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Reducing Length of Hospital Stay for Intellectually Disabled Psychiatric Patients with Chronic Medical Problems

Joseph Wigwe
Walden University

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Walden University

College of Health Sciences

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Joseph Wigwe

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Walden University
2016

Abstract

Reducing Length of Hospital Stay for

Intellectually Disabled Psychiatric Patients with Chronic Medical Problems

by

Joseph Wigwe

Project Submitted in Partial Fulfillment of the Requirement for the

Degree of Doctor of Nursing Practice

Walden University

August, 2016

Abstract

Length of hospital stay (LOS) is a major indicator for measuring efficient care. Intellectually disabled psychiatric patients (IDPP) with chronic medical problems have longer LOS due to challenges faced by providers in jointly managing both psychiatric and medical problems. The purposes of this study were to understand the significance of LOS for IDPP, create an intervention toolkit to reduce LOS, establish the content validity of the toolkit, and recommend its implementation. The items of the toolkit are pharmacology, somatic, rehabilitation, psychosocial, and monitoring patients' psychiatric and medical symptoms across care domains. The toolkit was created from the constructs of the psychiatric rehabilitation process model to jointly manage psychiatric and medical issues. The project question asked if a universal agreement rating will be achieved to establish content validity of the toolkit. Orem's self-care deficit theory was used to guide this study. Ten experts with experience in the clinical, financial, legal, and psycho-social aspects of IDPP care, were recruited from 5 county facilities and asked to participate in the study. The inclusion criteria focused on the experts' leadership roles in those facilities. The experts answered two online quantitative surveys. Survey 1 asked 9 questions and elicited opinions on LOS issues for IDPP. Survey 2 asked the experts to rate the efficacy of the toolkit to reduce LOS for IDPP. Survey 1 finding showed that 8 of 10 experts agreed that LOS for IDPP needed to be reduced. Survey 2 finding showed a universal agreement toolkit rating of 0.84, indicating the experts' readiness to adopt the toolkit to reduce LOS for IDPP. This study has the potential to promote social change by enhancing interdisciplinary and collaborative use of best care processes in psychiatry to reduce LOS and jointly manage psychiatric and medical problems affecting IDPP.

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Section 1: Nature of the Project

Introduction

Healthcare delivery has entered a new era of accountability where the focus for planning, funding, and implementing services has shifted from service delivery funding to funding for results (Kettner, Moroney, & Martin, 2013). In other words, the focus has shifted considerably to a results-oriented approach for gauging the efficacy of healthcare delivery, especially in view of the immense cost of care delivery. Consequently, seeking cost-effective care delivery modules that promote positive outcomes for patients, organizations, and providers is crucial.

Length of hospital stay (LOS) remains one of the most prevalent indicators of resource utilization and efficiency in care delivery. According to Cho, Park, Jeon, Chang, and Hong (2014), there are financial ramifications involved in LOS, which impact reimbursement and the continued need for hospitals to reduce LOS. Additionally, the factors that affect LOS include patient diagnoses, hospital ownership, the competitive healthcare situation, and payment systems. Consequently, reducing LOS has been the motivating goal in the creation of diagnoses related group (DRG) protocols that have been implemented in the United States to help clinicians streamline care plans that ultimately aim at promoting quality and expediting care delivery.

In behavioral health (psychiatry), reducing LOS is a major determinant of care delivery. For instance, Memel (2012) stated that cost containment within behavioral health has been one of the hallmarks of gauging efficacious care by seeking to create a balance between promoting quality without incurring unnecessary expenses. Promoting such cost effective care has been associated with reimbursement where reduced hospital stays, prevention of unneeded inpatient hospital admissions, and promotion of alternatives to inpatient hospitalization in less expensive and restrictive environments such as partial hospitalization programs have been encouraged.

Moreover, partial hospitalization programs--outpatient programs aimed at managing active mental health problems while concurrently promoting patients functionality thus preventing relapse or full hospitalization--have been advocated by such organizations as the National Association of Private Hospitals and the American Association for Partial Hospitalization Programs. In sum, LOS continues to be a factor associated with efficacious care that affects every specialty area of healthcare including psychiatry.

Chronic medical diseases remain a significant population health issue. In fact, the Centers for Disease Control and Prevention ([CDC]; 2014) stated that as many as 117 million adults in the United States have one or more chronic health problems, and a quarter of those people have two or more chronic health problems. Moreover, the bulk of healthcare expenditure is associated with chronic medical problems with costs to manage such problems as diabetes, heart disease, and arthritis amounting to several billion dollars annually. Furthermore, it is important to identify the correlation between mental illness and chronic medical problems relative to increased LOS. For instance, the National Alliance on Mental Illness ([NAMI]; 2013) identified the link between mental illness and chronic medical problems such that individuals with serious mental illnesses have an increased risk for chronic medical problems and die an average of 25 years earlier than other populations. Additionally, the American Psychological Association ([APA]; 2015) stated that chronic medical problems such as cardiovascular disease, diabetes, obesity, asthma, epilepsy, and cancer have higher occurrences in those with serious mental illnesses. Finally, from a financial perspective relative to LOS, inpatient costs account for 16% of total mental health spending (Tulloch, Fearon, & David, 2011).

I subsequently determined that it was necessary to identify the factors that affect LOS for IDPPs with chronic medical problems. According to Wu, Desarkar, Palucka, Lusky, and Liu (2013), these factors are linked with poor coordination that affect medication management, costs, and rehabilitation that ultimately leads to longer LOS. IDPPs receive significantly lower doses of antipsychotics, mood stabilizers, lithium, and benzodiazepines, and are discharged less successfully than patients without intellectual disability. The longer LOS of IDPPs indicates slower clinical stabilization, limited pharmacological intervention, and difficulty with community placement. Care for IDPPs is under-funded, as indicated by the lower daily average reimbursement, yet the direct clinical costs due to longer LOS is higher and puts a greater economic strain on the healthcare system.

In sum, care for IDPP is under-supported. For instance, Garfield (2011) reported that over 60% of adults with mental health issues and as much as 70% of children with mental illnesses do not receive optimal mental health services despite the greater promotion of behavioral health services that focuses on medications, rehabilitation, and follow-up care. Additionally, the APA (2015) reported that patients with psychotic disorders are 44% less likely to have a primary care provider than those without mental health issues. Therefore, the reduced access to mental health services affects their ability to receive treatment including medications and rehabilitation.

According to the director of the medical-psychiatric facility that served as my study site and that provides care for a plethora of patients including IDPPs with chronic medical problems, IDPPs with chronic medical problems stay a minimum of a month longer within the hospital than their counterparts without intellectual disabilities (personal communication, March 20, 2015). In fact, there have been IDPPs who have remained at this facility for more than 6 months due to difficulty finding placement for them within the community where both their psychiatric and

medical problems could be concurrently managed. Noting the costs associated with LOS for IDPPs, the facility director further stated that reducing LOS for IDPPs with chronic medical problems by at least two weeks would save the facility an average cost margin of about 18% a year (personal communication, March 20, 2015). Consequently, mitigating the clinical practice issue is critical and requires recommending and utilizing an evidence-based practice (EBP) tools that, as Jacobs et al. (2012) have described, integrate best available research evidence, provider expertise, and the needs, values, characteristics, and preferences of those who will be affected by the intervention(s). Hence, my goal for this DNP project was to develop and implement an EBP tool to reduce LOS for IDPPs with chronic medical problems.

The EBP model I selected for this project was the psychiatric rehabilitation process model which the National Registry of Evidence-Based Programs and Practices ([NREPP]; 2015) described as an evidence-based model that guides interaction between providers and individuals with severe mental illness. Moreover, it is a client-driven, strength-based intervention aimed at building patients' positive social relationships. It encourages self-determination of goals, connects patients to needed human service supports, and provides direct skills training to maximize independence. Furthermore, the model is aimed at improving function, promoting stability, and facilitating access to community services to enhance quality of life and manage psychological symptoms. This model is applicable in various mental health settings including hospitals and long-term care facilities, and focuses on both mental health and concomitant health issues. Consequently, I created an intervention toolkit from the constructs of this model which includes pharmacological, psychosocial, somatic, and rehabilitative interventions in conjunction with the monitoring of acute and long-term effects on functioning across care domains (see Figure 1).

Problem Statement

The problem I explored for this project LOS for IDPP with chronic medical problems through the creation of an intervention toolkit from the psychiatric rehabilitation process model. Caring for IDPP with chronic medical problems is a daunting task, as frequent exacerbation of both the psychiatric and medical problems complicate the coordination of care delivery that results in longer hospital stays. In fact, Charlot et al. (2011) stated that the physical distress caused by medical problems exacerbates behavior problems in psychiatric patients with intellectual disability that ultimately lengthens their hospital stay. At my study site, reducing LOS for IDPP with chronic medical problems remains a challenge with the average LOS for this population being a month longer than for non-IDPP. Mitigating the problem therefore entailed selecting and recommending the most appropriate EBP tool. Hence, by creating the intervention toolkit from the psychiatric rehabilitation process model, I sought to develop the most ideal best-care practice intervention.

Purpose Statement, Project Objectives, and Question

The purpose of this project was to understand the significance of LOS among IDPPs with chronic medical problems, to create an intervention toolkit using the psychiatric rehabilitation process model to address LOS for IDPPs with chronic medical problems, to elicit the participation of ten experts to establish the content validity of the intervention toolkit, and to make recommendations on its implementation into practice.

Project Objectives

My objectives for this project included: (a) articulating the significance of LOS for IDPP with chronic medical problems relative to the psychiatric rehabilitation process model and the intervention toolkit created from its constructs to address the problem. (b) Establishing the content validity of the intervention toolkit by eliciting the participation of ten experts. (c) Making recommendations on the implementation of the intervention toolkit to reduce LOS for IDPP with chronic medical problems.

Project Question

I used the following question to guide the study: Will a universal agreement rating among the experts be achieved to establish content validity for the intervention toolkit vital to recommending its implementation to reduce LOS for IDPP with chronic medical problems?

Nature of the Doctoral Project

The nature of the project entailed identifying and discussing the discrepancy in care affecting IDPP with chronic medical problem by weighing and corroborating the evidence both from a clinical standpoint (my organizational experience) and from a scholarly review of the literature thus establishing the magnitude of the practice issue. As I sought to identify the gap in practice, it was equally important to develop an intervention. This entailed creating an intervention toolkit from the psychiatric rehabilitation process model; eliciting the participation of ten experts within the field to establish its content validity via online surveys; and making recommendations on its implementation.

At the facility which served as the site for the DNP project, it was vital that I consider and identify the factors that contribute to longer LOS for those patients relative to the issue. According to the director of the facility, the combination of legal, financial, social, medical, and

mental health factors contribute to longer LOS (personal communication, March 20, 2015). Hence, those factors are more significant in prolonging LOS for IDPP with chronic medical problems. Therefore, the challenge was to reconcile those factors while coordinating and utilizing DRGs to promote quality care thus minimizing LOS. Moreover, the director stated that even when the patients are stabilized, discharging them was not always prompt due to insurance and community placement problems (personal communication, March 15, 2015).

Further review of the care processes used at the facility that served as the site for this project led me to discover that physicians may typically recommend home health providers for some IDPP who reside with family to assist them manage their chronic health problems. However, insurance coverages may not allow for home health providers; thus, the only other option was to consider placing those patients in long-term care facilities. Additionally, placement issues based on the patients' socioeconomic status, age, or previous living arrangements (homeless versus living with relatives or in board and care facilities) impacted how quickly the patients could be placed. Finally, frequent readmissions of some IDPP further complicated the problem of longer LOS relative the time it took to stabilize both the medical and psychiatric symptoms and arranging placement within the community. In fact, the administrative office that coordinates admissions and discharges at the facility provided information that showed that within the last six months, there were five IDPP patients with chronic medical problems who were readmitted for a combined seven times due to decompensation in both their psychiatric and medical problems. Consequently, the average length of time to stabilize those patients and arrange for placement within the community after discharge was four weeks. Finally, understanding the practice issue relative to this project entailed articulating the assumptions, limitations/delimitations affecting the issue to highlight its significance.

Assumptions

Assumptions represent generalized statements that have no scientific basis and are unrecognized in thinking and behavior. However, assumptions influence logic that enables more thorough review of an issue (Burns & Grove, 2009). Relative to increased LOS for patients with concomitant psychiatric and medical problems, Walders (2007) identified the following assumptions: (a) mental health does not affect physical health in patients with concomitant psychiatric and medical problems. (b) Mental health does not affect the quality of medical care, health outcomes, and functioning. (c) Interventions to enhance mental health does not affect physical health outcomes. (d) Promoting integrated mental health services is too expensive and does not reduce healthcare expenditures. Subsequently, the assumption of separating mental health from physical health and the resulting failure to appreciate the interrelatedness between both realms of health does affect how care is coordinated with patients who have both psychiatric and medical problems including IDPP. Therefore, the delay in concurrently managing psychiatric and medical problems ultimately affects how long patients remain in hospitals.

During the course of this study, I discovered a similarity with the general assumptions articulated above. For instance, I discovered that psychiatrists at the facility where this study was based tended to focus more on managing psychiatric symptoms rather than promptly engaging the internists at the time of admission (internists are usually consulted between two to three days after admission) to create care plans that considered both medical and psychiatric problems. Hence, the assumption was minimizing the interrelatedness of medical and psychiatric symptoms. Another discovery I made relative to longer LOS for IDPP with chronic medical problems at the facility was the assumption that integrating mental health services was

expensive. Therefore, outpatient programs such as partial hospitalization program were not adequately utilized, as psychiatrists at the facility preferred having IDPP remain admitted. However, extended hospital stays of at least two weeks cost the facility about 18% more according to the director of the facility (personal communication, March 15, 2015).

Limitations

Limitations from a medical standpoint, affect how prompt and judicious policy and subsequent care are implemented. White and Dudley-Brown (2012) discussed limitations that affect best-care utilization and they include: (a) the misconception on the part of clinicians that application of the evidence-based module(s) might be time-consuming. (b) Inadequate evidence-based practice knowledge and skills. (c) The lack of organizational support for utilization of evidence-based practice modalities. (d) Lack of evidence-based practice mentors and the needed resources. (e) Resistance from clinicians including physicians, nursing managers/leaders, and other professionals within the organization. In the facility where I work and conducted this study, the limitations listed above were reflected in the challenges faced by the facility to reduce LOS for IDPP with chronic medical problems. In fact, the director of the psychiatric department stated that there was no specific evidence-based module to address the issue of increased LOS for IDPP with chronic medical problems (personal communication, June 29, 2015).

The biggest limitation affecting this DNP project was knowledge deficit of clinicians within the organization that I interviewed about the psychiatric rehabilitation process model from I created the intervention toolkit. This knowledge deficit presented me with a challenge it was critical to explain how and why the psychiatric rehabilitation process model and the intervention toolkit created from it was the most appropriate EBP module to reduce LOS for IDPP with chronic medical problems. In addition, recommending the implementation of the intervention

toolkit into practice was contingent on engaging the experts who represent the stakeholders who are concerned with the cost-effectiveness, timeliness, ease of application, effectiveness, and sustainability of the intervention.

Delimitation

In view of the limitation affecting this project (knowledge deficit of clinicians about the psychiatric rehabilitation process model), the chief delimitation affecting this project was the sample of the ten experts who I surveyed to establish the content validity of the intervention toolkit, and who represent the facets of care affecting IDPP including my facility and the related departments (social worker, discharge planner, case management); the legal conservator department; Medi-Cal office (the state of California's Medicaid health care program); and long-term care facilities within the county where this study was conducted.

Significance

Evidence-based practice evolves from the aggregation of best research evidence, clinical expertise, and patient needs (Terry, 2012). For IDPP with chronic medical problems however, promoting quality remains a challenge. For instance, the APA (2015) discussed the limited access to treatment affecting mentally ill patients, which is compounded when those patients have concomitant chronic medical problems. I thus created the intervention toolkit for this DNP project and recommended its implementation to enhance quality of care that specifically decreases LOS and ensuring that continuity of care is maintained beyond the acute setting to prevent decompensation that ultimately warrants subsequent readmissions for IDPP with chronic medical problems. The larger impact of my study for nursing practice is that it promotes knowledge dissemination that supports utilization of the intervention toolkit to reduce LOS thus

promoting the principles of delivering cost-effective care and achieving positive clinical outcomes.

An example of such an impact on practice relative to cost-effectiveness was promoting shorter LOS not just for IDPP, but subsequently for all patient populations. For instance, the director of the study site stated that providing an intervention such as electroconvulsive therapy (ECT) on an outpatient basis rather than having patients admitted specifically for the procedure would save the hospital at least 15% in costs annually (personal communication, March 20, 2015). Therefore, recommending the implementation of the intervention toolkit represented my effort to promote cost-effective, quality care because creating the toolkit was contingent on considering the factors that affect care delivery including financially, legally, clinically, and socially, and on facilitating concurrent attention psychiatric and medical problems. In addition, I created the toolkit to maintain functioning across care domains, which was a vital component because continuity of care should be consistent regardless of the care setting. Hence, ECT treatments, for instance, could be sustained on an outpatient basis without lengthy hospital stays.

Summary

In this first section of the DNP project, I discussed the scope and depth of reducing LOS for IDPP with concomitant chronic medical problems; articulated the problem statement; outlined the purpose including project objectives and question; identified the nature of the project including the assumptions, limitations, and delimitations; and marked the study's significance. Moreover, I identified the psychiatric rehabilitation process model was as the EBP tool from which I created an intervention toolkit to address the practice issue. This DNP project represents my goal to incorporate the principles of being a DNP in identifying a practice issue affecting care delivery and subsequently recommending evidence-based interventions to resolve

the issue, thus promoting quality of care delivery. To further articulate the importance of the project, in Section 2 I discuss the theoretical model that guided this project, its relevance to nursing practice, its local background and context, and my role as researcher.

Section Two: Background and Context

The purpose of the project was to understand the significance of LOS among IDPP with chronic medical problems; to create an intervention toolkit from the psychiatric rehabilitation process model to address LOS for IDPP with chronic medical problems, to elicit the participation of ten experts to establish the content validity of the intervention toolkit, and make recommendations on its implementation into practice. In this section, I discuss the concepts, models, and theories that guided this project; its relevance to nursing practice; its local background and context; and my role as researcher.

Concepts, Models, and Theories

Conceptual models provide constructs that broadly explains phenomena of interests; and frameworks provide logical structures that guide development of a study and yields knowledge for practice (Burns & Grove, 2009). I selected Orem's self-care deficit theory as the theoretical framework to guide this project. According to McEwen and Wills (2011), Orem's theory has its foundation in exploring the role the nursing practice could play in providing specialized assistance to persons with disabilities by considering the factors that affect the individuals' wellbeing. Additionally, the therapeutic self-care demand concept of the framework explores the nursing care provided as a result of an individual's inability to calculate or to meet therapeutic self-care needs. Moreover, the self-care requisites concept focuses on the actions performed by or for individuals with the aim of controlling human or environmental factors that impact human functioning or development. Therefore, Orem's theory was congruent with my rationale for creating the intervention toolkit from the psychiatric rehabilitation process model. I was able to recognize the limited functionality IDPP face relative to self-managing both their psychiatric and chronic medical problems. Hence, by incorporating pharmacologic, psychosocial, somatic,

rehabilitative, and monitoring acute and long-term effects on functioning across care domains (intervention toolkit), the therapeutic needs of IDPP relative to reducing LOS, improving access to treatment beyond the hospital, and improving outcomes for those patients including reducing/preventing decompensation are met.

Definitions of Terms

The significant terms I use repeatedly throughout this project are IDPP, chronic medical problems, intervention toolkit, and LOS.

Intellectually disabled psychiatric patients (IDPP): The American Association of Intellectual and Developmental Disabilities (2013) described intellectual disability as significant limitations in both intellectual functioning (mental capacity) and adaptive behavior (collection of conceptual, social, and practical skills). IDPP therefore relates to intellectually disabled patients with psychiatric problems such as schizophrenia, bi-polar disorder, psychosis...etc.

Chronic Medical Problems: A chronic medical problem is a disease or illness that persists longer than three months and cannot be prevented by vaccines or cured with medications (MedicineNet, 2015).

Intervention toolkit: An intervention is an activity undertaken to resolve a clinical problem; and to improve, maintain, or restore wellness (“Medical-Dictionary,” 2015). A toolkit is a set of tools assembled together for a specific purpose (Collins Dictionary, 2015). Therefore, an intervention toolkit is a set of protocols that is designed to address a clinical problem.

Length of hospital stay (LOS): The Organisation for Economic Cooperation and Development (2015) defined LOS as the average number of days patients spend in a hospital. Moreover, it is determined by dividing the number of days as an inpatient by the number of readmissions and discharges.

Relevance to Nursing Practice

The DNP focuses on incorporating research into clinical practice and evaluating practice and care delivery models. Moreover, by evaluating practice and care delivery models. By evaluating practice and care delivery models, the DNP is able to identify problem areas in the healthcare delivery system (Terry, 2012). In relation to my DNP project, reducing LOS for IDPP with chronic medical problems has major implications for promoting evidence-based care, and the creation and implementation of the intervention toolkit represented a quality of care delivery improvement. In addition, the significance of LOS is contingent on financial, social, clinical, and legal factors; and in the case of IDPP, mental capacity was another crucial factor. For instance, in this writer's facility the type of insurance coverage (financial); the ability to seek and secure placement for patients in long-term care facilities (social); managing the psychiatric and chronic medical problems (clinical); the legal status of the patients i.e. those who are wards of the state through conservatorship; and the ability of IDPP to participate in self-care are all factors that influenced LOS. Accordingly, by creating, recommending, and ultimately implementing the intervention toolkit, promoting positive outcomes from a financial, clinical, policy, legal, and social standpoint and greatly enhanced.

Local Background and Context

Healthcare dynamics have changed considerably over the years as the ultimate premise has shifted from funding for service delivery to funding for outcomes and a return on investment. In fact, Kettner et al. (2013) stated that the healthcare system in the U.S. has entered a phase of care delivery that centers on accountability, measuring outcomes, and cost-benefit analysis. Therefore, it is imperative to critically appraise care delivery modalities in order to identify both effective and ineffective modalities that enhance or hinder quality of care. Reducing LOS has implications to promote positive outcomes for patients in general and IDPP in particular given that their concomitant psychiatric and chronic medical problems that makes them especially vulnerable. Furthermore, promoting functionality for otherwise disabled individuals represents a shift in a positive direction that embodied the principles of accountability and return on investment.

The fact that the patients with severe mental illnesses in general have a higher susceptibility to contract chronic medical problems; and subsequently have a life expectancy 25 years less than other patient populations (NAMI, 2013) means that the poor coordination of care affecting this particular population (IDPP with chronic medical problems) warranted review. In addition, my first-hand experiences working in an organization where IDPP with chronic medical problems remained hospitalized longer, even when medically and psychiatrically stabilized have shown me the difficulty in managing care for this population beyond the acute care setting. Therefore, discussion about promoting quality, cost-effective care are moot when such disparities in care exist like those I have identified in IDPPs with chronic medical problems.

Literature Review

I gathered scholarly evidence for this project using Walden University's online library through the nursing databases such as CINAHL Plus with Full Text and Proquest Nursing and Allied Health Source. I searched for information on IDPP, LOS, the factors that contribute to the problem, and recommendations on mitigating the problem through the use of evidence-based care modules. I based the search for information on evidence-based interventions was based on relevance, accuracy, currency, and viability. Thus, I limited the search to articles published within the past 10 years. I reviewed a total of 30 articles were relative to this project that I found using the keywords and search terms associated with mental illnesses in relation to chronic medical conditions, LOS, cost factor, interventions. Furthermore, I graded the articles based on the strength of the evidence presented, the currency of the evidence, and its relevance. Searching for relevant information entailed using Boolean operators specifically the words "and" and "or" to narrow the search to information that showed the strength of the relationship between mental illnesses and chronic medical problems in the context of LOS. Consequently, I selected 13 articles to help me understand the significance of the practice issue.

My literature review provided me with valuable information on the practice issue for this project. For instance, in relation to LOS, Cho, Park, Jeon, Chang, and Hong (2013) identified LOS as one of the most commonly used indicators for resource utilization and efficiency in care delivery. They noted strong financial incentives from the prospective payment system, and encouraged development of clinical practice guidelines to reduce LOS. Specifically focusing on LOS relative to IDPPs with chronic medical problems, Charlot et al (2011) conducted a study that showed that this particular population had an average LOS of 17.6 days in inpatient psychiatric units. In contrast, patients without intellectual disability who still faced chronic

medical problems had an average LOS of 4 to 5 days in inpatient psychiatric units. In another study focusing on LOS for IDPPs with chronic medical problems, Oxley, Sathanandan, Gazizova, Fitzgerald, and Puri (2013) identified limited funding and placement issues (securing accommodations within the community) as major factors that contribute to increased LOS. Additionally, caring for IDPP remains a challenge; in fact, Blair (2013) discussed the evidence that showed clinicians not being adequately prepared and having limited knowledge about frameworks that facilitate care coordination for patients with intellectual disability, which is classified as “special needs.” Additionally, the limited ability to fully assess mental capacity exacerbates the problem of determining what constitutes those patients’ best interests.

Blair (2013) identified diagnostic and treatment delays, and the difficulty in identifying the needs of IDPPs with chronic medical problems as one of the major factors related to longer LOS. Moreover, NAMI (2013) conducted a study that showed an average decrease of life expectancy by 25 years for IDPPs with chronic medical problems compared to the general population. Hence, care for IDPPs with chronic medical problems is poorly coordinated, which affects LOS and clinical outcomes, and is related to increased morbidity and mortality.

Knowledge deficit in care coordination for IDPPs with chronic medical problems is another major problem leading to longer LOS. In fact, Aggarwal, Guanci, and Appareddy (2013) found that as much as 90% of psychiatrists reported not having adequate knowledge in treating and diagnosing problems within IDPP population. Additionally, a higher rate of comorbidities, diagnostic limitations secondary to communication barriers, and lack of formal diagnostic tools are prevalent within the IDPP population. Consequently, Aggarwal et al (2013) stated that difficulty in reconciling the factors affecting care delivery such as pharmacologic, diagnostic, non-pharmacologic interventions such as therapy delay discharge times for IDPP with chronic

medical problems. Moreover, Aggarwal et al. (2013) noted that obtaining direct health histories from psychiatric patients without intellectual disabilities enhances psychiatrists' ability to expedite care by. However, within the IDPP population, collateral information is often obtained from caregivers rather than from IDPPs due to their limited mental capacity that hampers obtaining complete health histories. For instance, obtaining a complete health history is vital in determining pharmacological interventions needed to manage both psychiatric and non-psychiatric problems in view of medication reactions that could exacerbate ongoing health problems. Aggarwal et al. (2013) discussed such psychotropic medications as Risperidone, Quetiapine, Olanzapine, and Ziprasidone that are effective in managing psychiatric disorders and symptoms, may cause exacerbation of medical problems ranging from neurological, hematological, cardiac, and metabolic problems. Consequently, in a psychiatric unit where the focus of care is mainly on managing psychiatric problems, the limited health history pertaining to IDPPs with chronic medical problems means that there is a greater risk of not adequately titrating doses of psychotropic medications relative to chronic medical problems (Aggarwal et al., 2013). Therefore, the unintended consequences of trying to manage psychiatric symptoms increase the risks of exacerbating medical symptoms thus prolonging LOS for IDPPs.

Before creating the intervention toolkit, I reviewed literature focused on the interventions to resolve the practice issue. That is, I sought to understand the psychiatric rehabilitation process model and its constructs. NREPP (2014) described the psychiatric rehabilitation process model as one that considers the pharmacological, social rehabilitative, and care coordination across care domains affecting intellectually disabled patients with the aim of improving outcomes for this population. Additionally, examples of the current application of the model were critical in order to understand how its constructs were used to promote positive outcomes. For instance, NREPP

(2015) provided descriptive information that entailed using the model in both patients with mental and concomitant medical problems that included both males and females, adolescents, adults, and older adults. Furthermore, NREPP (2015) stated that the National Institutes of Health recognized the significance of the psychiatric rehabilitation process model and has facilitated the disbursement of federal funding to organizations using the model. Hence, the intended outcomes for using the model have been to improve functionality, access to housing, access to human services, and managing psychological symptoms of anxiety, depression, and thought disturbances.

Organizational Review

I deemed it necessary to obtain first-hand information from those close to the issue. That approach entailed identifying and interviewing stakeholders at my study site (including the director of behavioral health, the chief medical director, the nurse manager, social workers, case managers, discharge planners, and staff nurses), Medi-Cal representatives, legal conservators, and managers of long-term care facilities in order to gain an understanding of their perspectives on the problem. My organizational review at the study site sought to understand the practice issue. For instance, I reviewed data related to admission rates, LOS, discharge rates, and readmission rates of six IDPP within a 6-month timeframe from October 2014 to April 2015. The review showed that IDPPs remained in the hospital an average of 3 to 4 weeks longer than patients without intellectual disability.

The chief medical director at my study site (personal communication, March 20, 2015) articulated the frustrations clinicians faced at the facility in caring for IDPPs due to their reduced ability to provide adequate medical history that would otherwise enable providers better coordinate their care. The problem is further exacerbated when those patients are homeless

because their housing instability makes it even more difficult to garner any collateral information. Hence, clinicians could not adequately confirm pertinent information related to IDPPs in such areas as medication histories, medication allergies, diagnostic tests, and so on. Accordingly, with little or no psychiatric and medical history, the immediate focus was on managing psychiatric symptoms rather than considering any underlying medical problems that may have contributed to the psychiatric symptoms.

I interviewed the director of the social and case management department at my study site who stated that the issue of longer LOS for IDPPs is complicated by needing to secure insurance coverage for such patients through Medi-Cal, and by securing a legal conservator to act as a liaison and advocate for these patients (personal communication, April 15, 2015). Subsequently, these processes could take anywhere from one to three weeks, thus contributing to longer LOS for IDPPs in addition to the time it took to stabilize the patients both psychiatrically and medically.

Role of the DNP Student

As a provider, I have had first-hand organizational experience involving the deficits in care affecting IDPP with chronic medical problems that affects their subsequent rehabilitation following stabilization of both the psychiatric and medical symptoms. While, this project is purely for academic purposes, engaging in it highlighted for me the crucial role a DNP plays in enhancing care delivery systems. For instance, American Association of Colleges of Nursing (2006) identified seven essentials that range from understanding the scientific foundation for nursing practice to facilitating the growth of advanced nursing practice. Therefore, the appreciation of those essentials was instrumental in assisting me understand the practice issue,

choosing to make it a DNP scholarly project, recognizing the factors affecting the issue, and providing a tangible intervention to address the issue.

Summary

In this section I discussed Orem's theory and the psychiatric rehabilitation process model I used to guide the project, the relevance of the project to nursing practice, the local background and context of the project, and my role as researcher consistent with being a DNP. Providing credence to a project aimed at enhancing practice is critical. Hence, in the next section, I elaborate the collection and analysis of evidence relative to reducing LOS for IDPP which chronic medical problems thus further showing the importance of projects such as these.

Section 3: Collection and Analysis of Evidence

The purpose of the project was to understand the significance of LOS among IDPP with chronic medical problems, to create an intervention toolkit from the psychiatric rehabilitation process model to address LOS for IDPP with chronic medical problems, to elicit the participation of ten experts to establish the content validity of the intervention toolkit, and to make recommendations on its implementation into practice. In this section, I offer the practice-focused question, discuss sources of evidence, and provide analysis and synthesis of my findings.

Practice-Focused Question

Reducing LOS for IDPP with chronic medical problems remains a practice issue that warrants an intervention to address the problem thus ultimately promoting positive outcomes for the affected patient population. This project consequently entailed identifying the gaps in practice affecting IDPP with chronic medical problems relative to LOS; understanding and selecting the most appropriate EBP through the creation of the intervention toolkit; establishing its content validity through the ten experts; and making recommendations on how its (toolkit) implementation represents one of the tenets of being a DNP as an agent of quality of care improvement in translating best-care modules into practice.

Sources of Evidence

The evidence I collected for this study was from the literature and organizational reviews which included evaluating scholarly articles, organizational reports at my study site, and interviewing the stakeholders I deemed critical to this project. My objectives were to identify the gap in practice, understand its significance, identify evidence-based interventions, determine evidence applicability, and recommend the evidence. The process of selecting appropriate evidence was articulated in Section 2 of this paper.

Project Design and Methods

The following steps highlight the methods I used for this project.

Step One: Identifying Facilities.

The first step entailed identifying all the facilities and organizations involved in the care of IDPP within the county where my study site is located in the Bay Area of Northern California. These facilities are all interrelated in the care affecting from a clinical, legal, financial, and social wellbeing. They included my study site, the legal conservatorship office, the Medi-Cal office, the case management department, and long-term psychiatric facilities in the cities of Berkeley, Oakland, Alameda, San Leandro, and Hayward. Since the premise of the study was to reduce LOS and promote positive outcomes for IDPP with chronic medical problem across the continuum of care, it was vital to identify the organizations pertinent to IDPP care.

Step Two: Population Sampling

This step entailed identifying the key stakeholders involved in care for IDPP with chronic medical problems relative to the facilities listed above. Hence, the criteria I used to identify those stakeholders involved identifying the roles they played within their respective organizations, the relevance of those roles, and how they would impact the recommendation and implementation of the intervention toolkit. According to Burns and Grove (2009), a population represents all the elements including individuals that warrant inclusion in a given project; and sampling represents the specificity of the population that enables closer review of the people, events, behaviors, settings, sample size, and other characteristics that ultimately provide information that helps plan and implement interventions. Therefore, to understand the population, I conducted a needs assessment which Kettner et al. (2013) described as a process whereby the researcher establishes standards and determining the number of people within the community who fall below the standard and are subsequently in need.

There are four perspectives to consider when performing a needs assessment and these include (a) normative need (defined by experts in the field); (b) perceived need (as seen by the people experiencing the need); (c) expressed need (from those seeking assistance); and (d) relative need (comparative needs and available resources within a geographic area). Hence, I incorporated these four perspectives into the intervention toolkit. For instance, it was vital that I determine the knowledge deficit of the participants involved in this project relative to the intervention toolkit (normative); their perceptions relative to the problem of LOS for IDPP with chronic medical problems (perceived); the reasons why they would consider or not consider the intervention toolkit (expressed); and the factors that could affect implementation such as costs and time (relative).

Population. The original population size included 30 stakeholders spanning physicians (psychiatrists and internists), clinical directors, case managers, nurse managers, case managers, social workers, discharge planners, legal conservators, Medi-Cal representatives, and long-term psychiatric facility administrators. I selected these stakeholders from the psychiatric unit where I conducted the study, the three long-term psychiatric facility where IDPP are transferred when discharged and remain within the county where this study was conducted, the legal conservator's office, and the Medi-Cal office.

Sampling. Sampling the stakeholders meant narrowing down the original population size of 30 in order to reflect "representativeness," which Burns and Grove (2009) articulated as ensuring that the settings and the variables included in a project are adequately reflected in the sample. Therefore, the inclusion criteria I used to select the sample size of ten experts was based on the leadership roles those experts have within their respective departments and facilities as these leaders (ten experts) are critical to establish the content validity of the intervention toolkit and their influence was needed to facilitate its implementation. The ten experts also represent the facilities and organizations involved in care for IDPPs across the continuum of care. Moreover, my rationale for using this sampling approach was based on the premise of the psychiatric rehabilitation process model whose constructs focuses on the wholeness of patients i.e. from a clinical, psychosocial, legal, and economic standpoints (NREPP, 2014). Hence, I needed to consider every factor affecting IDPP care and needed to establish content validity of the intervention toolkit. Doing so meant selecting a smaller sample of participants, which Galanis (2012) noted is vital when seeking to establish content validity. I deemed the sampling of ten stakeholders appropriate for this project. The ten stakeholders sampled included the psychiatric unit director, chief psychiatrist, chief internist, nurse manager, case manager, social worker,

discharge planner, legal conservator, director of the long-term psychiatric facility, and the Medi-Cal director of the county where my study site is located.

Step Three: Surveys

This step involved creating two online surveys in order to collect the necessary information from the participants. The first survey focused on understanding the perceptions of the ten experts relative to the practice issue. In it, I asked six questions that were related to the practice issue and that promoted conciseness, which Galanis (2012), has marked as essential in order to facilitate a greater response rate of participants. Furthermore, according to White and Dudley-Brown (2012), resistance to adopting EBP and lack of stakeholder support are two factors that hamper utilization of EBP within organizations. Therefore, considering that these same experts were needed to establish the content validity of the intervention toolkit, receiving their feedback regarding the practice issue was crucial. I used ordinal points ranging from number 1 to 5 were used to quantify the responses with “1” equaling the lowest score (strongly disagree, not relevant, very inadequate, very insignificant, not familiar) and “5” equaling the highest score (strongly agree, very relevant, very adequate, very significant, very familiar) including the appropriateness of using the intervention toolkit to address the issue. I designed the final three questions of the first survey to obtain the demographics of the participants (age range, job title, and length of time in current position), as these represented the variables (see Appendix A).

With the second survey, I focused on eliciting the participation of the experts in establishing the content validity. It entailed asking the participants to rate the items of the intervention toolkit individually, and then to rate the toolkit as a unit. I again used ordinal points with this survey with “1” representing “not relevant” and “5” representing “very relevant.”

Hence, the experts were able to rate the relevance of the items in the toolkit i.e. pharmacologic, psychosocial, somatic, rehabilitative, and monitoring functioning across domains both individually and collectively. According to Polit, Beck, and Owens (2007), this approach of using ordinal points facilitates the ability to rate the relevance of items individually and collectively to establish the content validity (See Appendix B).

Step Four: Submitting Documents for Approval

Obtaining Walden University's institutional review board (IRB) approval was the next critical step in the project methodology. For this stage, I submitted samples of the surveys, a sample letter of invitation, a completed letter of cooperation, a consent form, a certificate from the National Institutes of Health focusing on project ethics; and Walden University's ethics checklist form to the IRB committee. I received permission to proceed with this study from the IRB committee and was assigned the IRB number: 12-03-15-0156406.

Step Five: Eliciting Stakeholder Participation

Upon receiving IRB approval from Walden University to proceed with project implementation, I sent an encrypted electronic letter of invitation was sent to the ten experts which outlined the premise of this project. In addition, I included a link describing the psychiatric rehabilitation process model and a copy of the intervention toolkit detailing its components, the rationale for including the components, and my strategies for implementing those components. Furthermore, I attached a consent form that further explained the scope of the project, and the experts signaled their willingness to participate in the project by acknowledging "I consent" in the consent form. Next, after receiving the consent forms from all ten experts, I sent another encrypted email providing a link to the two surveys. The experts' responses to the

surveys served as data regarding their views about the practice issue and their assessment of the intervention toolkit, and I subsequently used them to establish the content validity of the toolkit.

Protection of Human Subjects.

This project conformed to the principles of promoting confidentiality and privacy of the participants and the data collected in accordance with the protocols guiding studies of this nature. For instance, I reviewed the Privacy Act of 1974 in preparing for this project. According to Burns and Grove (2009), this act focuses on protecting the privacy of participants in a study/project where knowledge transmission cannot occur without consent. Furthermore, the consent form I provided to the experts articulated the fact that this project was for research purposes, and had no bearing on my professional position within the organization. Participation in the project was voluntary and participants had the option to withdraw at any time. Hence, all conflicts of interest were addressed in the consent form. Moreover, since my study site does not have its own IRB protocol, Walden University's IRB protocol was the only one I used to ensure that all ethical guidelines were addressed in accordance with the university's guidelines. Ultimately, to maintain ethical protocols, I used encrypted emails for all information communicated to the ten experts, assigned unique identifiers to each participant, and created a password protocol that ensured that no one other than me had access to any information provided by the participants. I adequately updated the participants on every step of this project.

Data Collection

Hodges and Videto (2011) discussed the importance of designing survey questions in such a way to limit vagueness and ambiguity thus making data collection as straightforward as possible. Therefore, I designed data collection via the surveys to be succinct and direct. I collected electronically and managed it using NoviSurvey and subsequently an Excel Spreadsheet. In addition, I collected the data anonymously and included no identifying information from the participants because I used encrypted, password-protected emails. Since I used ordinal points to quantify the responses, the variables of age range, job title, and length of time current position used for this project provided an opportunity to match and quantify each respondent's answers to the first six questions while providing the demographics of the participants (see Table 1 and Table 2). For the second survey, the experts' ratings of the individual items of the intervention toolkit and the toolkit as a unit was facilitated by quantifying the responses with ordinal points. Consequently, it became easier to tabulate and evaluate the responses relative to establishing the content validity in accordance with the project purpose and objectives (see Table 3).

Content Validity

According to Polit (2010), reliability and validity of a project focuses on the degree of accuracy for which an instrument measures the attribute for which it was created to measure. Therefore, this project focused on establishing content validity of the intervention toolkit by the ten experts sampled for the project. Content Validity (CVI) focuses on the degree to which an item or set of items are reliable and effective in achieving the outcome they are meant to achieve (Polit, et al., 2007). Additionally, it is the most widely used method of establishing the relevance of items, which could entail establishing the relevance of individual items (item-level or I-CVI)

or the overall toolkit called the scale (S-CVI). Finally, establishing content validity through the S-CVI approach is contingent on achieving a universal agreement of the experts, which according to Polit et al. (2007), would entail achieving a rating of 3 out of 4 by all the content experts. I determined that a rating of at least 0.70 was subsequently the target needed to establish content validity for this project.

Analysis and Synthesis

In any project, reducing errors and increasing its validity and reliability is essential. Therefore, it was vital to I identify the factors that could threaten the validity of this project and strategies for limiting those threats. For instance, Polit (2010) identified such errors as poor constructed survey questions, misrepresentation of opinions by participants, misrepresentation of questions, smaller sample size, and shorter scales with lesser items. Consequently, limiting threats to validity of this project was contingent on using both I-CVI and the S-CVI approach that created a complete scale featuring all the constructs of the psychiatric rehabilitation process model. Therefore, this approach ensured that each construct was rated on its own merit and then rated collectively to bolster the validity of the toolkit. Furthermore, the survey design was important to limit the threat to the project validity by being succinct and direct thus eliminating any ambiguity that may otherwise hamper the results.

Data Analysis

I organized and analyzed the results for both surveys were presented and analyzed using Excel Spreadsheet and SPSS.

First survey. I used descriptive statistics was used to calculate the mean score (M) and standard deviation (SD) for each of the questions. In addition, I analyzed the demographics provided by the participants in order to establish the age range, job titles, and length of time in

the current positions i.e. variables used for the project (see Table 1). I then compiled the responses provided by the experts in an Excel spreadsheet with each of the first six questions related to the practice issue and the intervention toolkit tabulated to determine the distribution of the responses (see Table 2).

Second survey. I analyzed these survey responses using both Excel spreadsheet and SPSS to determine both the I-CVI and S-CVI, thus determining how each item in the intervention toolkit were rated individually, and how the toolkit as a unit was rated in order to establish its content validity (see Table 3).

Data Synthesis

After analyzing the responses provided by the experts in both surveys, I was able to determine how they regarded the practice issue, the intervention toolkit, and their ratings of the toolkit. Thus, I concluded that the experts deemed the practice issue as significant and the toolkit was highly rated. However, the knowledge deficit of most of the experts based on their responses regarding the psychiatric rehabilitation process model, provided me with an insight that the issue of longer LOS for IDPPs with chronic medical problems was in large part due to the stakeholders not understanding appropriate EBP interventions rather than the unwillingness to use those interventions (see Table 2 and Table 3).

Summary

In this section, I discussed the collection and analysis of evidence related to the practice issue, identified the sources of evidence, and offered synthesis of the data subsequently collected. In Section 4, I present results garnered from this project relative to its purpose, and offer recommendations for implementing the intervention toolkit.

Section 4: Findings and Recommendations

The purpose of the project was to understand the significance of LOS among IDPP with chronic medical problems; to create an intervention toolkit from the psychiatric rehabilitation process model to address LOS for IDPP with chronic medical problems, to elicit the participation of ten experts to establish the content validity of the intervention toolkit, and make recommendations on its implementation into practice. In this section, I discuss the findings and implications, offer recommendations, and identify the strengths and limitations of this project.

Findings and Implications

I completed the process of eliciting the participation of the ten experts, obtaining their responses to the surveys, and analyzing the results of the survey within two weeks. All ten experts agreed to participate in the project, provided consent, and responded to all survey questions. I summarize the results of the surveys below.

Survey Results

The results of the first survey showed four ($n = 4$, 40%) of the experts self-reported being in the age group 50 – 59; 20% ($n = 2$) self-reported being in the age group of 20 – 29; 20% ($n = 2$) self-reported being in the age group of 40 – 49; and one ($n = 1$, 10%) expert self-reported being in the age group of 30 – 39. The majority of the experts (90%) reported being under 60 years. The average number of years in current position was 9.2 ($M = 6.83$) years with a range of three to eighteen years (see Table 1). A majority of the experts ($n = 8$) considered the practice issue of LOS for IDPP with chronic medical problems significant with a mean score of 4 ($M = 4$, $SD = 0.6$). An overwhelming majority ($n = 9$) of the experts agreed that the practice issue warrants an intervention ($M = 4$, $SD = 0.4$). Another majority ($n = 8$) of the experts

($M = 2$, $SD = 0.6$) rated the current care protocols affecting care for IDPP with chronic medical problems inadequate. More than half of the experts ($n = 6$, $M = 2$, $SD = 0.6$) agreed that community resources were not adequate to meet the needs of IDPP with chronic medical problems that ultimately increases the likelihood of these patients needing frequent hospitalization. Less than half of the experts ($n = 4$, $M = 3$, $SD = 0.9$) reported being familiar with the psychiatric rehabilitation process model prior to participating in this project. However, providing explanation of the model and the toolkit through the link attached to the invitation letter sent to the experts proved crucial because more than half of the experts ($n = 7$, $M = 4$, $SD = 0.8$) agreed that the intervention toolkit was the best-care practice tool to address the practice issue (see Table 2). Therefore, the results of the first survey provided valuable insight on how the practice issue was regarded and helped me to gauge the willingness of the experts' to adopt and facilitate the implementation of the toolkit.

The second survey focused on establishing the content validity of the intervention toolkit and the results showed how each item of the toolkit was rated individually and then collectively as a unit. The mean of both the I-CVI and S-CVI were 0.84; and the mean expert proportion was 0.84 with a universal agreement rating of 8.4 (see Table 3). Subsequently, a content validity of 0.84 was established for the intervention toolkit thus providing a critical benchmark for this project, as a rating of at least 0.70 was needed based on the universal agreement approach of 3 out of 4 content experts agreeing and establishing content validity (Polit et al., 2007). Consequently, establishing a content validity of 0.84 facilitated recommending the toolkit as the most appropriate intervention to reduce LOS for IDPP with chronic medical problems and ultimately promoting positive outcomes for this population across the continuum of care.

Discussion of Findings

The psychiatric rehabilitative process model has shown evidence of its effectiveness in all the areas included in its construct. According to NREPP (2015), studies have been done using the psychiatric rehabilitation process model with the focus on IDPPs ability to meet basic survival needs; housing status; use of human services; quality of life; and psychological symptoms of anxiety, depression, and thought disturbance. The studies showed that IDPPs with chronic medical problems had positive outcomes with the use of the model in all of these areas. The model specifically addresses how function and care coordination is promoted and maintained for IDPPs within communities, thus deemphasizing the need for them to remain hospitalized for extended periods of time due to decompensation from both their psychiatric and medical problems.

From a cost perspective, Swanson et al. (2013) conducted a study that supports the cost-effectiveness of outpatient treatment for severely mentally ill patients. In fact, one result showed a decrease by as much as 43% of care costs for assisted outpatient care treatment. Moreover, Anthony and Farkas (2009) discussed the use of the psychiatric rehabilitation process model to address the negative impact of intellectual disability relative to both physiological and psychological impairment, dysfunction, disability, and disadvantage (disparity) faced by this population. These studies found that the use of the model to address those issues improved coordination through consumer involvement, consumer choice, consumer strengths/growth, shared decision-making, and outcome accountability for providers.

It is equally vital to consider the efficacy of interventions used to promote care and wellness beyond the acute care setting. For instance, Mirenda (2014) discussed significant improvements in adaptive behavior skills for IDPPs who moved from institutions to community

settings. Such adaptive skills improvements were noted even for patients with severe/profound intellectual disabilities. Consequently, promoting and maintaining care for IDPPs with medical problems beyond acute care settings is essential in enhancing their wellness. My use of the psychiatric rehabilitation process model is grounded in reviewing and reorganizing care processes that lead to greater resource utilization and that ensure care is sustained to support IDPPs with chronic medical problems within the community. Moreover, the intervention toolkit I created from the constructs of the psychiatric rehabilitation model and used for this project demonstrates the holistic underpinning of the model that considers the interrelatedness of the factors affecting care for IDPPs with chronic medical problems.

As previously noted, the framework that guided this project was Orem's self-care deficit theory. According to McEwen and Wills (2011), this theory examines nursing's role in promoting function for populations with health deficits by considering the human and environmental factors that affect human functioning or development. Therefore, my intervention toolkit embodied the principles of Orem's theory by reconciling dimensions of care affecting IDPPs with chronic medical problems so as to reduce LOS while maintaining care coordination across domains. Furthermore, in this project, I examined the parallel between care affecting IDPPs and population health. Nash, Reifsnyder, Fabius, and Pracilio (2011) described population health as an evaluation of the health determinants that influence distribution of health services, healthcare policies, and the interventions that affect the determinants. Thus, I worked to identify those health determinants including the needs of IDPPs and to develop approaches to address those needs. Specifically, I identified care affecting IDPPs with chronic medical problems relative to longer LOS for this population. Finally, the intervention toolkit implementation

provided an opportunity to reconcile the social, financial, clinical, and legal determinants of care aimed at improving outcomes for this population.

Implications for Practice and Action, Future Research, and Social Change.

This project highlighted the importance of a DNP as a critical component in advocating and promoting healthcare systems. For instance, there remain health disparities affecting many populations, which impact their access to healthcare and subsequently the level of care they will receive. Stevens and Sidlinger (2015) have identified the disparities faced by mentally ill patients including decreased access to primary care services and a higher incidence of chronic comorbidities that results in frequent hospitalization. Additionally, PublicHealth (2015) stated that 70% of deaths in the United States are attributed to chronic illnesses. Of course mentally ill patients have a greater incidence of facing chronic illnesses, so morbidity and mortality is higher within this population.

Another implication of this type of project relates to incorporating the principles of state and federal health initiatives focused on community health. For instance, Panning (2014) noted that one of the goals of the Affordable Care Act is to promote coordination of care focused on preventive care, and to emphasize public health initiatives aimed at enhancing care delivery. Consequently, this I designed this DNP project to embody the principles of seeking to reduce healthcare disparity, promoting care coordination across the continuum of care, and enhancing care delivery affecting vulnerable populations. It represents a call to action for practicing accountability in healthcare and promoting resource optimization through policy development to enhance delivery systems.

When promoting social change, it is vital to consider equity and justice as two of the cornerstones of healthcare delivery. For instance, according to Arc (2015), legislative policy for the fiscal year of 2015-2016 is to increase federal public funding to ensure that IDPPs can live and maintain fully inclusive and productive lives within the community. Hence, the policies to promote equity and justice include timely access to quality care, comprehensive care, affordable care, individualized healthcare services, adequate accommodation, accessible transportation programs, and a robust insurance to coverage for both acute and long-term care services. Consequently, I affect social change by appreciating the significance of the practice issue and identifying the best intervention to remedy the problem.

Terry (2012) noted that engaging in DNP projects entails having the knowledge base to appreciate the factors that affect care delivery from a financial, clinical, legal, and social standpoint. Consequently, future projects similar to this one must reconcile those factors (financial, clinical, legal, and social elements) that influence care delivery for patient populations. Reconciling those factors to promote quality of care improvements is grounded in the selection and implementation of best available research evidence. Likewise, it is important to note that the clinical, financial, legal, and social components represent an aggregation of the determinants of health. For instance, the World Health Organization (2015) identified the access and use of health services that prevent and manage diseases (clinical), the economics affecting health (financial), the availability of social/community services (social), and policies affecting care delivery (legal) as major determinants of healthcare delivery.

The implication for recommending the intervention toolkit is to reconcile the clinical, financial, social, and legal determinants of care, and I sought to create a toolkit that reflected those determinants in coordinating care for IDPPs with chronic medical problems. Ultimately,

my creation of the toolkit embodies the principles of promoting beneficence, autonomy, and justice in improving outcomes for vulnerable populations such as IDPPs.

Clinical

The implication for recommending the intervention toolkit from a clinical viewpoint focused on promoting the collaborative and concurrent treatment directed by the psychiatrist and internist leading to stabilization of both the psychiatric and physiological symptoms experienced by IDPPs. The clinical stabilization time for patients with chronic medical problems, but without intellectual disability is typically 4 to 5 days after admission at my study site based on the records made available by the quality improvement department. However, for IDPPs with chronic medical problems, one of the biggest delays at the facility is the tendency for clinicians to primarily focus on the psychiatric symptoms rather than concurrently focusing on the physiological issues that may be contributing to the psychiatric and behavior problems. The chief psychiatrist at the facility noted that the delay was typically due to the difficulty in obtaining detailed health histories about medical conditions from IDPPs at time of admission (personal communication, April 15, 2015). Consequently, this lag in simultaneously managing both psychiatric and medical symptoms contributes to longer LOS. Moreover, it took an average of 2 to 3 days after admission for internist consults to be ordered for IDPPs with chronic medical problems compared to an average of 24 hours for non-IDPPs.

Sadly, the poor coordination of concurrently managing psychiatric and medical symptoms is typical. For instance, Walders (2007) noted the tendency of clinicians to ignore the impact of physiological health issues on psychiatric symptoms. Thus, I sought to address this gap in practice by creating the intervention toolkit. My objective was to recommend the use of the toolkit to improve care coordination so that IDPPs receive care at the same level as non-IDPP.

Relying on collateral information about IDPP's health problems was an approach I deemed insufficient to deliver efficacious care. Instead, I created the toolkit to promote psychiatrist and internist collaboration at the study site in simultaneously addressing the psychiatric and medical problems upon admission of IDPPs with chronic medical problems. Subsequently, this collaboration was vital to coordinate a more comprehensive treatment plan, and appreciating the interrelatedness of the psychiatric and physiological dimensions of wellness. Moreover, concurrent management of physical and mental health issues, provides greater insight on how systemic imbalances could alter both mental and physiological equilibrium, and help identify any underlying issues.

Concurrent management of psychiatric and medical symptoms facilitates using diagnostic testing to identify physiological imbalances that affect level of consciousness and behavior changes. For instance the U.S. National Library of Medicine (2015) noted that such diagnostic tests as determining ammonia levels could yield information that suggests congestive heart failure, gastrointestinal bleeding, leukemia, liver failure, low potassium level, metabolic alkalosis, severe muscle exertion, and changes in mentation such as confusion, disorientation, and lethargy. Therefore, the pharmacological and somatic components of the intervention toolkit is aimed at concurrently addressing both the psychiatric and medical problems rather than attributing behavioral problems exhibited by IDPPs as merely psychiatric symptoms.

Financial

The financial implication of recommending the intervention toolkit focused on evaluating the cost margin of inpatient versus outpatient care for IDPPs, and the related insurance coverage and reimbursement. I interviewed the director of Medi-Cal services for the county where my study was conducted, who stated that Medi-Cal does provide extensive outpatient coverage for IDPPs (personal communication, December 4, 2015). In fact, according to California Department of Healthcare Services (2015) which coordinates Medi-Cal coverage and reimbursement, outpatient coverage includes mental and behavioral health treatment, rehabilitative and habilitative services, chronic disease management through preventive and wellness services, laboratory testing to monitor and maintain therapeutic medication levels, medical supplies, medications, and psychiatric consultations. Furthermore, from a cost margin perspective, the clinical director of my study site stated that the average cost for inpatient treatment is between \$3, 000 to \$10,000 per a 7-day stay depending on the level of care being provided. However, on an outpatient basis, the average cost in a month is about 20% less per the case manager (personal communication, December 4, 2015).

The argument for inpatient versus outpatient care led me to conclude that resource utilization is necessary to reduce the inpatient costs of care for IDPPs, and to maximize the use of outpatient care services, especially since Medi-Cal makes adequate provision for those services. Therefore, my recommendation for using the intervention toolkit and the subsequent financial implication relative to LOS is to promote greater interdisciplinary collaboration in planning care for IDPPs. For instance, while clinical stabilization is ongoing for IDPPs with chronic medical problems, the implication of using the intervention toolkit entails concurrent involvement of the discharge planning, social worker, and case management who focus on

coordinating community placement, and scheduling subsequent outpatient treatment for IDPPs upon discharge. Hence, this ensures that any delays affecting placement after discharge are minimized such as promptly securing accommodation including to long-term care facilities by keeping those facilities apprised, and providing estimated discharge dates, which enables those facilities to reserve accommodation for the patients. Subsequently, the delay between treatment completion, discharge, and community placement causing longer LOS is minimized. My approach highlights the financial implication of reducing inpatient costs caused by longer LOS for IDPPs with chronic medical problems.

Legal

Exploring the legal implication of recommending the intervention toolkit enabled me to understand the role of the legal conservatorship department relative to caring for IDPPs with chronic medical problems. According, California Courts (2015), the legal conservator in many cases acts as the durable power of attorney for IDPPs, and acts as a liaison between the patients and other professionals involved in IDPP care such clinicians, Medi-Cal representatives, social workers, and case managers. Furthermore, legal conservatorship in the state of California covers care and protection for persons in the areas of arranging nutrition, healthcare, clothing, personal care, housekeeping, transportation, shelter, recreation, and social wellbeing. The legal conservatorship department also acts as counsel for IDPP in legal proceedings and court hearings (California Courts, 2015).

The role of legal conservators is therefore crucial in care coordination for IDPPs, and in view of that role, the elements of the intervention toolkit that is pharmacology, somatic, rehabilitation, psychosocial, and monitoring function across care domains are reflected to improve care for IDPPs. Thus the legal implication of recommending the intervention toolkit

focuses on promptly engaging legal conservators in the care of IDPP at time of admission to expedite care as the legal conservators coordinate access to community services, establish legal statuses, and work on maintaining continuous care which enhances care coordination relative to reducing LOS.

I examined the impact of promptly establishing legal status of IDPPs relative to reducing LOS. For instance, since the decreased cognitive function of these patients affect their ability to make informed decisions, healthcare decisions are deferred to legal conservators who have the power of attorney and act on behalf of these patients. Hence, the legal implication of recommending the toolkit ensures timely treatment of IDPPs with chronic medical problems. For instance, prescribing certain medications such as Olanzapine, Lamictal, Seroquel, Lithium and so on is contingent on obtaining patients' or legal representatives' consent. Consequently, engaging legal conservators means promptly establishing the legal status of IDPPs whether it is temporary or permanent conservatorship, thus facilitating obtaining consents to prescribe and administer those medications. Additionally, such procedures as ECT also requires consent and again the legal conservator is able to provide consent for performing involuntary ECTs when medically indicated including outpatient ECTs. Hence, care is not delayed when legal conservators are included throughout the continuum of care, and the intervention toolkit which I created to reconcile the factors affecting care for IDPPs relative to LOS and maintaining care across care domains recognizes that component of quality of care improvement.

Further noting the legal implication of recommending the toolkit to expedite care, the director of my study site stated that establishing power of attorney could take between two to four weeks, especially when it comes to seeking legal clearance to perform ECT (personal communication, December 4, 2015). In fact, during my review of the care processes used at my

study site, I noticed that in one particular case, ECT was delayed for an IDPP who required the procedure for severe depression due to the poor coordination in establishing legal conservatorship. Consequently, the patient had to wait for six weeks before finally being able to receive ECT after legal conservatorship was achieved. However, by promptly addressing legal guardianship, treatment for IDPPs is expedited, as the legal conservator is immediately included in the treatment plan to act on behalf of the patients across care domains.

Social

The fourth and final implication of recommending the intervention toolkit focuses on the social determinant of care. This entails promoting functionality for IDPPs through rehabilitative services such as occupational therapy, physical therapy, individual and group psychotherapy, partial hospitalization program, and wellness programs provided by community mental health centers in the county where my study site is located. Hence, IDPPs with chronic medical problems are able to participate in these programs regularly, which provides the opportunity for continued monitoring of functioning affecting both their psychiatric and physiological issues. Subsequently, this reinforces the principle of maintaining wellness for IDPP with chronic medical problems within the community setting thus reducing decompensation from both those psychiatric and medical problems that may warrant hospitalization and consequently leading to longer LOS. I concluded that this approach promotes both collaborative coordination among the stakeholders involved in care for IDPPs with chronic medical problems, and enhancing continuity of care across care domains.

Recommendations

My recommendations for implementing the intervention toolkit into practice was aimed at articulating the strategies for applying all its elements into practice to reduce LOS for IDPPs with chronic medical problems.

Implementing Pharmacologic Interventions

I identified two strategies for implementing pharmacological interventions to reduce LOS. The first strategy focuses on expediting inpatient care to reduce LOS while the second strategy focuses on promoting medication adherence beyond the acute setting, thus reducing the risk of decompensation, frequent hospitalizations, and subsequent LOS.

First strategy. This strategy involves concurrently addressing both mental and medical conditions with drug therapy in view of the common oversight clinicians make in misattributing medical symptoms to mental symptoms. For instance, de Jong (2011) noted that medical symptoms often manifest as psychiatric symptoms, and subsequently misdiagnosed as psychiatric symptoms. Some of those medical misattribution include neurological disorders presenting as psychosis, hyperthyroidism presenting as anxiety disorder, and hypoglycemia presenting as confusion. Therefore, upon admission of IDPPs with chronic medical problems, the first step I recommend is notifying both the psychiatrist and internist. Next, I recommend obtaining data regarding all the medications the patients are receiving from the facilities those patients resided in prior to admission, and for those patients being cared for by family members, interviewing and requesting medication lists from the family members.

Continuing with the first strategy, I recommend obtaining recent diagnostic and laboratory test results that include toxicology screening, serology tests, urine culture, complete blood work, metabolic tests, HIV and AIDS tests, magnetic resonance imaging, computed

tomography, and so on. Finally, the admitting order sets currently being used at my study site facility must be modified to include those diagnostic and laboratory tests listed above in order to enhance planning for medication therapy by identifying and ruling out underlying medical conditions relative to psychiatric symptoms, especially when collateral information about the patients' medical history is not immediately known at time of admission.

According to de Jong (2011), drug therapy interventions are best accomplished using the DIVINE MD TEST approach, which is a mnemonic where each letter represents medical conditions and symptoms, and detailed assessment and testing needed to identify concomitant medical problems and how they affect mental health symptoms. This approach helps confirm medical versus psychiatric symptoms, thus showing the link between medical and psychiatric manifestations. Hence, I recommend this approach to concurrently address medical conditions that may present with mental health symptoms (see Table 4). Likewise, this approach facilitates utilizing clinical practice guidelines to help formulate diagnoses and subsequent care plans relative to pharmacologic management of both medical and mental symptoms. Consequently, judicious medication therapy is promoted, thus reducing misrepresentation of medical symptoms as psychiatric manifestations. By recommending this strategy, I highlighted the significance of the pharmacologic component of the toolkit to minimize exacerbation of both medical and mental symptoms, and subsequently leading to faster stabilization times that reduces LOS for IDPPs with chronic medical conditions.

Second strategy. This second strategy I recommend focuses on promoting medication adherence beyond the hospital setting, and involves environmental support through cognitive adaptive training (CAT) and cognitive behavioral therapy (CBT). According to Velligan and Weiden (2006), medication compliance remains a challenge that hampers physicians' ability to

adequately prescribe medications. For instance, physicians may unnecessarily discontinue medications, increase doses, or add concomitant medications due to misattributing adherence problems to poor medication response. Moreover, non-adherence could be inadvertent or intentional on the part of patients. Inadvertent non-adherence results when cognitive impairment hampers medication compliance, and intentional non-adherence is the conscious decision by patients to stop taking medications.

According to Velligan and Weiden (2006), using CAT is the most effective intervention for unintentional non-adherence with evidence supporting its use to improve symptomatology and adaptive functioning to reduce rates of relapse outside the acute care setting. This entails using a systematic approach of triggers such as large calendars to help patients track appointments, using signs, medication container alarms, labeled single-dose containers, arranging transportation for appointments, and using notebooks to track side effects. These triggers serve the purpose of assisting patients avoid under-dosing or overdosing, maintaining routine follow-up meetings, and discussing medical and psychiatric symptoms with clinicians.

In view of assisting IDPPs with chronic medical problems maintain functioning within the community with as little professional help as possible, using CAT within the community involves the collaborative effort of case managers, physicians, pharmacists, care providers at long-term care facilities, legal conservators, and family members to integrate those cues. Hence, with improved compliance with medication use, the risk of decompensation, frequent hospitalization, and longer LOS are reduced.

Applying CBT is aimed at addressing intentional nonadherence and involves focusing on subjective and behavioral connections relative to patients' beliefs, feelings, and actions revolving around medications (Velligan & Weiden, 2006). In addition, CBT facilitates educating patients

about the issue of adherence consistent with the patients learning needs and perspectives about medication intake. Thus facilitating the patients' participation in their care across the continuum of care. Consequently, recommending CBT within practice is contingent on routine therapy sessions for IDPP with chronic medical problems through the concerted participation of clinicians (physicians, nurses, therapists); patients and their family members; care providers at long-term care facilities within the community. Hence, it is a continuous process of reinforcing the need to maintain medication regimen regardless of the setting to reduce exacerbation of both medical and psychiatric symptoms that would warrant hospitalization and contribute to longer LOS.

Implementing Somatic Intervention

The strategy I recommend again involves simultaneously addressing both medical and psychiatric symptoms using the DIVINE MD TEST approach (see Table 4). This approach helps establish underlying medical conditions that could be contributing to psychiatric symptoms and vice versa (de Jong, 2006). Furthermore, using the DIVINE MD TEST entails recognizing the impact of psychiatric medications such as the side-effects on the body, and subsequently prescribing medications to relieve those side-effects. For instance, Muench and Hamer (2010) noted that second-generation antipsychotic medications such as clozapine and olanzapine are linked with causing metabolic syndromes such as obesity and diabetes mellitus. Therefore, using the DIVINE MD TEST approach facilitates promptly ordering diagnostic and laboratory testing in view of the side-effects of psychiatric medications on physical health.

Diagnostic and laboratory testing should focus on establishing systemic baselines such as functioning such as kidney and liver function, and ruling out or confirming diabetes through the glycosylated hemoglobin test, fasting plasma glucose test, and oral glucose tolerance test. Other

testing should include cardiac enzyme test, electrolyte levels, and an electrocardiogram. Finally, using the DIVINE MD TEST approach of identifying underlying medical issues relative to psychiatric symptoms could enhance coordinating lifestyle changes for patients from dietary modifications to promoting physical activity. Hence, managing somatic issues relative to LOS would result in faster stabilization times that reduces LOS for IDPPs with chronic medical problems.

Implementing Rehabilitation Intervention

The strategy I recommend for implementing the rehabilitation element of the toolkit is based on from the principle of the International Classification of Functioning, Disability, and Health (ICF). According to Rossler (2006), ICF entails changing the perception and negative connotation of impairments, disabilities, and handicaps to the neutral descriptions of body structure, function, activities, and participation. In addition, ICF has been modified to include environmental factors and recognizing how those factors enhance or hamper functioning for individuals with disabilities. Thus including environmental factors sought to determine the degree to which they (environmental factors) interact with any given health condition to create disability or restore function.

Applying ICF involves identifying the needs of mentally ill patients and utilizing rehabilitative resources to assist them maintain functioning within the community (Rossler, 2006). The core of this strategy is placing patients within the community based on their needs and levels of functioning. For instance, both cognitive and physical assessments will help clinicians, social workers, case managers, discharge planners, insurance representatives, and family members identify which resources within the community best meet the patients' needs from housing, employment, to integration in the community. Furthermore, this strategy must be

initiated within 24 hours of admission thus facilitating a concurrent approach of stabilizing the patients while making arrangements for them to be placed within the community upon discharge. Hence, LOS for IDPPs with chronic medical problems is reduced as the amount of time between stabilization times and community placement is minimized.

With regards to housing, the options include round-the-clock sheltered homes, more independent, less-staffed accommodation to independent housing within the community. I realized the importance of balancing the goal of enhancing IDPP independence and functioning with the level of assistance some IDPPs may need. Thus, community placement must be congruent with the level of assistance and functioning of the patients.

Implementing Psychosocial Intervention

The strategy I recommend strategy for implementing the psychosocial component of the toolkit is the assertive community treatment (ACT). According to NAMI (2016), ACT has been reported to promote effective outpatient maintenance of wellness while reducing hospitalizations by as much as 20%. Therefore, by recommending ACT as the psychosocial implementation strategy, I recognized its usefulness of achieving this project's goal reducing LOS for IDPPs with chronic medical conditions while boosting utilization of community services. Furthermore, NAMI (2016) stated that using ACT as a psychosocial intervention entails incorporating medication therapy, community placement, community support, and interdisciplinary collaboration. Consequently, ACT reflects components of the intervention toolkit, and a represents a continuum of care intervention that reinforces all the toolkit. Likewise, recommending ACT captures the principle for which I created the toolkit which is recognizing the roles the stakeholders involved in the care for IDPP with chronic medical problems play in care coordination across the continuum of care.

My recommendation of ACT as a psychosocial intervention is also based on its melding of the other intervention toolkit strategies such as medication management, somatic management, rehabilitation management, and function across care domain management.

Implementing Monitoring of Function across Care Domains Intervention

The strategy I recommend for implementing this component encompasses incorporating biological, psychological, and social interventions across the continuum of care. This entails designing care plans to reflect consistent coordination across the continuum of care for IDPPs with chronic medical problem. I based this strategy on recommendations by Zauszniewski, Suresky, Bekhet, and Kidd (2007) who identified (a) biological intervention as one focusing on the physical functioning directed towards patients' self-care, activities, sleep, nutrition, and medication management. (b) Psychological interventions focus on behavior therapy. (c) Social and interventions are geared towards enhancing the patients' ability to maintain function within the community.

Recommending this strategy entailed my acknowledgement of devising an evaluation protocol to gauge how effective the intervention toolkit is in meeting the needs of IDPP with chronic medical problems to prevent relapse, reduce hospitalization, and subsequently reducing LOS. Moreover, communication among the stakeholders involved in IDPP care is crucial to ensure that they continue to work in concert to enhance wellness for these patients. For instance, clinicians' assessment across the continuum of care would entail checking that medication prescriptions and refills are maintained, and ordering routine laboratory testing to determine if therapeutic levels are being maintained for those medications that require routine evaluation critical for dosing adjustment (warfarin, Depakote, clozaril, abilify, trileptal, and so on). Likewise, routine monitoring of serum lipids, glucose levels, complete blood work, electrolyte

levels, and so on is sustained to identify any abnormalities and promptly resolving them. Thus pharmacological and somatic monitoring are facilitated.

Monitoring functioning across care domains equally ensures that nonpharmacological interventions such as occupational therapy, behavior therapy are sustained. Those interventions are aimed at promoting IDPP participation their care and independence with activities of daily living. Similarly, the collaboration of physicians, case managers, social workers, discharge planners, legal conservators, Medi-Cal representatives, and in some cases, family members facilitates arranging community placement that meets the needs of the patients. Furthermore, such collaboration promote maintaining access such as arranging routine follow-up care, diagnostic and laboratory screening, assistance with transportation, and adequate accommodation. Consequently, monitoring of function ensures that care is sustained and continuous thus reducing the risks of decompensation, hospitalizations, and longer LOS.

Project Evaluation Plan

An evaluation plan is vital to determine the effectiveness of an intervention, and for this project that involves reducing LOS for IDPPs with chronic medical problems while maintaining function beyond the acute setting. In addition, outlining the evaluation plan is crucial to determine the degree of success and the factors that contributed or hampered the success of the intervention. Therefore, my recommended evaluation plan is the “empowerment evaluation model.” According to the CDC (2009), empowerment evaluation model provides an opportunity to develop new insights on how effective strategies are in addressing an issue; and identifying factors that support or hinder the strategy’s ability to achieve positive outcomes. Furthermore, empowerment evaluation is a collaborative process that is inclusive of all stakeholders involved in a program, promotes the utilization of evidence-based strategies to implement programs,

facilitates the generation of data to determine if the program goals have been achieved, facilitates improvement strategies that will continue to enhance a program's goals and objectives, and promotes capacity building where both individuals and organizations are able to gauge their progress in utilizing intervention strategies (self-determination). Accordingly, I recommend conducting evaluations of the intervention toolkit within a six to twelve month interval.

Strengths and Limitations of the Project

According to Kettner et al. (2013), the implementation phase of a project is the most challenging, as a concerted effort on the part of stakeholders is needed to apply all aspects of the project; and monitoring the project's performance thus being able to determine its cost-effectiveness and intended outcomes. However, with careful planning, identification of appropriate interventions, and effective monitoring of the project, implementation challenges are minimized. Consequently, I used the "quality metric" approach to evaluate the strengths of this DNP project. Barnhorst, Martinez, and Gershengorn (2015) described the quality metric as one using a structural, process, and clinical outcome approach to enhance the success of an EBP project. For instance, from a structural perspective, I examined the settings where care is delivered for IDPPs with chronic medical problems including the providers and their areas of specialty. The process criterion of the quality metric enabled me to examine the specific care processes used to deliver care for IDPPs with chronic medical problems from admission through discharge including how those care processes were maintained to achieve successful outcomes. Finally, the clinical outcomes criterion helped me examine the health outcome resulting from care delivery including evaluating mortality rates, complication rates, LOS, readmission rates, patient satisfaction, functional health status, and overall quality of life. Therefore using this quality metric became the biggest strength of the project because it provided me with the

incentive to explore the right intervention, the right situation, the right time, the right patients, and at the right cost.

Likewise, the project design added strength to the project, as I streamlined it to focus on the most critical participants relative to the project. For instance, the ten experts who established the content validity were sampled based on their specific areas of specialty that was vital in how care was coordinated and provided for IDPPs with chronic medical problems. Moreover, the two online surveys I used to collect data were effective in eliciting maximum participation from the ten experts. Thus, the experts were able to complete the two surveys in within a week. Therefore, I had adequate time to compile and analyze their responses. Finally, the ease of application of the intervention toolkit was another major strength because I did not need to create a new care protocol. Instead, I focused on evaluating current care processes and recommending how to modify them to emphasize the interconnectedness of the factors (clinical, financial, legal, and social) affecting care delivery for IDPPs with chronic health problems.

Conversely, the only limitation I encountered during this study related was the majority of the experts' knowledge deficit regarding the psychiatric rehabilitation process model. In fact, Swanson et al. (2009) discussed the lack of thorough comprehension of the model and its concepts and application as the most distinct drawback to its utilization. Hence, I was not surprising to discover that only four out of the ten experts were conversant with the model during my data analysis. Consequently, such knowledge deficit becomes a critical factor with EBP projects such as this because it could affect participants' willingness to engage in a project for which they do not fully grasp the intervention tool and its implications. However, I was able to mitigate that issue by providing a link attached to the invitation letter sent to the experts at the start of the project. The link provided a detailed explanation of the psychiatric rehabilitation

process model, and copy of the intervention toolkit I sent including its applicability reducing LOS for IDPP with chronic medical problems were effective.

Finally, my recommendation for future projects such as this is to understand the significance of a practice issue, examine the effectiveness of the proposed interventions, identify the stakeholders critical to its implementation, provide a thorough clarification of the project processes, determining the timeliness of intervention implementation, and identify appropriate project evaluations.

Summary

In this section, I discussed the findings of the project, its implications, made recommendations for its implementation, its evaluation plan, and its strengths and limitations. In Section 5, I will discuss my dissemination plan as part of a scholarly product, and off an analysis of myself as fledgling DNP.

Section 5: Dissemination Plan

Oermann and Hays (2011) have noted the importance of nurses engaging in research studies and EBP projects, disseminating the findings and outcomes of projects to evaluate the efficacy of nursing interventions, and subsequently building the knowledge base of nursing to yield new evidence for practice and develop new studies that complement each other. Given that my project has academic, clinical, and social implications, my dissemination plan entailed identifying and using a forum that includes those areas. Hence, I will disseminate this project electronically in the form of manuscript publication on Walden University's library database because this approach will make the study available to those working in academic, clinical, and social settings. Additionally, I will provide a link to the stakeholders involved in this project so that they can view the manuscript electronically.

Analysis of Self

This project provided an excellent learning opportunity for me to appreciate the systematic processes involved in trying to address a practice issue. Those processes include understanding the breadth of the issue and the factors that could facilitate or hinder its resolution. Additionally, as a professional close to the practice issue addressed in this project (reducing LOS for IDPPs with chronic medical problems), I gained an understanding of how nurses can be instrumental in affecting change within healthcare systems. White and Dudley-Brown (2013) noted that it is important for nurses to routinely examine their practice and seek modalities to enhance the processes of care. They further noted that nurses should use critical thinking to question if the best and most current practices are being utilized and the extent to which those practices are yielding the best outcomes for patient populations. It was critical thinking that enabled me to examine the care processes used to coordinate care for IDPPs with chronic

medical problems. Moreover, I began to appreciate factors such as cost and resource utilization that impact care for patient populations and subsequently became better able to identify the disparity of care affecting IDPPs at the facility where I conducted the study.

It is important for a DNP student to understand the roles and influence a DNP has in healthcare systems. Hence, engaging in this project has enhanced my understanding of the value of being active in healthcare policy and advocacy, and of how inter-professional collaboration can improve population health outcomes. Likewise, my future plans as a DNP entail becoming more involved in policy development, advocating for care improvements, and collaboratively addressing issues affecting patient populations. Finally, as a project developer, my challenge was to identify the steps necessary when engaging in scholarly projects. For instance, the steps of the nursing process, which the American Nurses Association (2015) have described as assessment, diagnoses, outcomes/planning, implementation, and evaluation, provided a strong foundation that enabled me to devise an approach to guide the project by identifying the practice issue, applying clinical judgment, selecting an intervention, devising a plan for implementing it, and identifying an evaluation approach to monitor its effectiveness.

Summary

This DNP project identified extended LOS for IDPPs with chronic medical problems as a practice issue that necessitated an intervention to mitigate the issue and achieve positive outcomes for the affected patient population. The intervention I deemed most appropriate to address the lag in care coordination affecting IDPPs with chronic medical problems was the creation of an intervention toolkit that used the constructs of the psychiatric rehabilitation process model. The toolkit was rated by ten experts to establish the validity of its content, and I subsequently made recommendations about its implementation. Kettner et al. (2013) made an important point about the nurse being an advocate in evaluating not only the practice itself, but also how care is coordinated and delivered. Hence, as a fledgling DNP, I came to appreciate the value of the changes affecting care systems and the need to embrace those changes aimed at promoting quality of care across all settings.

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Table 1

Demographics

| | N (%) | Mean (SD) | Range |
|--|---------|------------|--------|
| Age Range | | | |
| 20 to 29 | 2 (20%) | | |
| 30 to 39 | 1 (10%) | | 0 - 4 |
| 40 to 49 | 2 (20%) | | |
| 50 to 59 | 4 (40%) | | |
| 60 to 69 | 1 (10%) | | |
| Over 70 | 0 (0%) | | |
| Job Title | | | |
| Medi-Cal Director | 1 (10%) | | |
| Case Manager | 1 (10%) | | |
| Discharge Planner | 1 (10%) | | |
| Social Worker | 1 (10%) | | |
| Medical Director | 1 (10%) | | |
| Chief Internist | 1 (10%) | | |
| Legal Conservator | 1 (10%) | | |
| Chief Psychiatrist | 1 (10%) | | |
| Long Term Director | 1 (10%) | | |
| Nurse Manager | 1 (10%) | | |
| Number of Years in Current Position | | | |
| | | 9.2 (6.83) | 3 - 18 |

Table 2

Content Questions

| Questions | N | Mean (SD) | Range |
|---|---|-----------|-------|
| How would you rate the clinical significance of LOS for IDPP with chronic medical problems? | 8 | 4 (0.6) | 3-5 |
| Do you think the problem of increased LOS for IDPP with chronic medical problems warrants prompt intervention(s)? | 9 | 4 (0.4) | 3-5 |
| Do you think the current protocols used in planning care for IDPP with chronic medical problems within the acute care setting (hospital) are adequate? | 8 | 2 (0.6) | 1-3 |
| Do you think community resources available to IDPP with chronic medical problems are adequate to decrease relapse and frequent hospitalizations? | 6 | 2 (0.6) | 1-3 |
| Are you familiar with the “psychiatric rehabilitation process model” prior to receiving information about it during the course of this project? | 4 | 3 (0.9) | 2-4 |
| Would you consider the intervention toolkit (pharmacology, somatic, psychosocial, rehabilitative, and monitoring of function across care domains) created from the psychiatric rehabilitation process model relevant to resolving the practice issue? | 7 | 4 (0.8) | 3-5 |

Table 3

Content Validity Results by Experts

| Toolkit Item | #1 | #2 | #3 | #4 | #5 | #6 | #7 | #8 | #9 | #10 | # in agreement | Item CVI |
|---------------------------------|------|------|------|------|------|------|------|------|------|------|----------------|----------|
| Pharmacology | X | - | X | X | X | X | X | X | X | X | 9 | 0.9 |
| Somatic | X | X | X | X | - | - | X | X | X | X | 8 | 0.8 |
| Rehabilitative | X | - | X | X | X | X | X | X | X | X | 9 | 0.9 |
| Psychosocial | X | X | X | - | X | X | - | X | X | X | 8 | 0.8 |
| Functioning across care domains | X | X | - | X | X | X | X | X | X | - | 8 | 0.8 |
| Population Relevant | 1.00 | 0.60 | 0.80 | 0.80 | 0.80 | 0.80 | 0.80 | 1.00 | 1.00 | 0.80 | | |

Mean I-CVI = 0.84; S-CVI = 0.84; Mean expert proportion = 0.84

Table 4

DIVINE MD TEST

| Letter | General medical conditions: diagnosis/clinical presentations |
|--------|---|
| D | Drug and other substances abuse |
| I | Infectious diseases: meningitis, cerebral malaria, encephalitis, sepsis, HIV/AIDS-related, neurosyphilis |
| V | Vascular diseases: stroke |
| I | Inflammatory/immunologic disorders: fever, arthralgia |
| N | Nutritional/vitamin deficiencies: vitamin B12, thiamine (Wernicke's encephalopathy related to chronic alcohol abuse), ataxia, ophthalmoplegia |
| E | Endocrine disorders: hyperthyroidism (tremor, tachycardia, heat intolerance, exophthalmoses), hypothyroidism (lethargy, bradycardia, cold intolerance), Cushing syndrome (buffalo hump, moon face, stria, muscle wasting), Addison's disease (hypotension, hyper pigmentation), pheochromocytoma (hypertension, anxiety) |
| M | Metabolic disorders: fluid/electrolyte imbalance (skin turgor, mucous membrane), hyper and hypoglycaemia, liver encephalopathy (asterixis, lethargy), uremic encephalopathy (apathy, lethargy, myoclonus, asterixis), rare diseases such as Wilson disease (tremor, rigidity, chorea, Kayser-Fleiser ring) and acute intermittent porphyria (bouts of abdominal pain, paresthesias) |
| D | Degenerative/ Demyelinating diseases: Neurological signs/ symptoms |
| T | Trauma: subdural haematoma (signs/symptoms of specific trauma) |
| E | Epilepsy: aura, ictal, and postictal stages |
| S | Structural disorders: headache, papilledema |
| T | Toxins/ heavy metals: depending on agent (headache, tremor, lethargy, encephalopathy, coma) |

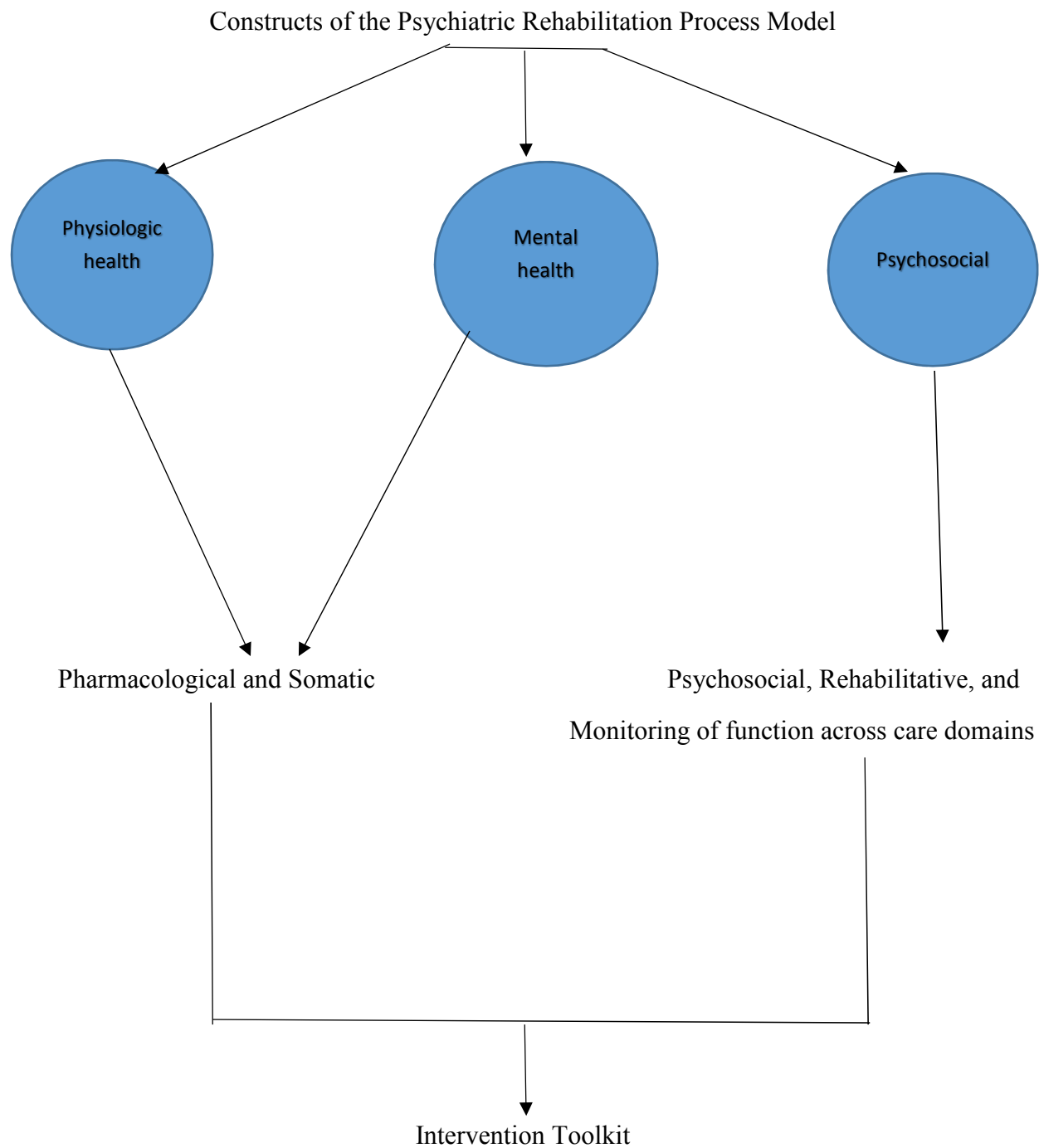


Figure 1. Creation of the intervention toolkit.

Appendix A: Survey One

Survey 1 (Participants perception/opinion about the practice issue and familiarity with the psychiatric rehabilitation process model)

LOS = Length of hospital stay; IDPP = intellectually disabled psychiatric patients.

1. How would you rate the clinical significance of LOS for IDPP with chronic medical problems?

(1 = not significant; 2 = somewhat significant; 3 = neutral; 4 = significant; 5 = very significant)

- 1
2
3
4
5

2. Do you think the problem of increased LOS for IDPP with chronic medical problems warrants prompt intervention(s)?

(1 = strongly disagree; 2 = disagree; 3 = neutral; 4 = agree; 5 = strongly agree)

- 1
2
3
4
5

3. Do you think the current protocols used in planning care for IDPP with chronic medical problems within the acute care setting (hospital) are adequate?

(1 = very inadequate; 2 = inadequate; 3 = about right; 4 = adequate; 5 = very adequate)

- 1
2
3
4
5

4. Do you think community resources available to IDPP with chronic medical problems are adequate to decrease relapse and frequent hospitalizations?

(1 = very inadequate; 2 = somewhat inadequate; 3 = neutral; 4 = adequate; 5 = very adequate)

- 1
2
3
4
5

5. Are you familiar with the "psychiatric rehabilitation process model" prior to receiving information about it during the course of this project?

(1 = not familiar; 2 = somewhat familiar; 3 = neutral; 4 = familiar; 5 = very familiar)

- 1
2
3
4
5

6. Would you consider the intervention toolkit (pharmacology, somatic, psychosocial, rehabilitative, and monitoring of function across care domains) created from the psychiatric rehabilitation process model relevant to resolving the practice issue?

(1 = not relevant; 2 = somewhat relevant; 3 = neutral; 4 = relevant; 5 = very relevant)

- 1
2
3
4
5

7. Please identify your age range by checking one of the boxes below:

- 20 – 39
40 – 49
50 – 59
60 – 69
70 and over

8. Please identify your specialty area by checking one of the boxes below:

- Psychiatrist Internist Hospital director Nurse Manager Discharge planner
Social worker Long-term care director Legal conservator Case manager
Medi-Cal representative

9. Please identify the length of time you have spent in your current position by checking one of the boxes below

- 5 – 10 10 – 20 20 – 30 Over 30 years

Appendix B: Survey Two

Survey 2 (Establishing content validity)

The intervention toolkit is created from the constructs of the psychiatric rehabilitation process model; and those constructs include pharmacological, somatic, psychosocial, rehabilitative, and monitoring across care domains. These constructs are equally weighted and will be rated both individually and as a unit.

The rating system is as follows: 1 = not relevant; 2 = somewhat relevant; 3 = neutral; 4 = relevant; and 5 = very relevant.

Please rate this toolkit, as the rating will help establish its content validity.

Individual intervention toolkit items:

Pharmacological: 1 ; 2 ; 3 ; 4 ; 5

Somatic: 1 ; 2 ; 3 ; 4 ; 5

Psychosocial: 1 ; 2 ; 3 ; 4 ; 5

Rehabilitative: 1 ; 2 ; 3 ; 4 ; 5

Monitoring of function across care domains: 1 ; 2 ; 3 ; 4 ; 5

Intervention toolkit as a unit

1

2

3

4

5

Appendix C: Intervention Toolkit

The intervention toolkit created from the psychiatric rehabilitation process model featuring the constructs of pharmacology, somatic, rehabilitative, psychosocial, and monitoring of function across care domains highlights the interrelatedness of those constructs in planning and implementing care for IDPP with chronic medical problems. Hence, the premise for recommending the intervention toolkit was to promote holism and appreciate the dimensions of wellness that cover the physical, mental, emotional, social, environmental, economic, and spiritual realms of health. Furthermore, creating this toolkit recognized that promptly and concurrently addressing the psychiatric and medical issues affecting IDPP was critical because this project highlighted the discrepancy in care that resulted from not valuing the interrelatedness between psychiatric and chronic medical problems. Moreover, coordinating care for vulnerable populations, which in this case focused on IDPP with chronic medical problems, it was paramount to embody the principles of beneficence, justice, and equality. Finally, as an agent for quality of care improvements, the DNP becomes a critical component to bridging the gap between research evidence and its translation into practice; thus the intervention toolkit was an example of best care practice that reconciles the dynamics of care delivery affecting IDPP with chronic medical problems.