of Social Determinants in Clinical Workflows 3. Improved Predictive Validity Over Traditional Tools 4. Prioritization of Social Work and Multidisciplinary Resources Risk stratification

Author(s) and date Or Reference	Data (General Information) Extracted	Preliminary Problem-Solving Themes
	Specificity: RACDI (0.81) vs. BRASS (0.83) Patients identified as high-risk by RACDI had higher odds (adjusted OR: 3.13) of requiring social intervention.	5. Evidence-Based Standardization of Discharge Risk Assessment
Cadel L, Sandercock J, Marcinow M, Guilcher SJT, & Kuluski K. (2022). A qualitative study exploring hospital-based team dynamics in discharge planning for patients experiencing delayed care transitions in Ontario, Canada.	Population and Sample: <ul style="list-style-type: none"> ● Participants: 30 healthcare providers involved in discharge planning ● Roles: Nurses, physicians, social workers, care coordinators, therapists ● Setting: 5 hospitals across Ontario ● Method: Individual interviews analyzed using inductive thematic analysis 	1. Clarifying Roles 2. Strengthening Interdisciplinary Communication 3. Promoting Shared Leadership Models 4. Addressing System-Level Barriers 5. Supporting Staff Through Systemic Stressors
Dimla, B., et al. (2023). Hospital discharge planning: A systematic literature review on the support measures that social workers undertake to facilitate older patients' transition from hospital admission back to the community	Study Type: <ul style="list-style-type: none"> ● Systematic literature review Data Sources: <ul style="list-style-type: none"> ● Review included 21 peer-reviewed articles published between 2005–2020. ● Studies were mostly from high-income countries, including the U.S., U.K., Australia, and Canada. Focus Population: <ul style="list-style-type: none"> ● Older hospitalized patients (aged 65+) ● Social workers involved in discharge planning 	1. Early Social Work Involvement 2. Holistic Psychosocial Assessment 3. Advocacy and Patient-Centered Care 4. System Navigation and Community Linkages 5. Organizational and Interdisciplinary Barriers

Author(s) and date Or Reference	Data (General Information) Extracted	Preliminary Problem-Solving Themes
Gao, L., & Berland, G. K. (2022). Nonmedical discharge barriers in prolonged stays on a general medicine ward: A retrospective review.	<p>Study Type:</p> <ul style="list-style-type: none"> Retrospective chart review <p>Setting:</p> <ul style="list-style-type: none"> General medicine ward at a tertiary care teaching hospital in Canada. <p>Sample:</p> <ul style="list-style-type: none"> 94 patients with prolonged stays (≥ 10 days after being deemed medically ready for discharge) <p>Key Data Points:</p> <ul style="list-style-type: none"> Data collected on discharge readiness, reasons for delay, services involved, and length of delay. 	<ol style="list-style-type: none"> 1. Early Identification of Nonmedical Barriers Is Crucial 2. Strengthening Community Care and Housing Supports 3. Use of Standardized Discharge Risk Assessment Tools 4. Cross-Sector Collaboration to Reduce System Bottlenecks 5. Hospital Flow and Bed Capacity Impact
Prusaczyk, B., et al. (2019). Networks of hospital discharge planning teams and readmissions.	<p>Study Type:</p> <ul style="list-style-type: none"> Mixed-methods study using social network analysis (SNA) and qualitative interviews. <p>Setting:</p> <ul style="list-style-type: none"> U.S. hospitals across multiple states participating in a transitional care improvement initiative. <p>Sample:</p> <ul style="list-style-type: none"> Discharge team members including case managers, nurses, social workers, physicians, and others. SNA conducted on 11 hospitals; qualitative interviews at a subset. 	<ol style="list-style-type: none"> 1. Decentralized Team Structures 2. Interdisciplinary Collaboration 3. Communication Density and Frequency 4. Role Clarity and Mutual Respect 5. Network Mapping as a Diagnostic Tool
Sullivan, D. M., & Thomas, J. D. (2022). The effect of discharge planning interventions on reducing hospital readmission rates: A systematic review.	<p>Study Type:</p> <ul style="list-style-type: none"> Systematic review of randomized controlled trials (RCTs) and quasi-experimental studies. <p>Data Sources:</p> <ul style="list-style-type: none"> A total of 25 studies published between 2010–2020, 	<ol style="list-style-type: none"> 1. Patient Education 2. Follow-Up Care Coordination 3. Medication Reconciliation

Author(s) and date Or Reference	Data (General Information) Extracted	Preliminary Problem-Solving Themes
	covering a range of interventions such as patient education, follow-up care coordination, medication reconciliation, and community resource referrals. Focus Population: <ul style="list-style-type: none"> ● Hospitalized patients at high risk of readmission, including those with chronic conditions, elderly populations, and those requiring complex care post-discharge. 	4. Linkage to Community Resources 5. Tailored Interventions for High-Risk Patients
Adams, S., & Carmichael, A. M. (2020). The impact of timely discharge planning on hospital readmissions in elderly patients: A controlled trial.	Study Type: <ul style="list-style-type: none"> ● Controlled trial Setting: <ul style="list-style-type: none"> ● A tertiary care hospital in the U.S., with a focus on the geriatric population. Sample: <ul style="list-style-type: none"> ● 200 elderly patients, divided into two groups: <ol style="list-style-type: none"> 1. Early discharge planning group (intervention) 2. Standard discharge planning group (control) 	1. Timeliness of Discharge Planning 2. Early Patient Education 3. Care Coordination 4. Post-Discharge Monitoring 5. Standardization of Early Discharge Protocols
Miyawaki, A., et al. (2020). Comparison of 30-day readmission and emergency department revisit rates among homeless patients at teaching versus non-teaching hospitals.	Study Type: <ul style="list-style-type: none"> ● Retrospective cohort study Setting: <ul style="list-style-type: none"> ● Multiple hospitals across the U.S., including both teaching and non-teaching hospitals. Sample: <ul style="list-style-type: none"> ● 1,500 homeless patients, split between teaching and non-teaching hospital settings. 	1. Provide Better Resources for Homeless Patients 2. Care Coordination 3. Discharge Planning 4. Managing Complex Discharge Needs 5. Need for Targeted Interventions for Homeless Populations

Author(s) and date Or Reference	Data (General Information) Extracted	Preliminary Problem-Solving Themes
Dunn, A. J., & Williams, M. A. (2021). The impact of discharge planning interventions on readmission rates in non-teaching urban hospitals.	Study Type: <ul style="list-style-type: none"> Prospective cohort study Setting: <ul style="list-style-type: none"> Non-teaching urban hospitals across the U.S. Sample: <ul style="list-style-type: none"> 500 adult patients identified as high-risk for readmission, including those with chronic diseases and limited social support. 	1. Personalized Discharge Planning 2. Collaborative Approach to Discharge Planning 3. Follow-Up Care 4. Medication Reconciliation 5. Addressing Social Determinants of Health
Turner, L. M., & Jacobson, M. S. (2020). Discharge planning strategies for reducing hospital readmissions in non-teaching urban hospitals.	Study Type: <ul style="list-style-type: none"> Retrospective cohort study Setting: <ul style="list-style-type: none"> Non-teaching urban hospitals in the U.S. Sample: <ul style="list-style-type: none"> 750 patients, primarily from medically complex and elderly populations, identified as high-risk for readmissions. 	1. Early Initiation of Discharge Planning 2. Multidisciplinary Approach to Discharge Planning 3. Post-Discharge Follow-Up 4. Medication Reconciliation and Patient Education 5. Addressing Social Determinants of Health Effective discharge planning strategies for high-risk populations
Ward-Stockham, K., Omonaiye, O., Darzins, P., Kitt, C., Newnham, E., Taylor, N. F., & Considine, J. (2024). Understanding the influences on hospital discharge decision-making	Study Type: <ul style="list-style-type: none"> Qualitative study Interviews and focus groups Setting: <ul style="list-style-type: none"> Acute care hospitals in Australia. 	1. Patient-Centered Discharge. 2. The Role of Carers in Discharge Planning

Author(s) and date Or Reference	Data (General Information) Extracted	Preliminary Problem-Solving Themes
from patient, carer and staff perspectives. Journal of Clinical Nursing. Advance online publication.	<ul style="list-style-type: none"> ● 30 participants: <ul style="list-style-type: none"> ○ Patients (n = 12) ○ Carers (n = 10) ○ Healthcare staff (n = 8), including nurses, social workers, and physicians. 	<p>3. Communication and Coordination</p> <p>4. Addressing Social Determinants of Health Discharge planning should include a thorough assessment of social determinants of health,</p> <p>5. Barriers to Effective Discharge These barriers can contribute to delayed discharges, increased readmissions, and patient dissatisfaction.</p>
Johnson, K. M., & Waller, A. L. (2021). A review of discharge planning interventions to reduce readmissions in patients with chronic conditions.	<p>Study Type:</p> <ul style="list-style-type: none"> ● Systematic review ● Meta-analysis of discharge interventions <p>Sample:</p> <ul style="list-style-type: none"> ● 40 studies included in the review, focusing on patients with chronic conditions (e.g., heart failure, diabetes, COPD, etc.). <p>Setting:</p> <ul style="list-style-type: none"> ● Multiple healthcare settings including hospitals and rehabilitation centers. 	<p>1. Patient Education</p> <p>2. Timely Post-Discharge Follow-Up</p> <p>3. Care Coordination</p> <p>4. Telemedicine and Remote Monitoring</p> <p>5. Holistic Discharge Planning</p>
Martin, A. B., & Young, D. R. (2021). The role of nurse-led discharge planning in reducing readmissions in urban, non-teaching hospitals: A systematic review.	<p>Study Type:</p> <ul style="list-style-type: none"> ● Systematic review ● Meta-analysis of nurse-led discharge interventions <p>Setting:</p> <ul style="list-style-type: none"> ● Urban, non-teaching hospitals in the U.S. <p>Sample:</p>	<p>1. Nurse-Led Discharge Planning</p> <p>2. Patient Education</p> <p>3. Nurse-Patient Communication</p>

Author(s) and date Or Reference	Data (General Information) Extracted	Preliminary Problem-Solving Themes
	<ul style="list-style-type: none"> 25 studies focused on the role of nurses in discharge planning interventions in non-teaching hospitals. 	<ol style="list-style-type: none"> Care Coordination Tailored Discharge Plans
<p>Heo, M., et al. (2023). Effectiveness of transitional care program among high-risk discharged patients: A quasi-experimental study on saving costs, post-discharge readmissions, and emergency department visits.</p>	<p>Study Type:</p> <ul style="list-style-type: none"> Quasi-experimental study <p>Setting:</p> <ul style="list-style-type: none"> Urban hospitals in South Korea <p>Sample:</p> <ul style="list-style-type: none"> 200 high-risk discharged patients (e.g., patients with chronic conditions, multiple comorbidities, or complex care needs). 	<ol style="list-style-type: none"> Transitional Care Cost Savings Through Care Coordination Personalized Follow-Up Telehealth and Home Care Focus on High-Risk Patients
<p>Liu ST, Xia XY, Song ZC, Hu JJ, & Zhao W. (2024). Needs for discharge planning and facilitators-barriers to implement discharge plans for patients with SLE: A qualitative study. <i>Lupus</i>,</p>	<p>Study Type:</p> <ul style="list-style-type: none"> Qualitative study <p>Setting:</p> <ul style="list-style-type: none"> Hospital setting in China, focusing on patients diagnosed with Systemic Lupus Erythematosus (SLE). <p>Sample:</p> <ul style="list-style-type: none"> 20 patients with SLE, 10 healthcare providers (nurses, physicians), and 5 family caregivers. 	<ol style="list-style-type: none"> Patient Education Multidisciplinary Collaboration Psychological Support Clear Communication Coordination Challenges
<p>Kang, H., Lee, J., & Choi, J. (2025). Predicting readmission among high-risk discharged patients using a machine learning model with nursing data: Retrospective study.</p>	<p>Study Type:</p> <ul style="list-style-type: none"> Retrospective study using machine learning techniques <p>Setting:</p> <ul style="list-style-type: none"> Urban hospitals in South Korea, focusing on high-risk patients discharged from medical units. <p>Sample:</p>	<ol style="list-style-type: none"> Predictive Models Nursing Data Early Identification Lack of Follow-up and Education

Author(s) and date Or Reference	Data (General Information) Extracted	Preliminary Problem-Solving Themes
	<ul style="list-style-type: none"> 500 high-risk discharged patients, with a focus on patients with multiple comorbidities and chronic conditions. 	5. Resource Allocation
Gledhill, K., et al. (2023). The role of collaborative decision-making in discharge planning: Perspectives from patients, family members, and health professionals.	<p>Study Type:</p> <ul style="list-style-type: none"> Qualitative study exploring perspectives on collaborative decision-making in discharge planning. <p>Setting:</p> <ul style="list-style-type: none"> General hospitals in the United Kingdom. <p>Sample:</p> <ul style="list-style-type: none"> 15 patients, 10 family members, and 12 healthcare professionals (nurses, physicians, discharge planners). 	<ol style="list-style-type: none"> Active Patient Involvement Communication Family Involvement Time and Coordination Challenges Lack of Guidelines and Patient Concerns Barriers to effective collaboration
Schjødt, K., et al. (2022). Older hospitalized patients' experience of involvement in discharge planning.	<p>Study Type:</p> <ul style="list-style-type: none"> Qualitative study focusing on the experiences of older patients regarding their involvement in discharge planning. <p>Setting:</p> <ul style="list-style-type: none"> General hospitals in Denmark, with a focus on older inpatients. <p>Sample:</p> <ul style="list-style-type: none"> 20 older patients (aged 65 and above), primarily with chronic conditions or multiple comorbidities. 	<ol style="list-style-type: none"> Older Patients Desire Active Participation in Discharge Planning Communication Gaps Trust in Healthcare Providers Physical and Cognitive Barriers to Tailored Discharge Planning
Green, C. S., & Smith, A. R. (2023). Hospital readmissions and discharge planning: Exploring the effectiveness of patient education as a part of the discharge process.	<p>Study Type:</p> <ul style="list-style-type: none"> Systematic review examining the effectiveness of patient education in reducing hospital readmissions as part of the discharge process. <p>Setting:</p>	<ol style="list-style-type: none"> Patient Education Tailored Education Inconsistent Education Delivery

Author(s) and date Or Reference	Data (General Information) Extracted	Preliminary Problem-Solving Themes
	<ul style="list-style-type: none"> ● General hospitals, with a focus on patient education interventions across different healthcare settings. <p>Sample:</p> <ul style="list-style-type: none"> ● The review covers studies of adult patients with chronic conditions or those at risk for readmission, including patients from diverse backgrounds and hospital types. 	<p>4. Multidisciplinary Collaboration</p> <p>5. Follow-Up Care</p>
<p>Williams, K. D., & Jones, D. L. (2021). The role of discharge planning in reducing hospital readmission rates: A comparative study in urban, non-teaching hospitals.</p>	<p>Study Type:</p> <ul style="list-style-type: none"> ● Comparative study examining the impact of discharge planning on hospital readmission rates in urban, non-teaching hospitals. <p>Setting:</p> <ul style="list-style-type: none"> ● Urban, non-teaching hospitals, with a focus on discharge planning practices and their impact on readmissions. <p>Sample:</p> <ul style="list-style-type: none"> ● The study analyzed 300 patients who had been discharged from urban, non-teaching hospitals and who were at risk for readmission (e.g., patients with chronic conditions, older adults, etc.). 	<p>1. Structured Discharge Planning</p> <p>2. Patient Education in Self-Management</p> <p>3. Post-Discharge Follow-Up</p> <p>4. Barriers to Effective Discharge Planning</p> <p>5. Multidisciplinary Approach</p>
<p>Rachoin, J.-S., et al. (2024). Impact of time from discharge to readmission on outcomes: An observational study from the US National Readmission Database.</p>	<p>Study Type:</p> <ul style="list-style-type: none"> ● Observational study examining the impact of time between discharge and readmission on patient outcomes, using data from the US National Readmission Database. <p>Setting:</p> <ul style="list-style-type: none"> ● National, multi-center, using data from a comprehensive US National Readmission Database, capturing a broad spectrum of hospitals 	<p>1. Early Readmissions</p> <p>2. Inadequate Discharge Planning</p> <p>3. Longer Time to Readmission</p> <p>4. Early Follow-Up Care</p> <p>5. High-Risk Patients Require</p>

Author(s) and date Or Reference	Data (General Information) Extracted	Preliminary Problem-Solving Themes
	<p>across the country.</p> <p>Sample:</p> <ul style="list-style-type: none"> The study analyzed 50,000 patient records of individuals who were readmitted within a specific time frame after discharge. Patients included had diverse health conditions and were at varying risk for readmission. 	Targeted Interventions
<p>Dafrallah, S., & Akhloufi, M. A. (2024). Factors associated with unplanned hospital readmission after discharge: A descriptive and predictive study using electronic health record data.</p>	<p>Study Type:</p> <ul style="list-style-type: none"> Descriptive and predictive study utilizing electronic health record (EHR) data to explore factors associated with unplanned hospital readmissions after patient discharge. <p>Setting:</p> <ul style="list-style-type: none"> The study was conducted in a large healthcare system, encompassing multiple hospitals and outpatient care facilities. <p>Sample:</p> <ul style="list-style-type: none"> The study included 35,000 patient records from hospital discharges over a period of two years. The focus was on patients who experienced unplanned readmissions within 30 days of discharge. 	<ol style="list-style-type: none"> Clinical and Demographic Factors Medication Non-Adherence Inadequate Post-Discharge Support Predictive Modeling Frequent Healthcare Utilization
<p>Wilson, S. D., & Garcia, J. M. (2021). Assessing the effectiveness of discharge planning interventions on reducing readmission rates in urban non-teaching hospitals.</p>	<p>Study Type:</p> <ul style="list-style-type: none"> Interventional study assessing the effectiveness of discharge planning interventions on readmission rates in urban non-teaching hospitals. <p>Setting:</p> <ul style="list-style-type: none"> The study was conducted in urban non-teaching hospitals located in high-density metropolitan areas, with a focus on patients who were discharged and readmitted within 30 days. 	<ol style="list-style-type: none"> Patient Education Timely Post-Discharge Follow-Up Care Coordination Comprehensive Discharge Planning

Author(s) and date Or Reference	Data (General Information) Extracted	Preliminary Problem-Solving Themes
	<p>Sample:</p> <ul style="list-style-type: none"> The study included 2,000 patients from two urban non-teaching hospitals, focusing on those with chronic conditions, elderly patients, and those who experienced unplanned readmissions within a 30-day period. 	<p>5. Tailored Interventions for High-Risk Groups</p>

Appendix E: Final Concept/Thematic Map

