International Journal of Scientific Research and Management (IJSRM)
||Volume||12||Issue||03||Pages||1378-1413||2025||
Website: www.ijsrm.net ISSN (e): 2321-3418
DOI: 10.18535/ijsrm/v13i03.mp01

Experiences and Perceptions of Hospital Social Workers Regarding Discharge Planning and Readmission

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Abstract

The Centers for Medicare and Medicaid Services created the Hospital Readmission Reduction Program in 2010 to decrease the problem of hospital readmissions. This program reduces hospital reimbursements from Medicare or Medicaid when patients with specific diagnoses are readmitted within 30 days of discharge. This generic qualitative study explored hospital social workers' experiences and perceptions of the impact of discharge planning on hospital readmission. Meleis's transitions theory provided the conceptual framework for this study. Data were collected from semistructured interviews with 10 female medical social workers. Data analysis entailed categorizing and classifying the data into emerging themes to answer the research question. The themes were (a) lack of community resources, (b) hospital administrative challenges, (c) lack of family/social support, and (d) RN versus social worker issues/lack of role definition.

Recommendations include standardizing health care social worker roles and providing more time for complex patients to ensure the implementation of all needed services before discharge. Implications for social change include improved discharge planning outcomes, increased support from administration, and consistent social worker role definition and tasks. Positive social change is possible at the policy level because findings showed that providing enough care for patients can reduce hospital readmissions.

Introduction to the Study

Hospital readmission and discharge planning affect patients of all ages and demographics and have negative financial impacts on society. Hospital readmission is defined as being readmitted into the hospital setting within 30 days of discharge (Henke et al., 2017). Discharge planning is the process of identifying and preparing for a patient's anticipated health care needs after they leave the hospital (Agency for Health care Research and Quality [AHQR], 2018). In 2016, 13.9% of individuals discharged from hospitals were readmitted within 30 days (Bailey et al., 2019). Changes in health insurance guidelines have led to yearly increases in hospital readmission, which impacts patients and taxpayers. Alper et al. (2017) found that hospitals decreased readmission rates within 6 months with proper discharge planning.

Social workers are an essential part of the health care team. The role of the hospital social worker is to provide patients with safe discharge plans and appropriate community resources to lessen the impact of negative social determinants (Rowlands et al., 2017). Some of those social determinants are housing insecurity and lack of caregiver services. However, social workers cannot always provide safe discharge plans because of various issues outside their control (Zurlo & Zuliani, 2018), such as if the patient's caregiver gets sick or equipment is on backorder.

Chapter 1 includes a summary of the existing literature on hospital readmission and discharge planning. An introduction to the study is provided, including the problem statement, conceptual framework, methodology, research question, and definitions. I also provide the assumptions, scope, delimitations, limitations, and significance of the study.

Background

The significant problem of hospital readmissions led to the creation of a program to reduce the high numbers of

readmissions. The Centers for Medicare and Medicaid Services (CMS) created the Hospital Readmission Reduction Program (HRRP) in 2010 to decrease the hospital readmission rate (Ody et al., 2019). To ensure safe discharge planning, HRRP reduces Medicare or Medicaid payments for hospital patients who have specific diagnoses and are readmitted within 30 days of discharge (Wadhera et al., 2019). Currently, the program includes six patient diagnoses identified as having a high readmission rate: acute myocardial infarction, chronic obstructive pulmonary disease, heart failure, pneumonia, coronary artery bypass graft surgery, and elective primary total hip arthroplasty and/or total knee arthroplasty. However, there has been an increase in the number of critical patients due to the COVID-19 pandemic.

Since HRRP debuted in 2012, readmission rates have remained high (Ody et al., 2019). Hospital readmission remains a problem in the health care system and, by extension, society. The financial impacts of hospital readmissions are significant (Himmelstein & Woolhandler, 2016), costing U.S. taxpayers $26 billion annually through Medicare (federal insurance) and Medicaid (state insurance) reimbursement (Wilson, 2019).

One of the social worker's most important roles is conducting patient assessments to develop and share a holistic patient discharge plan with other staff (Alvarez et al., 2016). Based on this role in discharging patients, hospital social workers are crucial in the functioning of the HRRP program. However, even when a social worker has created and implemented a discharge plan, patient readmissions can still occur (Zurlo & Zuliani, 2018). The readmitted patient is often labeled as noncompliant, which can be attributed to a lack of understanding at the time of discharge (Ivic et al., 2020).

In this study, I gathered knowledge from social workers' perspectives. Despite existing literature about hospital readmissions and discharge planning, research from the social worker's perspective was lacking. This study's findings addressed the gap in knowledge specific to hospital social workers' perceptions of hospital readmission and discharge planning. This study was needed to provide new information regarding hospital readmission and discharge planning.

Problem Statement

The focus of the health care system has shifted, with the main concern now being how to reduce costs associated with lengthy hospital stays (Wadhera et al., 2019).

Creating a discharge plan has become a common practice for many hospital social workers, ensuring the patient's appropriate and safe discharge. With HRRP creating more accountability, hospital social workers create discharge plans to prevent financial penalties (Ayabakan et al., 2021). According to Henke et al. (2017), individualized discharge planning reduces the length of hospital stays and readmission rates, particularly for older individuals.

The problem the current study addressed was the increasing hospital readmission rate due to a lack of adherence to the 2010 HRRP. Readmissions could increase if policymakers apply HRRP universally to all diagnoses. However, if HRRP is ignored in diagnoses, clinicians decrease their chances of realizing safe and effective discharge plans (Alper et al., 2017; Ayabakan et al., 2021; Hoffman et al., 2020). Patients could incur increased financial burdens if hospitals are not able to ensure proper admittance and reduced readmittance.

Purpose of the Study

This generic qualitative study explored hospital social workers' experiences and perceptions of the impact of discharge planning on hospital readmission. The study addressed the documented social problem of excessive hospital readmission by providing information and insight from the perspectives of hospital social workers who work directly with discharge planning and readmissions. Insight from this study added to the existing body of literature.

Research Question

The following research question guided the current study: What are the experiences and perceptions of hospital social workers regarding the influence of discharge planning on hospital readmissions?

Conceptual Framework

Meleis's (2010) transitions theory indicates that an individual's environment is vital in the transition process. The theory of situational transition incorporating discharge and relocation served as the conceptual framework for this study. As applied to this study, situational transitions theory focuses on discharge from a facility to any environment and from home to a nursing facility. During a discharge planning assessment, practitioners must consider various factors, including caregiver status, needed items at home, and patient understanding of the treatment plan (Davies, 2005).

The discharge environment is a direct indicator of whether hospital readmission will occur, including whether a patient will be home alone or have food and other necessary supplies.

According to the theory of situational transition, a holistic understanding influences the transition experience of patient discharge from the hospital setting (Schumacher & Meleis, 1994), including the conditions of discharge placement. This theory helped guide the current study by providing a framework to show the importance of discharge planning and the conditions of the patient's environment. Meleis's (2010) theory was useful in understanding the social workers' perceptions and experiences and their understanding of what is necessary for the discharge planning process to reduce the likelihood of hospital readmission.

Nature of the Study

This research was a generic qualitative study focused on hospital social workers' experiences and perceptions of the hospital discharge planning process. A generic qualitative approach enables researchers to decide what works best for their study based on the available information (Benoot et al., 2018; Percy et al., 2015). The qualitative approach was ideal for exploring participants' perceptions and experiences. Generic qualitative research was consistent with the goal of understanding hospital social workers' perceptions and experiences regarding discharge planning and hospital readmission, allowing participant perspectives to shape the study. I followed an inductive approach for data analysis to identify emerging codes and themes.

Definitions

Discharge planner: Often a hospital social worker who plans, coordinates, and communicates with patients, families, and other health care providers while observing the discharge process (Hayajneh et al., 2020).

Discharge planning: Activities that guide patients to community services after discharge from any care setting (Hayajneh et al., 2020).

Hospital readmission: The process of patients being readmitted to the hospital within 30 days of discharge (Roshanghalb et al., 2019).

Hospital Readmission Reduction Program: A program established by the CMS in 2010 to reduce preventable hospitalizations by imposing financial penalties on hospitals with higher-than-expected 30-day readmission rates (Wadhera et al., 2019).

Hospital social worker: Licensed social workers who practice in an acute hospital setting (Cowan et al., 2020).

Medical social worker: The social worker responsible for conducting interventions for inpatient and outpatient care as well as offering guidance to other care professionals based on an understanding of how trauma, disease, or chronic illness can affect individuals, their families, and the social situation (Udo et al., 2019).

Social worker: A professional with a master's or bachelor's degree in social work (Udo et al., 2019).

Assumptions

There were several claims presumed but not proven to be true for this study. The first assumption was that hospital social workers would have the knowledge and in-depth understanding of readmissions and discharge planning. Also, I assumed that participating hospital social workers would be willing to discuss their perspectives of and experiences with discharge planning and hospital readmission. A third assumption was that participants would be honest in their responses and provide accurate and detailed information about their experiences working as hospital social workers. Finally, a methodological assumption was that generic qualitative research was appropriate to explore varying truths and realities and explain different trends (see

Babbie, 2017).

Scope and Delimitations

I focused on hospital social workers' perceptions of and experiences with the influence of discharge planning on readmission. Participants were social workers who served in an acute hospital setting within the last 2 years. The social workers resided in the United States.

Hospital social worker eligibility did not depend on geographical area, allowing for a gender and racially balanced participant pool. There were no age limitations for participants. These broader participation criteria could allow for transferability to mental health social workers responsible for discharge planning and readmissions. This study focused only on acute medical hospital social workers; mental health facilities and psychiatric hospitals were not included. Another delimitation was that participants must have had experiences with and perceptions of discharge planning and readmission.

Limitations

Several limitations outside of my control may have affected the study. The first limitation was researcher bias because I worked as a social worker in a health care setting at the time of the study and formerly served as a hospital social worker. It is essential to address researcher bias because it can impact a study's validity and reliability (Babbie, 2017). I used member checking to minimize bias.

Access to participants could have also been a limitation. Because the findings included experiences with discharge planning, some social workers might not have wanted to participate. Due to the specific focus on hospital social workers contributing to discharge planning, the findings might not apply to social workers in general health care settings. Participant access also created a geographic limitation because I sampled only participants from within the United States.

Social workers' high caseloads and time constraints may have limited the number of individuals willing to participate in the study. I addressed this limitation with flexible interview times and remote interviews via Zoom videoconferencing software. To minimize the risk of researcher bias, I implemented member checking, allowing the participants to review the preliminary findings to ensure that my interpretations accurately reflected their perceptions. Recruitment occurred via social media and the Walden University participation pool to prevent the need for Institutional Review Board (IRB) approval for each hospital.

Significance

This research is significant in providing insight into the experiences of discharge planning and hospital readmissions from the perspectives of hospital social workers.

Offering an increased understanding of the problem of readmissions has the potential for positive social change because it may contribute to creating new interventions and policies. Because social workers are critical agents in proper discharge planning, their perceptions and experiences are significant, allowing for increased understanding of proper discharge planning from the perspectives of essential agents (Alvarez et al., 2016).

Summary

In this chapter, I presented the background and justification for this study. This study explored hospital social workers' experiences and perceptions of the impact of discharge planning on hospital readmission. The chapter also included discussions of assumptions, limitations, significance, and implications for positive social change.

Chapter 2 includes an in-depth literature review related to the study phenomenon, including the literature gap as well as a discussion of the study's conceptual framework.

Literature Review

The high rate of hospital readmissions is a multisystemic problem with health and economic implications (Himmelstein & Woolhandler, 2016). Substantial losses in revenue from hospital readmissions led the CMS to create the HRRP. Under the HRRP, insurance company reimbursements decline for specific diagnoses upon patient readmission within 30 days of discharge (Zuckerman et al., 2017). Hospital systems receive payments

based on patient admissions, but they lose revenue with readmissions (Himmelstein & Woolhandler, 2016).

The discharge planning process impacts hospital readmission rates (Henke et al., 2017). A social worker or nurse usually conducts discharge planning (Frankel et al., 2018). In response to the HRRP, hospitals have begun to hire more social workers to assist with complicated patient cases, thereby addressing psychosocial issues that could interfere with discharge planning (Boccuti & Casillas, 2017). In the current study, I focused on the perspectives of the social workers specific to the discharge planning process and hospital readmissions. In Chapter 2, I present the concepts and theories that support social workers, discharge planning, and hospital readmissions. A review of the current research revealed the literature gap that this study addressed. This generic qualitative study explored hospital social workers' experiences and perceptions of the impact of discharge planning on hospital readmission. The problem that was addressed was the increasing hospital readmission rate due to a lack of adherence to the 2010 HRRP. The study addressed the documented social problem of excessive hospital readmission by providing information and insight from the perspectives of hospital social workers who work directly with discharge planning and readmissions. Insight from this study added to the existing body of literature.

Literature Search Strategy

Several academic databases and search engines provided literature for this study.

Through the Walden University library, I accessed databases including SocINDEX, EBSCO, PsycINFO, ProQuest, SAGE Journals, and ProQuest Nursing & Allied Health. To identify peer-reviewed articles useful for the study, I searched the following keywords: *discharge planning*, *hospital readmissions*, *medical social workers*, *hospital social workers*, *case management*, *hospital readmission reduction program*, and *experiences of hospital social workers*. After reviewing relevant literature, I identified leading researchers in discharge planning, subsequently searching for them via search engines such as Google Scholar and Academia.edu. After an exhaustive review of the literature, I could not find any studies specific to the perspectives of hospital social workers regarding discharge planning and hospital readmissions.

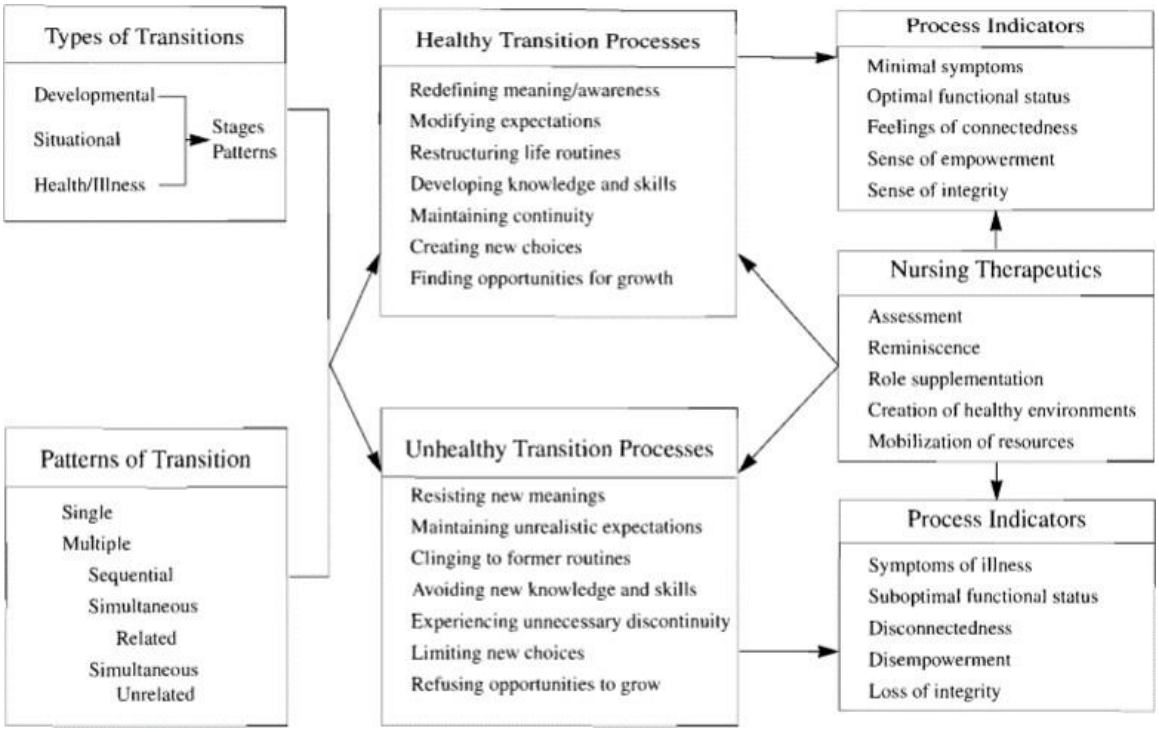
Conceptual Framework

Meleis's (2010) transitions theory served as the conceptual framework for this study. Meleis developed the theory in 1985 to understand the transition from one level of care to another (Meleis et al., 2000). Meleis et al. (2000) asserted that the health of informal caregivers of chronically ill patients and their spouses improved with informed dialogue and interaction clarity. As a practicing clinical nurse, Meleis et al. (2000) found that transitions such as trauma or childbirth altered patients because they were no longer the same individual they were before the experience.

Meleis et al. (2000) based the theory on the transition that occurs when an individual shifts from one level of care to another. Psychosocial, emotional, and physiological changes happen when an individual moves from one life event to the next (Schumacher et al., 1999). Schumacher et al. (1999) found these transitions often consist of a pattern of experiences and conditions that allow an individual to move from their current stage in life to the next. Individuals undergo many transitions as they age, such as attending college, getting married, and having children. As an individual continues to age, changes in health become a part of the transition. Meleis et al. categorized these transitions into three areas: (a) developmental, (b) situational, and (c) related to health and illness.

Transitions can occur either singly or on multiple occasions and may require the individual to develop new skills, knowledge, or coping mechanisms (Schumacher et al., 1999). Transitions may sometimes lead to worry, doubt, and depression not only by the individual undergoing the change but also by caregivers and family members. Figure 1 shows how maintaining unrealistic expectations and restricting new choices can lead to symptoms of illness as well as a loss of integrity and self-empowerment.

Figure 1: Elements of the Transitions in Health Theory



Note. Adapted from Schumacher et al. (1999).

In addition to occurring as a one-time event, such as moving from college to the workforce, transitions can be a composite of simultaneous thoughts, feelings, and actions (Meleis et al., 2000). Meleis et al. (2000) identified the following five similarities in all transitions: (a) awareness, (b) engagement, (c) change and difference, (d) time span, and
(e) critical points and events. Rather than presenting individually, the components often compose an interlocked process. Because individuals are diverse, they will pass through the various areas at different times when facing new life events in an undefined time frame. When the transition begins, the individual becomes aware of the upcoming change, takes an active involvement in that change, and accepts the change.

Meleis's transitions theory aligned with this study's purpose by positing that an individual's environment is vital in the transition process. The environment in the current study would explain the difference in the condition of patients when in the hospital and following discharges (at home). To avoid readmissions, both environments need to be controlled and planned for effectively. Before a patient's discharge, hospital staff conduct a discharge planning assessment to gather information on the individual's support system and financial situation (Finfeld-Connett, 2008; Schumacher & Meleis, 1994). This assessment is vital to deciding what might be needed before discharge, such as placement, equipment, medications, education, or transportation. Without such considerations, there is an increased risk of hospital readmission, which indicates the need for therapeutic-focused patient services. Therapeutic interventions may include efforts such as performing ongoing client assessments to help manage any symptoms, providing opportunities for individuals to remain self-reliant, and allowing patients to consider putting the past behind them and embarking on new paths (Finfeld-Connett, 2008; Meleis et al., 2000). Meleis's transitions theory helped me explain why the lack of adherence to HRRP in a hospital environment could result in an unfavorable environment for a patient following discharge, a situation that would likely result in readmission. The theory assisted with the examination of the environmental influences surrounding transition experience of patients from hospital to home.

Literature Review

History of Medical Social Work

Medical social work was among the first specializations in the field of medicine (Ruth & Marshall, 2017). These medical social workers would sometimes perform as physicians in hospitals (Shuster et al., 2018). In the mid-19th century, a range of volunteers and employees became known as social workers. They went into the homes of new mothers and babies to assess the environmental and social conditions possibly connected to infant mortality (Seo et al., 2019). The caseworker's role included evaluating environmental and social conditions. In 1907, the Charity Organization Societies and John Hopkins Medical School merged to address the medical and social factors affecting hospital patients (Ruth & Marshall, 2017). To successfully address physical and social issues, caseworkers and medical students conducted home visits in the more poverty-stricken neighborhoods of Baltimore, gaining firsthand knowledge of the social and environmental factors affecting their patients (Connell et al., 2019).

Around the same time as the alliance between John Hopkins and Charity Organization Societies, Dr. Richard Cabot of Massachusetts General Hospital proposed combining social work and medical care to legitimize social work in hospital settings. The medical system was also changing, with the delivery system shifting from home- based to outpatient physician visits (Massachusetts General Hospital, 2011). As a result, social workers were able to provide physicians with knowledge of social and environmental factors.

In 1918, the first professional social work organization, the American Association of Hospital Social Workers, helped to formalize the health care social work field (Connell et al., 2019). Influenced by public health changes and the increasing social problem presented by a growing number of immigrants, social workers began to act as leaders in the community by advocating for health care. Jane Addams' introduced community- based social work, providing a psychosocial perspective to health care.

In the years following, social workers began to play a significant role in developing health care programs in the settlement house movement, maternal–child health, and working with those who were poor. The increased need for social work allowed these providers to take on more roles, such as spearheading a national campaign to promote the increased health of children and mothers in the 1930s. One of the critical social workers was Julia Lathrop, director of the Children's Bureau (Madgett, 2017). The new role of social workers was to link health care customers with physicians and other health care systems beneficial to patients' presenting problems. The individual-in- environment perspective emerged from increased knowledge of clients' needs, differentiating the social work profession from nursing.

By the 1950s, medical social workers had become more visible in the hospital, making community referrals for needed services. As social workers transitioned from home-based to hospital-based settings, they adopted the medical model of diagnosis and treatment, focusing only on what brought the patient to the hospital

(Browne, 2019).
Hospital social workers had a three-part role in identifying hospitalization, medical intervention, and discharge needs. As time passed, the title changed from medical social worker to discharge planner, as social workers explored the factors contributing to discharge (Browne, 2019).. More recently, the focus on community health and evidence of the relationships between physical illness as well as psychosocial, behavioral, and cultural issues led to the introduction of social work in ambulatory health care practice (Browne, 2019).

Current Role of Medical Social Work

The medical social worker serves as a liaison between the care team and the patients across various medical fields, including hospitals, home health, and hospice. In the health care field, social workers focus on the presenting problem and discharge needs (Browne, 2019), often for patients with chronic health conditions. The presenting issue may pose psychosocial stressors for patients, such as depression, anger, anxiety, and other health conditions (Wilkinson et al., 2014). In the hospital, social workers serve in units where patients require more psychosocial attention, such as trauma/emergency, oncology, transplant, nephrology, intensive care, and pediatrics (Craig & Muskat, 2013).

Beyond the basics of this role, such as addressing the patient's needs, social workers also educate other care team members about the social and emotional aspects of the patient's condition (Ambrose-Miller & Ashcroft, 2016). In a study of social work practice and chronic illness and disability, Findley (2014) found social workers were excluded from most chronic care models. Despite this exclusion, social workers were necessary due to the health and social care process complexities resulting from the barriers with which clients present.

Mann et al. (2016) asserted that social workers should serve as behavioral consultants in the primary care setting. Mann et al. found social workers well suited to leadership in this area because they were exceptional in integrating physical and mental health. Using the biopsychosocial approach to address a patient's presenting issue, the social worker can obtain a holistic understanding of the individual, which assists in solving the patient's problem. For example, if an individual has hypertension but is homeless, the condition will persist until the housing deficiency is addressed. The presenting issue of hypertension is the biological issue, and homelessness is the psychosocial issue. The social worker, therefore, addresses the psychosocial issue so the medical doctor can handle the physical presenting issue.

In social work practice, case management comprises many roles, including partnership in completing the assessment, coordinating services, planning, advocating, and evaluating intervention options for patients and families (Sullivan et al., 2015). By communicating and using available resources, the case manager contributes to quality, cost-effective outcomes (Stokes et al., 2015). Over time, the social worker's role has changed from advocating for the patient to advocating for the agency by implementing cost-effective interventions for the hospital (Ramos, 2015). A medical social worker in a hospital setting engages in many different roles, including advocacy, discharge planning, and community resource coordination.

Advocacy

Professionals in the field of medical social work often take on the role of patient advocate. Making patients' preferences known to caregivers and providing correct information about their care and treatment are examples of this (Ayabakan et al., 2021). Helping patients draft advanced directives that clarify their intentions for how they want to be cared for in the event of their terminal illness is a key component of the social worker's role in this area (Barnes et al., 2020). A hospital social worker is responsible for facilitating the patient's understanding of and adaptation to hospital processes, translating and explaining medical plans, giving emotional venting space, and aiding the family with financial preparation.

The social worker's primary role in the therapy process is to act as a conduit for information sharing among the patient, their loved ones, and the medical staff members. The medical social worker adds value by identifying the patient's family's resources and advocating for those strengths to be used by the entire health care team (Boccuti & Casillas, 2017). When it comes to patients' rights to obtain care that is respectful of their culture, a medical social worker is expected to take a stand. For example, if a patient has trouble reading, paying

for medical care, or getting to appointments, it is important to bring these issues to their care team's attention so they may be addressed (Frankel et al., 2018). Physicians are often frustrated by patients who do not follow medical orders, but a hospital social worker can help medical workers understand the barriers their patients face.

Discharge Planning

The activities that comprise discharge planning are essential components of social work practice. Since the 1970s, demands to control health care spending have increased the need for discharge planning (Judd & Sheffield, 2010). Social workers play a role in discharge planning in medical and mental health settings as well as some outpatient settings. The purpose of discharge planning is to support patients' independence and rehabilitation to prevent readmission and unnecessary treatments (Judd & Sheffield, 2010). The discharge planner helps with facilitating the appropriate level of care for the patient, including providing any needed resources before discharge. The discharge planning process often also includes the patient's caregivers and other family members (Hayajneh et al., 2020). Steps in the process are assessment, referral, and education, among others. The social worker's role in the discharge planning process is to reduce spending by addressing the psychosocial issues presented by many high-risk patients.

Community Resource Finding

In the hospital setting, the social worker works with many types of patients, often those who are uninsured. Because part of social workers' jobs is identifying needed resources for the patient, they have to be familiar with the resources available in the community and provide solutions to the patient's problems (Loskutova et al., 2016). If the hospital has resources such as medical equipment, they may be provided to the patient; if not, the social worker should identify resources to fulfill the patient's needs. In many hospitals, the social worker has a list of resources available in the community, including food pantries, clothing donations, and group homes (Henke et al., 2017).

Identifying community resources may be very time-consuming, depending on the patient's needs. Many social workers start by calling their local helpline, which can connect them with the appropriate agency to obtain the necessary resources.

Readmission Rates in the United States

The top two hospital payers in the United States are Medicare and Medicaid (Ody et al., 2019). Medicare is a federal insurance plan for individuals 65 years or older (Roshanghalb et al., 2019), and Medicaid is a state insurance plan for individuals living under the poverty level (Chernof, 2019). The recipients of these benefits have the highest readmission rates, at 26% and 30%, respectively (AHRQ, 2018).

Patients with private insurance had a readmission rate of 17% compared to 13% among those who did not (AHRQ, 2018). Private insurance is any coverage not provided by the federal or state government (i.e., Medicare or Medicaid) and is often employer- provided. Patients who are uninsured usually cannot afford health care coverage and do not have the money to follow up with a physician postdischarge (Seo et al., 2019).

Patients diagnosed with congestive heart failure, schizophrenia, or renal failure had the highest readmission rates within 30 days, at 25%, 22%, and 22%, respectively (AHRQ,
2018).

The greater the rate of readmission, the more money paid by taxpayers for Medicare and Medicaid coverage. An annual average of $15 to $20 billion of federal taxes goes to hospital readmissions (Himmelstein & Woolhandler, 2016). Readmissions also affect hospital finances. Depending on the diagnosis and payer, the hospital receives a lower payout for the readmission, with a model used for each insurance type to determine what the insurance company will pay for follow-up of a specific diagnosis.

International Journal of Scientific Research and Management (IJSRM)
||Volume||12||Issue||03||Pages||1378-1413||2025||
Website: www.ijsrm.net ISSN (e): 2321-3418
DOI: 10.18535/ijsrm/v13i03.mp01

Hospital Readmissions and Discharge Planning

Hospital readmission occurs when a patient is admitted to a hospital within a specified period following discharge from a prior (initial) hospitalization (Boccuti & Casillas, 2017). Patient dissatisfaction may increase based on the perspective of whether the readmission was preventable (Shuster et al., 2018). Reducing the hospital readmission rate requires improved quality of care, increased patient satisfaction, and lower health care costs (Klein, 2018). An AHRQ study found that 19% of patient readmissions within 6 months of discharge were preventable (Liao & Hitchcock, 2018).

Unplanned readmission is associated with patient dissatisfaction, higher health care costs, and increased mortality and morbidity rates. Discharge planning entails determining what a patient needs for a smooth transition from one level to another (Pellett, 2016). Based on hospital protocol, this assessment is the responsibility of social workers or other health care professionals (Browne, 2019). Discharge planning is vital in the transition process due to the significant change experienced by many patients (Rodakowski et al., 2017). Discharge planning is sometimes a complex task requiring extensive time and effort to determine if the transition will be complicated or straightforward (Yam et al., 2012). To address all areas of the patient's posthospital experience, discharge planners ask about family support, insurance, and needs at home (Rodakowski et al., 2017).

Many patients discharged from the hospital transition into new environments, such as nursing homes or assisted living facilities, with patients discharged back home often having new or increased needs. A patient may walk into the hospital independently and come out needing a walker or cane. This change is an indicator that patients need education before discharge, as identified in the discharge planning assessment process.

Discharge Planning and Readmission Relationship

During a simple discharge, the patient may need something simple, such as medication education or durable medical equipment. A patient experiencing a complex discharge has multiple needs due to physical or psychosocial issues. For example, a patient without insurance may require a new device with in-home care or an elderly patient with dementia living alone may require assistance. Typically, postdischarge screeners identify complex patients as high risk (Yam et al., 2012).

Identifying a patient's needs through discharge planning assists in lowering the readmission rate (Shepperd et al., 2013). Discharge planning extends beyond the initial assessment to include providing the identified needs (Yam et al., 2012). The most effective way to conduct discharge planning is to complete an initial assessment on the day of admission and begin working on and scheduling a plan (Shepperd et al., 2013; Yam et al., 2012). The needs of each patient will determine the effort and time needed to fulfill the requirements. Because the hospital is for acute issues, individuals' physical and mental health could change while they are admitted, which may require a new discharge plan (Shepperd et al., 2013).

Yam et al. (2012) conducted a study using a specific discharge planning model based on the Delphi approach. The Delphi approach relies on multiple rounds of questionnaires sent to a panel of experts to work toward a mutual agreement or consensus opinion (Nasa et al., 2021). Twenty-four medical professionals, including social workers, doctors, nurses, and therapists, responded to a questionnaire regarding discharge planning and readmissions. Participants attended a training class to address the necessary areas of improvement identified from the questionnaire. Based on the results of this training session, Yam et al. implemented a pilot to determine if using a specific evidence-based model would alleviate the gaps in discharge planning. The model used in the study incorporated the initial screening, discharge planning process, discharge coordination, discharge implementation, and postdischarge follow-up, with a required set of questions to ask. The health care

professional was responsible for assessing each patient to ensure a discharge plan was included as part of the care plan. Discharge entailed coordinating with selected vendors to provide the services needed by the patients, with all documentation and transportation completed the day before release. Follow-up included calling the patients within 1 week after discharge to ensure they were doing well. By implementing this model, the hospital saw a 75% decrease in its readmission rates. Because the programs were effective in decreasing readmission rates, the model continued after the pilot.

The discharge planning and readmission relationship shows that one is needed for the other to be successful. According to Henke et al. (2017), effective discharge planning reduces hospital readmissions. Individualized discharge planning also minimizes the length of hospital stay and readmission rates for older individuals (Shepperd et al., 2013).

Ohta et al. (2016) examined the discharge planning process to determine if it met the necessary, comprehensive standards. To measure the results, the researchers examined the readmission rate after discharge, finding that the rate decreased following comprehensive discharge planning. The relationship between discharge planning and readmission can also be negative. When discharge planning is not comprehensive, the readmission rate may increase. Wong et al. (2011) found that patients discharged on weekends or holidays had a higher likelihood of readmission. According to the participants in the researchers' study, this result was due to limited staff availability on weekends, particularly Saturdays, and holidays, particularly Christmas, which meant a lack of comprehensive discharge planning.

Characteristics of Effective Discharge Planning

The effectiveness of discharge planning depends mainly on the patient.

Researchers have conducted studies to discover success factors for most patients who experienced discharges with no complications (Mazloum et al., 2016). Effective discharge planning characteristics include systemwide planning protocol, discharge education, follow-up calls, and communication between all parties (Wong et al., 2011). In a study conducted by Wong et al. (2011), 41 health care professionals reported that their hospital had no discharge planning protocol. Participants believed an effective protocol would assist case managers when working with more complex patients.

In a study by Yam et al. (2012), after the hospital discharge planner implemented a new call follow-up protocol with patients discharged within the past week, the patient satisfaction rate rose by 75%. The patients could speak to the discharge planner about additional resources they may have needed, such as education and medication. The discharge planner could also follow up on the services put into place, such as home health care and skilled nursing facilities.

Communication was a significant issue for health care professionals in Wong et al.'s (2011) qualitative case study. The care team members, including the doctors, nurses, therapists, and social workers, were not in communication regarding the patient's needs. Although a social worker might have known a patient was uninsured, the doctor failed to access that information in the patient's file, instead recommending discharge to a skilled nursing facility. The care team wanted to implement a discharge planning meeting.

Decreased Risk for Readmission

Readmission rates are an important measurement for hospitals due to financial costs. Some hospitals are responsible for the cost of all medical care of patients readmitted within 30 days of discharge under an initiative called Bundled Payments for Care Improvement (CMS, 2016). Because federal programs often penalize hospitals with high readmission rates, hospital administrators have increased their case management/social services department to ensure an effective discharge planning process.

Studies have shown that effectively completing discharge planning leads to decreased readmission rates (Mazloum et al., 2016). Fewer readmissions benefit the patient's health and finances as well as the hospitals. Discharge planning shows that the staff are optimally performing their due diligence to ensure proper patient care.

In surveys meant to examine patients after discharge, patients answer questions such as how often they saw the nurse and the doctor. The CMS (2016) uses hospital readmission rates as an indicator of the quality of

patient care, assessing the discharge planning process and the patient care received. With proper discharge planning, patient

mortality rates are lower (Klein, 2018). Discharge planning is an important factor in decreasing the patient readmission rate.

Hospital Readmission Reduction Program

The HRRP is a Medicare-based program that reduces payments to hospitals with excessive readmission rates within 30 days (CMS, 2016). The goal of HRRP, to decrease the readmission rate, is founded on various approved diagnoses, like acute myocardial infarction, COPD, heart failure, pneumonia, coronary artery bypass graft surgery, and elective primary total hip arthroplasty or total knee arthroplasty (CMS, 2016). These diagnoses have the greatest amount of Medicare and Medicaid spending on readmission at over $1.5 billion yearly. The HRRP supports the national aim of improving health care for Americans by connecting reimbursement to the quality of care. Under this readmission penalty program, hospitals must decrease the practice of early discharges, affecting not only patient quality of care but also the financial burden associated with hospital readmissions (CMS, 2016).

Effects of HRRP

HRRP achieved the expected initial program financial results for the implementation period. The Kaiser Family Foundation showed that Medicare hospital spending decreased by $1.9 billion from 2013 to 2017 (Boccuti & Casillas, 2017; see Table 1). After the program's first year, Medicare inpatient discharges decreased by 4.4%, representing 100,000 fewer readmissions in 2013 than in 2012 (Miller, 2015). From 2006 to 2013, the annual readmission rate dropped by 17%, and the hospital admission rate fell from 64% to 60%. This number of hospital readmissions dropped more quickly in rural hospitals than urban ones.

Many hospitals have implemented interventions to prevent the rapid increase of readmissions and mitigate withheld payments, including engaging a case management or social services department to assist with discharge planning. Hospitals also implemented new interventions not previously used in such settings, including follow-up calls and medication reconciliation. With these efforts, hospitals have tried to increase the patient quality of care and decrease the financial burdens.

Table 1: Hospital Readmission Reduction Program (2013–2017)

Parameter		Penalty fiscal year			
	2013	2014	2015	2016	2017
Performance measurement period	June 2008–July 2011	June 2008–July 2011	June 2008–July 2011	June 2008–July 2011	June 2008–July 2011
Maximum rate of penalty	1%	2%	3%	3%	3%
Average hospital payment adjustment	-.27%	-.25%	-.49%	-.48%	-.58%
Percent of hospitals penalized	64%	66%	78%	78%	79%
Percent of hospitals at max penalty	8%	0.6%	1.2%	1.1%	1.8%
CMS estimated total penalties (million)	$290	$227	$428	$420	$528

Note. Adapted from Boccuti and Casillas (2017). Copyright 2017 by the Kaiser Family Foundation.

Possible Change to HRRP

The HRRP pertains only to the specific diagnosis, but there is support to move forward with a hospital-wide measure that includes penalties for all diagnoses (Zuckerman et al., 2017). This modification would also change hospital operations.

Despite the reduced readmission rates brought about by the HRRP, policymakers have suggested more improvement is needed (Birmingham & Oglesby, 2018). Program expansion would affect the hospital setting due to the change in payments and would also increase the pressure placed on hospitals to decrease readmission rates.

Moving to an all-diagnosis readmission penalty would increase hospital penalties to 2 years (Zuckerman et al., 2017). The fines come from the payments provided for the patients' admitting diagnosis. With HRRP expansion, the measure would include all diagnoses, some of which have not had any specialized intervention. The hospital system would be impacted because they would be penalized financially. The HRRP is shifting from six diagnoses to all, which can be over 1,000 diagnoses (Kahlke, 2018). The hospitals would not have any grace period; this would start from the first time the individual is readmitted.

Summary and Conclusion

Chapter 2 began with a discussion of the framework of Meleis's (2010) transitions theory, which focuses on an individual's transition through levels of care. This theory served as the conceptual framework for understanding the perspectives of hospital social workers. Discharge planning is one tool to reduce the number of hospital readmissions.

Meleis's transitions theory indicates the factors that are important to discharge planning and readmission rates.

I presented a broad overview of hospital social workers' typical roles and how they assist with discharge planning. I discussed the relationship between readmission and discharge planning. As identified in the literature review, many researchers discovered effective interventions that helped with patient satisfaction and readmission rates.

Although several studies have examined the factors that affect readmission rates and discharge planning (see Hoffman et al., 2020; Ivic et al., 2020), previous studies have not specifically examined readmission rates with regards to hospital social workers. This study filled this research gap, with a specific focus on hospital social workers' views on hospital readmission and discharge planning.

Research Method

The purpose of this generic qualitative study was to explore the perceptions and experiences of hospital social workers regarding what they believe to be their role in discharge planning and readmissions. The findings provided narrative information on hospital readmission rates, justifying the need for hospitals to examine readmissions. The information from this study could provide opportunities for improvement in service delivery for hospital social workers. Chapter 3 includes a description of the research design and rationale to show the appropriateness of the methodology. The researcher's role, methodology, recruitment procedures, trustworthiness issues, and ethical concerns are additional components of the chapter. Chapter 3 concludes with a summary of the main points and research method.

Research Design and Rationale

The research question that guided this study was the following: What are the experiences and perceptions of hospital social workers regarding their role in discharge planning and hospital readmissions? Answering this question required a generic qualitative approach with fewer constraints than a standard design (see Kennedy, 2016). The generic qualitative approach is appropriate to understand how individuals interpret their experiences and what factors they attribute to those experiences (Kennedy, 2016). According to Kennedy (2016), generic qualitative research does not conform to an established set of philosophical assumptions as required by more structured approaches. Instead, a generic qualitative researcher draws from and builds on previous traditions and concepts (Kahlke, 2014). With this approach, I used the strengths of established

qualitative designs while maintaining the flexibility to make any changes needed to answer the research question.

The intent of this generic qualitative study was to contribute to the existing body of literature on discharge planning and hospital readmission, viewing the problem from the social worker's perspective. Another rationale for this research approach was that it allowed for inductive and not deductive research. The generic qualitative approach is one way to create a platform for new research (Kahlke, 2014). The other advantage of the design was the ability to generate new questions and articulate new approaches.

Role of the Researcher

My role as the researcher was to conceptualize the study. I also ensured that the data collected and analyzed were free from bias and personal views and that the study occurred ethically. In qualitative studies, researchers serve as the chief data collection instrument; as such, they must remain aware of any personal beliefs, views, or biases that could affect the findings (Sutton & Austin, 2015). As a former hospital social worker, I acknowledged a commonality between myself and the participants. Before and during the interviews, I focused only on the information provided by the participants. Member checking was another means of minimizing researcher bias in this study. I did not have any instructor or supervisory roles over any of the participants; therefore, I had no power that might have influenced their responses to interview questions. I was also involved in the sampling and recruitment exercises, all of which took place online.

Methodology

Participant Selection Logic

The population relevant to this study was hospital social workers. The purpose of this study was to gather information from hospital social workers regarding their experiences with discharge planning and hospital readmissions. Recruitment occurred via purposive sampling with the following inclusion eligibility criteria: (a) be a licensed social worker, (b) have worked in the hospital setting within the last 2 years, (c) have worked on discharge planning, and (d) reside in the United States. I intended to recruit six to 10 participants or as many as needed until data saturation occurred. According to Fusch and Ness (2015), six to 10 participants is an ideal number for a generic qualitative study.

In the invitation message posted on Facebook, I included my email and indicated that potential participants could contact me through the email. Once any potential client reached out, I emailed them an informed consent form to review and electronically sign. Next, the participant and I determined a mutually convenient time for the interviews, which occurred via videoconferencing due to COVID-19 concerns.

Instrumentation

Qualitative data collection depends on saturation, which occurs when no new information or material emerges from continued data collection. As the researcher, I served as the primary instrument for gathering data, which entailed conducting semistructured interviews with participants. I prepared an interview protocol to guide the interviews, asking the same questions of each participant yet allowing for follow-up questions if needed (see Appendix B). The development of all interview questions was to answer the overarching research question.

Procedures for Recruitment, Participation, and Data Collection Recruitment

Social media was the primary source used to recruit participants. I posted invitations to participate on Facebook pages and groups dedicated to subjects and discussions about medical social workers. I identified the specific group sites and, using purposive sampling, selected only social media pages with member sizes above 4,000. Another recruitment platform was the Walden participant pool. Researchers use purposive sampling when seeking to select participants who will provide information beneficial to the study (Fusch and Ness, 2015). Fusch and Ness (2015) recommended conducting qualitative, in-depth interviews with between six to 10 participants; therefore, the anticipated sample size for the current study was eight social workers who met the criteria for participation.

Participation

The participants were hospital social workers. I did not include the names or identifying information of participants in this study. Among the requirements for participation was strong internet connectivity to allow for the interview to be conducted without interruption. Apart from strong and reliable internet connectivity, the participants also needed to have Zoom installed on their PCs or smartphones. This application was designed to enable teleconferencing.

Data Collection

As the researcher, I was the data collection instrument. Data came from participants' responses to open-ended questions during semistructured interviews via Zoom videoconferencing. With the participants' signed permission, I recorded all interviews using the zoom recording feature. Individual videoconference interviews took place via the Zoom platform between August 18, 2021, and August 27, 2021. Following interview completion, transcripts were mailed to participants, and they were given the opportunity to contact me with corrections. Through this process, participants ensured that the information accurately reflected what they said or meant to say during the interview. After the data collection process, I debriefed the participants to ensure they experienced no anxiety or stress due to their participation in the study. If necessary, I would have provided participants with a hotline or counselor contact number for follow- up. The semistructured interview consisted of a short list of follow-up questions. All questions were open-ended, neutral, and worded to avoid leading language. In addition, interview questions included familiar language and avoided jargon.

Data Analysis Plan

To ensure confidentiality, I assigned pseudonyms to the participants. I began data analysis with thematic coding, a method allowing the researcher to sort information collected from the participants into common themes (see Braun & Clarke, 2014).

Identifying themes from the data is the primary goal of qualitative research (Hussein, 2015). In the current study, the emerging themes provided insight into the experiences and perceptions of hospital social workers who assist with discharge planning. The findings provided scholarly and practical insight into discharge planning and hospital readmission processes from the perspective of the hospital social worker.

Issue of Trustworthiness

Credibility

In qualitative research, ensuring trustworthiness entails establishing credibility, transferability, dependability, and confirmability (Anney, 2014). Credibility is a means of determining the strength of the data analysis method and the validity and believability of the results (Cope, 2014). All planning, data collection, and analysis stages must be thorough and accurate to ensure credible results. Transcript review was conducted to ensure the credibility of the collected data. Transcript review was used as a means to ensure the data collected reflected only the individual participants' perceptions and experiences. One participant declined to participate in transcript review. After completing the interviews, I transcribed the audio recordings and emailed the participants their transcripts to review for accuracy. Although I gave participants 2 weeks to request changes or approve the transcript, they all responded within 1 week. All participants agreed that the information was accurate with no changes needed and expressed enthusiasm for seeing the study's outcomes.

Transferability

A study is transferable if readers can apply the findings to a separate, similar population. Transferability requires accurate and thorough transcription and note taking; therefore, I maintained a detailed description of the steps taken, the setting, and the participants (Daniel, 2019). It is also vital to present the information in a generalized

format, which means that experts and nonexperts can understand the findings regardless of the area of study. In qualitative studies, the findings from one situation do not directly apply to a different situation (Daniel, 2019) . Therefore, it is essential to take steps to ensure a study's transferability. Because participation was available to social workers in the United States, the findings should be transferable to any geographical area. This study was specific to hospital social workers, but the setting could have included other hospital types, such as inpatient hospice facilities and psychiatric hospitals.

Dependability

Dependability in qualitative studies is the equivalent of reliability in quantitative research (Connelly, 2016). A study has dependability when, if replicated, it produces similar results. A peer review of the study ensures that no personal or professional bias affects the research. There can be no credibility without dependability and no validity without reliability (Amankwaa, 2016).

Confirmability

A researcher achieves confirmability when a study is free of bias (Korstjens & Moser, 2017). Confirmability helps to ensure that data analysis is shaped by the data rather than the researcher's influence (Amankwaa, 2016). Triangulations and journaling are means of ensuring confirmability. I acted only as a researcher in exploring the experiences and perceptions of the participating hospital social workers. I refrained from discrimination or prejudice while recruiting participants, conducting interviews, and analyzing data, including allowing all social workers who met study qualifications a chance to participate. If there had been any concerns or issues of prejudice or discrimination from the participants, I conferred with my dissertation chair and followed Walden University IRB ethical guidelines.

Ethical Procedures

I took steps to prevent ethical violations in this study. Before recruiting participants or scheduling interviews, I obtained Walden University IRB approval (Approval No. 08-18-21-0744453) to proceed with this study. Before conducting one-on- one interviews, I provided each participant with an informed consent form detailing the study's purpose, procedures, and postinterview support, as well as the confidential and voluntary nature of participation and a request for permission to record the interview. I was aware of the topic's sensitive nature and informed participants that they could withdraw their participation at any time. To maintain confidentiality, I used pseudonyms in place of participants' names. Each social worker signed the informed consent form before the interview began.

Gathering data for the study was in accordance with the procedures for the protection of human participants. The Walden University IRB approved the informed consent form to ensure I implemented all critical safeguards to protect my participants. The IRB also approved the recruitment post for social media, email messages, and flyers. I further ensured the confidentiality of participant information by storing all study files and data in a locked safe or a password-protected computer. The data will be stored up to 5 years following completion of the study. After that time, I will securely destroy all materials.

I provided resources to ensure that participants who experienced discomfort during or after the interview could receive the necessary care. These resources included the names of free or sliding-scale practitioners. After the interview, I had a practitioner on call to provide any needed debriefing services.

Summary

The generic qualitative method was the most appropriate approach to answer the research question. In Chapter 3, I presented the research design and rationale, the role of the researcher, a description of the methodology including purposive sampling, and the participant selection process. Other areas addressed included data collection and analysis and issues of trustworthiness through transferability, confirmability, dependability, and credibility. Finally, I addressed the ethical policies that I adhered to throughout the research process. Chapter 4

includes a detailed discussion of the research findings based on an analysis of the data.

Results

The purpose of this generic qualitative study was to explore the experiences and perceptions of hospital social workers regarding discharge planning and hospital readmissions. I conducted videoconference interviews with 10 hospital social workers located throughout the United States. I sought to answer the following research question: What are the experiences and perceptions of hospital social workers regarding the influence of discharge planning on hospital readmissions? In this chapter, I present information on the research setting, participant profiles, data collection procedure, data analysis technique, evidence of trustworthiness, and the findings.

Setting

I selected a videoconferencing method to conduct interviews due to geographical distance and COVID-19 limitations. Individual videoconference interviews took place via the Zoom platform between August 18, 2021, and August 27, 2021. I received signed informed consent from all individuals willing to participate in the research. The consent form presented the purpose of the study, the benefits and risks of participation, the assurance of confidentiality, and my contact information. In addition, the consent informed participants they could refuse to answer any question and could leave the study at any time without penalty.

Demographics

The demographic diversity of the participants was a way to ensure the collection of various perspectives and experiences. Participants ranged in age from 25 to 46 years, were licensed social workers with master's degrees, and worked in the hospital setting for 5 months to 15 years. There was a mix of licensed master's-level social workers and licensed clinical social workers. All participants were familiar with discharge planning and hospital readmissions, assisting a range of two to 25 patients with discharge planning each day. During the videoconference interview, the participants answered the demographic questionnaire (see Appendix A). Each participant received a pseudonym (e.g., Participant 1, Participant 2) to ensure confidentiality (see Table 2).

Table 2: Participant Demographics

Participant code	Age	Gender	Location	Social work experience	Hospital social work experience
1	34	Female	Florida	3 years	6 months
2	38	Female	Alabama	12 years	4 years
3	33	Female	Texas	10 years	6 years
4	34	Female	Arizona	15 years	7 years
5	46	Female	North Carolina	7 years	6 months
6	45	Female	Texas	10 years	5 years
7	29	Female	Alabama	4 years	1.5 years
8	25	Female	Texas	1.5 years	5 months
9	26	Female	Ohio	5 years	2 years
10	30	Female	Maryland	6 years	6 years

Interview Protocol

Semistructured interviews are an effective way of gathering data when researchers want to (a) collect open qualitative data, (b) understand participants' thoughts and feelings on a particular topic and investigate beliefs,

and (c) understand personal and sometimes sensitive issues (Kahlke, 2018; Liu, 2016; Percy et al., 2015). The semistructured interviews used for this study included seven open-ended questions created and designed by me to elicit the participants' perceptions and experiences on the influence of discharge planning on hospital readmissions. The use of an interview protocol (see Appendix B) ensured consistency in the data collection process. There was no compensation for participating in the study.

Before the start of each interview, I reviewed the study's purpose and the participants' consent. I informed them of their rights, including the right to withdraw from the study at any time. Participants were encouraged to ask questions about the study and the interview process. I told the participants I would use pseudonyms to prevent the use of personal or identifying information. I also informed participants that a follow-up phone call or email might be necessary for clarification, and they would receive an invitation to review the transcript. The participants also knew I would email the findings after the study's conclusion. The participants agreed and signed the consent before starting the videoconference interview and provided their written consent for me to audio record the interview to ensure accuracy.

The ethical considerations of the research method included respect and sensitivity toward the participants throughout the research process. Semistructured interviews often require participants to disclose personal and sensitive information to the interviewer.

Therefore, I needed to consider the power imbalance between me and the participant. Other ethical considerations included reducing the risk of harm, protecting the interviewee's information, informing the interviewee of the purpose and format of the interviews, and reducing the risk of exploitation.

Data Collection

No unusual circumstances were encountered during data collection; therefore, there were no variations from the data collection plan presented in Chapter 3. Data collection commenced after receipt of Walden University IRB approval. I completed a web-based training course on Protecting Human Research Participants from the National Institutes of Health Office of Extramural Research (see Appendix C). The submission of the National Institutes of Health certificate, recruitment flyer, approved proposal, and completed application were requirements for IRB approval. I conducted audio-recorded interviews with 10 hospital social workers throughout the United States. The interviews took place via videoconference and lasted 30 to 40 minutes. I transcribed the recordings into a Microsoft Word file. I observed no unpleasant or unusual circumstances during the interviews.

Before the interviews, I emailed participants the IRB-approved informed consent form for their review and agreement for digital signature. All participants agreed to the terms of the study and signed the informed consent form. At the start of the videoconference interview, I encouraged participants to feel relaxed and comfortable as they responded to the seven open-ended questions indicated in the interview protocol. I collected the demographic information before asking the open-ended interview questions. I audio recorded the conversations via a digital recorder to capture participants' responses. Participants had adequate time to respond to each question. As the interviewer/researcher, my goal was to present the questions thoroughly, listen attentively, and allow respondents to answer without interruption. I took field notes during the interviews to capture relevant details, including facial expressions and body language.

During the interview sessions, I listened attentively to participants' reactions, summarized their responses, and sometimes repeated the questions to get a clearer understanding. After the last question, I discussed transcript review with the participants to strengthen the credibility of the elicited data. The participants consented to transcript review as the final step of the interview process.

After transcribing the audio recordings into Microsoft Word, I emailed the participants a PDF of their transcripts for transcript review. The purpose was for participants to check the transcripts to clarify anything missing or unclear to ensure the accuracy of the collected data. Nine of the 10 participants engaged in transcript review, as agreed. I met again with the first participant to gather more information and follow up on missed opportunities to probe.

Data collection in generic qualitative research often requires participant observation, content-specific questions, and semistructured or structured interviews. As the researcher, I was the primary data collection

instrument, posing open-ended questions in semistructured videoconference interviews. All participants consented to the audio recording. Additional data sources were the field notes taken during the conversations to capture the participants' expressions and body language. After transcribing each recording, I shared the transcripts with participants to confirm that all information reflected what they said or intended to say.

Data Analysis

Following data collection, I organized all data sources, including interview transcripts, field notes, and follow-up notes. Next, I created an individual folder for each participant labeled with their assigned pseudonym. The folder consisted of the consent form, field notes, interview protocol, and transcripts, allowing easy reference during data analysis. I performed an initial review of the data, repeatedly reading the transcripts to ensure a complete understanding of the information. This first step familiarized me with the data to better understand the participants' experiences and perceptions.

The second stage entailed a more intense and careful analysis of the data. I used Microsoft Word to identify the most recurring words in the transcripts (see Wicks, 2017). This stage involved the following steps: (a) identify 30 words; (b) remove words that had little meaning, such as "also," "too," and "have"; (c) only accept words with at least four letters; and (d) identify similar words used by respondents. Next, I categorized the data into sets and created themes from the highlighted words. After finding and creating themes, I reviewed them to ensure they were consistent with the data.

Coding

Qualitative coding entails systematically grouping data to find themes and patterns. Coding allowed me to capture unstructured or semistructured data such as detailed interview texts and discussion groups, organize them into topics, and format them for analysis (see Hadi & Closs, 2016). Qualitative data encryption made the analysis more systematic and rigorous, providing transparency to readers. In coding, qualitative researchers find information representing the data and the human story behind them (Kahlke, 2018; Percy et al., 2015).

There are ways to systematically check data to improve the accuracy of the analysis. Bias reduction qualitative coding allows researchers to recognize potential biases in the data analysis method. In comparison, correctly qualitative coding helps a scholar assess whether the analysis represents a participant base and avoid introducing too many individuals or groups (Liu, 2016).

The process of encoding qualitative data varies depending on the purpose of the research. The current study involved reading the data, applying codes to excerpts, grouping codes by multiple coding cycle topics, and drawing interpretations that led to the findings. I summarized or explained the example, starting with the first round of coding, and wrote the second round of codes to add to the current writing. There is often no right or wrong way to encrypt a data set, with few methods more or less appropriate, depending on the purpose of the study (Hadi & Closs, 2016). Finally, I manually identified four emerging themes based on the interview data and research question: (a) lack of community resources, (b) hospital administrative challenges, (c) lack of family/social support, and (d) RN versus social worker issues/lack of role definition. The lack of role definition appeared in all social workers' interviews.

Evidence of Trustworthiness

Establishing confidence and trust in the approach employed and the findings generated is a significant concern for qualitative inquiry. Throughout the interviews, I ensured trustworthiness, including transferability, confirmability, dependability, and credibility. Interviews are a unique relationship in which the interviewer and interviewee converse about important and often personal topics. Therefore, I had to build rapport quickly by listening attentively and respectfully to the information shared. As the interview progressed, I continued to demonstrate respect, encouraged the interviewees to share their perspectives, and acknowledged the sensitive nature of the conversation.

To build a relationship, it is essential to remain honest and open to the interviewee's perspective. The participants chosen for the research could have had preconceptions about the study, including distrust. For this reason, I needed to explain why I was conducting the research and what their contribution meant. I used

conversational tones to allow the participants to discuss their experiences comfortably. I also recognized using contextual or cultural factors that influenced their opinions could assist in establishing prior knowledge.

Transferability

One means of achieving transferability was by providing a detailed description of the research setting and participants. I recruited participants from Facebook pages and groups dedicated to subjects and discussions about medical social workers. Open-ended and follow-up questions allowed me to probe for more information during the interview. Although qualitative findings are not generalizable, following documented data analysis steps resulted in findings likely useful in hospital settings, such as inpatient hospice and discharge planning.

Confirmability

A researcher achieves confirmability when a study is free of bias (Korstjens & Moser, 2017). Confirmability helps to ensure the findings emerged only from the data without researcher influence (Amankwaa, 2016). One way of achieving confirmability was allowing all respondents who met the requirements to participate in the study. I recruited all eligible participants based on their experience and education in the interview without following any bias such as gender differences, racial differences, and salary differences. Participants could also decline to answer any questions. Participants reviewed their transcripts to ensure no bias, which further contributed to the study's confirmability. Finally, I asked follow-up questions to obtain more data.

Dependability

Dependability in qualitative studies is the equivalent of reliability in quantitative research (Connelly, 2016). A study has dependability when the findings are similar when replicated. To ensure the dependability of this research, I asked all participants the same questions as specified in the interview protocol to allow for consistency in eliciting their experiences. I maintained an audit trail of the research process to document the collected data and emergent themes.

Credibility

Credibility indicates the strength of data analysis and the validity and believability of the findings (Alrubaian et al., 2018). To ensure credibility, I asked participants to completed transcript reviews, and nine of the 10 participants engaged in the requested transcript review process. After participants approved their interview transcripts without changes, I analyzed the data, identified themes, and solicited participants' feedback on the preliminary findings. Member checking allows researchers to identify misrepresentations in the data or the findings (Daniel , 2019).

I used several criteria to determine reliability, including whether the findings presented the information accurately and fairly. One means of achieving credibility was including thick verbatim descriptions of participants' interviews to support the findings. Credibility means that the finding applies to other settings and contexts, certainty suggests the findings are free of researcher bias, and reliability indicates the results are consistent and sustainable over the long term (Amankwaa, 2016).

Results

The research question that guided the study was the following: What are hospital social workers' experiences and perceptions regarding the influence of discharge planning on hospital readmissions? To answer this question, I collected detailed information on what hospital social workers identified as hindering successful discharge planning and contributing to hospital readmissions. I used hand coding to identify initial codes and then, through further exploration, established the overall themes for the study. In the second round of coding, I analyzed the audio recordings, written transcripts, and established codes. Four themes emerged from this analysis: (a) lack of community resources, (b) hospital administrative challenges, (c) lack of family/social support, and (d) RN versus social worker issues/lack of role definition. I organized the themes from each interview question to answer the research question.

Theme 1: Lack of Community Resources

Participants identified a lack of community resources as an issue they faced regarding discharge planning and hospital readmission. The participants reported issues with a lack of community resources. Some of the participants' responses follow.

Participant 1 spoke about the lack of community resources, including discharge planning, level of care, and living facilities:

Well, to tell you about the discharge planning. My experience has been that there are certain factors we have to take into consideration 'cause we're looking at that person as a whole individual. Where I'm at, which is in a very west part of Florida, I live in the poorest county in Florida, and a lot of times, there's not a lot of resources here, so we try our best to get them. If they need a higher level, well, I won't say they need higher-level care, but if they need a treatment center to go to, whether that be for substance use or mental health care or [an] assisted living facility. Sometimes that can be very, very, very hard.

This helped to show how social workers are working with limited to no resources to help patients.

Participant 8 discussed good sound community resources as the lack of resources at the health care workplace, saying, "I think if we can properly cut down the processes and have good sound community resources, that will help the discharge." This showed how the systems is focused on making some changes, but not always changes that are helpful to the patients.

Participant 5 discussed how patients should find resources outside of their community to survive due to the lack of resources. Participant 5 shared, "Individuals need to learn how to be self-sufficient and use resources outside of the community for their benefits beside the hospital." This helped to show how some areas may have more resources than another, but there is still a lack. Patients had to drives miles away from their homes to receive some assistance.

Participants 2 and 3 both reported having used their own money to help patients to get home safely. Participant 3 stated, "There have been many times where I will pay for a client to get home by taxi." This represents a real issues, as staff felt that in order to keep their jobs, they had to spend their own money to buy things for patients. Participant 6 stated that they have also brought the patients clothes with their own money, sharing, "I had a client who went to a nursing home about 2 weeks ago, and I paid for them to have clothes due to them having no family." Participant 10 reported that as a newer social worker, it was hard to find resources. Even if resources were found, most of the time, the client did not qualify for the resources. Participant 10 stated, "As new social worker I need help at times finding resources, even with seeking help there is still noting for the client."

Participant 7 reported that the community resources that are available in their area are always exhausted, and no one can access the resources. Participant 7 stated, "When one calls the popular community agencies, they will always say we do not have funding at the moment." Participants 4 and 9 both reported reaching out to colleagues and even management to find resources for clients, and having not luck. "When management does even have resources that is a real problem." Community resources are an important factor in successful discharge planning, and a lack of resources is not good for the clients.

Theme 2: Hospital Administrative Challenges

Participants recognized that administration is a significant element of any business. In the interviews, some participants mentioned issues surrounding the lack of understanding from the administrators' standpoint. There were also discussions of the administrators' unrealistic goals for the department, as eight of 10 participants reported hospital administrative challenges. Participant 1, for example, spoke about the issues with hospital administration:

We're in a fight with the hospital administration. A lot of times about the type of discharge that they're going to be receiving, or what they can't receive because a lot of times individuals want to come in there and they need to go to rehabilitation, or they need an assisted living facility, but they may not qualify for that depending on their insurance and the availability, or that's just a plain lack of resources. So it's been very, very hard trying to get that.

Participant 5 found it difficult to deal with administrators' moods and stated, "It depends on the mood of the administrative person, what they feel like doing, and so those difficulties." Participant 7 felt that the administration treated hospital social workers unfairly and that social workers knew more about ongoing hospital situations than administrators. The participant said, "You know how vital we are, but it's the administration that I don't think they really know what we do, you know? We help the hospital a lot with the difficult patients, but we are not treated this way."

Participant 5 commented about working with nurse case managers and remarked, "The first thing that comes out when I think about it is the lack of knowledge that both social workers and we work." Participant 7 discussed having to ensure everything was connected during discharge planning, saying, "It's just really honestly a giant juggling act." Participant 9 reported facing issues with patients' family involvement during discharge planning:

I think you know one of the biggest challenges sometimes to patients and families is you know, especially when you have a patient that is frequently readmitted to the hospital over some time, trying to help them understand that you know.

Participant 10 also experienced issues with patients' families during discharge planning, explaining,

An issue a lot of the times when it comes to patients and families, you know, they come in there, and they're like, Oh, my God, I'm so sick. And then, like even when you're doing an initial assessment, you're [asking] probing questions for discharge planning, and they freak out. These issues that the social workers have with administration policies created not only a barrier for proper discharge planning, but also ethical dilemmas.

Participant 2 asked, "How can I work somewhere and sleep at night that forces us to discharge patients that are not ready?" These administrative issues were very diverse among participants, but all reported serious issues with administration. Participant 4 stated that there was lack of goals set from administration by sharing, "There is so much emphasis on discharging patient within a certain time, that there are no real goals set for us." Participant 8 also reported that she experienced receiving unclear directions from administration by stating, "I came for setting where we given clear directions, this does not happen in the hospital, the only thing that administration likes to talk about is length of stay and getting patients out."

During their interviews, the social workers identified issues within the health care system. Participant 5 said that health care system issues usually involve discharge planning, insurance, and a lack of knowledge of an individual. Participant 5 shared,

When I think about discharge planning, it is actually an obstacle. [It] is the lack of knowledge the average person has about how the U.S. health care system works. I mean, by far, that is the biggest issue to face, so we have to sit there and explain to them, your insurance doesn't cover this. Medicare doesn't cover this, or Medicare has this particular rule, and you're going to have to pay more." So that, by far, that's the biggest problem. And so when I think about discharge planning, I think about all the times that we have to educate patients on things that really and truly should be…the insurance companies' responsibility to educate them in a way that they understand.

Participant 9 identified limited patient resources as an issue in the health care system, noting, "I'm sure other states face it, too, that there are such limited resources for patients who are in state-based insurance so that, you know, we can't send them out of state." While many of the issues reported were issues that the hospitals social workers perceive as being on a smaller scale, when they began discussing the issue on a macro scale, it was shown that there are limited insurance resources for certain populations.

According to Participant 3, "Some of the patients who have Medicaid cannot discharge to a decent facility. Some of the facilities I am embarrassed to send anyone to them." Many patients are discharged below standard facilities due to insurance coverage or lack thereof.

Theme 3: Lack of Family/Social Support

Participants mentioned that having a support system was essential for anyone dealing with health care issues, and patients who come to the hospital frequently lack a support system. During the interviews, the social workers shared stories about patients who lacked support and how the absence contributed to frequent hospitalizations. Eight of 10 reported a lack of family/social support. Participant 2 said, "Patient barriers, the patient needs UM potential services. …Family supports those kinds of things." Participant 3 suggested, "Just different support so the family can feel a little bit more secure." Participant 5 recalled,

Two months ago, we sent [the patient] to a facility in the middle of nowhere Alabama because, you know, the wife and his family said, "We can't take care of him," and we sent him to this facility with this very hard [time] placing him.

Nobody wants him. It's a very undesirable placement. Um, we finally placed him, and within 2 days, he was calling family to come to get him, and within, you know, 4 days, he was back in our hospital.

Participant 6 discussed the actions nurses take to ensure their patients receive support from family or social groups and a better care process. She explained, "Nursing does wrap-around services, you know, such as make sure they have home health if they have supportive family and stuff like that." Having a support system has shown to be a positive indicator for better recovery around patients who have been admitted. Participant 1 stated, "Each patient that we see on a frequent bases either has no support system or a lack of a good support system." Support systems are important to the physical recovery process.

Participants 4 and 8 reported that there have been some sad situations for patients with no or little family support. Participant 4 stated, "We had one client who we had to purse guardianship due to him being noncoherent and having no family that we could find." Participant 8 also stated that, "There was so many clients who end up going to a facility because their family did not want to take care of them." Participant 7 shared, "If a patient was not safe to ambulate then there is time the physical therapist will keep them there. These were often the patient who ended going to a facility." Participant 9 stated that family helps the patient deal with their emotions after being in the hospital.

Participant 9 stated,

We have a lot of patients who leave the hospital not the same as they were before. Having a supportive family is important for them to feel worthy. Family leaves their family member when they get sick, and this is the time they need them the most.

Theme 4: RN Versus Social Worker Issues/Lack of Role Definition

Participants mentioned that in the hospital setting, social workers and nurse case managers often work on discharge planning. In the hospital setting, there is not always a clear understanding of the roles' similarities and differences. All participants reported this issue.

Participant 3 suggested that social workers and RNs have more duties to return their patients home with good care, saying, "So, I would definitely say having a little bit more specific roles within the medical social worker and the RN case manager and then also having us having access to more of those funds to get patients back home." Participant 6 stated, "I think that the nurses should go back to being nurses, like, do the floor." Participant 6 reported that more nurses' patients get readmitted to the hospitals, explaining, "[Of] 30 patients, [the] 25 that [are] readmitted would be the nurse's patients." Participant 10 appreciated the nurses but said they do not always understand the case. She said, "Well, nurses do a, you know, a fantastic job of being compassionate [but] I think, at times, they don't always understand."

In the case manager role, there are both nurses and social workers. There is often no defined role regarding who will perform the needed task. Participant 2 stated, "Whenever there is a complex patient the

social workers are always assigned to them." Participant 7 stated, "It feels like we are important when they want us to be, any other time the nurses are the heroes." Social workers and nurses have both been working in hospitals in the case management department for years. Participant 1 stated, "We both work in the department, and they have the easy stuff, it's not fair." Participants 4 and 5 both reported feeling less than the nurses due to the lack of equality in the role.

Participant 8 reported, "I think that having both social workers and nurses is helpful. We both have different things that we are strong in, but sometimes this gets blurred." In some hospitals settings, there is a lack of role definition, creating issues for the staff which, in return, projects on clients at times. Participant 9 stated,

I love my job, and I want to stay but sometimes the issues within the department between the social workers and the nurses make me feel like I am not an important person in this team. Have not real definition of the roles is confusing.

Understanding and defining the roles between social workers and nurses is important for all of the social workers who were interviewed.

Summary

In Chapter 4, I presented the data collection procedure, including participant selection, interview settings, participant demographics, and the semi-structured interview protocol. Participants shared their experiences and perceptions of hospital readmissions and discharge planning from a hospital social worker's viewpoint. Multiple transcript reviews resulted in the generation of several codes, which were subsequently grouped to form themes. The identified themes were (a) lack of community resources, (b) hospital administrative challenges, (c) lack of family/social support, and (d) RN versus social worker issues/lack of role definition. Chapter 5 provides an interpretation of the research data, conclusions, recommendations for future research, social change implications, and the study's overall findings.

Chapter 5: Discussion, Conclusions, and Recommendations This generic qualitative study explored discharge planning and hospital

readmissions from the hospital social worker's point of view. Semistructured interviews were conducted to elicit the perspectives and experiences of hospital social workers to better understand discharge planning and hospital readmissions. Policymakers across the United States have created programs to minimize hospital readmissions, such as the HRRP, which reduces hospital payments based on readmissions (Fonarow et al., 2017). The current study provided insight into the experiences and perceptions of hospital social workers and the influence of discharge planning on hospital readmissions.

During data analysis, only one interviewee's response showed discrepancy related to the study's theoretical framework, given that its emergent themes were contrary to the claim that failure to adhere to proper discharge planning results in higher readmission rates. Instead, the participant hinted at the opposite of this. However, I included this information because it would allow for future exploration to gain a deeper understanding of the perceptions and experiences of hospital social workers.

Interpretation of the Findings

Addressing the research question entailed employing a generic qualitative approach incorporating semistructured interviews with in-depth, open-ended questions. I used Meleis's (2010) transitions theory as the conceptual framework to interpret the findings and understand the hospital social workers' perspectives and experiences regarding the influence of discharge planning on hospital readmissions. As discussed in Chapter 4, I identified, coded, and categorized patterns into themes by analyzing the participants' narratives. This section presents an interpretation of the findings and a description of the emergent themes related to the research question and conceptual framework described in Chapter 2.

The findings of this study supplement existing literature on discharge planning and hospital readmissions. According to Ercia (2021), there is a gap in the literature on this topic from the social worker's point of view. Current study findings indicated that social workers have significant issues with discharge planning. However, there are many reasons for patient readmission outside of discharge planning that the social worker cannot change. Participants discussed patients who did not have insurance and could not afford to pay

out of pocket for some of their needed services, such as dialysis and primary care visits. Participants also spoke about nonmedical services, such as food pantries and family support groups.

The four themes that emerged from the interviews were (a) lack of community resources, (b) hospital administrative challenges, (c) lack of family/social support, and (d) RN versus social worker issues/lack of role definition. Community resources are services available to community members (Boll et al., 2021) and are often low-cost or free. The lack of community resources experienced by the hospital social workers was an essential factor in discharge planning. Administrative issues stemmed from the social worker feeling that the hospital administration did not understand their role and the complexities involved. According to Rosner (2019), the administration is often only involved in hospital operations and might be disconnected from the hands-on work. Lack of support creates a barrier that is often difficult to overcome. Patients who have been in a hospital may, at times, require someone to assist them while recovering. The lack of a support system contributes to higher readmission rates (Barnes et al., 2020). Without any strategies in place to counter the current lack of community resources, hospital administrative challenges, lack of family/social support, and lack of role definition, medical social workers will remain incapacitated to discharge quality services. Because of this existent disconnect, readmission rates are still very high for most hospitals in the United States (Connell et al., 2019).

Issues within the U.S. health care system are not new. Despite the Affordable Care Act of 2010, the health care system does not meet the needs of every American (Ercia, 2021). Some U.S. residents cannot afford insurance, and if they can it might not cover the services they require. Many hospitalized patients need services, such as rehabilitation; however, depending on the state of residence, Medicaid might not pay for the service. Finally, all interviewees identified the problem of the RN case manager.

According to Smith et al. (2018), social workers are better equipped than RN case managers to handle patients with more complex issues, having learned in school how to address specific problems. With the relative newness of the RN case manager role, many hospitals lack clear job descriptions for case managers and social workers.

The transitions theory developed by Meleis (Schumacher & Meleis, 1994) served as the framework for the current study. The theory's focus is on the patient transition from the hospital to the posthospital setting. This theory supported this study's findings because the hospital social workers felt patients had to be prepared before discharge to ensure a smooth transition. Hospital social workers provide a patient assessment to obtain the information needed to create a discharge plan. Patients and their families need help setting up and locating needed services. A discharge planning process is a tool that makes the transition from the hospital to a lower level of care manageable, as suggested in Meleis's (2010) theory. Meleis's theory was useful in the development of recommendations because analysis through this lens helped to reveal the challenges that exist or emanate as patients transition from the hospital to outside settings (e.g., their homes), influencing the chances of their readmission.

Limitations of the Study

One of the limitations of this study was that participants were recruited from the internet; therefore, the population might not be an accurate representation of social workers in other areas. Another limitation is that the participants were from the United States only, and outcomes may differ in other countries. I also limited the study population to hospital social workers currently working in the hospital or having worked there within the last 2 years. Another limitation was that the interviews occurred via videoconference, limiting some of the interactions available in person. The small sample size of 10 was also a limitation. Lastly, all participants were women. This demographic limitation excluded the male point of view, which could have provided different perspectives and experiences.

It was necessary to address issues of trustworthiness. For transferability, the study needs to apply to participants who work in other social work and medical settings. The limitations of recruiting only women posed an issue to credibility and confirmability. To confirm this study's credibility, researchers should conduct a similar study with male participants to ensure the information is accurate and sufficient. Although individual experiences and perceptions are real to the individual, the absence of evidence to support some of the experiences, in addition to the possible exaggerations of some individuals' experiences, posed a threat to the

study's trustworthiness (see Liao & Hitchcock, 2018).

Although individual experiences and perceptions are meaningful, they are susceptible to social desirability bias. Such bias occurs when participants respond how they think researchers want them to respond or in a way that puts them in a favorable light. I addressed issues of trustworthiness during data collection and analysis to strengthen the credibility, reliability, and transferability of the results.

Positive Social Change

The goal of this study was to promote positive social change among social work practitioners on the micro, mezzo, and macro levels of social work practice. On the micro level, this research may help increase social workers' awareness of the issues clients face that prevent a successful discharge-planning process. Increasing social awareness could involve providing more education for social workers to understand the psychosocial factors that affect discharge planning. This awareness may also include educating patients and their support system on what is needed for a successful transition/discharge.

Understanding how discharge planning can affect hospital readmission could help the social workers achieve more successful discharges and fewer hospital readmissions by engaging in education to increase their knowledge on burnout and its prevention.

On the mezzo level of social work practice, social workers could advocate for programs, training, and resources to provide education and support to prevent burnout, high readmission, and barriers to discharge planning. Organizations could educate staff on the roles of social workers and nurse case managers, ensuring the professionals responsible for certain aspects of discharge planning will be informed and held accountable. Lastly, on the macro level of social work practice, this research could promote positive social change by encouraging the development of policies and procedures that could address social workers' concerns to decrease hospital readmission rates and achieve more successful discharge planning. During this study, participants discussed how their organizations had many issues with administration, including that administrators did not fully understand the social worker's role. There were also issues with tasking social workers to complete unethical discharge planning methods. Some of these methods were to discharge patients even when they had no place to live or lacked needed equipment. Social workers felt their opinion did not matter to the administration, which would not change.

This study was a means to encourage discussions among social workers and administration to create awareness of the challenges social workers face with discharge planning. In the hospital setting, social workers are highly involved in hospital readmissions and discharge planning (Browne, 2019). Creating more support for the social workers who assist with discharge planning could elicit change across all levels of social work practice by increasing successful discharge planning, decreasing hospital readmission, and producing better patient outcomes (see Browne, 2019).

Recommendations

The recommendations stemmed from the study's strengths and the peer-reviewed literature referenced in Chapter 2. Based on the limitations affecting trustworthiness, there is a need for future research to explore the experiences and perceptions of hospital social workers regarding discharge planning and hospital readmissions. The literature showed that a lack of discharge planning contributes to many incidents of patient readmission due to lack of resources, complex medical history, and poor medication reconciliation (Yam et al., 2012). For example, when social workers receive a more complex patient, they spend additional time securing the necessary resources for a smooth transition. According to the (Rodakowski et al., 2017), social workers are responsible for complex patients who require significantly more time and resources.

Hospital social workers and hospital administrations also need to increase their social awareness to ensure that they are able to provide and access sufficient community resources. According to Loskutova et al. (2016), increasing social awareness could involve providing more education for social workers to understand the psychosocial factors that affect discharge planning. Moreover, to help their patients, social workers need to be well versed in the community's available services and solutions (Loskutova et al., 2016). If the hospital possesses the necessary supplies or equipment, they may be given to the patient; otherwise, the social worker is

responsible for finding those supplies or equipment elsewhere. The social worker in many hospitals can provide information about local services such as food banks, clothing banks, and residential treatment centers (Henke et al., 2017). Depending on the patient's circumstances, it may take a long time to locate appropriate community resources (Henke et al., 2017). With more social awareness, hospital workers may be able to advise their patients accordingly upon discharge.

Hospital administrations in the United States could work in partnership with the federal and state medical agencies to lobby for the institution of laws and policies by Congress that ensure consumer protections and nondiscriminatory policies will remain and will be required of any proposal or option being considered to achieve health care coverage for all. Such laws and protections can help to ensure that every patient with whom hospital social workers interact has health coverage and, therefore, can afford quality treatment (AAFP, 2022). Recommendations for such laws, according to AAFP (2022), include but are not limited to the maintenance of guaranteed issue; the outlawing of underwriting based on a person's health, age, gender, or socioeconomic status; the elimination of annual and/or lifetime limits on benefits and coverage; the mandated provision of essential health benefits; and the exclusion of patient cost sharing for certain preventive services and vaccines.

To encourage family support and involvement in patient care, hospital social workers could embrace sufficient communication with the family members of patients regarding the importance of their involvement in their patients' treatment. Health practitioners should contact family members individually to encourage participation, questions, and comments (Prior & Campbell, 2018) and to discuss ways in which family members can assist with care routines or activities and how they can provide assistance.

Hospital social workers generally need to participate in activities that strengthen family bonds.

Role clarity is also important to ensure that RNs and hospital social workers work collaboratively and not against each other in delivering quality care. Some of the suggestions presented by Buljac-Samardzic et al. (2020) to ensure this role clarity include describing one's role and that of others and recognizing and respecting the diversity of other health care and social care roles, responsibilities, and competencies. Buljac- Samardzic et al. also suggested performing one's roles in a culturally respectful way and considering the roles of others in determining one's professional and interprofessional roles. Finally, there is a need for hospital administrations to ensure that they integrate competencies/roles seamlessly into models of service delivery (Buljac-Samardzic et al., 2020). Role clarity is, therefore, an effective strategy to overcome issues of responsibility conflicts between RNs and hospital social workers. All of these recommendations could result in a robust support system for patients and could create a conducive environment for the discharge of efficient administrative functions by hospital management.

There is a need for further research to explore social workers' experiences and perceptions related to discharge planning and hospital readmissions. In addition, research is needed on other areas of hospital social work, such as children and mental health. It would also be helpful to explore the experiences and perceptions of different specialty hospital social workers in line with discharge planning and readmissions challenges related to lack of financial and community resources. Future researchers could identify the community and financial resources necessary to improve discharge planning and reduce hospital readmissions. Another recommendation for further research is to engage professionals from different regions to determine whether hospital social workers' perceptions and experiences to discharge planning with different patients persist among alternative geographic locations. Other recommendations for further study are to solicit a wider range of hospital social workers for interviews and adopt a mixed-methods approach involving quantitative data to increase credibility of the final outcomes.

Implications

The insight obtained from the current study provided invaluable information about hospital social workers' perspectives regarding hospital readmissions and discharge planning. The current study was necessary to fill the gap in knowledge from the hospital social worker's perspective on hospital readmissions and discharge planning. The findings could help hospital administrators address the issues faced by hospital social workers regarding discharging planning and hospital readmissions. Despite the hospital social workers' efforts, many elements are out of their control. According to Henke et al. (2017), discharge planning is only a part of helping

to reduce hospital readmissions. The current study's findings provide information on possible changes from a medical social worker's perspective to better serve the patients. Although researchers have addressed hospital readmission and discharge, none have adopted the social work perspective, yet these professionals play a crucial role in the discharge of quality health care services. The ability of hospitals to deliver quality care and thereby reduce readmission rates is threatened.

Positive social change for the hospital system could include providing more assistance to the social workers when working with patients with limited resources. Giving staff the time necessary to discharge and deliver resources to patients could lead to fewer hospital readmissions, helping both the individuals and their families. Proper support could also help the hospital systems by reducing hospital readmission rates.

Positive social change at the societal level could be apparent through overall improved citizen health. Positive social change is also possible at the policy level, with the current study's findings showing that providing enough care for patients may have beneficial results.

Conclusion

The purpose of this generic qualitative study was to explore the experiences and perceptions of hospital social workers regarding the influence of discharge planning on hospital readmissions. Four themes emerged as influencing discharge planning on hospital readmissions: (a) lack of community resources, (b) hospital administrative challenges, (c) lack of family/social support, and (d) RN versus social worker issues/lack of role definition. Ten hospital social workers participated in semistructured interviews and shared their perspectives and experiences regarding the influence of discharge planning on hospital readmissions. Although discharge planning helps reduce hospital readmissions, there are challenges with the process. Many of these issues come from factors outside the hospital's and social worker's control, such as a lack of community resources. The findings of the current study reduce the gap in knowledge in the literature regarding discharge planning and hospital readmission. The findings also suggest the need for further exploration from the hospital social worker's perspective.

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Appendix A: Demographic Questionnaire

1. What is your age?
2. What is your gender?
3. Where do you reside in the United States?
4. What is your current educational level?
5. Are you a licensed social worker?
6. How long have you been in the social work field?
7. What is your primary practice setting?
8. How long have you been in this setting?
9. What is your official title?
10. How long have you been in the social work field?
11. Are you familiar with discharge planning and readmission?
12. On average, how many clients have you assisted with discharge planning?

International Journal of Scientific Research and Management (IJSRM)
||Volume||12||Issue||03||Pages||1378-1413||2025||
Website: www.ijsrm.net ISSN (e): 2321-3418
DOI: 10.18535/ijsrm/v13i03.mp01

Appendix B: Interview Protocol Form

Experiences and Perceptions of Hospital Social Workers Regarding Discharge Planning and Readmission

Date _____

Time _____

Location _____
Interviewer _____
Interviewee _____
Release form signed? _____

Notes to interviewee:

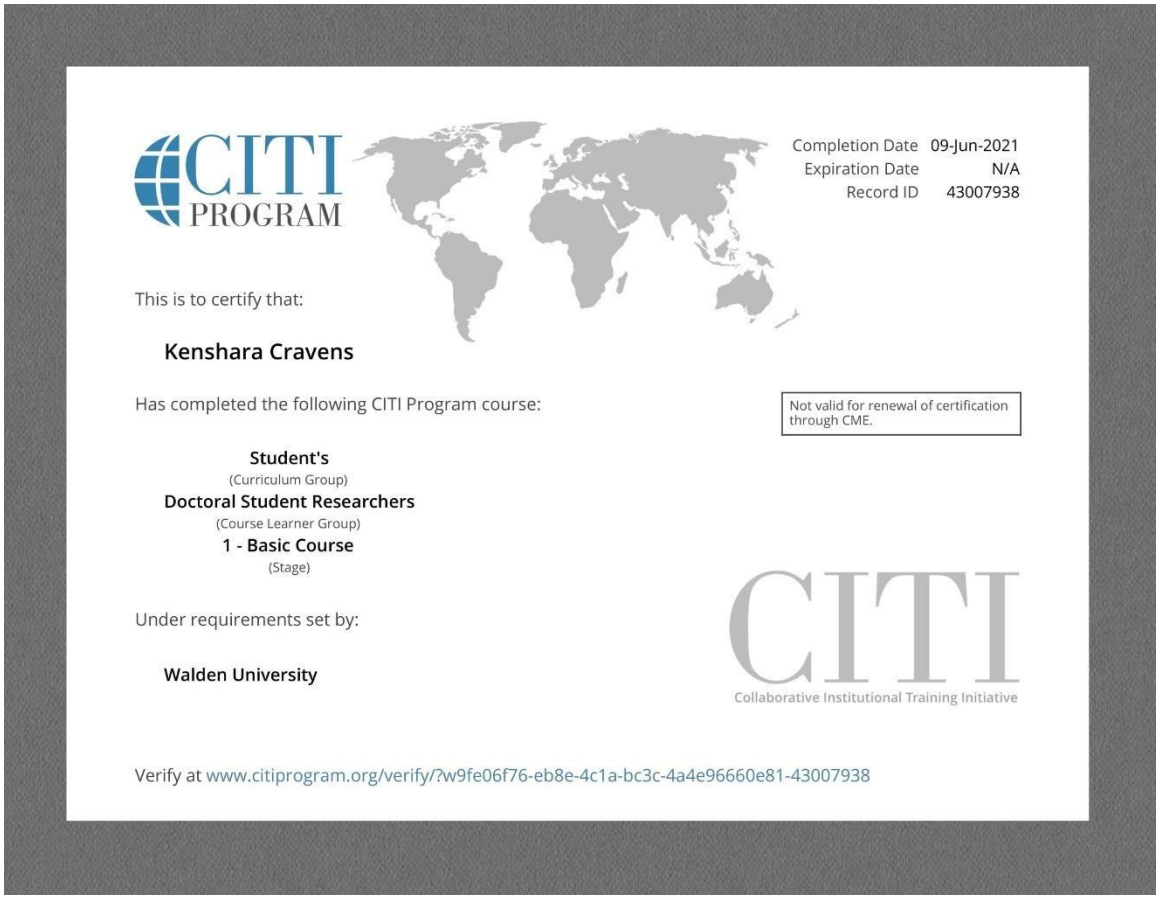
- Thank you for your participation. I believe your input will be valuable to this research and in helping grow all of our professional practice.
- Confidentiality of responses is guaranteed
- Approximate length of interview: 60minutes, six major questions
- Purpose of research: The purpose of this study is to understand the experiences that medical social workers have had with discharge planning and hospital readmission.

1. Tell me about your experiences conducting discharge planning?
2. What is your perception of the discharge planning process at your practice setting?
3. Tell me about the challenges you have experienced with discharge planning?
4. How do you feel discharge planning can be improved in your practice setting?
5. Tell me about a time that one of your patients was readmitted within 30 days of discharge?
6. How do you believe the current discharge planning process at your setting contributes to hospital readmission?
7. How do you believe the rate of hospital readmission can be improved in your practice setting?

Closure

- Thank you to interviewee
- Reassure confidentiality
- Ask permission to follow-up

Appendix C: National Institutes of Health Certificate of Completion



CITI PROGRAM

Completion Date 09-Jun-2021
Expiration Date N/A
Record ID 43007938

This is to certify that:

Kenshara Cravens

Has completed the following CITI Program course:

Not valid for renewal of certification through CME.

Student's
(Curriculum Group)
Doctoral Student Researchers
(Course Learner Group)
1 - Basic Course
(Stage)

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