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A Discharge Checklist to Combat Patient Readmission: A Case Study in a Skilled Nursing Facility

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Abstract

A Discharge Checklist to Combat Patient Readmission: A Case Study in a Skilled Nursing Facility focuses on the creation of a discharge checklist, as an intervention, to increase the competency for occupational therapists working in skilled nursing facilities discharging clients back to their home environment. A SNF (Skilled Nursing Facility) provides post-acute healthcare services and rehabilitation for patients following a hospitalization prior to discharging home (Burke et al., 2017). This case study for clinical improvement uses the DMAIC (define, measure, analyze, improve, control) quality model and a multiple case study research design for evaluation. The goal of the quality improvement process is to increase the competency of occupational therapists discharging clients to prevent reoccurring hospitalizations due to missed information during the discharge process. Based on the overall findings through a pretest and posttest design, an outcomes survey using a Likert scale, and a qualitative survey, the three participants self reported higher clinical competency following use of the intervention. This case study approach found anecdotal evidence that the discharge checklist benefitted three occupational therapists by providing a streamlined approach to identify and address potential barriers for clients returning to their home setting.

This project provides the development of a comprehensive discharge checklist for implementation by occupational therapists working in a SNF. The checklist was initially informed by a literature review and the author's clinical experience. Qualitative feedback from three additional occupational therapists supported the revisions to the discharge checklist. The improved version of discharge checklist is available for occupational therapist to use in the future following this case study. The George Washington University IRB review board approved this research project.

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Literature Review

Research currently indicates there is a significant financial loss and increased patient complications occurring from unnecessary hospital readmissions (Mileski et al, 2017). The Department of Health and Human Services Office of the Inspector General found that 31% of patients' stays did not meet discharge planning requirements (Levinson & General, 2013). One example included not having a post discharge plan of care which specifies the instructions to meet the patient's needs at the time of discharge (Levinson & General, 2013). This resulted in Medicare paying approximately $5.1 billion for patients staying at skilled nursing facilities who did not receive the required discharge planning resulting in reduced quality of care (Levinson & General, 2013). With this large financial burden, healthcare systems are looking for solutions to eliminate high, preventable costs by updating their current systems and processes to avoid this problem to avoid hospital readmissions. Some avoidable readmissions are related to poor communication throughout the transition of care and lack of patient and family member engagement and understanding of the overall plan of care (Berkowitz et al., 2013).

Due to the high costs associated with patients being readmitted shortly after discharge, there is an opportunity to identify and evaluate strategies that will reduce readmissions. Tole and colleagues, (2016) discuss how patients' preparedness for discharge and hospital readmissions in the acute hospital setting are improved through discharge interventions provided by professional staff. Additionally, Rogers and colleagues, (2017) discuss how occupational therapists in hospitals are associated with lower readmission for patients with heart failure, pneumonia, and

acute myocardial infarction. The study further discusses how discharge planning in occupational therapy interventions may lead to lower readmission rates by addressing the critical question about the patient's safety to return to their home environment. The occupational therapist who can further provide skilled intervention services to increase the patient's ability to be discharged to prevent further rehospitalization addresses the patient's safety through discharge planning (Rogers et al., 2017).

Occupational therapy and a systematic discharge planning mechanism may reduce hospital readmission and improve patient safety for individuals discharging from a skilled nursing facility. A more structured and systematic discharge process may improve the transition between the healthcare facility and home by ensuring a patient has the proper support and training at the time of discharge to address the completion of activities of daily living. Furthermore, a competency-based education approach with the patient ensures that the instructions and education from the discharge checklist are understood by the patient as the patient demonstrates what they have learned and their mastery of knowledge (Krause et al., 2015). Without addressing and researching potential solutions to prevent readmissions, we will continue to see increased money spent by Medicare, Medicaid, insurance companies, and clients who were prepared or safe to be discharged home.

According to the "Occupational Therapy Practice Framework (OTPF): Domain and Process", it is within the domain of occupational therapy practice to create an intervention plan inclusive of discharge planning (AOTA, 2014). Occupational therapists need to consider the patient's discharge plans to determine their needs within occupational therapy's scope of

practice. This may increase the outcomes stated in the OTPF to prevent and reduce the patient's risk factors, barriers and limitations, which could result in a rehospitalization (AOTA, 2014).

Problem Statement

With inconsistencies during the discharge planning process, both occupational therapists and patients are uncertain when it comes to the discharge process. Occupational therapists need to ensure that patients returning home are able to complete activities of daily living (ADLs) and instrumental activities of daily living (IADLs) safely and independently or if they need assistance for activities, a caregiver demonstrates ability to provide the level of assistance needed. Discharge specific interventions for patients transitioning from the hospital to home have shown positive outcomes such as increased preparedness for discharge and decreased hospital readmission within 30 days (Tole et al., 2016). Based on these findings, there is an opportunity to improve the discharge process for patients transitioning from skilled nursing facilities to home by having occupational therapist utilize a systematic discharge checklist to facilitate the patient's preparedness and ultimately reduce hospital readmissions.

Project Statement and Study Objectives

The objective of this doctoral capstone is to create a discharge checklist (Appendix A) for occupational therapists working in skilled nursing facilities. This discharge checklist will be initially created by conduction a literature review and using the author's clinical experience. The feasibility of this initiation version will be evaluated by three occupational therapist who will utilize this tool with two or more patients during their initial evaluation. By using this checklist at the start of care, it ensures that the occupational therapist will focus the plan of care around goals and treatment that are needed to facilitate a successful discharge. After the initial implementation and feasibility testing, the discharge checklist will be refined and improved.

The third objective is to understand if the discharge checklist improves the occupational therapist's competency to systematically and efficiently review all aspects of the discharge checklist. When the occupational therapist test the initial discharge checklist, a pre-post survey will be conducted to understand if the checklist improved their perceived competency.

The intended result of this capstone is to increase the perceived competency of occupational therapists discharging clients throughout the discharge process and improve the quality of care provided to the patients using a discharge checklist. This capstone's goal is to benefit both occupational therapist and patients by provided streamlined discharge checklist to address potential barriers for safe and successful completion of activities of daily living for patients discharging home.

Research Goals

Currently, there is no standardized set of questions or consistent process for occupational therapists to discharge a patient from a skilled nursing facility. Each evaluating occupational therapist asks different questions in the initial evaluation without a consistent template resulting in missing crucial information when discussing discharge plans. This presents the need for a discharge checklist to support occupational therapists to discharge patients systematically and efficiently. The goal is to implement a discharge checklist to determine if it is feasible to provide a consistent planning tool between the evaluating occupational therapists to eliminate any gaps in care prior to a patient discharging home based on using the discharge checklist. These needs will be addressed by developing and introducing a streamlined occupational therapy discharge checklist to address potential barriers and challenges for clients returning home (Toles et al., 2016).

Study Site & Participants

Inclusion & Eligibility

The site for this study was a 250+ bed, skilled nursing facility located in an urban area. Participants were eligible to participate in this study if they were a licensed occupational therapist, English speaking, and currently working at the study site.

Sampling Strategy

Recruitment of the potential subjects occurred through a verbal announcement from the student researcher in order to recruit a convenience sample of occupational therapists from one skilled nursing facility. The verbal announcement provided the research study topic, purpose, problem statement and research questions.

Informed Consent

Occupational therapists contact the student researcher if they were interested in participated in the study. After the potential participants initiated contact, the student researcher, provided a verbal informed consent process and answered any questions. Once the participants were consented, we protected their privacy by using an anonymous identifier through the data collection process.

Conceptual Framework

The DMAIC framework (define, measure, analyze, improve, control) creates a roadmap to support a quality improvement project at a skilled nursing facility. This framework provides a strategy to improve the discharge process (Pyzdek, 2003). Each step of the roadmap highlights the specifics of the DMAIC framework in order improve discharge planning by defining the problem, measuring and analyzing the current outcomes, providing an improvement and providing a control to determine the feasibility.

Define

The DMAIC model first defines that many patients who are readmitted to hospitals following a previous hospitalization results in unnecessary and increased healthcare spending (Vasilevskis et al, 2017). It is estimated that 23% of Medicare patients who are discharged from a skilled nursing facility will be readmitted within 30 days (Mor et al, 2010).

Measure & Analyze

Readmissions are publicly reported in post-acute care on the nursing home compare website ("Medicare Nursing Home Profile"). The most recent publicly reported score for this facility is based on the Quality of Resident Care Measure from CMS (Centers for Medicare & Medicaid Services) current collection from July 1, 2017 through June 30, 2018 ("Medicare Nursing Home Profile"). For short-term residents in this specific facility, CMS calculated and provided the data regarding the percentage of short-stay residents who were re-hospitalized after a nursing home admission. 22.1% of short-term residents were re-hospitalized after admission, which is slightly higher than the District of Columbia's average of 21.2%. However, compared to the national average of 22.3%, this facility has a lower percentage of short-stay residents who were re-hospitalized ("Medicare Nursing Home Profile"). The facility's readmission score indicates this is an area to address. The discharge checklist may facilitate higher quality of care in areas that are related to lower readmission rates.

Improve

One potential solution to this problem is further evaluation of the discharge process in skilled nursing facilities to develop a discharge checklist for occupational therapists to use. The discharge checklist aims to facilitate successful transitions upon discharge from the skilled

nursing facility back into the community. This checklist serves as a reminder and tool for occupational therapists to review key elements of a client's occupational performance prior to discharge. This project explores the feasibility of implementing a discharge checklist in this setting. A pretest and posttest survey has been derived and expanded from previous research in order to assess clinician's self-rated competency prior to utilizing the discharge checklist and following the use of the tool (Langford et al., 2019; Lescinskas et al., 2018). Additionally, a qualitative survey was utilized for feedback in order to create a second iteration of this tool. The changes in the overall measurements for the readmission rate are beyond the scope of this project. If the occupational therapists find the discharge checklist useful through this case study, the facility may implement this process as specified in the DMAIC. A feasible checklist may be a potential quality improvement tool that could be implemented in other facilities in the future.

Assessing Feasibility and Control

To support quality improvement and analysis, each participant provided feedback through debriefing to provide feedback for a second version of the discharge checklist to utilize in potential future research. The improvements were informed by the prioritization of trends from the debrief, the themes identified and the specific recommendations of the therapists. The data collection highlighted the occupational therapist's updated clinical competencies around the discharge planning process. This information was collected through a pretest and posttest survey to gain insight on the potential improved competency and confidence of the occupational therapists participating in this capstone.

Methods and Data Collection

Discharge Checklist Creation

A discharge checklist was created and expanded upon based on multiple sources (American Occupational Therapy Association, 2014; Folstein et al., 1975; Halasyamani et al., 2006; Levinson & General, 2013; Mahoney & Barthel, 1965). This discharge checklist uses information from the Modified Mini Mental (Folstein et al., 1975), Barthel Index (Mahoney & Barthel, 1965) and Occupational Therapy Practice Framework (American Occupational Therapy Association, 2014) to focus on occupations, client factors, performance skills and factors, and context and environment and the author's clinical experience. These sources were used to best create an overarching picture of the client's previous level of function, current level of function, and the gaps that need to be addressed to create a safe discharge plan home to reduce the readmission rate. The discharge checklist evaluates the client's discharge environment, the durable medical equipment they currently have and the durable medical equipment they will need based on the new onset of deficits. The discharge checklist also looks at the client's current ADL and IADL completion, including their community mobility for personal and medical related appointment (Appendix A).

Pretest and Posttest Evaluation

The pretest survey (Appendix B) and posttest survey (Appendix C) were derived and expanded from previous research to assess the occupational therapists' competency prior to utilizing the discharge checklist and following the use of the tool to define and analyze potential improvements (Langford et al., 2019; Lescinskas et al., 2018). A Likert Scale was used to determine the outcomes using a 1-5 scale (1: strongly agree-5 strongly disagree). The pretest and posttest data collection was collected through paper surveys and were identified by a numerical labeling system to protect the participants' privacy. The answer key to the surveys was stored

in a locked filing cabinet and only one person had access to the key. The answer key never remained in the facility without the key holder's presence.

The occupational therapists' competency for discharge planning was first collected immediately following the introduction of the project (Appendix B). Once those findings were collected, the student researcher explained in detail all parts of the discharge checklist including the instructions for use and the goal to use it with at least two clients during the initial evaluation. The student researcher answered any questions and provided an open line for communication throughout the project for any questions from the participants. Following the implementation of the discharge checklist with a minimum of two separate clients, participants completed the posttest survey, a quantitative outcomes survey and a qualitative survey in order to provide more specific feedback and critiques of the discharge checklist. The data was collected to provide detailed feedback for the creation of the second version based on the use of the first iteration in practice. The individual results are summarized below through de-identified data.

Training in the Discharge Checklist

Three occupational therapists were trained on the use of the discharge checklist by the student researcher. The training included a review of the checklist and a question and answer session with any concerns regarding implementing this checklist in the therapist's practice. The goal was for the therapist to use the checklist with at least two clients and then provide initial written feedback to the student researcher. Following use of the discharge checklist, the participants completed the posttest competency survey (Appendix C), an additional quantitative outcomes survey to look at the impact and comfort with discharge planning (Appendix D) and a qualitative survey for overall feedback of the discharge checklist (Appendix E).

Outcome Evaluation

There are a number of immediate and long-term outcomes highlighted in a logic model (Appendix F) that may occur based on this capstone to create a streamlined discharge checklist for a skilled nursing facility. The focus of the data collection for the outcomes is to analyze the change in competency during the discharge process. The outcome for the goal is to implement a discharge checklist to determine if it is feasible to provide a consistent planning tool, which will be measured, based on the feedback from the participants of the project. This will be evaluated through the data collection from the occupational therapists based on their overall experience with the capstone project. Specifically, the occupational therapists will be rating their perceived clinical competency with discharge planning.

The program will be found successful if the occupational therapists have shown an increased competency discharging patients using the discharge checklist prior to patients returning home. If the checklist is found to increase the competency of occupational therapists in this case study, the project can move forward in future research to examine more comprehensive outcomes, including client satisfaction. The long-term outcomes include lower hospitalization readmissions, increased quality of life for clients, and decreased spending for CMS. These long-term outcomes will not be measured as part of this capstone based on the time frame for completion, however, based on the findings, future research will be recommended which will require additional time and financial resources.

The overall goal is to update and change the practice of the discharge planning process based on evidence-based practices. If the capstone delivers on the intended results that support the idea that a discharge checklist will increase occupational therapists' competency during the discharge process, this may further encourage the idea of utilizing the created discharge checklist

at this one SNF. This capstone will provide a streamlined discharge checklist to give a physical planning tool for occupational therapists in order to support increased competency during the discharge planning process.

Analysis

For the quantitative data collection, a pretest and posttest design looked to analyze the data for the feasibility of using the discharge checklist in clinical practice and the potential improvements to the occupational therapists' clinical competencies. The single group of participants included three occupational therapists who agreed to participate in the pretest survey prior to the participation of the quality improvement phase and then the posttest survey to measure the results at the conclusion of the study. The dependent variable is the occupational therapist's perceived clinical competency with discharge planning using the discharge checklist. This was measured twice, one before use of the discharged checklist tool and once following the use of the checklist. All the participants were given the same surveys with instructions how to participate in the capstone. Descriptive statistics will be provided for each individual therapist.

The pretest and posttest quantitative data collect was further analyzed in Microsoft Excel to look at the differences following the intervention. Additionally, in the posttest section, there was an additional outcomes sections created using a Likert scale to measure the overall findings of participation from the occupational therapists to rate their current knowledge and comfort with discharge planning. The qualitative data collection occurred through open-ended survey questions following the training. These responses were analyzed through categorization to determine the themes presented based on the feedback from the questions to assist with final edits of creating the second version of the discharge checklist.

Findings and Results

Based on the quantitative findings each participant improved their overall competency with discharge planning at varying levels based on the specific questions collected prior to the intervention and following the intervention for comparison. The interesting findings of the case study approach are the data of each individual participant from their experience to highlight themes that were presented. See Table 1 for scores from all participants.

Participant One: For participant one, it was found that all of the scores following the quantitative survey improved (Appendix G) for questions 1-5 demonstrating an increase in agreeing with the items related to comfort discharging a client to the community and confidence with discharge recommendations and using the discharge checklist. However, question "6.) I collect the same information each time I discuss discharge planning in an initial evaluation with a patient", participant one found to have the same score at the pretest. Overall participant one decreased their overall score of 1.83, which demonstrates improvement following the use of the discharge checklist. The outcomes survey (Appendix D) collected feedback from the participant following the use of the discharge checklist. Based on the 1-5 scale (1: strongly agree- 5: strongly disagree), participant one's average score was 1.33 for the provided questions.

Participant Two: Participant two had scores that lowered following the quantitative survey (Appendix H) for questions 1-6 demonstrating increased agreement with all the items in Table 1. Overall participant one decreased their overall score of 3, which demonstrates improvement following the use of the discharge checklist. The outcomes survey (Appendix D) collected feedback from the participant following the use of the discharge checklist. Based on the 1-5 scale (1: strongly agree- 5: strongly disagree), participant one's average score was 1.66 for the provided questions.

Participant Three: Participant three's scores following the quantitative survey lowered (Appendix I) for question 2 demonstrating increased agreement with item two, "I am confident using a discharge checklist tool." This participant did not see any changes in score from the pretest to posttest for the remaining questions. Overall participant three decreased their overall score by 0.5, which demonstrates improvement following use of the discharge checklist. The outcomes survey (Appendix D) collected feedback from the participant following the use of the discharge checklist. Based on the 1-5 scale (1: strongly agree- 5: strongly disagree), participant one's average score was 2.83 for the provided questions.

Table 1 (Quantitative pretest and posttest findings of the participants using the discharge checklist):

Items	Participant 1		Participant 2		Participant 3	
	Pre	Post	Pre	Post	Pre	Post
1.) I feel comfortable with recommending patients to be discharged back into the community	4	1	5	1	1	1
2.) I am confident using a discharge checklist tool	4	2	3	1	5	2
3.) I am confident in identifying factors pertinent from a discharge checklist to provide an effective discharge plan	3	2	3	1	1	1
4.) I am competent collecting the correct information in the beginning of discharge planning	3	1	5	1	1	1
5.) I have a thorough process when collecting discharge planning information	4	1	3	1	2	2
6.) I collect the same information each time I discuss discharge planning in an initial evaluation with a patien	2	2	5	1	2	2

Another view of the findings compared each participant side by side based on their overall pretest and posttest score difference by the questions to see if any of the questions stood out of having the most difference following the intervention (Appendix J). It was found that question 2, *I am confident using a discharge checklist tool*, had the most overall change for all the participants which they all ended up responding saying they either "agree or strongly agree" to that question.

From the outcomes survey (see Table 2), a Likert scale (1-5) (Appendix D) was used at the end of the project, all participants either "agreed" (2) or "strongly agreed" (1) for all parts of question one (a-d), that the discharge checklist "helped me improve my knowledge of how to a.) Identify risk factors prior to discharge, b.) Articulate goals of discharge planning, c.) Safely initiate discharge planning, d.) Safely modify discharge planning through a patient's stay". The findings for question two were neutral at a 3.33 as the participants stated that as a result of completing the discharge checklist, I am now more likely to use the discharge checklist in care of patients. Lastly, for all parts of question three (a-g), participants stated that after completing the discharge checklist training they "agreed" (2) to "strongly agreed" (1) that a.) I am confident in my ability to manage discharge planning, b.) I am capable of managing a discharge checklist throughout discharge planning, c.) I am able to provide thorough recommendations for patient to be discharged home, d.) I am able to meet the challenges of discharge planning for skilled nursing facility patients, e.) My perception of my discharge planning knowledge has improved, f.) The discharge checklist has a positive impact on my use of discharge checklist, g.) My competence in discharge planning has improved. Specific numerical findings are found in the appendix section.

Table 2 (Outcome survey provided to participant following their participation with discharge checklist):

		Participant 1	Participant 2	Participant 3
Question	1a	1	2	4
	1b	1	1	4
	1c	1	1	3
	1d	1	2	3
	2a	2	3	5
	3a	2	1	1
	3b	1	1	2
	3c	2	2	2
	3d	2	2	2
	3e	1	1	2
	3f	1	1	2
	3g	1	3	4

The qualitative questions were completed by participants (Appendix E) and further discussed with the student researcher to collect additional information regarding the participants and findings from utilizing the discharge checklist in practice. That data was divided into themes and generalized into trends in order to assist the researcher to determine areas for edits to be made for the second iteration of the discharge checklist. The theme found in the qualitative survey for the first question of what worked well included the structure and organization of the questions with the inclusion of open ended questions throughout discharge checklist. For the second question, the summary of feedback for what did not work included the mini mental exam and the specific checklist having too many pages impacted the therapist's time management during the evaluation. The majority of participants stated in their feedback for question three the removal of the mini mental exam. And finally for the fourth question asked if anything was missing from the checklist which all three participants discussed the formatting for some of the

questions that only had a few options for answers, to actually include those answer options so the therapist can check those boxes versus spending the time writing the information in.

Additionally, highlighted below is a unique piece of specific feedback from the individual participants. Participant one stated having a physical discharge checklist was helpful in order to provide continuity for every evaluation he or she completed which would match the information collected from the other evaluating therapists. Participant two stated the perceived value of using the open-ended questions as he or she is a tenured therapist so the checklist provided a update to their approach to gather additional information from the patient. Lastly, participant three suggested shortening the entire checklist and providing more opportunities to limit the boxes to write in the answers and instead check the answers off. He or she also discussed the challenge with time management when using the Mini Mental Exam and to remove it entirely.

With all the feedback and findings provided, the first version of the discharge checklist was updated to create a second iteration of the discharge checklist (Appendix K). This updated version is available for future research to further analysis the implications to determine if this iteration better aligns with the goals occupational therapists are trying to accomplish to increase their competency and overall use of this tool during discharge planning.

Discussion

Following the evaluation for this capstone project, it was found that a discharge checklist resulted in self reported higher clinical competency following the use of an intervention in skilled nursing facilities discharging clients back to their prior home environment. This was based on the overall findings through a pretest and posttest design, an outcomes survey using a Likert scale, and a qualitative survey. This case study approach found anecdotal evidence that

the discharge checklist benefitted three occupational therapists by providing a streamlined discharge checklist to address potential barriers for clients returning to their home setting. These findings relate to the literature from Tole and colleagues, (2016) who discussed how patients' preparedness for discharge is improved through discharge interventions provided by professional staff.

This case study approach supports more comprehensive assessment of the potential for a discharge checklist in skilled nursing facilities. The descriptive data analysis supported that all the participants increased their overall competency and comfort discharging patients using the discharge checklist. The difference in scores from the pretest to posttest (Appendix L) further supported the value of a consistent discharge checklist in a skilled nursing facility.

One limitation presented was small number of participants. There presents an opportunity for an additional, more comprehensive assessment in future research addressing a larger sample size. As a case study approach, the three participants provided the opportunity to test the feasibility of the project, in hopes that future researchers are able to administer this project with a larger group of participants to further expand the data collection.

Additionally, another barrier was the time frame. The timeframe of this capstone was one semester from January through May. However a limitation on the timeframe was the IRB process. The data collection began in April once IRB approval was received. This required a change in the scope of the project from initially expecting to include a second iteration of this revised discharge checklist in practice to creating the second iteration for future use. Following the updates to the program, the opportunity presents next steps for future research to utilize the second version of the discharge checklist (Appendix K) to further evaluate the discharge

checklist's feasibility and usability in clinical practice. Future researchers should utilize the second version of the checklist with more participants from different skilled nursing facilities.

Lastly, in the data collection, there is the opportunity to include a section of interviews from the patients participating to evaluate how the discharge checklist aligns with their goals to discharge home. This would further support a patients centered approach. If the second version provides continued assistance and value to the occupational therapists partaking in this study, there is the opportunity to for a larger discussion for future research to implement this checklist in multiple skilled nursing facilities across the country to address the ultimate outcome of reducing hospital readmissions and improving quality care.

Conclusion

Utilizing a streamline discharge checklist in a SNF allow for occupational therapists to discharge patients systematically and efficiently. During this capstone, a discharge checklist was created and provided a systematic tool for evaluating occupational therapists to increase their competency and collect streamlined, pertinent information prior to a patient discharging home. This tool has shown increased self-reported competence and comfort through the discharge process by occupational therapists resulting in overall better care provided by practitioners.

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Appendix A

Discharge Checklist

This is a guide towards a structured discussion. Further discussion into aspects of the checklist is recommended; however make sure all areas are addressed throughout the discussion with a client.

Client Name & DOB:	
Client's subjective explanation for reason of admission:	
Current Symptoms: *(additionally note anything new)*	
Pain Level & Description:	**0 1 2 3 4 5 6 7 8 9 10**
Previous therapies received in hospital and what was patient able to do for themselves at the hospital:	

Mini Mental State Examination Score: ___

<u>Previous Level of Function</u>

Home Environment	**[__] House [__] Apartment [__] Other:**
Social and care support *(i.e. family members, home health support)*	
Stairs	**Enter front door:** **Stairs based on levels in house:**

	Handrails:
Location of bedroom and bathroom (first floor or multi level house?)	
Describe the setup of bathroom (tub/ walk in shower, grab bars, DME)	
Does the patient owns any Durable Medical Equipment	**[__]** wheelchair, **[__]** r/w, **[__]** shower chair, **[__]** BSC, **[__]** grab bars, **[__]** hip kit,**[__]** weighted utensils, **[__] other:**
Previous completion of ADLs and IADLs (*utilizing the Barthel Index Scoring Form in order to address ADLs with added IADLs*) **and note changes in physical function/ new limitations in the past 6 months**	**Feeding** **Transfers** **Bathing** **Mobility** **Grooming** **Stairs** **Dressing** **Cooking** **Bowels** **Cleaning** **Bladder** **Laundry** **Toilet Use**
Describe visual or hearing deficits	**[__] Visual:** **[__] Hearing:**
Is the patient currently managing his or her own medicines? Describe. **Expand on medicine management system.**	**[__] Yes [__] No**

Recent history of falls or hospitalizations prior to most recent one?	
Community mobility (How did the client previously get to appointment(s) in order to gather additional functional limitations)	
What does the patient have to be able to do at home when they return and if their plan to return home?	
Expand on any discharge barriers and client's current concerns related to discharge.	
Does the patient have any follow up appointments? Are there any instructions or precautions until the follow up?	
Are there any anticipated discharge barriers that should be escalated to rehab manager or social work to address immediately	

Appendix B

Respondents rate their level of agreement with the following statements:

Measurement: 1-5 scale (1: strongly agree- 5: strongly disagree)

Pretest survey:

1.) I feel comfortable with recommending patients to be discharged back into the community _____
2.) I am confident using a discharge checklist tool _____
3.) I am confident in identifying factors pertinent from a discharge checklist to provide an effective discharge plan _____
4.) I am competent collecting the correct information in the beginning of discharge planning _____
5.) I have a thorough process when collecting discharge planning information _____
6.) I collect the same information each time I discuss discharge planning in an initial evaluation with a patient _____

Appendix C

Respondents rate their level of agreement with the following statements:

Measurement: 1-5 scale (1: strongly agree- 5: strongly disagree)

Posttest survey:

1.) I feel comfortable with recommending patients to be discharged back into the community _____
2.) I am confident using a discharge checklist tool _____
3.) I am confident in identifying factors pertinent from a discharge checklist to provide an effective discharge plan _____
4.) I am competent collecting the correct information in the beginning of discharge planning _____
5.) I have a thorough process when collecting discharge planning information _____
6.) I collect the same information each time I discuss discharge planning in an initial evaluation with a patient _____

Appendix D

Outcome survey provided to participant following their participation with discharge checklist.

Measurement: 1-5 scale (1: strongly agree- 5: strongly disagree)

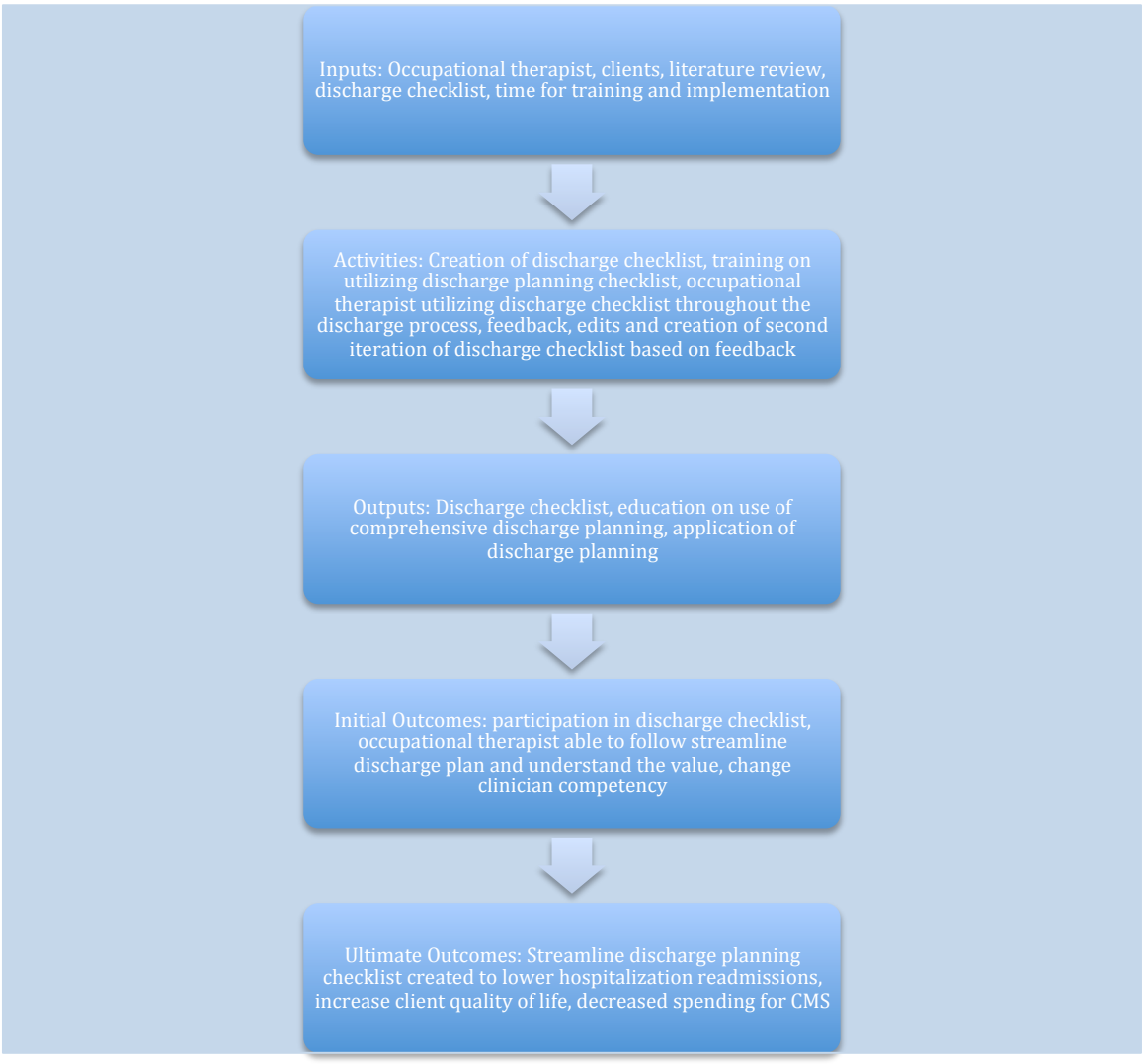
1.) The Discharge Checklist helped me improve my knowledge of how to:
a.) Identify risk factors prior to discharge
b.) Articulate goals of discharge planning
c.) Safely initiate discharge planning
d.) Safely modify discharge planning through a patient's stay
2.) As a result of completing the discharge checklist, I am now more likely to:
a.) Use the discharge checklist in care of patients
3.) After completing the discharge checklist training
a.) I am confident in my ability to manage discharge planning
b.) I am capable of managing a discharge checklist throughout discharge planning
c.) I am able to provide thorough recommendations for patient to be discharged home
d.) I am able to meet the challenges of discharge planning for skilled nursing facility patients
e.) My perception of my discharge planning knowledge has improved
f.) The discharge checklist has a positive impact on my use of discharge checklist
g.) My competence in discharge planning has improved

Appendix E

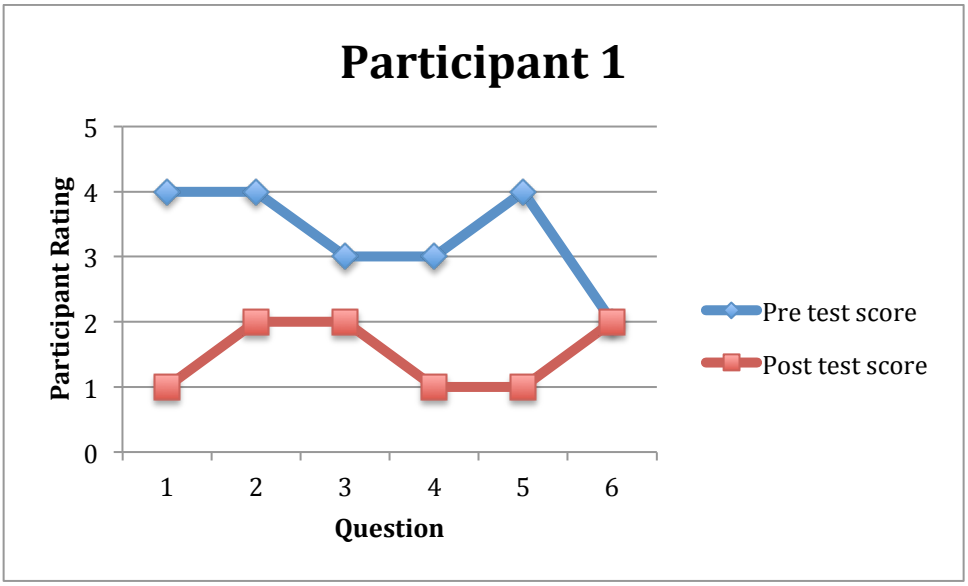
Qualitative Questions

(1) What on the discharge checklist worked well?
(2) What on the discharge checklist did not work well and why?
(3) Is there anything on the checklist that is not needed and should be removed?
(4) Is there anything missing from the checklist? Then, the therapist will complete the competency review.

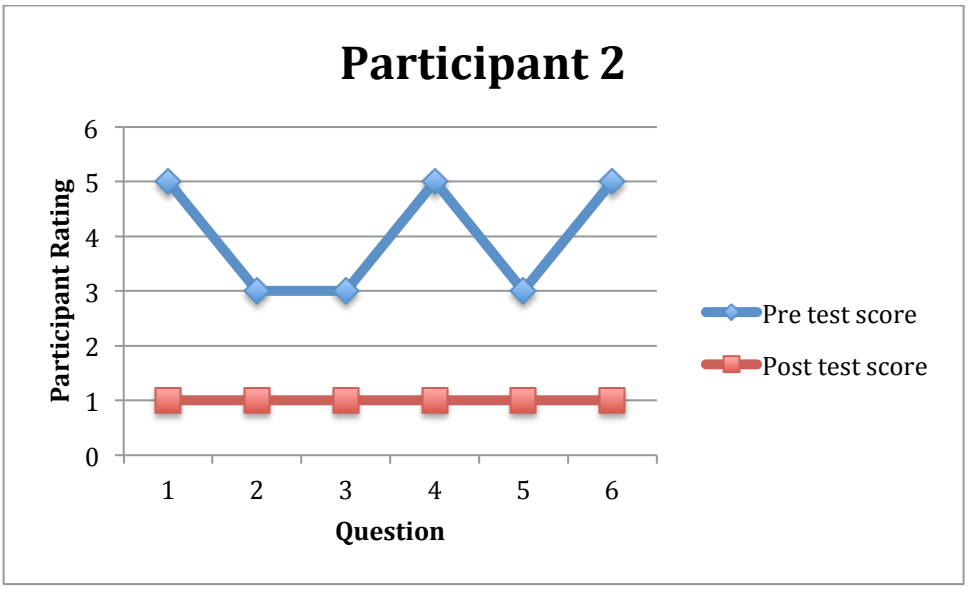
Appendix F



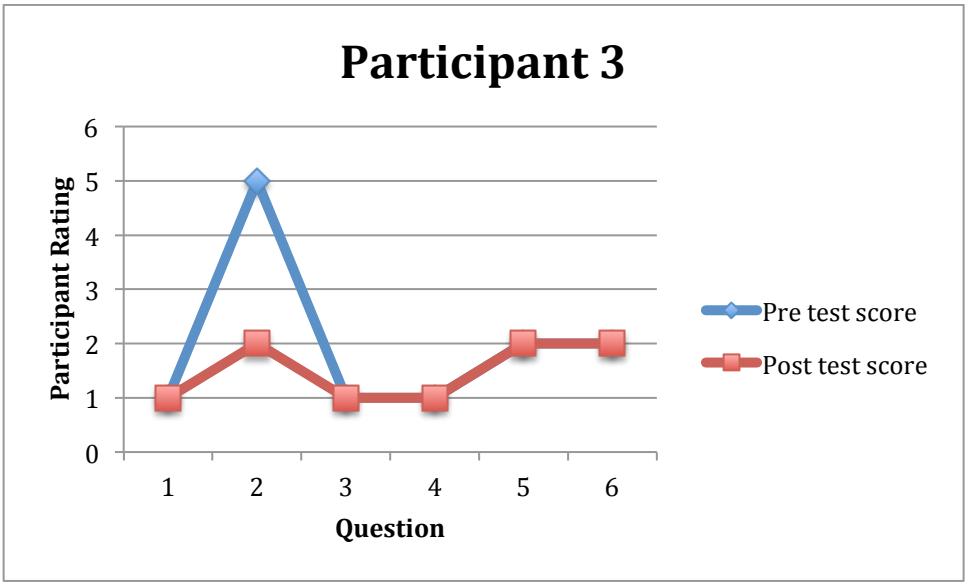
Appendix G



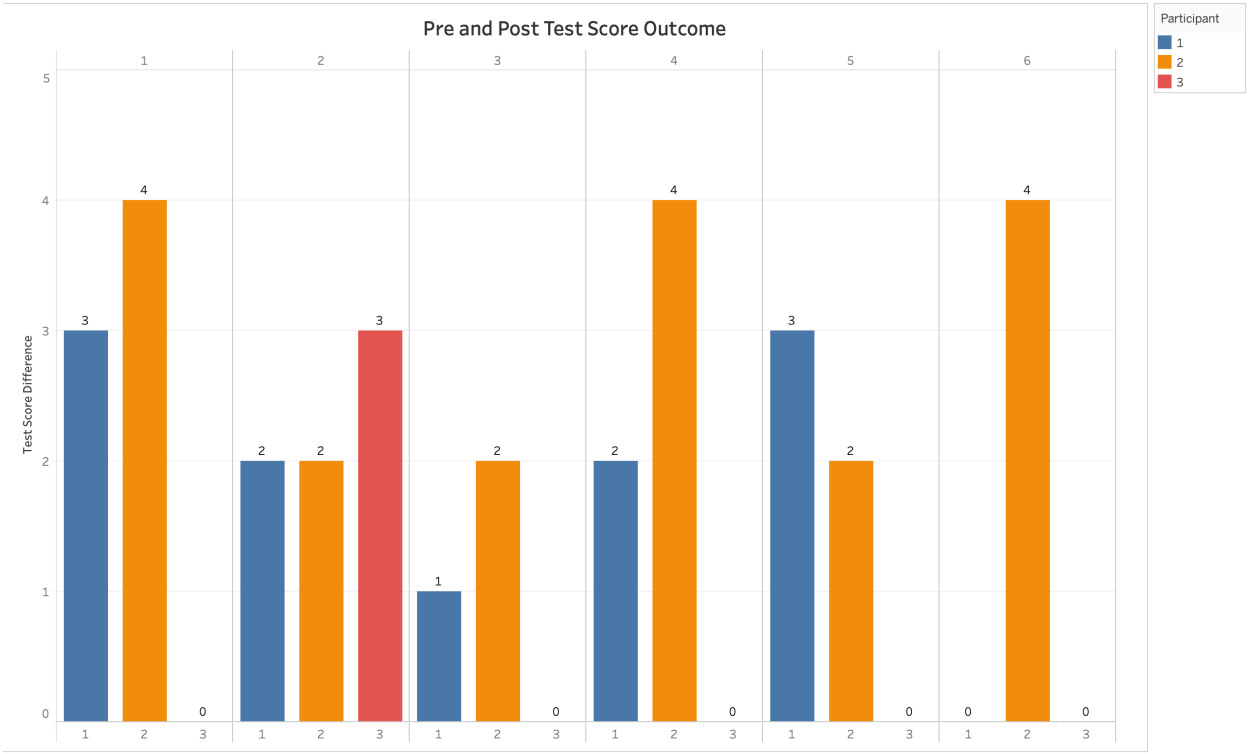
Appendix H



Appendix I



Appendix J



Appendix K

Discharge Checklist

This is a guide towards a structured discussion. Further discussion into aspects of the checklist is recommended; however make sure all areas are addressed throughout the discussion with a client.

Client Name & DOB:	
Client's subjective explanation for reason of admission:	
Current Symptoms: *(additionally note anything new)*	
Pain Level & Description:	**0 1 2 3 4 5 6 7 8 9 10**
Previous therapies received in hospital and what was patient able to do for themselves at the hospital:	**[__] Therapy** **[__] Stand** **[__] Transfer to toilet** **[__] Dress/ bathe**

Previous Level of Function

Home Environment	**[__] House [__] Apartment [__] Other:**
Social and care support *(i.e. family members, home health support)*	
Stairs	**Enter front door:** **Stairs based on levels in house:** **Handrails:**
Location of bedroom and bathroom	**[__] First floor** **[__] Second floor**

	[__] Other
Describe the setup of bathroom	**[__] Tub** **[__] Walk in shower** **[__] Grab bars** **[__] DME**
Does the patient owns any Durable Medical Equipment	**[__]** wheelchair, **[__]** r/w, **[__]** shower chair, **[__]** BSC, **[__]** grab bars, **[__]** hip kit,**[__]** weighted utensils, **[__] other:**
Previous completion of ADLs and IADLs (*utilizing the Barthel Index Scoring Form in order to address ADLs with added IADLs*) **and note changes in physical function/ new limitations in the past 6 months**	**Feeding** **Transfers** **Bathing** **Mobility** **Grooming** **Stairs** **Dressing** **Cooking** **Bowels** **Cleaning** **Bladder** **Laundry** **Toilet Use**
Describe visual or hearing deficits	**[__] Visual:** **[__] Hearing:**
Is the patient currently managing his or her own medicines? Describe. **Expand on medicine management system.**	**[__] Yes [__] No**
Recent history of falls or hospitalizations prior to	

most recent one?	
Community mobility (How did the client previously get to appointment(s) in order to gather additional functional limitations)	
What does the patient have to be able to do at home when they return and if their plan to return home?	
Expand on any discharge barriers and client's current concerns related to discharge.	
Does the patient have any follow up appointments? Are there any instructions or precautions until the follow up?	
Are there any anticipated discharge barriers that should be escalated to rehab manager or social work to address immediately	

Appendix L

Participant	Question	Pretest score	Posttest score	Difference
1	1	4	1	3
1	2	4	2	2
1	3	3	2	1
1	4	3	1	2
1	5	4	1	3
1	6	2	2	0
2	1	5	1	4
2	2	3	1	2
2	3	3	1	2
2	4	5	1	4
2	5	3	1	2
2	6	5	1	4
3	1	1	1	0
3	2	5	2	3
3	3	1	1	0
3	4	1	1	0
3	5	2	2	0
3	6	2	2	0