Evidence-Based Best Practice for Discharge Planning: A Policy Review

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Evidence-Based Best Practice for Discharge Planning: A Policy Review

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This Manuscript Partially Fulfills the Requirements for the
Doctor of Nursing Practice Program and is Approved by:

Kathleen Farrell, DNSc, RN
Lilian Chan, MSN, RN, PCCN-K

Approved: written as March 27, 2022
University of St. Augustine for Health Sciences  
DNP Scholarly Project  
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Abstract

Ineffective discharge planning produces poor patient healthcare outcomes, potential adverse events, and medical errors. A primary deterrent to successful discharge planning is communication, either within the interdisciplinary team or during handoff to the receiving transition of care facilities of home health, skilled nursing, or acute rehabilitation. The purpose of the evaluation project was to determine if current policies, communication tools, and workflows of three healthcare organizations were based on evidence and make recommendations for policy revisions. The Johns Hopkins Evidence-Based Practice for Nurses and Healthcare Professionals Model (JHNEBP) was used with the Centers for Disease Control (CDC) Policy Process (POLARIS) Framework in appraising the literature and guiding the policy evaluation. The Centers for Medicare & Medicaid Services (CMS) and the Joint Commission (JC) were also included to support best practice recommendations. The six best practice themes include early discharge planning, patient and care support engagement and education, established follow-up, consistent and timely communication of pertinent medical information, and standardized discharge planning. A Policy Evaluation Tool was developed to evaluate current healthcare policy against best practices criteria found in the evidence. Policy templates were specific to each healthcare organization with recommended revisions to current policy and discharge communication workflow. The recommendations were then vetted by each organization to incorporate the change policy into current practice. The evaluation was beneficial to ensure the discharge planning process was current, relevant, and promoted best patient outcomes. Policy revision and current best practice evidence supports processes to prevent and avoid obstacles to proper transitional care.
Evidence-Based Best Practice for Discharge Planning: A Policy Review

Lack of adequate transition planning can produce suboptimal patient healthcare outcomes, adverse events, and medical errors. These issues can cost hospitals between $12 billion to $44 billion yearly (Dreyer, 2014). Effective care coordination programs that support transitions from the hospital to the home, a skilled nursing facility, or a post-acute care facility are essential. Healthcare organizations are encouraged and incentivized to improve care transitions through reimbursement payments developed by the Centers of Medicare and Medicaid Services, private insurance organizations, and regulatory agencies. These incentives also led to programs that encouraged coordination by offering bundled payments or shared saving (Dreyer, 2014). Current discharge planning best practices support workflows that prevent and avoid obstacles to proper transition care.

This policy review of the discharge planning process was an evidence-based evaluation. A rigorous literature search on discharge planning and transitions of care was performed. Best practice recommendations were found from common themes within the literature. An evaluation of three Southern California healthcare organizations’ policies and procedures was conducted and compared to best practice recommendations for discharge planning. The project’s focus was on risk-assessment tools and communication within each organization toward different transitions of care types and locations. These transitions of care options included home health, skilled nursing facility, and acute rehabilitation. Identification of the potential barriers to discharge and securing facility transfer was considered with strategies to combat inadequate transitions of care obstacles.
Significance of the Practice Problem

Discharge planning is a complex process that requires effective communication. Collaboration between all clinicians involved in the patient’s care, including the patient and sometimes family caregivers, promote effective communication. Evidence shows that half or more preventable adverse events post-hospitalization were related to poor handoff communication and lack of continuity of care within the discharge process (Patel et al., 2019). Prioritizing which patient requires attention to ensure all patient needs are met for a safe and timely discharge is difficult with limited number of case managers on staff. Because patient needs are complex, it can be difficult to assess the present needs and anticipate the patient’s future needs if the care manager does not have appropriate time to assess and strategize a discharge plan. This leads to potential time and resources wasted by assessing patients that may have little-to-no additional discharge needs and making unnecessary referrals. There is a high number of factors associated with individuals that may have higher discharge needs, which can be utilized to improve priority setting. These factors include age and comorbidity. Older patients with multiple comorbidities are at higher risk for prolonged inpatient hospital stays and require more in-depth discharge planning to meet care needs (Fox et al., 2013).

Poor preparation in discharge planning can provide significant cost ramifications for both the patient and the hospital. Avoidable hospital fees can occur, such as the cost for the hospital room and board when a patient is cleared for discharge but stays because of a delayed approval for transfer of care to an accepted outside facility. Additional delays can occur related to lack of interoperability of electronic medical records. Documentation of patient records in different systems can create potential communication gaps within handoff reporting from the hospital to the outside facility (Dreyer, 2014). Greater length of stay is also associated with the risk of the
patient developing hospital-acquired infections, incurring additional medical costs outside of the initial admission diagnosis. Within the healthcare organization, lack of patient flow and hospital bed shortages can occur. This backlog can impact overall quality of care and patient satisfaction as patients with acute care needs will not be able to transfer to an inpatient medical bed (Weiss et al., 2011). The likelihood for readmission is greater for patients if there is poor discharge planning as follow-up and post discharge needs may not have been in place to prevent the readmission from occurring. This can incur significant penalties toward the healthcare organization through CMS, especially if the readmission is among the identified diagnoses that are notable to be associated to readmissions (Khullar & Chokshi, 2018). Utilizing proven evidence-based strategies to guide organizational discharge planning policies can help reduce barriers to length-of-stay, readmission rates, and promote effective transitions of care workflows.

**Purpose of the Policy Evaluation**

Ineffective communication and unnecessary delays related to discharge planning is an ongoing problem. Older individuals with a myriad of acute and chronic conditions are significantly impacted, as these delays can lead to poor health outcomes. This can result in increased hospital length of stay and lead to long-term care needs (Pellett, 2016).

The population of interest for this project was the acute care patient population, primarily the older adult demographic. This policy evaluation had two agendas or aims. First, an appraisal of the literature determined common themes of best practices focused on the discharge planning process within inpatient hospitals (See Appendix A for Summary of Primary Research Evidence and Appendix B for Summary of Systematic Reviews). Then, a review of three specific healthcare organization’s discharge planning policies and workflows with specific transitions of care areas and communications were evaluated. A comparison of the hospital’s current discharge
planning policies and communication tools against the best practice themes the evidence identified was used to evaluate each organization’s policies and communication process and tools (See Appendix C for Policy Evaluation Tool). The differences found in the current documents determined areas of emphasis to reveal potential obstacles within the institution’s continuum of transitions of care and recommended potential policy change.

**Problem Statement**

One of the primary deterrents to timely discharge planning in the project included obstacles with communication, either within the interdisciplinary team or during handoff to the receiving transition of care facilities of home health, skilled nursing, or rehabilitation facilities. This project was an evaluation of current policies within three healthcare organizations and compared the best practice evidence found from a literature review. A recommended change policy with communication tools that includes the most current best practices were proposed to each specific organization.

Adult patients 18 years of age and older within the acute, inpatient hospital setting were the population of interest. The current discharge planning policies and communication process with other agencies within each healthcare organization was the comparison intervention. The recommended policy changes and communication tools based upon best practice was the proposed intervention.

The recommended revisions to the healthcare organizations’ policy and communication tools regarding discharge planning was the outcome. These recommended revisions and communication tool templates were made specific to each organization and templated to support current best practice. Duration of time from literature analysis to policy review and recommendations was over the course of 16 weeks.
Utility of Policy Review

Evidence-based research promotes interventions that demonstrate clinical outcomes. Informed decisions based on evidence are recommended for policy development, review, and revision (Oliver et al., 2014). A review of organizational policies was beneficial to ensure patient care toward the discharge planning process was current, relevant, and promoted quality interventions toward best patient outcomes. Policy revision incorporating up-to-date best practices significantly impacts the patient population. Policy revision requires effective communication of transition of care needs are performed and no delay of discharge occurs. Improved communication promotes increased patient satisfaction and reduces costs for the patient by avoiding additional hospital care (An, 2015).

Engagement of key stakeholders are essential for buy-in and success for potential policy changes. These stakeholders included physicians, nurses, social workers, and therapists all within the inpatient and outpatient settings. The policy recommendations improved discharge planning workflows and processes that lead to increased collaboration of clinicians within these environments to produce more efficient and reliable communication of the patient’s plan of care. This ultimately improves the patient’s healthcare outcomes.

Analytical Framework

This white paper project was guided by the Centers for Disease Control (CDC) and Prevention’s Policy Analytical Framework. There are three key strategic concepts within this framework. These include identifying the issue, determining pertinent policy solutions, and developing adoption strategies (CDC, 2015). The CDC’s (POLARIS) resources provide a more in-depth understanding and explanation of the five domains of the policy process. Each domain includes significant stakeholders, essential education, and evaluation strategies. These domains
include problem identification, policy analysis, strategy and policy development, policy enactment, and policy implementation (Centers for Disease Control and Prevention, 2019).

In addition, the Johns Hopkins Evidence-Based Practice for Nurses and Healthcare Professionals Model (JHNEBP) was also utilized to help support and promote credibility to the evidence appraisal from the literature. It has been revised for 2022 to emphasize the interprofessional team collaboration within the model (Dang et al., 2022). The JHNEBP was used concurrently with the CDC POLARIS Framework to guide this project. Both the JHNEBP and the CDC POLARIS are multi-step processes that enhanced the project effectiveness. Possible policy solutions and revisions were recommended based on the evidence themes of best practice.

**Evidence Search Strategy**

The databases used include PubMed, the Cumulative Index of Nursing and Allied Health Literature (CINAHL), and ProQuest. The key terms used in all inquiries included the terms “Patient Discharge”, “Practice Guidelines”, and “Nursing”, as these were Medical Subject Headings (MeSH) for the PubMed search. Previous terms that were utilized included “Case Management”, “Case Manager”, “Communication tools”, and “Handoff” used interchangeably produced little to no results. To ensure consistency, the key terms were reproduced in the other two database searches. The primary Boolean operator AND was used with all databases. Search limits that were similar in all databases include ‘English’, ‘full text, and ‘publication date within 10 years. In PubMed, 21 articles resulted from this inquiry. The same search limits were utilized within the CINAHL database and produced 176 articles. Limits to only ‘USA’ articles and only to include ‘adult’ age-ranges decreased the final count to eight academic journals. Finally, for the ProQuest database, the filters ‘Scholarly Journals’ and ‘United States’ location were applied.
This database yielded 26 articles. A total of 53 articles were produced from all databases with two duplicates further eliminated. When reviewing the final search results, articles that included pediatric patients were excluded. This was important to ensure evaluation of the evidence was directed towards the intended demographic of the intervention. After removing the pediatric population literature and full text review ensuring relevance to best practice, 44 were further eliminated. This made a total of 9 articles that were appraised from this literature database search.

An additional electronic search was performed to seek federal and state regulatory practices relevant to discharge planning. A total of five sources were discovered from this inquiry. The Centers for Medicare & Medicaid Services (CMS), the Joint Commission (JC) for hospital accreditation standards, and the Agency for Healthcare Research and Quality (AHRQ) were three of the national, regulatory organizations utilized. Guidelines and standards were retrieved and assessed from these organizations. An additional two sources relevant to discharge planning guidelines and best practices were also included from this search. The final total combined from the literature search and the electronic search produced 14 sources to develop discharge planning best practice recommendations (see Figure 1).

**Results**

The use of the synthesis process and the recommendations tool through JHNEBP was utilized to evaluate the literature (see Appendix A and B). This tool supported the process in discovering the common themes and the strength of the evidence to guide practice recommendations (Dang et al., 2022). Of the total 14 resources, six were Level V. Three of these six resources were Grade A content due to credibility of the organization, with the remaining graded B. Additionally, there were two Level III Grade B and two Level IV Grade A and one
level IV grade B. There were three Level I grade A systematic reviews. Based on the JHNEBP tool, the level of evidence gathered is not strong, but the quality of the content is supportive of best practice recommendations. Common themes were developed and compared primarily to CMS and Joint Commission standards for finalization of policy recommendations. These agencies were selected for supportive policy criteria as the Joint Commission’s accreditation standards align with CMS. Therefore, healthcare organizations that receive accreditation automatically adhere to CMS requirements (R1RCM, 2014).

According to CMS, there are five primary best practices for effective coordination of care and reduction of avoidable readmission. These include discharge planning that is comprehensive, medication reconciliation that is current, engagement of patient, family, and/or caregivers, supportive services that include clinician follow-up, and effective transitional communication that is timely and pertinent. In addition, there are essential standards listed under the CMS guidelines Conditions of Participation (CoP) for Discharge Planning. These standards involve identifying patients that require priority discharge planning early in hospitalization confinement, which must be specified in writing within the agencies policies and procedures. Discharge planning evaluation for those identified needs to be done early to avoid unnecessary delays and ensure discharge arrangements are done before the discharge date.

Best practice states all patients need a discharge planning evaluation. The case management assessment should include the discharge planning evaluation, determine the need for home care services based upon patient’s capacity for self-care, and document post-hospital services and the availability of these services within the evaluation if appropriate. Discussion of patient’s medical record and results with family or caregivers should be part of the evaluation. Implementation of the discharge plan developed needs to be performed throughout the patient
encounter. The plan would be conducted by qualified personnel, such as supervision from a registered nurse or social worker. Transparency is required in provider referrals and patient choice per section 1802 within CMS guidelines. This is to ensure that during the discharge planning process, providers with a financial interest are identified and documentation of patient choice is given and clearly stated. A list of home health agencies or skilled nursing facilities that participate in CMS that serve the geographical area the patient resides or that are covered under the patient’s current enrollment should be given and included within the patient choice letter.

CMS has updated these standards to include new rules focusing on patient treatment preferences and promoting interoperability and quality data. Under the New Rules for Discharge Planning, patient’s care preferences take priority in patient’s goals of care during the discharge planning process. To increase patient’s autonomy in making their own care decisions, quality data such as outcome measures and star ratings must be shared to patients regarding relevant post-acute services or suppliers so that their continued care would be based upon their health goals and preference. Necessary and appropriate medical information is required to be provided to referrals and clinicians responsible for follow-up care and prior to transfers to post-acute services, hospitals, and home health agencies to ensure continuity and transition of care is safe. A standard data set regarding patient medical records is required to be sent either electronically or written to post-acute providers when patient is transferred. Access to medical records for patients must be accessible and available when requested. Support people including families and caregivers must be included in the discharge planning and agree with the plan, as appropriate to patient preference. To be compliant with these standards, correct documentation of these tasks is required (Centers for Medicare & Medicaid Services, 2019).
The Joint Commission lists seven foundations for transitions of care. These include leadership support, early identification of at-risk patients, a thorough psychosocial assessment, involvement of a multidisciplinary team, patient and family engagement, management of medications, and transfer of information (The Joint Commission, 2013). Leadership support was not particularly emphasized within CMS but is integral to ensure garnered support for appropriate best practice processes that are supported by evidence and can be incorporated into policies. The items of patient engagement through patient choice and importance of effective transfer of medical information appeared to be consistent to ensure for successful transitions of care planning.

Critical Appraisal of the Evidence with Themes

There are several items under the CMS guidelines and the Joint Commission standards supported by the evidence. Six themes were observed and further explained with the supportive evidence that steered these themes. The final theme that was included from the literature, outside of CMS and Joint Commission guidelines, focused on utilizing standardized strategies to promote effective discharge planning.

Discharge Planning Early

A common theme in the literature and from regulatory organizations that is highly emphasized is discharge planning should always start early. Assessing and evaluating the plan as soon as the start of the patient admission is the best course of action to ensure best patient outcomes, avoid unnecessary delays in discharge, or incur avoidable readmissions (Centers for Medicare & Medicaid Services, 2019).

Patient and care support engagement
Evidence supports patients, caregivers or supportive entities that are actively involved with all elements of the discharge plan can produce successful discharge outcomes. Discharge planning can be overwhelming for a patient and having care support can help ensure the patient comprehends and has confidence in making medical decisions that consider their personal preferences and values (Pellet, 2016). Individualized patient discharge plans help reduce hospital length of stay and readmission rates with improved patient quality of life scores and patient satisfaction (An, 2015). Access to patient portals, which patients can view their medical records online at any time, also promotes patient engagement. The ability to make medical appointment and ask doctor’s questions through these portals increase the patient’s ability to make informed, medical decisions (Sheehan, et al. 2021).

Encouraging patients to be motivated and including their care support in the process can help determine whether specific services should be considered, such as home health, assistive living, or rehabilitation services. It is important to consider the patient’s preferences in the continued plan of care, but it is equally as important to ensure the safety at transitions of care by including and evaluating the patient’s care support (O’Connor et al., 2016; Zhao et al., 2019).  

**Patient and care support education**

Patient education should be done throughout patient’s hospitalization and further emphasized at discharge planning. Education must be provided in a language the patient communicates and at a level of understanding the patient can comprehend the information. This is vital to ensure the patient can make appropriate medical decisions about their care. The medication reconciliation, which is a process of reviewing and ensuring prescribed medications are accurate prior to the patient being discharged, is conducted with the patient and support caregivers to discuss any updates or changes (Limpahan et al., 2013; Horwitz et al., 2013).
Establishing follow-up

Continuity of care is important throughout patient hospitalization and as patient transitions to an outpatient setting. It has been found that only 23% of US primary care physicians (PCP) reported notification of patients visits to the emergency department. Closing the gap in communication of patient’s health course supports successful patient health outcomes (Limpahan et al., 2013). Input from all members of the clinical interdisciplinary team, which directly cared for the patient should be considered within the patient’s plan of care. Advance care planning also should be included in this plan of care (Ryan et al., 2019). Some methods in which organizations are ensuring these follow-up appointments and advance care planning are completed include having a team to perform follow-up calls and make patient appointments with their PCP and/or developing discharge decision support tools within their electronic medical records that require clinicians to complete these necessary follow-up steps and documentation (O’Connor et al., 2016).

Consistent, timely communication of pertinent medical information

Under the 21st Century Cures Act, there is a call to action to ensure health information is securely available to support the well-being and health of all American citizens (HealthIT.gov, 2022). A major barrier toward effective coordination of care includes the inability to transfer health information clearly and easily. Electronic health records, patient portals, and telehealth programs are all methods that support and enable a more seamless transition of care. This substantially impacts continuity of care by helping standardize communication and share plans of care to all clinicians through the course of the patient’s health span. It promotes patient safety and improves patient outcomes by avoiding or reducing potential re-hospitalization (Labson, 2015). It is essential for a healthcare organization to have some form of health information
technology (IT) to help facilitate interoperability of care that can provide consistent, protected, sharing of patient-centered health information that is accessible to all health care providers involved in the patient’s care (Sheehan et al., 2021).

**Standardized, discharge planning process**

Handoffs, toolkits, and discharge bundles are emphasized to ensure consistent and appropriate discharge assessments and evaluations are performed. Some known evidence-based toolkits that were mentioned include Better Outcomes for Older Adults Through Safe Transitions (BOOST), RED (Reengineering Discharge), the Care Transitions program, and IDEAL through the Agency for Healthcare Research and Quality. IDEAL focuses on five items: including the patient and family in discharge planning, discussing five items to prevent potential problems at home upon discharge evaluation plan, educating patient throughout hospital stay, assessing patient literacy through teach-back, and listening to patient’s and family goals of care, preferences, and concerns (Agency for Healthcare Research and Quality, 2017).

A specific study encouraged standardizing the discharge time by streamlining the process to promote patient discharge to occur before 11am. Having a standardized process, such as meeting a set discharge time can address patient flow and decrease overcrowding by improving availability of patient beds (Gray et al., 2016). A study involving an oncology unit, used a standardized discharge bundle that showed 80% improvement in patient’s accurately verbalizing their treatment plans evaluated through the teach back method. This demonstrated that a consistent discharge process can contribute to improving patient engagement and comprehension of their medical care. There is also evidence that using a standardized transitional care discharge checklist between inpatient and outpatient providers increased communication between
clinicians and increased the number of follow-up appointments completed (Callaway et al., 2018; Prince et al., 2019).

**Evaluation**

For this policy review, a policy evaluation checklist was developed from the common themes appraised from the evidence and considered standards from CMS and the Joint Commission (See Appendix C for Policy Evaluation tool). Policies from three healthcare organizations in southern California were collected and reviewed with permission from the case management leadership from each organization. Organization A is an academic health care system with two sites totaling 808 hospital beds with a Level I trauma, burn, stroke, and National Cancer Institute-designated centers. Organization B is an affiliated health care system with 417 acute care beds with a Level I and Level II pediatric trauma and burn center. Organization C is a federally funded healthcare system with 304 beds serving the veteran population. Obtaining policy information and maintaining project timeline were adjusted and subject to availability of case management leadership from each organization. Not all necessary documentation to support criteria were found in a single policy and multiple correspondences were conducted through the course of the practicum (see Appendix D for Project Schedule).

**Policy Review Recommendation Statement**

The six best practice themes developed into the Policy Evaluation Tool for this policy review were consistent recommendations from the literature surrounding discharge planning. Specific criteria within each theme were examined against each organization’s policies to support that the organization is meeting the best practice guideline. These themes included: discharge planning early, patient and care support engagement, patient and care support education, establishing follow-up, consistent and timely communication of medical information,
and standardized discharge planning process. If specific criteria were missing, a meeting or correspondence with the organization’s leadership was established to clarify that this process is available and where it can be found. Final recommendations were specific and detailed to each organization with results discussed based upon meeting the Policy Evaluation Tool best practices criteria.

**Policy Analysis and Evaluation Plan**

**Organization A**

Primary recommendations are focused on four best practice areas: discharge planning early, establishing follow-up, consistent, timely communication of medical information, and standardized discharge process (see Appendix H Organization A Evaluation). Within the discharge planning policy, the verbiage when case management assessment was to be done stated “as soon as possible or before the end of the second day”. According to the literature, it was determined a parameter within 24 hours of admission would be the recommended standard. Also, prioritization of assessment of patients did not note the identification of “at-risk” patients. Upon further investigation, there are prioritization charts given to case management staff, typically during new employee orientation, that support how to identify patients that require higher level discharge planning. This included the verbiage “at-risk” patients due to comorbidities and risk for readmission.

In regard to establishing follow-up, it was also noted that the advance directive policy was last dated in 2007 and this would need to be updated. It is also known within this organization, there is an appointment concierge program available to conduct follow-up physician appointments targeted towards patients who have a high admission risk. This program and the workflow in utilizing this staff is not written within the policy. Patients who were
transferred or to be transferred to other acute care facilities was found in policy, but none were specific to transitional care facilities as each agency had their own standard for communication. This workflow was documented and found in case management references but was not included in policy. It is recognized that agencies standards for communication can change so that is a possible reason why there was no standard tool found.

In regard to standardized, discharge planning process practice, overall discharge planning was guided by elements of Better Outcomes for Older Adults Through Safe Transitions (BOOST). Outside of ensuring a physician discharge order was placed, specific discharge parameters or set timeline when patient needed to be officially discharged from the hospital was not defined.

**Organization B**

The focus for policy recommendations involved establishing follow-up and standardized, discharge planning process (see Appendix H Organization B Evaluation). There was no documentation in available policies regarding physician follow-up appointments and advance care planning. Additional correspondence needed for clarification to ensure these elements are found in a case management workflow and to incorporate this documentation within policy if it is not already. In regard to standardized, discharge planning process, no specific discharge toolkit or bundle was documented within policies received. Ongoing correspondence with organizational leader was done to ensure all criteria within the six best practice recommendations were met.

**Organization C**

For this organization, policy recommendations focused upon the discharge planning early, patient and care support engagement, establishing follow-up, consistent, timely
communication of pertinent medical information, and standardized, discharge planning process themes (see Appendix H Organization C Evaluation). There was no timeline regarding when discharge assessment should be done outside of verbiage “as soon as possible.”

Within patient and care support engagement, policy provided did not have patient choice addressed. But upon discussion with case management leader, it is done and essential part of the case management workflow. In establishing follow-up, treating physician and community health nurse coordinator conducts follow-up visits, skilled nursing facility placements, hospice, and advance care planning if appropriate. This was all verbalized by the case management leader and not found within policy.

For consistent, timely communication of pertinent medical information, it was discussed that this is a significant barrier. Majority of patients qualify under a specific payor that continues to use faxing as a main source of communication. Electronic medical records need to be printed for this primary payor and case managers are unable to reach this source by phone. Workflow is documented within case management resources and not included within policy as this is very specific process.

Limitations existed regarding policy retrieval for this organization since the case management organizational model was different from the other two organizations reviewed. This facility’s case management department has only two discharge planners. Other case managers within the organization are specialty-based and under different leadership. Therefore, any policy changes may not be as impactful if it is not all inclusive of the specialty case managers.

Overall, each organization documented key criteria within each best practice theme. If elements of the best practice theme were not included within the policy, it was found within a case management workflow or included in a nursing or interdisciplinary policy. Discussions are
ongoing among all three organizations to ensure if specific communication workflows are included or should be included within policy. Agreed upon revisions should be accurate based upon specific transitions of care and align with organizational goals of care.

Transitions of care communication was generalized within policy or found within discharge workflow processes, which was not included within policy. Insurance and/or lack of funding was a common obstacle that was revealed per interviewing case management leadership from each organization regarding communication barriers to discharge planning. This financial aspect of case management was found to be a burden in obtaining specific resources and securing placement, if appropriate, for patients that lack coverage. No standard tool was found outside of a handoff discharge planning workflow that drove communication. Workflows were discussed from case management leadership and appeared to be specific to the referring facility that was providing placement needed for the patient.

**Policy Recommendations**

For each organization, the Policy Evaluation Tool was used as a basis in providing change recommendations to policies. A formal meeting with case management leadership was conducted and a PowerPoint presentation was utilized to guide the discussion. A brief introduction of significance of white paper evaluation project and encouraging policy review was stated. For Organization A, best practice changes were highlighted specific to practice guidelines discharge planning early, establishing follow-up, timely communication of pertinent medical information, and standardized discharge planning process. Specific verbiage was provided to include within specific policies to help with policy revision (See Appendix E for Organization A Policy Evaluation PowerPoint). Organization B was very thorough and only had establishing follow-up and standardized, discharge planning process as key practice guidelines for policy
revision (See Appendix F for Organization B Policy Evaluation). Organization C only provided one policy where a few criteria items within best practices needed to be documented or clarified in policy. The most significant items to ensure to be included are verbiage regarding time for initial case management assessment, Patient Choice, physician follow-up appointments, advance care planning, and if discharge toolkit is used for case management workflow or process (See Appendix G for Organization C Policy Evaluation). Organization A and C, both leaders stated policies are actively under review. Organization B is up for renewal in 2023.

**Dissemination Plan**

Results and recommendations for policy evaluation checklist tool were presented to each individual case management leadership. Additional meetings with additional stakeholders to escalate and guide approval of these recommendations was based upon each organization’s policy development process. For instance, Organization A requires a multi-committee, interprofessional process in editing current policies. Final review and approval are then determined by the Organization’s Executive Team. A PowerPoint presentation with a template of the updated, recommended policy was included and made specific to each organization.

The manuscript was uploaded to Scholarship and Open Access Repository (SOAR@USA), which provides dissemination to students and faculty within the University of St. Augustine for Health Sciences (University of St. Augustine for Health Sciences, n.d.). An application was submitted to Sigma Theta Tau International (STTI) Honor Society of Nursing organization for a PowerPoint poster presentation this spring. This would promote increased dissemination among nursing leaders globally regarding discharge planning policies and employing best practices. Dissemination is an essential requirement and professional
responsibility within a Doctorate-prepared program to make the translation of new knowledge available.

Other symposiums to disseminate knowledge of this DNP white paper include the annual American Nurses Credentialing Center (ANCC) National Magnet and ANCC Pathway to Excellence conference sponsored by the American Nursing Association (ANA) and the National Association of Case Management both in the fall. The platforms of national journal publication and presenting at conferences would allow for a broader distribution of awareness regarding these best practices. A manuscript of the DNP white paper to submit for a journal is planned after receiving feedback from peer reviewers. Most applicable journals would include Nursing Research and Professional Case Management Journal since this white paper applies to these specialties.

**Conclusion**

Optimization of the discharge planning process by incorporating best practices can ensure safer care transitions. Greater communication among staff and interdisciplinary team can create a more collaborative culture, improving quality of care. Overall, it was found that these healthcare organizations do incorporate aspects of all best practice themes within policies. Continued partnership and discussions with these healthcare organizations would support further considerations of including specific elements within best practice criteria. These elements include defined verbiage or parameters and include discharge planning communication tools and workflows within policies. Therefore, a review of organizational policies was beneficial to ensure the discharge planning process was current, relevant, and promoted best patient outcomes. Policy revision and current best practice evidence supports processes to prevent and avoid obstacles to proper transitional care (Oliver et al., 2014).
References


difference#:~:text=The%20Joint%20Commission%20is%20one,Medicare%20and%20Medicaid%20reimbursement.&text=However%2C%20a%20hospital%20that%20is,accredited%20by%20The%20Joint%20Commission.


University of St. Augustine for Health Sciences. (n.d.). *SOAR@USA*. Retrieved from https://soar.usa.edu/


Figure 1

PRISMA

- PubMed 2012 - 2022: 21 Citation(s)
- CINAHL 2012 - 2022: 8 Citation(s)
- ProQuest 2012 - 2022: 26 Citation(s)
- Agency Standards/Regulations: 5 Citation(s)

58 Non-Duplicate Citations Screened

Inclusion/Exclusion Criteria Applied

10 Articles Excluded After Title/Abstract Screen

48 Articles Retrieved

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34 Articles Excluded After Full Text Screen

0 Articles Excluded During Data Extraction

14 Articles Included
## Appendix A

### Summary of Primary Research Evidence

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<tr>
<th>Citation</th>
<th>Design, Level Quality Grade</th>
<th>Sample Sample size</th>
<th>Intervention Comparison</th>
<th>Theoretical Foundation</th>
<th>Outcome Definition</th>
<th>Usefulness Results Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers for Medicare &amp; Medicaid Services, 2019</td>
<td>Level VA</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>Impact Act = standardized DCP; requirements, include: d/c plan within 24hrs of admit/registration, engage patients involved in decision-making, d/c instructions given to pts when d/c to home, med rec ready, med handoff when pt is transferred from one facility to another, establish post-d/c process, (IT) reportable data collection r/t care delivery</td>
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</tbody>
</table>
| Agency for Healthcare Research and Quality, 2017 | Level VA | n/a | n/a | n/a | n/a | IDEAL = tested, evidence-based resource; d/c planning toolkit and checklist guide to pt and family engagement in hospital quality and safety – can be used in conjunction with RED (Reengineering Discharge), the Care Transitions program, and BOOST (Better Outcomes for Older Adults Through Safe Transitions) Care Transitions  
I = include pt and family with d/c planning  
D = discuss 5 key areas to prevent problems at home (describe life at home, review meds, highlight warning s/s, explain test results, make follow-up appt)  
E = educate (plain language and throughout hospital stay), A = assess; use teach-back  
L = listen and honor pt/family goals, preferences, concerns |
Best practices include: determining pt and family goals at admission and track progress daily, involve family in nurse bedside report, share list of meds every morning, review meds at administration (include s/e and proper administration), encourage family involvement within hospital so they are prepared at home.

<table>
<thead>
<tr>
<th>Reference</th>
<th>Level</th>
<th>Data Collection Method</th>
<th>Findings</th>
<th>Recommendations for Effective D/C Planning</th>
</tr>
</thead>
</table>
| Pellett, 2016 | Level IV B | Data was gathered through a literature review, two online surveys and focus groups | n/a | - Improved communication (clear d/c summaries, multidisciplinary team planning, relevant contact #s)  
- Improved coordination services (start at admission, vulnerable older ppl not d/c until support/care packages in place, transport arrangements need to be confirmed, pt should be d/c at reasonable time of day, appropriate staffing, enough med/dressing etc avail to pt following d/c)  
- Improved collaboration (include family/carers for decision making PRIOR to d/c, prevent delayed d/c by making collaborative pathways/interventions within hospital teams – i.e. take home meds from hospital pharmacy)  
- IT |
| Ryan et al., 2019 | Level V B | Summarizes the evidence related to decreasing readmission for | n/a | Readmission may reflect a failure of the discharge process; thus d/c planning should start at the time of admission |
**Transition of care should be individualized**

8 common themes: planning for d/c, multiprofessional teamwork, communication, and collaboration, timely, clear, and organized information, medication reconciliation and adherence, engaging social and community support groups, monitoring and managing signs and symptoms after discharge, and delivering patient education, outpatient f/u advanced-care planning and palliative and end-of-life care

<table>
<thead>
<tr>
<th>Reference</th>
<th>Level</th>
<th>Setting</th>
<th>Approach</th>
<th>Sample</th>
<th>Conclusion</th>
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</thead>
<tbody>
<tr>
<td>Callaway et al., 2018</td>
<td>Level V</td>
<td>VA</td>
<td>Implement a multifaceted approach that included bedside handoff reports, the teach-back method, and discharge bundles guided by the PDSA framework and designed to improve communication and pt activation on an inpt oncology unit</td>
<td>n/a</td>
<td>n/a</td>
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<tr>
<td>Prince et al., 2019</td>
<td>Level V</td>
<td>31-bed hematologic</td>
<td>n/a</td>
<td>n/a</td>
<td>Implementation of the d/c d/c checklist with f/u appt and d/c handoff tool</td>
</tr>
<tr>
<td>Source</td>
<td>Level</td>
<td>Description</td>
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</table>
| O’Connor et al., 2016 | Level III | Medicare-certified skilled HH agency in the Northeastern part of the US
Interprofessional team comprising RNs, PTs, OTs, SLPs, MSWs, and MDs provided care to individual patients in their homes. |
| Gray et al., 2016 | Level IV | 28-bed medical-surgical unit in a 958-bed academic teaching hospital in southern California |

**B**
malignancies nursing unit at Duke University Hospital
On average, 1:4 d/c from the nursing unit per day

- **checklist resulted in a statistically significant increase in the number of pts who had a f/u appt scheduled prior to d/c.**
The d/c handoff tool standardized communication between inpatient and outpatient providers
standardized and tailored to patients’ needs can improve provider communication

**Implications for practice:** Assess pts’ d/c needs prior to the day of discharge to increase the chances that patients’ needs are met before they are d/c’ed from the hospital; use a d/c checklist to minimize the risk of d/c’ing pts without addressing all needs; Ensure that healthcare providers communicate pertinent information about the pt’s hospital course through the use of a d/c handoff tool

Five themes: patient safety, long-term plan is in place, reached maximum self-care potential, presence of a willing and able caregiver, and patient attributes
Serve as the basis of a HH d/c decision support tool

**Aiming for 11am d/c -- units experienced a 38.8% increase in the number of pts admitted to**
Successful in increasing unit revenue, decreasing wait times in transferring departments, and contributing to a culture of continuous quality improvement; Positively correlated with increased pt satisfaction and hospital ratings; can be
<table>
<thead>
<tr>
<th>Study</th>
<th>Level</th>
<th>Title</th>
<th>Methods</th>
<th>Findings</th>
<th>Discharge Policy Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limpahan et al., 2013</td>
<td>Level IV A</td>
<td>Reviewed medical literature, consensus statements, and materials from national campaigns</td>
<td>n/a</td>
<td>only 23% of PCP reported that they were always notified when their pts had visited the ED</td>
<td>adapted to suit the needs of many inpt settings, interprofessional approach to DCP</td>
</tr>
<tr>
<td>Horwitz et al., 2013</td>
<td>Level III B</td>
<td>N = 395 enrolled; 66.7% eligible Urban, academic medical center, 65+ yrs d/c’ed home after hospitalization for acute coronary syndrome, heart failure, or pneumonia.</td>
<td>n/a</td>
<td>written reasons for hospitalization (26.3%) did not use language likely to be intelligible to pts; (32.6%) d/c’ed with a scheduled MD appt; (43.9%) accurately recalled details of either appt.</td>
<td>F/u appts and advance DCP deficient, poor pt understanding of key aspects of post-d/c; pt perceptions and written documentation do not adequately reflect pt understanding of d/c care.</td>
</tr>
<tr>
<td>Labson, 2015</td>
<td>Level V A</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>Joint Commission’s 7 foundations of safe and effective transitions of care to home: leadership support; multidisciplinary collaboration; early identification of pts/clients at risk; transitional planning; medication management; pt and family action/engagement; and transfer of information.</td>
</tr>
</tbody>
</table>
Legend: discharge (d/c), discharge planning (DP), follow-up (f/u), appointment (appt), patient (pt), MD (medical doctor), years (yrs), emergency department (ED), primary care physician (PCP), inpatient (inpt), home health (HH), registered nurse (RN), physical therapist (PT), occupational therapist (OT), speech language practitioner (SLP), master of social work (MSW), plan-do-study-act (PDSA)
## Appendix B

### Summary of Systematic Reviews (SR)

<table>
<thead>
<tr>
<th>Citation</th>
<th>Quality Grade</th>
<th>Question</th>
<th>Search Strategy</th>
<th>Inclusion/ Exclusion Criteria</th>
<th>Data Extraction and Analysis</th>
<th>Key Findings</th>
<th>Usefulness/Recommendation/ Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>An, 2015</td>
<td>Level I A</td>
<td>Does discharge planning improve the appropriate use of acute care?</td>
<td>Summary of a Cochrane review containing 24 randomized controlled trials (RCTs) involving 8,098 participants. All patients in hospital were eligible to participate regardless of age, gender, or health condition.</td>
<td>Not included</td>
<td>The intervention group received individualized discharge care which included an assessment, planning, implementation, and monitoring phase. Half of the trials included a discharge planning advocate who was a nurse. The control group received routine discharge care that was not tailored to the individual patient.</td>
<td>d/c plan tailored to individual; unknown whether the intervention resulted in true cost savings or whether costs were merely shifted from secondary to primary care.</td>
<td>Evidence suggests that a discharge plan tailored to the individual patient may bring about reductions in hospital length of stay and readmission rates for older people admitted to hospital with a medical condition as well as positive effects of individualized discharge planning on patient health outcomes.</td>
</tr>
<tr>
<td>Zhao et al., 2019</td>
<td>Level I A</td>
<td>What extent of patient engagement in the development of best practice reports related to transitions from hospital to home.</td>
<td>included best practice reports related to the transition from hospital to a long-term care facility, community dwelling or rehabilitation centre. We included documents.</td>
<td>Electronic databases (MEDLINE, EMBASE, CINAHL, Scopus, Trip Database, DynaMed Plus and Public Health Plus) and multiple provincial regulatory agency and healthcare.</td>
<td>Two independent reviewers screened for eligibility and one extracted and analyzed data using a data extraction tool we developed based on established patient engagement framework; Appraisal of Most involved patients through direct or indirect consultation. The mean AGREE II domain 2 item 5 score (of those that actively engaged patients) was 5.9 out of 7.</td>
<td>Only half of existing best practice reports related to the transition from hospital to home actively involved patients in report development. However, the extent of patient engagement has been increasing over time. More organizations should strive to engage patients throughout the best practice development process and provide patients with opportunities for shared leadership.</td>
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<tr>
<td>Citation</td>
<td>Quality Grade</td>
<td>Question</td>
<td>Search Strategy</td>
<td>Inclusion/Exclusion Criteria</td>
<td>Data Extraction and Analysis</td>
<td>Key Findings</td>
<td>Usefulness/Recommendation/Implications</td>
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<tr>
<td>Sheehan, et al., 2021</td>
<td>Level I A</td>
<td>What are the effective methods and/or models of communication between hospital allied health and primary care practitioners?</td>
<td>disseminated in English between 1947 and 2019. organization websites.</td>
<td>Guidelines for Research and Evaluation II</td>
<td>Four emerging themes of “multidisciplinary care plans”, “patient and/or caregiver involvement”, “information technology” and “follow up”</td>
<td>Currently no “gold standard” method or measure of communication between hospital allied health and primary care practitioners. There is an urgent need to develop and evaluate multidisciplinary communication with enhanced information technologies to improve collaboration across care settings</td>
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<td></td>
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<td>What are the enablers and barriers to effective communication between hospital allied health and primary care practitioners?</td>
<td>Medline, CINAHL, EMBASE, PsycInfo and Proquest Nursing and Allied Health Sources were searched from January 2003 until January 2020 for studies that examined hospital-based allied health professionals communicating with community-based primary care practitioners.</td>
<td>Excluded protocols, abstracts, meeting summaries, theses, letters, editorials, opinions and conference papers. Qualitative research without thematic analysis</td>
<td>Standardized data extraction form based on the SPIDER tool</td>
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</tbody>
</table>

Legend: discharge (d/c)
Appendix C

**Policy Evaluation Tool**

<table>
<thead>
<tr>
<th>Healthcare Organization name:</th>
<th>Where written policies are located:</th>
<th>Time/Year policies published:</th>
</tr>
</thead>
</table>

**Discharge planning early** *(CMS guideline)*
- Qualified personnel, registered nurse or social worker, conduct discharge planning
- Assessment/evaluation documented within 24hrs of admission
- Documentation of discharge plan established within 24hrs of admission and/or PRIOR to discharge date
- Discharge plan is comprehensive
  - Was need for home care services or availability of services documented, if appropriate?
  - Notes: ____________________________
- Early identification of at-risk patients *(JC guideline)*
  - Psychosocial assessment performed and documented
  - Notes: ____________________________

**Patient and care support engagement** *(CMS guideline)*
- Patient discharge planning goals are based upon patient preferences
  - Notes: ____________________________
- Documentation patient support was assessed/available
  - Notes: ____________________________
- Patient choice given
  - List of home health agencies/skilled nursing facilitates that participate in CMS surrounding patient’s residence were provided within the patient choice letter
  - Star ratings are shared to patient for relevant post-acute services/suppliers

**Patient and care support education**
- Level of education and teaching is understandable and comprehended by patient
  - Notes: ____________________________
- Education available in all languages
  - Notes: ____________________________
- All mediums available for education (written, audio, verbal)
  - Notes: ____________________________
- Medication reconciliation performed and current *(CMS guideline)*

**Establishing follow-up**
- Was PCP follow-up appt established prior to d/c?
  - Notes: (how was this done?) ____________________________
- Was supportive services included in clinician follow-up? *(CMS guideline)*
  - Notes: (how was this done?) ____________________________
- Was advanced care planning mentioned or discussed?
  - Notes: (how was this done?) ____________________________

**Consistent, timely communication of pertinent medical information**
- Electronic medical records available
  - Name: ____________________________
  - Capability for interoperability (able to have patient medical information available for continuity of care to pertinent healthcare facilities)
- Patient can access their own health information *(i.e. myChart or patient portal)*
Other electronic interfaces available for handoff of patient information between clinicians and/or facilities / Name: ______________________

Was transitional communication timely and pertinent? (CMS guideline)
Notes: (how was this done?) ____________________________

<table>
<thead>
<tr>
<th>Standardized, discharge planning process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handoff, toolkit, or discharge bundle available:</td>
</tr>
<tr>
<td>• Better Outcomes for Older Adults Through Safe Transitions (BOOST)</td>
</tr>
<tr>
<td>• Reengineering Discharge (RED)</td>
</tr>
<tr>
<td>• Care Transitions program</td>
</tr>
<tr>
<td>• IDEAL through Agency for Healthcare Research and Quality</td>
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<tr>
<td>• Other: __________________________________________</td>
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</tbody>
</table>

Is there a discharge standard or parameters (i.e. discharge by 11am)
Notes: ____________________________

Leadership support available (JC guideline)
Notes: ____________________________

Legend: Centers for Medicare and Medicaid Services (CMS), The Joint Commission (JC), discharge (d/c)
## Appendix D

### Project Schedule

<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
<th>W1</th>
<th>W2</th>
<th>W3</th>
<th>W4</th>
<th>W5</th>
<th>W6</th>
<th>W7</th>
<th>W8</th>
<th>W9</th>
<th>W10</th>
<th>W11</th>
<th>W12</th>
<th>W13</th>
<th>W14</th>
<th>W15</th>
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</thead>
<tbody>
<tr>
<td>1. Faculty conferencing-weekly - Dr. Farrell</td>
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<td>2. DNP Preceptor conference biweekly - Dr.</td>
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<tr>
<td>3. Policy Review Proposal Development</td>
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<tr>
<td>3.1 Introduction, Significance of the Policy Problem, Purpose of the Policy Project, and Policy Problem Statement</td>
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<td>3.2 Utility of Policy Review, Analytical Framework, Evidence Search Strategy, Results, and Evaluation with PRISMA diagram</td>
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<td>3.3 Critical Appraisal of the Evidence with Themes, Policy Review Recommendation Statement</td>
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<td>3.4 Policy Analysis and Evaluation Plan, Required Appendices including pre-revision policies</td>
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<td>3.5 Dissemination Plan, and Conclusion</td>
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<td>4. Midterm Evaluation</td>
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<td>5. Policy Review Proposal Submission</td>
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<td>7. Policy Review Permission Letters from Organizations 1-3</td>
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<td>8. Peer Collaboration Discussions</td>
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<td>9. DNP Practicum Log with Reflection</td>
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<td>10. End of Term Evaluation</td>
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<td>11. Arrtival of Log to Excel</td>
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</table>

| Task                                                                 | Description                                                                                     | W1 | W2 | W3 | W4 | W5 | W6 | W7 | W8 | W9 | W10 | W11 | W12 | W13 | W14 | W15 |
|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|
| 11. Arrival of Log to Excel                                          |                                                                                               |    |    |    |    |    |    |    |    |    |     |     |     |     |     |     |

| Task                                                                 | Description                                                                                     | W1 | W2 | W3 | W4 | W5 | W6 | W7 | W8 | W9 | W10 | W11 | W12 | W13 | W14 | W15 |
|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|
| 12. DNP Essentials Reflection                                        |                                                                                               |    |    |    |    |    |    |    |    |    |     |     |     |     |     |     |
| 13. End of Term Evaluation                                           |                                                                                               |    |    |    |    |    |    |    |    |    |     |     |     |     |     |     |
| 14. Arrival of Log to Excel                                          |                                                                                               |    |    |    |    |    |    |    |    |    |     |     |     |     |     |     |
Appendix E

Organization A Policy Evaluation PowerPoint

Best Practices

- 1. Discharge planning early
- 2. Patient and care support engagement
- 3. Patient and care support education
- 4. Establishing follow-up
- 5. Consistent, timely communication of pertinent medical information
- 6. Standardized, discharge planning process

Policy Recommendations

- Discharge planning early
  - Update advance directive policy as it is dated 2007; include appointment concierge program within policy 305.9
- Establishing follow-up
  - Include transitional care facility workflow within policy 301.4
- Consistent, timely communication of pertinent medical information
- Standardized, discharge planning process
  - No discharge parameters within case management but found within nursing policy

Conclusion

- Optimization of the discharge planning process by incorporating best practices can ensure safer care transitions.
- Greater communication among staff and interdisciplinary team can create a more collaborative culture, improving quality of care = patient-centered care focus
- Review of organizational policies ensure patient care toward the discharge planning process is current, relevant, and promoted best patient outcomes

References


Appendix F

Organization B Policy Evaluation PowerPoint

Best Practices

Six themes supported by evidence and guided by Centers for Medicare and Medicaid Services (CMS) and Joint Commission standards

1. Discharge planning early
2. Patient and care support engagement
3. Patient and care support education
4. Establishing follow-up
5. Consistent, timely communication of pertinent medical information
6. Standardized, discharge planning process

Policy Recommendations

Establishing follow-up

- Encouraged documentation of discharge toolkit or bundle within policy if incorporated within workflow

References


Appendix G

*Organization C Policy Evaluation PowerPoint*

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**Best Practices**

<table>
<thead>
<tr>
<th>Best Practices</th>
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</thead>
<tbody>
<tr>
<td>Six themes supported by evidence and guided by Centers for Medicare and Medicaid Services (CMS) and Joint Commission standards</td>
<td></td>
</tr>
<tr>
<td>1. Discharge planning early</td>
<td></td>
</tr>
<tr>
<td>2. Patient and care support engagement</td>
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<tr>
<td>3. Patient and care support education</td>
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<tr>
<td>4. Establishing follow-up</td>
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<tr>
<td>5. Consistent, timely communication of pertinent medical information</td>
<td></td>
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<tr>
<td>6. Standardized, discharge planning process</td>
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</tbody>
</table>

**Policy Recommendations**

- **Discharge planning early**
  - No discharge parameters within case management but found within nursing policy - include timeline for documentation of initial CM assessment (i.e. complete within 24hrs of admission); include criteria for "at-risk" pts within policy
  - Include Patient Choice and workflow within policy

- **Patient and care support engagement**
  - PCP follow-up appt and advance care planning steps and workflow to include within policy

- **Establishing follow-up**
  - Coordinate with Community Care and include updated workflow within policy

- **Consistent, timely communication of pertinent medical information**
  - No standardized d/c toolkit or bundle – leadership support for projects to improve care coordination; include updated process if incorporating d/c bundle

**Conclusion**

- Optimization of the discharge planning process by incorporating best practices can ensure safer care transitions.
- Greater communication among staff and interdisciplinary team can create a more collaborative culture, improving quality of care = patient-centered care focus
- Review of organizational policies ensure patient care toward the discharge planning process is current, relevant, and promoted best patient outcomes

**References**


### Organization A Evaluation

#### Organization A

<table>
<thead>
<tr>
<th>Discharge planning early (CMS guideline)</th>
<th>Where and when current policy written:</th>
<th>New policy recommendations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Qualified personnel, registered nurse or social worker, conduct discharge planning</td>
<td>Policy 305.9; 2018</td>
<td>Change of verbiage of “as soon as possible or before the end of the second day” to within 24hrs of admission; include identification of “at risk” patients</td>
</tr>
<tr>
<td>- Assessment/evaluation documented within 24hrs of admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Documentation of discharge plan established within 24hrs of admission and/or PRIOR to discharge date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| - Discharge plan is comprehensive  
  - Was need for home care services or availability of services documented, if appropriate?  
  - Notes: ____________________________ | | |
| - Early identification of at-risk patients (JC guideline)  
  - Psychosocial assessment performed and documented  
  - Notes: ____________________________ | | |

<table>
<thead>
<tr>
<th>Patient and care support engagement (CMS guideline)</th>
<th>Where and when current policy written:</th>
<th>New policy recommendations:</th>
</tr>
</thead>
</table>
| - Patient discharge planning goals are based upon patient preferences  
  - Notes: | Policy 305.9; 2018 | None needed |
| - Documentation patient support was assessed/available  
  - Notes: ____________________________ | | |
| - Patient choice given  
  - List of home health agencies/skilled nursing facilities that participate in CMS surrounding patient’s residence were provided within the patient choice letter  
  - Star ratings are shared to patient for relevant post-acute services/suppliers | | |

<table>
<thead>
<tr>
<th>Patient and care support education</th>
<th>Where and when current policy written:</th>
<th>New policy recommendations:</th>
</tr>
</thead>
</table>
| - Level of education and teaching is understandable and comprehended by patient  
  - Notes: ____________________________ | Policy 301.4; February 4, 2018 | None needed |
| - Education available in all languages  
  - Notes: ____________________________ | | |
| - All mediums available for education (written, audio, verbal)  
  - Notes: ____________________________ | | |
| - Medication reconciliation performed and current (CMS guideline) | | |

<table>
<thead>
<tr>
<th>Establishing follow-up</th>
<th>Where and when current policy written:</th>
<th>New policy recommendations:</th>
</tr>
</thead>
</table>
| - Was PCP follow-up appt established prior to d/c?  
  - Notes: (how was this done?) ____________________________ | Policy 305.9; 2018 | Advance directive policy may need to be updated (2007); d/c appointment concierge program avail for f/u appts – not in policy |
| - Was supportive services included in clinician follow-up? (CMS guideline)  
  - Notes: (how was this done?) ____________________________ | | |
| - Was advanced care planning mentioned or discussed?  
  - Notes: (how was this done?) ____________________________ | | |
<table>
<thead>
<tr>
<th><strong>Consistent, timely communication of pertinent medical information</strong></th>
<th><strong>Standardized, discharge planning process</strong></th>
</tr>
</thead>
</table>
| ❑ Electronic medical records available  
  • Name: __________________________  
  • Capability for interoperability (able to have patient medical information available for continuity of care to pertinent healthcare facilities)  
| ❑ Patient can access their own health information (i.e. myChart or patient portal)  
| ❑ Other electronic interfaces available for handoff of patient information between clinicians and/or facilities / Name: __________________________  
| ❑ Was transitional communication timely and pertinent? (CMS guideline)  
  Notes: (how was this done?) ____________________________  
| ❑ Handoff, toolkit, or discharge bundle available:  
  • Better Outcomes for Older Adults Through Safe Transitions (BOOST)  
  • Reengineering Discharge (RED)  
  • Care Transitions program  
  • IDEAL through Agency for Healthcare Research and Quality  
  • Other: ____________________________  
| ❑ Is there a discharge standard or parameters (i.e. discharge by 11am)  
  Notes: ____________________________  
| ❑ Leadership support available (JC guideline)  
  Notes: ____________________________  
| **Policy 301.4; February 4, 2018** | **Policy 750.9; February 26, 2019** |
| EPIC; ECIN/allscripts used for referrals; myChart application avail to pts; handoff dependent on transitional care facility – workflow documented but not policy written | d/c process guided by elements of BOOST; no d/c parameters or set timeline; leadership support in all elements of d/c workflow |

Legend: Centers for Medicare and Medicaid Services (CMS), The Joint Commission (JC), discharge (d/c)
### Organization B Evaluation

<table>
<thead>
<tr>
<th><strong>Organization B</strong></th>
<th><strong>Where and when current policy written:</strong></th>
<th><strong>New policy recommendations:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discharge planning early</strong> (CMS guideline)</td>
<td></td>
<td>None needed as all items are addressed; several policies regarding specific at-risk patient populations</td>
</tr>
<tr>
<td>- Qualified personnel, registered nurse or social worker, conduct discharge planning</td>
<td>PolicyState ID: 9655639; 9/2021 / PolicyState ID: 9711617; 8/2021 / PolicyState ID: 8945950; 9/2021</td>
<td></td>
</tr>
<tr>
<td>- Assessment/evaluation documented within 24hrs of admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Documentation of discharge plan established within 24hrs of admission and/or PRIOR to discharge date</td>
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</tr>
</tbody>
</table>
| - Discharge plan is comprehensive  
  - Was need for home care services or availability of services documented, if appropriate?  
  - Notes: ____________________________ | | |
| - Early identification of at-risk patients (JC guideline)  
  - Psychosocial assessment performed and documented  
  - Notes: ____________________________ | | |
| **Patient and care support engagement** (CMS guideline) | | None needed as all items are addressed |
| - Patient discharge planning goals are based upon patient preferences  
  - Notes: ____________________________ | PolicyState ID: 9655639; 9/2021 | |
| - Documentation patient support was assessed/available  
  - Notes: ____________________________ | | |
| - Patient choice given  
  - List of home health agencies/skilled nursing facilites that participate in CMS surrounding patient’s residence were provided within the patient choice letter  
  - Star ratings are shared to patient for relevant post-acute services/suppliers | | |
| **Patient and care support education** | | None needed as all items are addressed |
| - Level of education and teaching is understandable and comprehended by patient  
  - Notes: ____________________________ | PolicyState ID: 9655639; 9/2021 | |
| - Education available in all languages  
  - Notes: ____________________________ | | |
| - All mediums available for education (written, audio, verbal)  
  - Notes: ____________________________ | | |
| - Medication reconciliation performed and current (CMS guideline) | | |
| **Establishing follow-up** | | need clarification workflow re: PCP f/u appt and advance care planning |
| - Was PCP follow-up appt established prior to d/c?  
  - Notes: (how was this done?) _______________________ | PolicyState ID: 9655639; 9/2021 | |
| - Was supportive services included in clinician follow-up? (CMS guideline)  
  - Notes: (how was this done?) _______________________ | | |
| - Was advanced care planning mentioned or discussed?  
  - Notes: (how was this done?) _______________________ | | |
### Consistent, timely communication of pertinent medical information

- Electronic medical records available
  - Name: ______________________
  - Capability for interoperability (able to have patient medical information available for continuity of care to pertinent healthcare facilities)
- Patient can access their own health information (i.e. myChart or patient portal)
- Other electronic interfaces available for handoff of patient information between clinicians and/or facilities / Name: ______________________
- Was transitional communication timely and pertinent? (CMS guideline)
  - Notes: (how was this done?) ____________________________

### Standardized, discharge planning process

- Handoff, toolkit, or discharge bundle available:
  - Better Outcomes for Older Adults Through Safe Transitions (BOOST)
  - Reengineering Discharge (RED)
  - Care Transitions program
  - IDEAL through Agency for Healthcare Research and Quality
  - Other: ______________________
- Is there a discharge standard or parameters (i.e. discharge by 11am)
  - Notes: ______________________
- Leadership support available (JC guideline)
  - Notes: ______________________

Legend: Centers for Medicare and Medicaid Services (CMS), The Joint Commission (JC), discharge (d/c)
### Organization C Evaluation

#### Discharge planning early (CMS guideline)
- Qualified personnel, registered nurse or social worker, conduct discharge planning
- Assessment/evaluation documented within 24hrs of admission
- Documentation of discharge plan established within 24hrs of admission and/or PRIOR to discharge date
- Discharge plan is comprehensive
  - Was need for home care services or availability of services documented, if appropriate?
  - Notes: __________
- Early identification of at-risk patients (JC guideline)
  - Psychosocial assessment performed and documented
  - Notes: __________________________

**Where and when current policy written:** Memorandum 11-14; Aug 5, 2018

**New policy recommendations:** No timeline indicated when d/c assessment is required to be done; criteria for at risk pts listed within policy

#### Patient and care support engagement (CMS guideline)
- Patient discharge planning goals are based upon patient preferences
  - Notes: __________________________
- Documentation patient support was assessed/available
  - Notes: __________________________
- Patient choice given
  - List of home health agencies/skilled nursing facilities that participate in CMS surrounding patient’s residence were provided within the patient choice letter
  - Star ratings are shared to patient for relevant post-acute services/suppliers

**Where and when current policy written:** Memorandum 11-14; Aug 5, 2018

**New policy recommendations:** Patient choice not addressed but discussed verbally in separate workflow

#### Patient and care support education
- Level of education and teaching is understandable and comprehended by patient
  - Notes: __________________________
- Education available in all languages
  - Notes: __________________________
- All mediums available for education (written, audio, verbal)
  - Notes: __________________________
- Medication reconciliation performed and current (CMS guideline)

**Where and when current policy written:** Memorandum 11-14; Aug 5, 2018

**New policy recommendations:** Nursing staff and pharmacy fulfills medication reconciliation responsibility, including comprehension of care and meds

#### Establishing follow-up
- Was PCP follow-up appt established prior to d/c?
  - Notes: (how was this done?) ______________
- Was supportive services included in clinician follow-up? (CMS guideline)
  - Notes: (how was this done?) ______________
- Was advanced care planning mentioned or discussed?
  - Notes: (how was this done?) ______________

**Where and when current policy written:** Memorandum 11-14; Aug 5, 2018

**New policy recommendations:** Treating MD provides f/u and Community Health Nurse Coordinator conduct f/u visits for pts placed in SNF; hospice provided but no add’l advance care planning included
<table>
<thead>
<tr>
<th>Consistent, timely communication of pertinent medical information</th>
<th>Memorandum 11-14; Aug 5, 2018</th>
<th>Continue to use fax to Community Care, unable to reach via phone</th>
</tr>
</thead>
<tbody>
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<td>☐ Electronic medical records available</td>
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<tr>
<th>Standardized, discharge planning process</th>
<th>Memorandum 11-14; Aug 5, 2018</th>
<th>Leadership support to pursue projects to improve care coordination as only 2 d/c planners for whole organization; CMs specialty based and under different leadership</th>
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<tbody>
<tr>
<td>☐ Handoff, toolkit, or discharge bundle available:</td>
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<tr>
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Legend: Centers for Medicare and Medicaid Services (CMS), The Joint Commission (JC), discharge (d/c)