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Mavis Johnson

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Identifying Best Practices to Decrease the High Rate of 30-Day Rehospitalization of
Patients with Dementia from Skilled Nursing Facilities

by

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Abstract

As CMS continues to prioritize quality care over quantity and positive patient outcomes, hospitals and nursing homes must ensure that their mission and goals align. The high rehospitalization rate is a current and ongoing concern among policymakers and healthcare administrators. Adverse patient outcomes and increased financial costs to both patients and Health Service Organization (HSO) administrators highlight the need to identify best practices to help reduce rehospitalization. The purpose of this integrative review is to identify best practices for reducing the high rate of 30-day rehospitalization among patients with dementia in skilled nursing facilities (SNF). The review question that guided this integrative review is: What best practices can be implemented to decrease the high rate of 30-day rehospitalization of patients with dementia from SNF? The theoretical framework used is the Donabedian framework. This framework structure encompasses the physical and organizational components of the facility, including ensuring adequate, qualified staff to care for patients. The process focuses on identifying best practices to help decrease the rehospitalization rate, while the outcome measure is a decrease in 30-day rehospitalization. The results of the thematic analysis identified four different themes. These themes include communication, risk prediction, incentives, and the specialty care unit. Skilled facilities must collaborate with hospitals and all relevant disciplines to help reduce the frequency of rehospitalizations among patients from these facilities. The implications of these findings provide best practices for decreasing the 30-day rehospitalization rate of patients with dementia from SNF, which helps promote positive social change.

Stage 1: Practice-Based Problem

Problem of Interest

The problem of interest is the high rate of rehospitalization within 30 days of patients with dementia from SNF. This integrative review is pertinent to tackling the ongoing challenges of identifying best practices to help decrease the high rehospitalization rate. The rehospitalization of patients with a dementia diagnosis has become a severe safety concern among healthcare personnel and families (Ma et al., 2019). Addressing this problem is essential in improving and reducing patient rehospitalization, improving patient outcomes, and reducing costs to the facility. This integrative review aims to identify best practices that can help reduce the rehospitalization rate of patients from SNF within 30 days.

This review is timely as it searches and examines literature and identifies best practices that can help to reduce rehospitalization. While the Center for Medicare and Medicaid Services (CMS) has implemented different programs, including Skilled Nursing Facility Value-Based Purchasing Programs (SNFVBP) and the Initiative to Reduce Avoidable Hospitalization Among Nursing Facility Residents, there is still a high rate of rehospitalization from skilled nursing facilities within 30 days (Burke et al., 2022). Furthermore, identifying best practices that can help decrease rehospitalization can promote overall quality care and better patient outcomes. In addition, identifying best practices can also help reduce the cost of rehospitalization of patients with dementia in healthcare systems and facilities (Anderson & Ferguson, 2020). Lastly, the findings of

this review can contribute to social change by improving outcomes, reducing costs, and contributing to policy changes within SNFs. While the CMS has implemented different programs, including SNFVBP and the Initiative to Reduce Avoidable Hospitalization Among Nursing Facility Residents, there is still a high rate of rehospitalization from skilled nursing facilities within 30 days (Burke et al., 2022). Furthermore, identifying best practices that can help decrease rehospitalization can promote overall quality care and better patient outcomes. In addition, identifying best practices can also help reduce the cost of rehospitalization of patients with dementia in healthcare systems and facilities (Anderson & Ferguson, 2020). Lastly, the findings of this review can contribute to social change by improving outcomes, reducing costs, and contributing to policy changes within SNFs.

There is a need for healthcare administrators and clinical managers to address the need to identify best practices that can help reduce rehospitalization of patients from SNF with a diagnosis of dementia. Identifying best practices may help patients and families be less emotionally stressed during their stay at SNF (Anderson & Ferguson, 2020).

Healthcare Administration Problem

Background

The high rate of rehospitalization of patients with a diagnosis of dementia within 30 days from SNF is a pressing and ongoing healthcare administration problem. About 44% of the patients leaving the hospital are transferred to SNF, and approximately 25% are re-hospitalized (Gomez et al., 2023; Gupta et al.,

2019). Adults with a diagnosis of dementia can experience a greater possibility of rehospitalization (Anderson et al., 2022). The rate of rehospitalization of patients with Alzheimer's disease and related dementias (ADRD) is 18.2 % compared to a similar age group of 17.3% (Kamdar et al., 2023). Over the years, the CMS has implemented several different programs to help reduce high rehospitalization rates. As the healthcare systems shifted from fee-for-service, the CMS has been pushing for a new focus on quality over quantity care and positive patient outcomes (Pickens et al., 2017).

Historically, healthcare systems focus, and priority were more clinical-based, outcomes-driven, and less concerned with positive patient experience. However, the shifting focus to positive patient outcomes emphasizes the need to implement best practices to reduce rehospitalization from skilled facilities. Post-hospital stays, some patients may require some form of rehabilitation prior to returning home to aid them in returning to their usual state of being before hospitalization. Skilled facilities are an option for transitional care for patients discharged from hospitals. A prolonged hospital stay may negatively affect patients' activities of daily living and require patients to be discharged to skilled nursing facilities where patient can be assisted with task to help them regain prior status and go back home (Heiks et al., 2022).

Operational Problem

Research confirms the urgency and drive for improved quality care and positive patient outcomes. The rehospitalization of patients with a diagnosis of dementia has

become a grave safety and cost concern among healthcare administration and clinical personnel (Anderson et al., 2022). Skilled facilities should ensure that patients stay at skilled facilities for the duration of time without the possibility of readmission before 30 days (Ma et al., 2019).

There is a need for SNF to address the high readmission rate of patients within 30 days (Ma et al., 2019). Identifying best practices that can help reduce the high rate of rehospitalization of patients with a diagnosis of dementia is vital in helping to decrease the high readmission rate within 30 days (Pasqualini et al., 2024).

Ideal State of Operations

Patience with dementia and other Alzheimer's disease diagnosis are re-hospitalized within 30 days of admission at the rate of 21.5% compared to those without dementia diagnosis at the rate of 14.7%. The ideal state of operations for hospitalizing patients from skilled facilities entails reducing readmission through a multi-dimensional approach and care coordination (Gupta et al., 2019). CMS measures acceptable rates through implemented programs such as SNFVBP.

According to Gai and Pachamano (2019), the Hospital Readmissions Reduction Program (HRRP) was established to help reduce the high rate of rehospitalization, decrease the cost of healthcare, and improve patient safety and outcomes. In addition, the CMS offers incentives to SNF through the SNFVBP program to help improve the high rate of rehospitalization and the quality of care for patients. For example, facilities with a high rehospitalization rate can be penalized under the HRRP. Penalties include a percentage reduction in Medicare payment and reimbursement. For patients with a

dementia diagnosis and other comorbidities, Medicare has implemented changes to the SNF reimbursement system under the Patient-Driven Payment Model to help ensure proper placement of patients with dementia to help prevent rehospitalization (Kosar et al., 2024).

In the ideal state, hospital and skilled facility clinicians are engaged and working together in care coordination. This not only can help reduce rehospitalization but also promote positive patient outcomes. Achieving this state requires teamwork with the interdisciplinary at the skilled nursing facility, which includes doctors, practitioners, discharge planning, admission, and nursing teams. In addition, effective communication between skilled facilities and hospitals pre- and post-discharge is important in preventing rehospitalization.

Professional Practice Gap Statement

The high rehospitalization of patients with a diagnosis of dementia (Anderson et al., 2022) has become a grave safety and cost concern among healthcare administration and clinical personnel (Ma et al., 2019) due the poor patient outcomes and cost to healthcare operations (Rammonhan et al., 2023). Evidence shows that patients with dementia are re-hospitalized from skilled facilities at a rate of 7% to 35% compared to those without dementia. Also, patients with dementia diagnosis require more than usual healthcare services and can experience three times the increased chance of preventable hospitalization (Pickens et al., 2017). This study will research best practices needed to decrease the high rate of rehospitalization of patients with dementia (Ma et al., 2019); however, there is a gap in the need for additional future studies that will help identify best

practices to help prevent rehospitalization. This integrative review will research best practices that can be implemented to help reduce the current high rate of rehospitalization of patients with dementia diagnosis from skilled facilities.

Summary of Evidence

The healthcare problem under analysis relates to the high rate of readmission of patients diagnosed with dementia (Ma et al., 2019). The readmission rate of patients within 30 days of discharge from a skilled facility has become a critical safety concern among health care leaders (Anderson et al., 2022). Readmission can severely impact patient outcomes and facility costs (Pasqualini, 2024). Evidence shows that skilled facilities and hospitals need to address patients' high rehospitalization rate within 30 days (Ma et al., 2019). Identifying best practices that can help reduce the high rate of rehospitalization of patients with a diagnosis of dementia is vital in helping to decrease rehospitalizations (Pasqualini et al., 2024). The CMS has implemented a new program called Medicare SNFVBP, which is geared toward helping skilled facilities thrive to ensure that patients are not returned to the hospital within 30 days of admission to the facility or pay a fine (Burke et al., 2022).

Purpose of the Integrative Review

The purpose of this integrative review is to identify best practices needed to decrease the high rate of 30-day hospitalization of patients with dementia from SNF. This review addresses the healthcare administration problem of rehospitalization by identifying best practices that can significantly help reduce the high rate of readmitted patients. By synthesizing existing literature related to patients rehospitalization, it is

imperative to highlight best practices that can help decreased the prominent issue in health care. Ultimately, this review aims to identify best practices that, when implemented, can help decrease rehospitalization, which can drive positive patient outcomes and reduce potential costs to facilities.

Integrative Review Question

The primary question guiding this integrative review is: What best practices can be implemented to decrease the high rate of 30-day rehospitalization of patients with dementia from SNF? This review question explicitly addresses the key element of the healthcare administrative problem, which includes the need to decrease the high rehospitalization rate at skilled facilities and focuses on identifying best practices needed to help decrease the frequent rehospitalization of patients. This review will help identify best practices that can provide potential solutions to help address the challenge of keeping patients in skilled facilities when discharged from hospitals.

The review question explores best practices that can improve patient outcomes and potentially prevent the facility from losing financially through the CMS Value Base Purchasing program. It addresses the critical need for healthcare administrators and clinicians to implement these best practices to prevent rehospitalization, promote positive patient outcomes, and decrease financial costs to the HSO. The review question is designed to identify and explore finding resolutions that can improve the patient's overall experience, reduce stress on the patient and family, and foster better trusting relationships with clinicians and healthcare systems.

Theoretical and/or Conceptual Framework

The Donabedian model lays out the framework to explore why patients are hospitalized and can help identify best practices that can help decrease rehospitalization. The Donabedian framework model encompasses and provides a structured approach to analyze and enhance healthcare delivery and promote quality care. Donabedian framework was developed by Avedis Donabedian in 1966. Donabedian was a physician and researcher who laid out his framework with three dimensions: structure, process, and outcome measures. The Donabedian framework, when implemented at skilled nursing facilities (SNFs), can help identify best practices that will help reduce 30-day readmission rates from SNFs to hospitals.

Structure measures include the physical and organizational components of the skilled nursing facility. Components such as adequate qualified staffing and availability of necessary equipment are necessary to ensure that when patients are admitted, they can be cared for timely. Adequate staffing and availability of necessary equipment are crucial in effectively operating patient care environments to help reduce rehospitalization. The process focuses on identifying best practices to help decrease rehospitalizations. The process also includes tracking the effectiveness of protocols and clinical guidelines, which can help guide patient care and focus on personalized care to help prevent rehospitalization. Outcome measures is a decrease in 30 days readmission rates from SNFs to hospital. This multifaceted approach is crucial for tackling and determining the

effectiveness of identifying best practices that can prevent rehospitalization and help promote positive patient outcomes.

Part 2: Literature Review, Quality Appraisal, and Analysis

Literature Search Strategy

An integrative review of literature published 2017-2025 was conducted using different databases, including Medline, Science Direct, Google Scholar, SCOPUS, BioMed Central, and JSTOR. Specific keywords, including structure and search strategy, were applied to systematically narrow down to relevant literature on identifying the best strategies to help reduce the high rate of rehospitalization from skilled nursing facilities.

The keywords and phrases used in the search include *rehospitalization*, *return to hospital*, *skilled nursing facilities*, *patients with dementia*, *dementia related diagnosis*, *30-day re-admission*, *best practices*, *high rate*, *decrease*, and *reduction*. Using these keywords in various combinations, the search aimed to locate pertinent articles pertaining to the high rate of rehospitalization of patients with dementia from skilled nursing facilities.

The search was refined with Boolean operators AND, OR, and NOT. Combinations such as “rehospitalization OR return to hospital,” and “skilled nursing facilities OR nursing homes” were utilized to narrow down and create a more specific search specific to the desired literature.

A total of 222 articles were found relevant to this integrative review. Further review identified that 38 articles were not peer reviewed, 44 were outdated, 55 were

related to rehospitalization but were from home instead of a skilled nursing facility, 27 were based outside of the United States of America, and 11 were not in English. The remaining 47 articles were reviewed for relevance to this integrative review topic, with a final 30 selected.

Table 1

Inclusion and Exclusion Search Criteria

Inclusion search criteria	Exclusion search criteria
Re-hospitalization OR return to hospital	Articles that are outdated or do not reflect
Skilled nursing facilities OR nursing home	current practices and theories really it into rehospitalization or readmission.
Patient with dementia OR dementia related diagnosis	Setting that do not include United States
30- day re-admission	Non-English Publication
Best practices	Non-English Language
High rate OR decrease OR reduction	
Language: English	
Published between 2019 to 2025	
location: United States, America, USA.	
Availability: Full text articles	
Setting: Nursing homes, skilled nursing facilities	

Quality Appraisal

For this integrative review, 30 articles and studies met the inclusive criteria spanning publications from 2017 to 2025, with a notable concentration of studies published between 2019 and 2025. These articles were selected for quality appraisal and used in the Johns Hopkins Nursing Evidence-Based Practice Model. The John Hopkins Nursing Evidence-Based Practice Model is a structured framework integrating evidence-based practice into nurses, clinical decision-making. The John Hopkins model classified evidence into 5 levels. The reviewed articles fall under the following categories

- LEVEL III: 9 articles. 5 rated high quality and 4 rated moderate quality
- LEVEL IV: 7 articles. 3 rated high, 2 rated moderate, 1 rated low to moderate quality.
- LEVEL V: 14 articles. 7 rated high, 5 rated moderate, 2 moderate-high, and one rated lower quality.

The 30 sources are secondary non-experimental research, including cross-sectional, systemic, observational studies with strategies to help decrease the high rehospitalization rate of patients with dementia within 30 days from skilled facilities. The articles focus on strategies that healthcare leaders can implement at both the discharging hospital and the receiving skilled facility, which can help decrease the risk of rehospitalization of patients with dementia.

Thematic Analysis of Literature

Of the 30 articles, three were literature reviews, and ten were integrative reviews; The other seventeen were research articles. The John Hopkins Nursing Evidence-Based Practice Model rated 14 articles as having a strength of evidence at Level V, seven articles having a strength of evidence at Level IV, and nine articles at evidence level III. The articles reviewed in this integrative review were non-experimental and focused on quality improvement in identifying best practices to decrease the rehospitalization of patients. The findings from the articles suggested several best practices that can be implemented to help decrease rehospitalization of patients with dementia diagnosis from skilled nursing facilities. Some best practices include early nurse practitioner (NP) involvement, excellent communication among discharging hospitals and receiving skilled nursing facilities, personalized care plans, and specialty-trained nurses and nurses' aides to care for patients. With these best practices, SNFs can help reduce the high rehospitalization rate. By reducing the high rehospitalization rate, patients can have a better outcome and a reduction in the cost of rehospitalization to skilled facilities.

Part 3: Presentation of Results

The integrative review question is: What best practices can be implemented to decrease the high rate of 30-day rehospitalization of patients with dementia from skilled nursing facilities (SNF)? These themes emerged from the data analyzed, focusing on answering the review question. Each theme is supported by a range of sub-themes that clarify specific processes and actions within each theme. The main themes include communication, risk prediction, incentives, and the specialty care unit.

Communication

The literature review highlighted the importance of the theme of communication, as it ties into other themes and subthemes, emphasizing the significance of effective communication in preventing rehospitalization. Gilmore-Bykovskiy et al. (2021) stressed the importance of accurate and effective communication from the hospital to the SNF regarding the neuropsychological aspects of the patient and other pertinent information to be relayed to the SNF for transferred patients. Additionally, Jackson et al. (2024) emphasized the importance of communication between hospitals and skilled facilities in preventing rehospitalization. Communication between the hospital and skilled facilities is crucial in ensuring the continuity of care for patients in these facilities.

Sub-themes for communication include a multidisciplinary approach with the sharing of information regarding patient care. Heiks and Sabine (2022) and Hahn et al. (2024) noted that multidisciplinary team members sharing the necessary information to care for patients effectively can help prevent rehospitalization. Similarly, both Gupta et

al. (2019) and Higbea et al. (2017) emphasized the importance of collaboration and sharing necessary information among facilities to help reduce rehospitalization.

Risk Prediction

Identifying a patient's risk of returning to the hospital is essential in preventing rehospitalization. Alaeddini et al. (2019) identified high-risk patients and implemented interventions to reduce the likelihood of hospital readmission. Additionally, Chandra et al. (2019) identified the risk associated with predictive model tools used to identify high-risk patients with a high probability of returning to the hospital. This tool helps in preventing the possibility of rehospitalization. Similarly, Duncan and Cantu-Cooper (2020) highlighted the importance of identifying risk factors of patients with dementia diagnosis who may benefit from palliative care services to reduce rehospitalization.

Sub-themes for risk prediction include Farid et al. (2024), which focuses on remote monitoring and the use of artificial intelligence (AI) to identify high-risk patients, thereby helping to prevent rehospitalization. Lastly, Ma et al. (2019) emphasized that identifying high-risk patients and understanding the clinical reasons for admission, along with implementing personalized care plans by an interdisciplinary team, can help prevent rehospitalization.

Incentives

The Medicare SNFVBP program reimburses skilled nursing facilities based on quality measures, including rehospitalization rates within 30 days of discharge. Both

Burke et al. (2022) and the Center for Medicare and Medicaid (2024) emphasized the Medicare SNFVBP program, a new incentives program that holds low performing nursing facilities to improve their return to hospital to avoid a financial penalty or provide an economic incentive for those facilities performing well for monetary gain.

Sub-themes for incentives include Gai and Pachamano (2019), highlighting that the HRRP offered incentives to SNFs to help decrease the high rehospitalization rate. Similarly, Wang et al. (2022) found that rehospitalization of residents with AD/DRD in partnership with the National Partnership in nursing homes has seen a significant decrease in rehospitalization.

Specialty Care Unit

A specialized care unit with trained staff that meet patient needs can help prevent rehospitalization. Chen et al. (2024) highlighted that there is a reduction in patient readmissions when patients are admitted to a specialty unit. Similarly, Gomez et al. (2023) identified that some Skilled Nursing Facilities (SNF) are better suited than others, depending on the patient's specific needs based on their clinical condition.

Sub-themes for the special care unit, as highlighted by Thomsen et al. (2021) and Hann et al. (2024), emphasize the importance of a trained multidisciplinary team in preventing rehospitalization. Additionally, Kosar et al. (2024) stress the importance of having specialized trained staff and higher staff ratings to avoid the rehospitalization of patients with a dementia diagnosis.

Interpretation of the Findings

This integrative review's findings confirm several principles from the literature reviewed regarding best practices for reducing the high rate of 30-day rehospitalization among patients with dementia from skilled facilities. This section also provides an overview of the theoretical background and empirical research. The literature reviewed for this research emphasized the importance of communication between the discharging hospital and the skilled facility, as well as the multidisciplinary team responsible for caring for the patient. This integrative review highlighted the importance of communication, early identification of high-risk patients, financial incentives, and specialty care units in helping to reduce rehospitalization.

One of the main themes of this integrative review is communication. The authors suggest that effective communication is a key element in preventing rehospitalization. Effective communication of key essential factors related to patient care is crucial for reducing the number of patients being hospitalized. Interdisciplinary teams, including discharge planners, nurse practitioners, social workers, nurses, and therapists, must be aligned with communication on patient care and needs to help prevent hospitalization. In addition, reviews emphasize the importance of both discharging hospitals and receiving skilled facilities communicating effectively to reduce rehospitalization.

Another recurring theme in this review was the prediction of high-risk patients. The authors of the reviewed articles found that it is essential to identify potential high risks for patients early. Identifying whether the patient is at high risk for admission is crucial in ensuring that specific interventions are implemented to mitigate the possibility

of rehospitalization. Empirical findings suggest that identifying high-risk comorbidities early can reduce the likelihood of rehospitalization. For instance, Mann (2024) found that if high risk patients are identified and personalized care plan implemented this can help reduce rehospitalization.

Having a specialty care unit with staff trained specifically to care for patients with a dementia diagnosis is linked to decreased rehospitalization. Chen et al. (2024) revealed in their study that units specializing in dementia care serve as a reassuring mechanism to improve care in skilled facilities. Also, Kosar et al. (2024) stressed the importance of having specialized trained staff and higher staff ratings to avoid the rehospitalization of patients with a dementia diagnosis. Similarly, Gomez et al. (2023) identified that some SNF are better suited than others, depending on the patient's specific needs based on their clinical condition.

Providing incentives was used to help some underperforming SNF improve key performance indicators, such as rehospitalization rates within 30 days. Both Burke et al. (2022) and the Center for Medicare and Medicaid (2024) emphasized the Medicare SNFVBP program, an incentives program that holds low-performing nursing facilities to improve their return to hospital to avoid a financial penalty or provide an economic incentive for those facilities performing well for monetary gain. Facilities that experience a lower return to hospital within 30 days will receive a higher payout than those that have a higher return to hospital. In addition, Gai and Pachamanova (2019) highlighted that the HRRP offered incentives to SNF to help decrease the high rehospitalization rate. Both the HRRP and the SNFVBP program work similarly with skilled facilities to improve patient

care, with key elements focused on, such as reducing the rehospitalization of patients within 30 days.

The results from this integrative review confirm that having a healthy relationship and strong network and rapport with both hospital and skilled facilities can help decrease rehospitalization. Additionally, comprehensive care coordination and discharge planning, along with adherence to standardized protocols for patient discharge, play a significant role in reducing rehospitalization. Lastly, these findings support the use of structured models, such as the Donabedian framework. This framework provides a comprehensive approach to evaluating healthcare quality by integrating process, structural, and outcome measures, which can help decrease patient rehospitalization from skilled facilities (Donabedian, 1988).

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

Recommendations for Professional Practice

The findings of this integrative review highlight the crucial role that communication, incentives, risk prediction, and specialty care unit best practices play in reducing the rehospitalization of patients with a dementia diagnosis from skilled facilities. Specifically, the study's findings highlighted the importance of strengthening the communication process among hospitals, skilled facilities, and various disciplines involved in patient care. The thematic map links communications as a central theme and thus connects it to several other themes and subthemes. This highlights the importance of communication and the essential role it plays in preventing rehospitalization of patients from SNFs.

Another key takeaway from this interactive review is that best practices are identifying patients who are at high risk of rehospitalization. Once a patient has been identified as having a high likelihood of being hospitalized, implementing interventions such as personalized care plans to address these comorbidities is crucial in reducing rehospitalizations. Addressing each high-risk issue promptly and finding practical solutions can help prevent rehospitalization. Incentives offered by various organizations, such as CMS, are being implemented to ensure patient safety and prevent readmissions within 30 days of admission to SNFs.

Lastly, having a specialty care unit has demonstrated that it is essential for all individuals caring for patients to be specifically trained to meet the needs of the patient, thereby decreasing rehospitalization rates. In addition, having specialty dementia units

includes ensuring that all staff and other disciplines, such as physical therapy, occupational therapy, social work nurses, and Certified Nurse Assistant (CNAs), are specifically trained to meet the needs of these patients.

The alignment with the theoretical framework, staff training, and collaborative partnership both relate to the structural component of the Donabedian model theory, which focuses on resources and the delivery of care to patients. This structure ensures that staff are thoroughly and consistently trained and establishes robust and healthy relationships with hospital teams and other healthcare affiliates responsible for patient care and transfer to skilled nursing facilities, which is crucial in reducing rehospitalization rates.

In essence, the take-home message from this integrative review is that clear communication, incentives, identifying high-risk patients, and specialty care units are not only desirable but also imperative in playing a positive role in preventing and reducing rehospitalization. Ensuring effective communication regarding patient discharge and care, with clear reports that indicate patients' needs and comorbidities, can help decrease rehospitalization rates for patients.

Implications for Social Change

With the conclusion of this integrative review, it is pertinent to examine the implications of social change. Social changes emerge when staff are thoroughly trained, as this can lead to better outcomes for patients and their families. The implication of rehospitalization on patients and families can take an emotional and physical toll on all. Rehospitalization can cause extremely high frustration levels, increased stress, and

anxiety among the patients and their families. Along with high stress levels and anxiety, the back and forth between the hospital and nursing homes can lead to exhaustion and physical and cognitive decline among patients. Therefore, skilled nursing facilities must collaborate with hospitals and all relevant disciplines to help reduce the frequency of rehospitalizations among patients from skilled nursing facilities. The implications of these findings provide best practices to decrease the 30-day rehospitalization rate of patients with dementia from SNFs.

Limitations

One limitation of this study was the limited number of literatures to choose from regarding patients with a dementia diagnosis. Although there were lots of studies relating to return to hospital with diagnosis as to why they were hospitalized, such as Congestive Heart Failure (CHF) or Chronic Obstructive Pulmonary Disease (COPD), there were not many relating to dementia. Additionally, there was some difficulty in relating to various methodologies. For example, the diverse designs used, such as randomized controlled trials and qualitative designs, make it challenging to synthesize findings, which can lead to bias.

Conclusion

The findings of this integrative review underscore the essential role that communication, risk prediction, incentives, and specialty care unit best practices play in decreasing rehospitalization of patients with a dementia diagnosis from SNF. Specifically, the study's findings highlighted the importance of effective communication among hospitals, skilled facilities, and various disciplines involved in patient care.

Another key takeaway from this interactive review is that best practices are identifying patients who are at high risk of rehospitalization. Once a patient has been identified as having a high likelihood of being hospitalized, implementing interventions to address these comorbidities is crucial in reducing rehospitalizations.

Incentives offered by various organizations, such as CMS, are being implemented to ensure patient safety and prevent readmissions within 30 days of admission to skilled facilities. Lastly, having a specialty care unit has shown that it is essential for all individuals caring for patients to be specifically trained to meet the needs of the patient, thereby preventing or decreasing complications. These specialty dementia units include ensuring that staff in other disciplines, such as physical therapy, occupational therapy, social workers, nurses, and CNAs are specifically trained to meet the needs of these patients.

In essence, the take-home message from this review is that clear communication, incentives, identifying high-risk patients, and specialty care units are not only desirable but also imperative in playing a positive role in preventing and reducing rehospitalization. Ensuring effective communication regarding patient discharge and care, with clear reports that indicate patients' needs and comorbidities, can help decrease rehospitalization rates for patients.

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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 future research	Implications for practice	Empirical research? (Yes or No)
Anderson, T. S., Marcantonio, E. R., McCarthy, E. P., Ngo, L., Schonberg, M. A., & Herzig, S. J. (2022).	N/A	Does patients with dementia have an increased risk of adverse outcomes following discharge?	Retrospective cohort study.	Dementia was associated with an increased risk of readmission of patients within 30 days of discharge from hospital.	Hospitalized Medicare patients diagnosed with dementia were associated with an increased risk of mortality and a high risk of readmission.	Implication for future research includes including functional status of patients at discharge from hospital which is associated with adverse post-hospital outcomes.	Implications for future practice includes ensuring that patients admitted with diagnosis of dementia are taken care of effectively to prevent rehospitalization.	Yes
Anderson, R. & Ferguson, R. (2020).	N/A	Will implementing an NP-led medication	The project used a pre- and postimple	Results showed that hospital readmission rate of 19.2% reimplementation	The benefits of NP intervention included reduced hospitalizations	Study on medication reconciliation upon	Nurse practitioners' education and skills help to provide quality	No

		on reconciliation intervention reduce all-cause hospital readmissions from a skilled nursing facility within 30 days?	mentation design to retrospectively compare 30-day hospital readmission rates.	and 13.5% postimplementation, reflecting a 29.7% decrease in the rate of hospital readmissions within a 30-day period	, improved quality measures, and positive patient outcomes.	admission by an NP.	care and help improve quality measures in skilled nursing facility settings.	
Al Sabei, S. D., & Ross, A. M. (2023)	N/A	N/A	A Systemic review.	This study identifies that leadership practices of nurses can have a positive impact on reducing rehospitalization.	Study results suggest a need for further studies investigating how nursing leadership relates to patient readmission rates.	Future studies are needed to advance the knowledge on how leadership relates to patient outcomes.	Findings identify that nurse's leadership practices can have a positive impact on rehospitalization.	No
Burke, R. E., Xu, Y., &	N/A	Does the Medicare Skilled	Cross-sectional study	Study results of the SNF VBP program shows	Some changes to the SNF VBP policy	The all-cause readmission	Some changes to the SNF VBP policy may	No

Rose, L. (2022).		Nursing Facility Value-Based Purchasing program help low-performing skilled nursing facilities improve to prevent financial penalties ?		that some facilities improved and avoided a fine.	may promote improvement of low-performing facilities.	on measure used in SNFs does not account for patients who are in hospice or have advance directives.	promote improvement of low-performing facilities.	
Center for Medicare & Medicaid Services. (2024).	N/A	N/A	N/A	The Hospital Value-Based Program (VBP) incentivizes and encourages hospitals to improve the care offered to patients which can promote positive patient	N/A	N/A	Facilities that give excellent care to patients can be rewarded financial gains from the Value-Based Program (VBP).	No

				outcomes by adopting evidence-based care.				
Davila, H., Shippee, T. P., Park, Y. S., Brauner, D., Werner, R. M., & Konetzka, R. T. (2021).	Donabedian conceptual framework.	N/A	N/A	Medicare payment policy Value-Based Purchasing (VBP) can help encourage hospitals and nursing homes to improve the quality of care rendered to patients.	Looking into the historical process and providing changes in response to policy can help anticipate future changes that may be different depending on Skilled Nursing Facilities (SNF).	N/A	Some policy changes can help to predict changes that will likely vary depending on SNF structural and framework.	No
Donabedian, A. (1988).	N/A	N/A	N/A	N/A	This is the original writing of Dr. Avedis Donabedian. This writing introduces the three stages of the framework which are structure,	N/A	The need for pertinent information regarding the connection among the structural aspects of the settings where care occurs, the processes of care,	No

					process and outcomes.		and the outcomes of care.	
Dziegielewski, C., Fernando, S. M., Milani, C., Mahdavi, R., Talarico, R., Thompson, L. H., Tanuseputro, P., & Kyremanteng, K. (2023).	N/A	N/A	Retrospective cohort study	Conclusion suggest that patients with dementia admitted to the Intensive Care Unit (ICU) have longer length of stay than others without dementia diagnosis.	Patients with dementia admitted to the ICU incurred higher total healthcare costs than others without dementia diagnosis.	Given the increasing prevalence of dementia and escalating demands for critical care, future studies should investigate preventable costs.	Decisions regarding pursuing critical care should be comprehensive and include informed goals of care discussions with consideration of the patient's frailty, comorbidities, and cognitive capabilities.	No

<p>Fogg, C., Meredith, P., Culliford, D., Bridges, J., Spice, C., & Griffiths, P. (2019).</p>	<p>N/A</p>	<p>If primary diagnoses, severity of illness, age, comorbidities and risk of malnutrition, there are independent associations between cognitive impairment (with or without a diagnosis of dementia) and each of: mortality</p>	<p>Retrospective cohort study.</p>	<p>This study routinely collected data from linked clinical and other databases which identified that there is link between cognitive impairment and increased hospital mortality and increased readmissions.</p>	<p>Per study results patients with cognitive impairment had the highest in-hospital mortality (12.6%), the most extended lengths of stay (median 12 days) and the highest readmission rates (10.3%).</p>	<p>The need for better interventions and changes to be put in place to improve positive outcomes for patients with dementia diagnosis.</p>	<p>The need for better interventions and changes to be put in place to improve positive outcomes for patients with dementia diagnosis.</p>	<p>Yes</p>
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		(in-hospital or within 30 days of discharge), days until hospital discharge and readmission to hospital within 30 days of discharge?						
Hahn, B., Ball, T., Diab, W., Choi, C., Bleau, H., & Flynn, A. (2024).	N/A	The purpose of this study was to evaluate if there was a reduction in 30-day readmissions	This retrospective pre-post study reviewed electronic health records (EHRs) of patients treated at Northwell	This study evaluated if an enhanced multidisciplinary communication workflow for transitional care reduced 30-day readmissions.	This study demonstrates the impact of a coordinated multidisciplinary approach on reducing 30-day readmissions. After implementing this approach,	The lack of coordination with Patient Navigation teams may limit the ability of the SNFs to address	Collaboration between all departments and teams involves in patient care, highlights how essential early involvement of teams in effective patient care..	No

		<p>ions in select patient populations at a large teaching hospital from an initiative that focused on multidisciplinary communication and collaboration between ED physicians and hospitalists when patients return to the ED.</p>	<p>Health's ED at SIUH.</p>		<p>there was a 45% decrease in readmissions.</p>	<p>any barriers to care effectively.</p>		
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Heiks, C., & Sabine, N. (2022).	N/A	N/A	N/A	Skilled nursing facilities (SNFs) aid with activities of daily living. Also, some SNF offers different therapies such as physical, occupational and speech therapy.	The LTC and SNF facilities must improvement on promoting positive patient outcomes.	More studies need to be done regarding to staffing shortages as this concern has worsen.	The supply of long-term care workers needs to be increased.	No
Kamdar N, Syrjamaki J, Aikens JE, Mahmoudi E. (2023).	N/A	The author wants to examine 30-day readmission rates and episode costs, including readmission costs, for patients with ADRD	Retrospective cohort study used 2012 to 2017 Michigan Value Collaborative data across different medical and surgical services stratified	Cost of 30-day readmission was \$467 higher (95% CI of difference, \$289-\$645) among patients with ADRD (\$8378; 95% CI, \$8263-\$8494) than those without (\$7912; 95% CI, \$7776-\$8047).	The study shows that patients with ADRD had higher readmission rates which cost more than other patients without ADRD.	What hospitals need to do to be better equipped to care for patients with ADRD?	Hospitalization may put patients with ADRD at a high risk of 30-day readmission.	No

		compare d with their counterp arts without ADRD	by ADRD diagnosis.					
Marra, K. K., & Laramée, A. S. (2021).	N/A	The author aims to review the HRRP policy, and consensu s opinion of healthcar e leaders in HF concerni ng inverse relations hip with HF mortality readmiss ions of Medicar	A comprehe nsive review of research related to readmissi ons of Medicare beneficiar ies with HF, a literature review of the HRRP policy, and consensus opinion of healthcare leaders in HF.	Closely monitoring the rate of fatality in patients with HF is essential in preventing harm to patients when hospitalized.	Groups such as The American Association of Heart Failure Nurses (AAHFN) strongly advocates for expenditure control and a focus on quality improvement that promotes treatments and safety of patients.	The American Associati on of Heart Failure Nurses (AAHFN) strongly advocates for expenditu re control and a focus on quality improvem ent that promotes treatment s and safety of patients.	Further study and reporting of interventions need implemented to promote improved outcomes.	No

		e beneficia ries with HF.						
McHugh, J. P., Shield, R. R., Gadbois, E. A., Winblad, U., Mor, V., & Tyler, D. A. (2021)	N/A	The authors aim objective was to understa nd different approach es for readmiss ion reductio n for patients discharg ed to SNFs	A case study methodol ogy was used to compare l hospital system that integrated with SNFs to a competin g system that did not. We compared interview data from clinical and administr ative staff and publicly reported rehospital	Integrated hospital system when focused on their most vulnerable patients risk of rehospitalization, resulting in an overall reduction in all-cause rehospitalization rate.	The process of the integration among caregivers in the process of transitioning patients along the continuum of care from hospital to post- acute is vital for positive patient outcomes.	Future research may include more rigorous study of specific interventi ons to improve care transition s for patients discharge d to SNFs.	Future research may include more rigorous study of interventions to improve care transitions for patients from hospital discharged to SNFs.	No

			ization rate changes from the 2 systems.					
Ma, C., Bao, S., Dull, P., Wu, B., & Yu, F. (2019).	N/A	The authors aim to assess published evidence on hospital readmissions in persons with dementia, including rate, clinical reasons, risk factors, and prevention	Systemic review of relevant literature was conducted.	In persons with dementia, all-cause 30-day readmission rate was most frequently reported and ranged from 7% to 35%. Compared with those without dementia, persons with dementia had significantly higher rate of readmission.	Persons with dementia are at high risk for hospital readmission, but many of the readmissions are potentially preventable.	Future studies should use multiple national data sources and advanced methodology to identify risk factors to prevent hospital readmissions.	Identifying high risk patients early during admission and implementing individualized care from interdisciplinary team can reduce preventable hospital readmission.	No

		program s.						
Pasqualini, I., Tidd, J. L., Klika, A. K., Jones, G., Johnson, J. K., & Piuze, N. S. (2024).	N/A	What are the odds of 30- and 90-day hospital readmission greater among patients initially discharged to SNFs than among those treated with home healthcare after THA?	Retrospective, comparative study	Patients recovering from Total Hip Arthroplasty (THA) discharged to an SNF were more likely to be readmitted within 30 days.	Patients recovering from Total Hip Arthroplasty (THA) discharged to an SNF were more likely to be readmitted within 30 days.	Further research using robust methods is needed to clarify the reasons for higher SNF rehospitalization of patient post Total Hip Arthroplasty (THA).	Policy makers could consider incentives and reform for care transitions and coordination across settings.	Yes
Pickens, S., Naik, A. D., Catic, A., & Kunik, M. E. (2017).	N/A	The authors aim to address this	Comprehensive review study.	Four of the 5 cohort studies showed statistically significant	The findings indicate that a dementia diagnosis may have a modest	Future research should develop and test	Understanding factors to prevent rehospitalization of patients with dementia diagnosis	No

		gap by attempting to determine whether a diagnosis of dementia contributes to increased hospital readmission rates and discusses potential intervention strategies.		increased readmission rates in patients with dementia.	impact on readmission rates	transitional care models specifically for persons with dementia.	and the factors that may lead to rehospitalization can help decrease the high rate.	
Kosar, C. M., Mor, V., Trivedi, A. N., & Rahman, M. (2024).	N/A	The author aims to investigate the effect of admission	This includes examining the relationship between	Research results show evidence that post-hospital admission to nursing homes with better staffing ratings	Hospital discharge planners should make more emphasis to ensure persons with dementia	Results may inform initiatives for increasing direct	Results of study highlights the need for increasing direct care staffing in nursing homes and enhancing equity for persons	No

		<p>n to nursing homes with higher staffing ratings on adverse outcomes for individuals with and without dementia post-hospitalization.</p>	<p>facility staffing star-ratings and short-term readmission and mortality using an instrumental variable approach to account for selection bias.</p>	<p>can help reduce rehospitalization.</p>	<p>are discharged in high quality nursing homes.</p>	<p>care staffing in nursing homes and enhancing equity for persons living with dementia. Results shows that discharge planning strategies for hospitalized older adults with dementia.</p>	<p>living with dementia.</p>	
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Appendix B: DHA Review Question(s) Search Log

Database or location name	Search terms	Results	Notes
	Re-hospitalization or readmission		
CINAHL Plus with Full text	<ul style="list-style-type: none"> • Re-hospitalization or return to hospital or Readmission Skilled nursing facility or nursing home <ul style="list-style-type: none"> • Full text • From Jan 2020 • English Language USA geographic subset <ul style="list-style-type: none"> • Inpatients 	33	<p>National partnership to help improve dementia care in skilled nursing facilities.</p> <p>Assessing readmission rate of patient with dementia and heart failure.</p>
Medline with Full Text	<ul style="list-style-type: none"> • Re-hospitalization or return to hospital or Readmission Skilled nursing facility or nursing home <ul style="list-style-type: none"> • Full text • From Jan 2020 • English Language USA geographic subset I don't think I need to do <ul style="list-style-type: none"> • Inpatients 	41	
	30-day Patient with Dementia Skilled Facility		
CINAHL Plus with Full text	<ul style="list-style-type: none"> Skilled nursing facility or nursing home United States or America or USA or U.S. <ul style="list-style-type: none"> • Full Text • From Jan 2019 Peer Reviewed scholarly journals <ul style="list-style-type: none"> • English Language 	18	Cognitive impairment increased risk of adverse outcomes in hospitalized older people with an unscheduled admission.

Database or location name	Search terms	Results	Notes
Medline with Full Text	Skilled nursing facility or nursing home United States or America or USA or U.S. <ul style="list-style-type: none"> • Full Text • From Jan 2019 Peer Reviewed scholarly journals <ul style="list-style-type: none"> • English Language 	31	Older adults with dementia have health trajectories that include hospital admission and care in a SNF.
	Best Practices and reduce re-hospitalization		
CINAHL Plus with Full Text	Best practices and reduce 30- day re-hospitalization Skilled nursing facility United States or America or USA or U.S. <ul style="list-style-type: none"> • Full Text • From Jan 2019 Peer Reviewed scholarly journals <ul style="list-style-type: none"> • English Language • Inpatient 	4	Multidisciplinary communication approaches show positive results with help reduce readmissions significantly. The implementation of the nurse practitioner intervention showed positive results with reduced hospitalizations.
Medline with Full Text	United States or America or USA or U.S. <ul style="list-style-type: none"> • Full Text • From Jan 2019 Peer Reviewed scholarly journal <ul style="list-style-type: none"> • English language • Inpatient 	31	This study suggests that adequate integrated care and sufficient care planning between care settings and healthcare professionals can help reduce rehospitalization.
Science Direct	30-day Patient with Dementia Skilled Facility	14	Did not yield useful results

Database or location name	Search terms	Results	Notes
	<p style="text-align: center;">Best practices to decrease the high rate of 30-day re-hospitalization of patient with dementia from SNF.</p>		
CINAHL Plus with Full Text	<p>Best practices to decrease the high rate of 30-day re-hospitalization of patient with dementia from SNF</p> <ul style="list-style-type: none"> • Full Text Publication 1/19 and after • English language <p>Geographic subset USA Research article and peer reviewed journals, USA subset.</p>	32	Many results were either already found or not directly related to study.
Medline with Full Text	<p>Best practices to decrease the high rate of 30-day re-hospitalization or readmission of patient with dementia from SNF or nursing home.</p> <ul style="list-style-type: none"> • English Language 	49	Many results were either already found or not directly related to study.
ProQuest	<p>Best practices to decrease the high rate of 30-day re-hospitalization or readmission of patient with dementia from SNF or nursing home.</p>	18	Results offered same sources previously found in other data bases.

Database or location name	Search terms	Results	Notes
	<ul style="list-style-type: none"> • Scholarly journals • English Language 		
PubMed	<p>Best practices to decrease the high rate of 30-day re-hospitalization or readmission of patient with dementia from SNF or nursing home.</p> <ul style="list-style-type: none"> • Scholarly journals • English Language 	23	Results offered same sources previously found in other data bases.

Appendix C: DHA Appraisal Results Log

Author, date, and title	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
Alaeddini, A., et al., 2019. An Integrated Framework for Reducing Hospital Readmissions using Risk Trajectories Characterization and Discharge Timing Optimization.	Evidence Level – IV Quality rating - Good	HSO -Nursing home. Domain – Quality improvement. Problem being addressed – Reducing readmission	This new readmission prediction model enables clinical personnel to identify patients with a high risk of readmission, which can help reduce rehospitalization.	The Five-fold validation method was used to compare methods for testing and training. Kernel principal component analysis (KPCA) and Cox are regression models, and other methods are (binary) classification models.	Source limitation includes the challenges of the amount and availability of data.
Anderson, R., & Ferguson, R. (2020). A nurse practitioner-led medication reconciliation process to reduce hospital readmissions	Evidence Level - V Quality rating - Good	HSO -Skilled nursing home Domain – Quality improvement. Specific problem being address – How nurse practitioner led medication reconciliation can help	Results revealed a hospital readmission rate of 19.2% pre-implementation and 13.5% postimplementation, reflecting a 29.7% decrease in the rate of hospital	A pre- and postimplementation design was used to compare 30-day hospital readmission rates over a 30-days.	The results of this study show that not all facilities have the capabilities of having an NP available to always perform medication reconciliations.

Author, date, and title	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
from a skilled nursing facility.		reduce rehospitalization.	readmissions within a 30-day period.		
Al Sabei, S. D., & Ross, A. M. (2023). The Relationship between Nursing Leadership and Patient Readmission Rate	Evidence level - IV Quality rating- Good	HSO – Nursing home. Domain – Quality improvement Specific problem being addressed - Patient readmission rates and how nurses’ impact on reducing readmission.	Study findings show that having leadership practices among nurses can have a positive impact on reducing patient readmission rates.	The Preferred Reporting Items for Systematic Reviews (PRISMA) guidelines were used to ensure consistent and precise reporting of search results.	One limitation of this study is that not all quantitative research examined the role of confounding variables, such as economic status and access to care, in relation to the rehospitalization rate.

Burke et al., (2022). Skilled nursing facility performance and readmission rates under Value-Based Purchasing.	Evidence Level – 1V Quality rating - Good	HSO – Nursing home Domain – Quality improvement Specific problem being addressed - How performing skilled nursing facilities at baseline	Changes to the SNF VBP policy may help drive improvements in low-performing facilities, which can lead to a reduction in rehospitalizations.	A cross-sectional study utilized inclusion and exclusion criteria, focusing on the first year that financial incentives and penalties were assessed (fiscal year 2019) within	Limitations of this research include the inability to make causal inferences about the effect of the SNF VBP program on individual SNFs.
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		able to improve rehospitalization.		the SNF VBP program.	
Center for Medicare & Medicaid Services. (2024). SNF VBP Program's Hospital Readmission Measure	Evidence Level - V Quality rating - Good	HSO – Nursing home Domain – Quality measure Specific problem being addressed - SNF VBP Program's Hospital Readmission Measure to help improve and prevent readmission.	The article helps with the review question because it gives an understanding of the SNF VBP Program's Hospital Readmission Measure which helps to improve readmission.	N/A	N/A
Chandra et al., 2019. Risk of 30-Day Hospital Readmission Among Patients Discharged to Skilled Nursing Facilities: Development and Validation of a Risk-Prediction Model.	Evidence level - IV Quality rating - Good	HSO type – Skilled nursing facility. Research domain – Quality improvement The specific problem being discussed – 30-day readmission among patients at skilled facilities.	This study aimed to develop a risk-prediction model to measure the risk of 30-day hospital readmission upon patient discharge.	This study used data from electronic health records (EHRs). This study also summarizes predictor variables used in the model for patients with and without 30-day readmissions.	Limitations of this study include the limited availability of diverse ethnic groups due to our geographic location, which prevented us from capturing hospitalizations that occurred outside of our healthcare system.

<p>Chen, A. C., et al., 2024. Impact of dementia special care units for short-stay nursing home patients.</p>	<p>Evidence Level - IV Quality rating - good quality</p>	<p>HSO – Nursing home Domain – Quality improvement Problem being addressed – Quality of care provided to short-stay patients with dementia in nursing homes.</p>	<p>The use of a dementia care unit was associated with modestly better performance in healthy days at home and decreased likelihood of a subsequent SNF rehospitalization compared to a counterfactual control of patients without dementia.</p>	<p>Metrics and measures include a study conducted in the U.S. that involved a national survey of SNFs to understand the care being rendered to patients and the barriers to reducing spending or improving care, specifically targeting services used for SNF short-stay patients. Details of the survey administration have been published previously.</p>	<p>Limitation of this study includes the identified facilities using the three dementia-focused care tools based on self-reported responses to our national survey. As a result, facilities may have interpreted the use of dementia-focused services differently.</p>
<p>David Gomez et al., 2023. Prediction of rehospitalization and mortality risks for skilled nursing facilities using a dimension reduction approach.</p>	<p>Evidence Level - IV Quality rating - good quality.</p>	<p>HSO type – Nursing home Research domain – Quality improvement The specific problem being discussed – Rehospitalization from SNF and the</p>	<p>Rate of rehospitalization from SNF varies depending on patients admitting diagnosis and the capabilities of SNF to take care of patients. It is important to identify the most suitable SNF for a patient based on</p>	<p>The research suggests that a factor analysis model can reduce patient and SNF variables, whereby the factors are more manageable. factor scores to categorize SNFs into groups.</p>	<p>N/A</p>

		identification of suitable SNF for patient based on their clinical conditions.	their current clinical conditions.		
Davila, H., 2021. Inside the Black Box of Improving on Nursing Home Quality Measures.	Evidence Level -III Quality rating - Good	HSO type – Nursing home Research domain – Quality improvement. The specific problem being discussed – To better understand how NHs interact with the quality measures and strategies to improve quality measure (QM) which includes rehospitalization.	This study suggests that when both medical directors from the discharging hospital interface with the external physicians from the receiving nursing home this can help reduce hospital transfer.	Sampling strategy based on the broader study’s quantitative findings, which grouped facilities into three categories. The criteria for these categories are based on the NHC/5-star performance ratio.	A relatively small sample of NHs participated, which may limit the generalizability of our findings to other facilities.
Duncan, I., & Cantu-Cooper, M. 2020. Identifying Risks of Readmission in Patients with Dementia in SNF for Targeted	Evidence Level - IV Quality rating - Good	HSO- Nursing home Domain – Quality improvement Problem being addressed – Risk factors associated with readmission from SNF.	Hospitalization and burdensome transitions of care negatively impact the dementia population and place them at risk for rehospitalization.	A descriptive retrospective cohort study was conducted on patients with ICD-10 coding of dementia and discharged to SNF. High-risk	N/A

Community-Based Palliative Consultation.				medication was determined using the 2019 AGS Beers Criteria list.	
Farid, F., et al., 2024. AI Technologies in Reducing Hospital Readmission for Chronic Diseases.	Evidence Level IV. Quality Level: Good	HSO type – N/A Research domain – Quality improvement The specific problem being discussed is the deployment of technological advancements, such as artificial intelligence (AI), sensors, mobile apps, and genomics, to reduce rehospitalization.	Readmission rates can be decreased if the quality of life for patients is increased. Which in turn can help reduce rehospitalization.	AI algorithm development component selects appropriate machine learning algorithms to develop predictive analytics algorithms. Then it trains the algorithms using the collected patient data from the Data module. The algorithms are optimized by iteratively adjusting model parameters and evaluating performance metrics.	Study limitation includes the use of AI raises questions about its algorithms, including biased training data, ambiguous correlations, a lack of comprehension, errors, and the possibility of unfair results.
Gai, Y., & Pachamanova, D. (2019). Impact of the Medicare hospital	Evidence Level - IV Quality rating - Good	HSO type – Nursing home. Research domain – Quality improvement	The HRRP has created the right incentives for reducing readmissions, also for vulnerable populations.	Using difference-in-difference (DD) models, linear probability regressions were conducted for the	N/A

readmissions reduction program on vulnerable populations.		The specific problem being discussed – Readmission of the vulnerable population.		entire sample and sub-samples of patients to isolate the effect of the HRRP on vulnerable populations.	
Gilmore-Bykovskiy, A. L., et al.,2021. Discharge Communication of Dementia-Related Neuropsychiatric Symptoms and Care Management Strategies During Hospital to Skilled Nursing Facility Transitions.	Evidence level – 111 Quality rating – Good	HSO – Hospital Domain – Quality improvement Problem being addressed - The significant under-communication of these critical details, particularly concerning NPS and their related care plans, during ERAg discharge.	This research emphasized the critical need for improved cross-setting communication regarding the care needs of individuals with dementia during transitions between healthcare facilities. These individuals often cannot effectively communicate their needs, making accurate and comprehensive discharge communication even more vital.	This study examined documentation of NPS and management strategies leading up to hospital discharge. The abstraction procedures were performed in a standardized manner with the aid of abstraction manuals.	Nurses primarily utilize the Transitional Care Model (TCM) for patients with chronic illnesses. In contrast, INTERACT is used in facilities to help reduce rehospitalization by ensuring that acute changes are addressed promptly and effectively.
Gupta, S. et al., 2019. Reduction in	Evidence Level- 111	HSO type - Hospital Research domain – Quality improvement	Findings from this study that help answer the review question includes the presence	The bivariate analysis is used to assess the differences in the	The independent variable mainly contains information related to the presence

Hospitals' Readmission Rates: Role of Hospital-Based Skilled Nursing Facilities.	Quality rating – Good	The specific problem being discussed – Reduction in Hospitals' Readmission Rates: Role of Hospital-Based Skilled Nursing Facilities	of hospital-based skilled nursing facility (HBSNF) was associated with lower readmission rates.	organizational and market characteristics between hospitals with and without HBSNFs.	or absence of HBSNFs in hospitals.
Hahn, B., et al., 2024. Utilization of a multidisciplinary hospital-based approach to reduce readmission rates.	Evidence Level - 111 Quality rating - Good	HSO type – Hospital Research domain – Quality improvement The specific problem being discussed – Reducing readmission.	Multidisciplinary team communication approaches led by emergency medicine can significantly reduce readmissions. Developing a culture of effective communication can reduce the need for rehospitalization.	Comparing readmission rates of discharges to patients who received transitional care management before creating a multidisciplinary communication for transitional care.	The study took place at a single institution in a specific area, which limits the ability to generalize the findings to other regions.
Heiks, C., & Sabine, N. 2022. Long Term Care and Skilled Nursing Facilities.	Evidence Level - IV Quality rating – Good	HSO type – Nursing home Research domain – Quality improvement The specific problem being discussed – The specific problem being discussed – Reduction in 30-day readmissions.	This research highlights the impact of a coordinated, multidisciplinary approach implemented to help reduce rehospitalization. After implementing this approach, there was a 45% decrease in readmissions.	Health records were identified via an electronic query. The hospital's Electronic Health Records (EHR) system was the primary source for data collection.	N/A.

<p>Higbea, R. J., Marzoll, S., & Haney, D. 2017. Reducing SNF readmissions through hospital-SNF collaboration.</p>	<p>Evidence Level - IV</p> <p>Quality rating - Good</p>	<p>HSO type – Nursing home</p> <p>Research domain – Quality improvement</p> <p>The specific problem being discussed – Preventing avoidable readmissions.</p>	<p>The Affordable Care Act provisions aimed to improve the quality of U.S. healthcare and reduce its cost, with a focus on preventing rehospitalizations.</p>	<p>An analysis of readmission data following implementation of the collaboration between the Affordable Care Act (ACA) and nursing facilities found that readmissions declined by 90.6 percent.</p>	<p>N/A</p>
<p>Jackson, A. E., et al 2024). Reduction of Rehospitalization with Addition of Geriatrics/Transitions of Care Consult Service.</p>	<p>Evidence - Level IV</p> <p>Quality rating - Good</p>	<p>HSO type – Nursing home</p> <p>Research domain – Quality improvement</p> <p>The specific problem being discussed - Reduction of Rehospitalization with Addition of Geriatrics/Transitions of Care Consult Service.</p>	<p>Ensuring that the information provided when patients are being discharged to skilled nursing facilities is tailored to the specific needs of each patient. Identifying high-risk individualized factors can help reduce rehospitalization from skilled nursing facilities.</p>	<p>Rates of 30-day rehospitalization were compared between the deidentified control group and patients seen by the Geriatrics and Transition of Care Consultation (GToC).</p>	<p>Limitations of our study include inability to capture rehospitalization data from nonaffiliated institutions.</p>

<p>Kosar, C. M., et al., 2024.</p> <p>Impact of skilled nursing facility quality on Medicare beneficiaries with dementia.</p>	<p>Evidence - Level V</p> <p>Quality rating - Good</p>	<p>HSO type – Nursing home</p> <p>Research domain – Quality improvement</p> <p>The specific problem being discussed - Admission to a higher-rated nursing home reduced 30- and 90-day readmission.</p>	<p>Admission to a higher-rated nursing home can have a positive impact on patients and reduce 30- and 90-day readmission.</p>	<p>Identifying nursing homes was based on the claim number that matched the Care Compare Star rating data. Additionally, the star rating is a direct reflection of the staffing clocked hours, which are used to train staff.</p>	<p>The limitations of the results can only be generalized to patients whose treatment status changed due to the instrument, specifically those entering better or poorer quality facilities because of bed availability at the time of discharge. Additionally, the results of this study cannot be generalized to patients who were not part of the selected sample.</p>
<p>Ma, C., et al., 2019.</p> <p>Hospital readmission in persons with Dementia.</p>	<p>Evidence Level -III</p> <p>Quality rating - Good</p>	<p>HSO type – Nursing home</p> <p>Research domain –</p> <p>The specific problem being discussed – The purpose of this review is to systematically assess published evidence on hospital readmissions in persons with dementia,</p>	<p>Multiple strategies such like identifying high-risk individuals and the clinical reasons for index admission and readmission and implementing home-based individualized care by interdisciplinary team</p>	<p>A systematic review of relevant literature was conducted. Quality of reviewed studies were assessed independently by reviewers using quality assessment checklists.</p>	<p>N/A</p>

		including rate, clinical reasons, risk factors, and prevention programs.	can reduce preventable hospital readmissions.		
Mann, A., 2024. Reducing Hospital Readmission Risk Using Predictive Analytics.	Evidence - Level IV Quality rating - Good	HSO type – Nursing home Research domain – Quality improvement The specific problem being discussed – Readmission of patients	The results suggest that such models can significantly improve resource allocation and the personalization of care plans, thereby reducing unnecessary readmissions	The technology was developed within several months, which included iterative testing and feedback trials. Once the technology solution reached production-level quality, it was deployed for enterprise use across our tri-state health system.	N/A
Marafino, B. J., et al., 2020. Predicting preventable hospital readmissions with causal machine learning	Evidence Level- IV Quality rating- Good	HSO type – Nursing home Research domain – Quality improvement The specific problem being discussed – Reducing readmissions.	Findings from this study that help answer review question includes Causal machine learning can be used to identify preventable hospital readmissions.	Using data from both before and after implementation, we apply causal forests to estimate individual-level treatment effects of the Transitions Program	The study is observational in nature, our analysis necessarily relies on certain assumptions, which, while we believe are plausible, are unverifiable.

				intervention on 30-day readmission.	
McHugh, J. P., 2021. Readmission reduction strategies for patients discharged to skilled nursing facilities.	Evidence Level- V Quality rating- Good	HSO type – Nursing home Research domain – Quality improvement The specific problem being discussed – Strategies to reduce hospital readmissions for patient discharge to skilled nursing facilities.	This study highlights the importance of hospital and nursing home developing a closer integrated relationship as a strategy to help reduce rehospitalization.	This study compared one hospital system that integrated with Skilled Nursing Facilities (SNFs) to a competing system. Data from previously recorded interviews with clinical and administrative staff were used, along with publicly reported changes in rehospitalization rates from the two systems.	Limitation of this study was that the study was limited to 2 hospital systems in 1 city, so findings may not be generalizable.
Mileski, M., et al., 2020. The Impact of Nurse Practitioners on Hospitalizations and Discharges from Long-term Nursing Facilities.	Evidence Level – 111 Quality rating - Good	HSO type – Nursing home Research Domain – Quality improvement Problem being addressed – The Impact of Nurse Practitioners on Hospitalizations and Discharges from Long-term Nursing Facilities.	The findings that help answer the review question include that the study outlines the pertinent role Nurse Practitioners (NPs) play in improving health outcomes, quality of care, and reducing	This study employed a systematic review of peer-reviewed articles retrieved from three research databases: Academic Search Ultimate (ASU), CINAHL	Many of the articles reviewed had small sample sizes which limited the generalizability of the individual study results. Additionally, because each long-term care facility had different dynamics, the results of this review

			hospitalizations in a long-term care setting.	Complete, and PubMed.	may not be generalizable.
Partner, Q. (2025). The value of real-time interventional analytics in reducing hospital readmissions and improving member outcomes.	Evidence level – V Quality rating – Good	HSO – Hospital Domain – Quality improvement Problem being addressed - The relationship between the number of evidence-based transitional care processes used and the risk standardized readmission rate (RSRR).	Real Time Medical Systems' (Real Time) interventional analytics platform continuously harnesses live data from the post-acute EHR, using proprietary algorithms to identify members at risk for hospital readmission.	A dynamic keyword search function scans for more than 400 clinical indicators that may signal an impending adverse event leading to rehospitalization. When risk is detected, an alert is sent to care teams along with recommended actions, enabling timely, targeted care interventions to prevent further decline.	N/A
Pugh, J., et al., 2021. Evidence based processes to prevent readmissions.	Evidence level – V Quality rating – Good	HSO – Hospital Domain – Quality improvement Problem being addressed - The relationship between the number of evidence-based	This study findings help answer the review questions as it suggests that the more domains of the ideal transitions in care framework were addressed in an intervention, the more likely it was to	This mixed-methods, multi-step observational study employed concurrent triangulation of data from 10 VA hospitals across the US. Sites were chosen based on	Limitation of this study includes that this study is a 10-site observational study in a single health care system. Our results may not apply broadly to all health care systems. Our data focuses on transitional

		transitional care processes used and the risk standardized readmission rate (RSRR).	significantly reduce readmissions	five years of either improving or worsening readmission rates before study start, and documented efforts to reduce readmissions.	care practices for all patients admitted to medical acute units, not just high-risk patients.
Rammohan, R., et al., 2023. The Path to Sustainable Healthcare: Implementing Care Transition Teams to Mitigate Hospital Readmissions and Improve Patient Outcomes.	Evidence Level -III Quality rating - Good	HSO – Hospital Domain – Quality improvement Problem being addressed – The role of care transition teams in reducing readmissions.	This research emphasizes the role of care transition teams in decreasing rehospitalization. By consistently applying transition strategies and prioritizing high-quality care, we can enhance positive patient outcomes.	Readmission data from the intervention period were compared to baseline data using statistical tests. Data, including demographics, medical conditions, and comorbidities, were collected from electronic medical records and the International Classification of Diseases (ICD-10) codes.	The study's significant limitation lies in its retrospective design, which could introduce various biases and confounding factors. Retrospective studies depend on previously collected data, which may be incomplete or inaccurate, leading to potential errors in the analysis.
Thomsen, K., et al., 2021. Does geriatric follow-up visits reduce hospital	Evidence level – IV	HSO – Hospital Domain – Quality improvement	Findings that from this study that helps answer my review question is per the study follow-up visits	Retrospective single-center, before-and-after cohort study. The primary outcome	This was a single-center study, which may limit the generalizability of study results.

<p>readmission among older patients discharged to temporary care at a skilled nursing facility.</p>	<p>Quality rating - Good</p>	<p>Problem being addressed - readmission in patients discharged to a skilled nursing facility (SNF).</p>	<p>by an outgoing multidisciplinary geriatric team (OGT) reduces unplanned hospital readmission in patients discharged to a skilled nursing facility (SNF).</p>	<p>was 30-day readmission rate. Readmission was defined as any acute/unplanned hospital admission within 4 hours and 30 days after discharge from the Department of Geriatric Medicine.</p>	
<p>Wang, S., et al., 2022. The National Partnership to Improve Dementia Care and Hospital Readmission Among Skilled Nursing Facility Residents.</p>	<p>Evidence Level - V Quality rating - Good</p>	<p>HSO – Hospital Domain – Quality improvement Problem being addressed - the association between the introduction of the National Partnership and 30-day hospital readmission rates among post-acute SNF residents.</p>	<p>Findings from the study highlight that the risk of hospital readmissions in residents with AD/DR decreased after the launch of the National Partnership, adjusting for individual covariates, facility fixed effects, and concurrent changes in 30-day readmissions among all SNF residents.</p>	<p>National data sets that included the MDS 3.0, Medicare Master Beneficiary Summary File (MBSF), Medicare Provider and Analysis Review (Med-Par) file, and NHC for the years 2010-2014. The MDS 3.0 is a comprehensive assessment tool that is required to be conducted for all residents in Medicare- or Medicaid-certified NHs.</p>	<p>Limitation includes the research were not able to investigate whether there were changes in procedure or process of dementia care in NHs other than the reduction in antipsychotic use, and the extent to which these other procedures or processes may have contributed to readmission decline.</p>

<p>Warchol, S. J., et al., 2019. Strategies to Reduce Hospital Readmission Rates in a Non-Medicaid-Expansion State.</p>	<p>Evidence Level - V Quality rating - Good</p>	<p>HSO – hospital Research domain – Quality improvement The specific problem being discussed – Reducing readmission rate in non-Medicaid expansion states.</p>	<p>This study highlights the importance of communication feedback loops with post-acute care facilities, health literacy, community-based care transition programs, use of EHRs, and patient socioeconomic factors. Also, we discuss the specific value of data analytics to help predict the likelihood of readmission after hospital discharge.</p>	<p>This study used a qualitative research method. Researchers using methodological triangulation discover themes and concepts from multiple sources of data including interviews, observations, personal notes, and organizational documentation. Using data triangulation in a research study increases the validity of the study.</p>	<p>Limitation of this study was that all the participants came from the same the geographic area of southwest Missouri. Because of the geographic location of the participants, their responses may not be generalizable to all hospitals.</p>
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Appendix D: DHA Thematic Analysis Results

Author(s) and date	Findings with Initial Codes	Code List for Theme Development
Alaeddini, A., et al., 2019.	Readmission prediction model readmission prediction on the first day of admission	Readmission prediction
Anderson, R., & Ferguson, R. (2020).	NP medication reconciliation	NP involvement
Burke et al., (2022).	Incentivize. Offering incentives from healthcare groups and organization when improvement is achieved.	Incentives for improvement and prevention
Center for Medicare & Medicaid Services. (2024).	Incentivize. Offering incentives from healthcare groups and organization when improvement is achieved.	Incentives for improvement and prevention
Chandra et al., 2019.	Start risk prediction before discharge and at admission.	Risk prediction as priority to identify patient at risk for rehospitalization.
Chen, A. C., et al., 2024	Specialty dementia unit Specialty training for dementia	Dementia unit specialty training for nurses and nurses' aides.
David Gomez et al., 2023.	Appropriate SNF facility selection SNF suitability	Appropriate staff selection

Duncan, I., & Cantu-Cooper, M. 2020.	Identifying high risk patient Of palliative care services during admission process as needed	Identify high risk Offer palliative care
Farid, F., et al., 2024.	Predictive risk stratification Chronic disease management Telehealth remote monitoring by NP and MD	Risk prediction Disease management Remote monitoring
Gai, Y., & Pachamanova, D. (2019).	Offering incentives	Incentives
Gilmore-Bykovskiy, A. L., et al., 2021.	Effective communication between hospital and SNF Appropriate data transfer	Effective communication Correct data transfer
Gupta, S. et al., 2019.	EHR improved information exchange between hospital and SNF	EHR information exchange
Hahn, B., et al., 2024.	Communication among multidisciplinary team	Communication multidisciplinary
Heiks, C., & Sabine, N. 2022.	Coordinated multidisciplinary approach	Multidisciplinary approach
Higbee, R. J., Marzoll, S., & Haney, D. 2017	Collaboration between hospital and SNF	Collaboration between hospital and SNF
Jackson, A. E., et al 2024).	Teamwork and communication between hospital and SNF	Teamwork and communication
Kosar, C. M., et al., 2024.	Highly rated SNF Specialized staff training	Highly rated SNF Specialized staff training

Ma, C., et al., 2019.	Identify high risk patients individualized care from interdisciplinary team	Identify high risk patients Individualized care
Mann, A., 2024	Identify high risk patient Personalized care plans	Personalized care plans
McHugh, J. P., 2021.	Intentional hospital and SNF integration	Hospital and SNF integration
Mileski, M., et al., 2020	Nurse practitioner involvement	Nurse practitioner role
Partner, Q. (2025).	Joint real time information medical systems live current data to identify high risk patients	Live current data accessibility
Rammohan, R., et al., 2023.	Care transition teams	Transition teams
Thomsen, K., et al., 2021	Multi-disciplinary discharge team	Multidisciplinary care
Wang, S., et al., 2022.	Incentives from CMS	Offering incentives
Warchol, S. J., et al., 2019	Communication feedback loop	Communication

Appendix E: Final Concept/Thematic Map

