

**THE OVERLOOKED MISSION-TRANSITIONAL CARE PROGRAMS FOR
VETERANS IN CIVILIAN SETTINGS: AN INTEGRATIVE REVIEW**

A Scholarly Project

Submitted to the

Faculty of Liberty University

In partial fulfillment of

The requirements for the degree

Of Doctor of Nursing Practice

By

Cynthia Louise Gonzales

Liberty University

Lynchburg, VA

August 2022

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Scholarly Project Chair Approval

Dr. Dana Kaye Woody, DNP, RN, Scholarly Project Chair

Abstract

The number of veterans within the United States continues to increase. With the addition of healthcare laws, veterans can seek care within the Veterans Health Administration (VHA) and civilian settings. The collaboration among multiple healthcare providers must ensure veterans are provided safe and efficient care when transitioning from provider to provider. Transitional care programs (TCPs) are effective strategies to ensure that veterans receive safe and efficient healthcare. The VHA employs interventions across their healthcare settings to facilitate optimal care. A variety of TCPs were discovered during the review. Most TCPs were used in VHA settings, which revealed an opportunity to further consider TCPs in civilian settings. Improved communication, standardization of practices, and increased awareness of the multiple comorbidities affecting the veteran population are needed to successfully develop, implement, and sustain TCPs in civilian settings to ensure optimal healthcare outcomes for veterans. The focus of this integrative review (IR) was to assess research on raising the awareness of TCPs among civilian settings for veterans to obtain optimal health outcomes.

Keywords: Veteran Health Administration, transitional care management, transitional care programs, veterans, transition of care, civilian healthcare settings.

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List of Abbreviations

Agency for Healthcare Research and Quality (AHRQ)

Behavioral Recovery Outreach (BRO)

Care Coordination and Integrated Case Management Initiative (CC&ICM)

Center for Disease Control (CDC)

Clinical Pharmacy Specialist (CPS)

Collaborative Institutional Training Initiative (CITI)

Community Health Transition Program (CHTP)

Community Living Centers (CLCs)

Coordinated Transitions of Care (C-TraC)

Evidence-Based Practice (EBP)

Health Information Exchange (HIE)

Institute for Healthcare Improvement (IHI)

Institutional Review Board (IRB)

Integrative Review (IR)

Levels of Evidence (LOE)

Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act

Office of Community Care (OCC) Care Coordination Model

Patient-Centered Home Model (PCHM)

Posttraumatic Stress Disorder (PTSD)

Skilled Nursing Facility (SNF)

The Geriatrics Medication Education at Discharge project (GMED)

Transition Nurse (TN)

THE OVERLOOKED MISSION

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Transitions Nurse Program (TNP)

Transitional Care Programs (TCPs)

Veterans Choice Program (VCP)

Veteran Health Administration (VHA)

Veterans Engaged in Treatment, Skills, and Transitions for Enhancing Psychiatric Safety

(VETSTEPS)

SECTION ONE: FORMULATING THE REVIEW QUESTIONS**Introduction**

Veterans are a complex populace with a culture that incorporates distinctive values, customs, and concepts of self-care (Crytzer, 2019). Veterans face numerous challenges, including complex care needs, access to timely healthcare, distance to VHA facilities, homelessness, and navigating medical care. The civilian sector of care works in collaboration with VHA and, in some cases, is the primary source of healthcare for veterans. A sizable proportion of veterans use both VHA and civilian healthcare. Because veterans may make up a substantial part of civilian healthcare providers' patient caseloads, providers must screen veteran status to identify service members' military-related health sequelae better. The number of veterans in the U.S. has decreased by about a third since 2000. From 26.4 million in 2000 to 18.0 million in 2018, the number of individuals who served has dropped (Vespa, 2020). Less than half receive care from the Veterans Health Administration (VHA) system, with the majority relying on civilian primary care physicians (Yedlinsky et al., 2019). Veterans are 75% more likely to receive care from civilian healthcare facilities.

Transitional care programs (TCPs) work to enhance healthcare outcomes for veterans. TCPs provided in-homes visits or telephonic follow-up, with focused support during the immediate post-hospital period, improving patient safety and reducing hospitalizations (Lovelace et al., 2016). The need for TCPs becomes increasingly important in addressing optimal healthcare outcomes for veterans receiving healthcare outside of the VHA system. Veterans were able to receive approved civilian healthcare with the introduction of the VHA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act (Ayele et al.,

2020). The MISSION Act estimated that more than 2.6 million veterans received care from community providers within the first 18 months that the Act was in place. (Ayele et al., 2020).

The failure of care transitions can lead to poor continuity of care and medication errors, which can cause patients to experience worse outcomes. TCPs support veterans and have been noted to reduce readmissions for this population. Factors related to increased risk for readmissions include: a complicated mixture of providers, practice insufficiency in which civilian providers may not be familiar with veterans' service connection health history (military-related disabilities), and ineffective transitional care. Veterans seek care based on several factors such as distance, cost, or access to timely services. Roughly, 75% of veterans are covered by Medicare or Medicaid healthcare insurance (Etchin et al., 2021). The prevalence of veteran transitions was analyzed and over 700,000 veterans from 5,379 hospitals analyzed. Four out of five (81.7%) veterans were between hospitals and civilian skilled nursing facilities (SNFs), while only 14.9% of these were at a VHA facility (Burke et al., 2019).

Civilian healthcare providers must be able to provide practical, culturally competent care to service members. According to Vest et al. (2019), civilian healthcare providers extrapolated that the veteran caseload in civilian settings is approximately 134 veterans per US primary care doctor, implying that veterans account for nearly 5% of the patient population in each practice. Vest et al. (2019) maintains that the veteran population in civilian care is underserved since the expectation is to get care from the VHA. Healthcare for this population is more complex and may incorporate any combination of care at the VHA and the civilian healthcare framework. Less than 50% of eligible veterans receive treatment through VHA facilities, and 25% to 45% of veterans who use the VHA simultaneously obtain care from other sources (Vest et al., 2019).

Veterans with multiple chronic health conditions often face limitations when participating

in the coordination of their care, especially care across multiple healthcare systems. These situations dictate the highest need for care coordination (Mattocks et al., 2019). Veterans who experience ineffective transitional care are frequently transitioning between multiple healthcare providers. The increase in accessibility of civilian healthcare providers increases the need for TCPs for veterans within civilian settings. Veterans are a vulnerable population that require a high level of care coordination. The literature documents that TCPs best support care coordination of the veteran population.

Findings from many studies reflect strategies to increase awareness of TCPs and their impact on healthcare outcomes among veterans in civilian settings. This IR will build upon nursing science, inform research and practice, and facilitate policy initiatives; it will also serve as a call to action to consider TCP use by civilian clinicians in support of optimal veteran healthcare outcomes.

Defining Concepts and Variables

The concepts and variables of interest for this IR included: TCPs, civilian healthcare settings, and VHA settings.

Transitional Care Programs

TCPs were a variable of interest for this IR. Transition of care involves a patient moving from one place to another or returning to a particular location. It can also involve a consultation with a health care professional at a different location. Some of the factors that can affect a patient's care includes the type of care they receive, the time they spend in a hospital, and the location they live. Coordination among various healthcare providers is a critical component of an effective healthcare system. It involves deliberate interactions between patients, their providers, and other healthcare workers to provide the best possible care (Olmos-Ochoa et al., 2019).

Coordination, involved in TCPs also involves the exchange of information and resources to improve the quality of care.

Civilian Healthcare Settings

Civilian healthcare settings are lacking in their support of veterans to ensure optimal healthcare outcomes. Civilian healthcare settings are deficient in their use of TCPs. Civilian clinicians are providing care to veterans; however, this care provision is not without its challenges. Veterans, according to the MISSION Act, have the opportunity to receive care from civilian healthcare settings. Although this is a step in the right direction of continuous care provision for veterans, the collaboration and communication across the spectrum of care continues to be a hindrance to patient safety and effective care.

VHA Settings

VHA continues to employ best practice methods in providing effective TCP utilization for veterans. TCPs are used in the VHA, C-TraC, pharmacy-led interventions, and CHTP (nurse-led) are examples, each has documented outcomes that include readmission reduction. Although the VHA and civilian healthcare settings are not directly in competition for use by veterans, collaborations among the two must be conducted to improve TCP use in support of optimal healthcare outcomes for veterans.

Rationale for Conducting the Review

The complexity of the health risks of veterans has raised concerns about their poor health outcomes. It is, therefore, vital that civilian clinicians are knowledgeable about their unique needs, which can lead to barriers in care delivery (Crytzer, 2019). The lack of coordination and the poor delineation of responsibilities among civilian clinicians affects the level of care provided to the veteran population. Civilian clinicians are limited in their overall knowledge

regarding treatment and care of veterans (Vest et al., 2019). As compared to the programs within the VHA, civilian healthcare settings report additional research is needed to consider TCP utilization for veterans.

Research further addresses fragmented healthcare for veterans in civilian healthcare settings. It reports that patients receiving care in various places, including clinics, emergency rooms, and inpatient care units, often have little or no communication between facilities (Roach & Hooke, 2019). VHA defines care coordination as the "integration of healthcare services and navigation of care through various care settings to enable patients to receive the care they need without duplications of services" (Cordasco, 2019, p.1). Veterans are a vulnerable population that require a high level of care coordination. TCP use among civilian clinicians is a vital area of support in the chain of care coordination. This IR sought to reveal the need for raising awareness among civilian clinicians to support the utilization of TCPs in support of optimal healthcare outcomes for veterans.

Effective strategies for implementing programs targeting optimal outcomes for veterans in civilian settings must include raising the awareness of TCP utilization among civilian clinicians. VHA and civilian providers have reported significant frustration with cross-system care coordination due to barriers in information exchange and decreased role clarity and care tracking processes (Mattocks et al., 2019). Practical techniques to improve transitions of care must focus on communication between providers. This IR included studies in which the relationship among providers, care teams, and veterans must be established in support of optimal healthcare outcomes (Olmos-Ochoa et al., 2019). Literature is still lacking regarding veterans within the civilian population and the impact of TCPs on healthcare outcomes. The review

revealed there must be focus on raising the awareness of TCP utilization among civilian clinicians.

Preliminary Review

A preliminary review of the literature included: 35 studies and three guides or resources from the Institute for Healthcare Improvement (IHI), Agency for Healthcare Research and Quality (AHRQ), and Centers of Disease Control (CDC) related to TCP utilization. The studies included: two systematic reviews of randomized controlled trials; five controlled trials without randomization; 20 cohort studies; four systematic reviews, and four descriptive studies. The review also included insight from the CDC, IHI, and AHRQ, providing insight to the care delivery of veterans. The literature provided ample information regarding TCPs and their impact on veterans within VHA settings.

The lack of care consistency among civilian clinicians regarding the utilization of TCPs was evident (Ayele et al., 2021). More than one-half of veterans received care only from the civilian sector (Yedlinsky et al., 2019). Major issues with the care of veterans noted in the literature were lack of effective standardization regarding the utilization of TCPs, accurate transfer of medical records, and collaboration with other providers (Ayele et al., 2021). Themes of discussion regarding veteran care in the literature included TCP use, outcomes related to use of TCPs, veterans and their vulnerability related to high readmission rates, and the impact civilian healthcare settings have on veteran health outcomes.

Supplemental Evidence

Supplemental evidence related to TCPs and their use related to readmission reduction was attained from a variety of studies. Studies have been conducted to support the prevention of readmissions. However, the VHA demonstrates a more robust prevention plan associated with

decrease readmissions of veterans than that seen in civilian settings. The prevention plan includes tailored patient education, post-discharge planning, effectively sharing of information, and medication reconciliation.

IHI reports that the rate of avoidable rehospitalizations can be reduced by improving discharge planning, coordinating care during transitions between settings, and improving support for patients (Institute for Healthcare Improvement [IHI], 2021). IHI conducted a seminar that discussed “Reducing Avoidable Readmissions by Improving Transitions in Care.” The seminar discussed assessing the comprehensive needs of patients and family caregivers, using health literacy strategies to enhance patient education, developing a customized post-discharge plan, effectively communicating discharge information to patients and community providers, and facilitating appropriate post-hospital follow-up.

The CDC also provides information on the various factors that can contribute to the high rate of hospital readmissions (Centers for Disease Control and Prevention, 2021). It also has resources that can help prevent these patients from returning. The agency offers various statistics and articles about interventions that can reduce the number of hospital readmissions.

The Agency for Healthcare Research and Quality (2019) has a variety of resources that provide information on various aspects of improving the quality of healthcare and reducing the number of hospital readmissions. These resources include enhanced care coordination through embedded nurse care managers, care delivery through a multidisciplinary approach, and patient engagement strategies (AHRQ, 2019).

The supplemental evidence highlighted the significance of collaboration and communication among clinicians responsible for care provided to veterans. The IHI endorses TCPs to reduce readmissions and smooth the transition care process (IHI, 2021). Coordination of

care, discharge planning, and transitions between levels of care were addressed throughout the resources, as well as strategies to avoid fragmented care outcomes for veterans in civilian settings.

Standards

There was limited information located in the National Guidelines Clearinghouse regarding the use of transitional care resources for veterans in civilian settings; several resources exist that offer recommendations in the prevention of readmissions in health systems (Agency for Healthcare Research and Quality [AHRQ], 2019). These are included in the supplemental literature. With the effective implementation of TCPs, clinical standards associated with complex diagnosis affecting the veteran population must be addressed within civilian healthcare settings. When implementing clinical standards related to a specific disease, it can help reduce the number of readmissions among individuals with that condition (AHRQ, 2019). The review of literature did not reveal specific guidelines or standards that were specific to veteran care and the utilization of TCPs in civilian healthcare settings.

Review of Studies

Veterans and Vulnerabilities

The American veteran population is unique due to the varying experiences and military occupations. Due to the varying wartime eras and health issues that members have experienced, the veteran population is prone to experiencing issues unique to their situation. Most recently, over 2.6 million U.S. troops were deployed to Afghanistan, Iraq, and Syria as part of Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn, where over 50,000 were wounded in action (Crytzer, 2019). Most of these injuries were documented as poly-trauma injuries. Despite the high number of injuries sustained by troops, over 90% of them have

survived (Crytzer, 2019). Coming back from active duty can be a daunting experience for many veterans. They have diverse healthcare needs and may experience various symptoms due to their military experiences. To improve the health of these individuals, it is important they receive the proper care and support across healthcare systems. Despite having access to a comprehensive healthcare system through the VHA, many military veterans choose to receive care from civilian healthcare providers. This choice makes veterans more vulnerable, as they are too often not understood by this healthcare sector.

Transitional Care Programs

TCPs support continuity of care for people who are at risk of experiencing poor health outcomes. TCP utilization involves the consideration of time and environments to ensure that these individuals receive the best possible care. Transitional care refers to actions to ensure coordination and continuity of healthcare for patients requiring transfers between multiple locations. The TCP care team includes physicians, nurses, receptionists, and nurse case managers. These individuals play a vital role in the care of patients across various settings. Transitions occur over time due to changes in the complexity of the illness and the care needs of the individual. TCPs provide a comprehensive approach to care that involves the coordination of various aspects of the patient's care, such as education, transportation, and communication. TCPs are ideal for people with complex care needs.

Readmission affects patients across the healthcare delivery system, especially when veterans have different healthcare delivery systems. Obstacles associated with veterans and TCPs include communication, difficulty translating medical care from one entity to another, and civilian providers having limited knowledge of veterans' ailments and illnesses. A study conducted on civilian healthcare providers revealed that the average veteran caseload in civilian

settings is 134 per doctor, which means that approximately 5% of a practice's patient population is composed of individuals who have served (Vest et al., 2019). It is important that veteran care is considered. This starts with asking about military status, which may leave veterans subject to care delivery that is often subpar. However, despite this, many service members are not asked about their military status at all.

VHA and civilian healthcare settings need to work together to provide veterans with the support of TCPs to ensure optimal healthcare outcomes. Reese et al. (2019) discussed the Coordinated Transitions of Care (C-TraC) program, which is a nurse-driven, telephone-based intervention developed for low-cost transitional care. The C-TraC intervention was associated with reduced readmissions and \$1,225 per patient cost savings. C-TraC program also garnered similar outcomes in civilian hospital settings (Reese et al., 2019). The goal of C-TraC is to empower individuals and their caregivers to manage their medication management and medical follow-up (Kind et al., 2016). The VHA Office of Community Care (OCC) Care Coordination Model and the Care Coordination and Integrated Case Management Initiative (CC&ICM) provide a framework for cross-system coordination that could generate broad awareness of new challenges and solutions for TCPs (Garvin et al., 2021). Kind et al. (2016), stated that the C-TraC program is a low-cost program that provides a variety of services to help veterans as they transition from a hospital to a community. It includes case management, inpatient team integration, and post-hospital telephone contacts. The program's goal is to empower veterans to manage their medication and improve their medical follow-up. It is important that TCPs are designed to meet the needs of their patients.

The OCC and CC&ICM are models that support interorganizational care coordination among veterans, especially those in rural areas. Veterans who are older and have complex

clinical issues and who face access to care barriers are most suitable for OCC and CC&ICM models. Veterans with a mental health diagnosis are at increased risk of readmission without effective TCPs. The transition from inpatient psychiatric care to community-based treatment is a critical time for veterans. The Veterans Engaged in Treatment, Skills, and Transitions for Enhancing Psychiatric Safety (VETSTEPS) is a program designed for this critical time (Wray et al., 2019). The goal of the VETSTEPS program is to improve the performance of a psychiatric hospital by implementing best practices to enhance the safety of its patients (Wray et al., 2019). The increasing number of veterans with complex healthcare needs is also contributing to the need for more effective TCPs. However, there are still many unanswered questions regarding the effects of these programs available to veterans within civilian settings. These findings support the need for a comprehensive review of literature on the subject.

Outcomes Related to the Use of TCPs

Veterans who have utilized TCPs have documented optimal healthcare outcomes. A study conducted on TCPs revealed that they can reduce the risk of 30-day hospital readmissions by up to 15% (Miller et al., 2020). Burke et al., (2019) noted a sample of over 100,000 veterans who were discharged from a hospital with data linked across the spectrum of care that accurately assessed the health outcomes contributing to decreased readmissions and healthcare costs. One of the most effective ways to reduce the risk of 30-day hospital readmissions was through a phone-based program known as C-TraC (Kind et al., 2016). The C-TraC program was able to reduce the number of patients who were hospitalized by about one third.

Vulnerability of High Readmission Rates. Veterans are most vulnerable to high readmission immediately following discharge. Readmissions back to the hospital, emergency department visits, and death within seven days of discharge are often related to ineffective

transitional care at the time of discharge (Burke et al., 2020). Veterans experience approximately 700,000 inpatient admissions and 1.2 million emergency department visits annually, demanding the need for care coordination (Cordasco et al., 2019). With a complex web of services spanning multiple providers and settings, veterans with many healthcare needs are assigned to a vast array of care coordinators, resulting in the lack of care continuity. Ineffective communication, health records transition, and provider-to-provider feedback is lacking, often relating to high readmission rates. TCPs support reducing readmission by offering interventions that are telephonic and multimodal with a variety of touchpoints considering medication reconciliation and appointment coordination (Bingham et al., 2019).

The VHA spent \$1.2 billion in 2011 on 30-day readmissions of veterans using its services; these veterans have more medical complexity adding to the risk of readmission (Reese et al., 2019). Lack of coordination and collaborations decreases the effectiveness of transitional care. Research has shown that VHA and civilian clinicians, staff, and veteran patients experienced care coordination challenges post civilian hospital discharge because of a fragmented process due to delay or incomplete picture of medical records (Ayele et al., 2021). Burke et al (2020) also noted VHA to VHA Community Living Centers (CLCs) had the lowest adverse outcomes for veterans when transitions were within VHA funded facilities (Burke et al., 2020).

Knowledge Deficit with Care Coordination

Veterans who mainly seek care from the VHA system are often less knowledgeable regarding care coordination services needed to support their complex health histories (Vaughan et al., 2018). Although the VHA offers a wide range of services, including acute medical and surgical care, general care, mental health services, prescription drugs, and other specialty care,

many veterans benefit from combining VHA and civilian healthcare services (Vaughan et al., 2018). Providers and nursing staff note the differences in caring for veterans versus civilians that affect patient outcomes. According to research, providers had inconsistent knowledge of the military population and its related culture (Vest et al., 2019).

Healthcare professionals at all levels must understand veteran needs, including nursing staff. Nursing staff must be able to assess for specific healthcare needs. In addition to clinical providers, nursing staff must be able to not only assess for military/veteran status, but also have a basic understanding of military culture and veteran-specific healthcare needs (Elliott, 2018). If a patient has not been identified as a veteran, the plan of care may be inconsistent with their experience in the military. According to a study conducted on healthcare providers, providing adequate care for veterans who use both the VHA and civilian systems is a challenge (Etchin et al., 2021). The study further revealed that there are various factors that affect the quality of care, such as lack of knowledge about the benefits of both systems.

Since veterans are documented as part of civilian providers' patient caseload, there is a need for providers to screen for veteran status to better identify service members and in turn, military-related health sequelae (Vest et al., 2019). Veterans have deficits related to understanding their health issues, including taking medications and following-up with care providers after hospitalization. Veterans often defer power to the medical providers and are less likely to take ownership for their own care. Because veterans may not actively participate in their care, civilian providers often lack the knowledge associated with what resources are available for veterans (Vest et al., 2019). Although cultural norms may prevent some veterans from seeking treatment, especially regarding mental health, it is critical to still address the needs of the veteran. This insight underscores the need to be knowledgeable about veteran care.

Civilian Healthcare Settings

A study found that 40% of veterans would be eligible for civilian care compared to the 8% eligible prior to the MISSION Act (Ayele et al., 2019). The MISSION Act provides veterans the access to seek care within civilian settings.

Challenges with Civilian Healthcare Settings

Coordinating care over health systems poses safety, patient satisfaction, and operational challenges (Schlosser et al., 2020). Rinne et al. (2017) noted that veterans are particularly vulnerable to fragmented care, as they are more likely to have access to multiple healthcare sources through Medicare and private insurance. In response to veterans' access to VHA care, Congress enacted the Veterans Access, Choice, and Accountability Act of 2014, requiring the VHA to establish the Veterans Choice Program (VCP) (Mattocks et al., 2019). The VCP allows providers in the civilian sector to perform care for veterans. The VCP represents about 25% of veterans to date (Mattocks et al., 2019). Ayele et al. (2019) described that expanded access to civilian care presents care coordination challenges for VHA and civilian hospitals. Rinne et al. (2017) discussed readmissions and post-discharge follow-up among veterans in civilian care. The literature revealed veterans in a civilian setting were associated with lower likelihood of follow-up visits after discharge than veterans in VHA settings (Rinne et al., 2017).

Post-discharge transitional care is especially challenging for veterans utilizing VHA and civilian settings due to the lack of standardized processes, transferring medical records, obtaining medications at a civilian pharmacy, and reestablishing VHA care (Ayele et al., 2021). The literature on the use of TCPs in civilian settings reveals the need to raise awareness about their importance to improve the healthcare outcomes of veterans. The literature also noted that high

readmission rates among veterans could be improved by implementing effective care processes regarding the utilization of TCPs in civilian healthcare settings.

Other challenges civilian healthcare facilities encounter include the inability to identify patients as veterans; providing, transferring, obtaining, and writing discharge notification to the VHA; transfer civilian medical records; obtain follow-up appointments; and write prescriptions to be filled at VHA pharmacies (Ayele et al., 2019). Research has shown that civilian providers have limited or no knowledge of a patient's status as a veteran. This contributes to coordination challenges due to insufficient information exchanges between VHA and civilian healthcare systems (Benzer et al., 2020). Civilian systems often rely on the patient to coordinate their own care. With the noted challenges, standards to ensure the safe transition of care for veterans outside of the VHA are critical.

Lack of Communication. TCPs require effective communication and collaboration among VHA and civilian providers. Communication between healthcare providers regarding TCPs continues to decrease the positive effects of care coordination. For example, VHA providers discuss the inability of having a complete picture of care provided by the civilian hospital because of delayed medical record retrieval. Also associated with the communication issues is the civilian provider's ability to communicate with the veteran regarding their health issue, comorbidities, and any effects combat may play in their physical and mental health status.

The literature described strategies providers can consider in supporting collaboration and communication methods to aid in the effective transfer of medical information needed to secure standards of care across the healthcare spectrum (Burke et al., 2020). Strategies associated with collaboration and communication methods include addressing network provider shortages (Mattocks et al., 2019). Additional strategies include continuous communication between

healthcare settings, cross-system standardization of care coordination, medication reconciliation, effective health information exchange (HIE) exchange, and raising the awareness among civilian clinicians regarding TCP use for veterans. Despite the efforts of the VHA to improve the use of HIE, the process of exchange to other healthcare organizations has remained low.

This lack of collaboration has prompted policymakers and administrators to conduct additional studies to determine the effectiveness of the VHA Community Care Network (CCN) program (Mattocks et al., 2019). The CCN program is a group of third-party resources that provide a framework for connecting local health care providers with members of the insurance industry. CCN connects providers caring for the veteran population and ensures timely payments and reimbursements (Mattocks et al., 2019). To improve the coordination of care, interprofessional teams should regularly coordinate care in support of optimal communication.

Problem Statement

Providing safe and effective healthcare to veterans is integral to the mission of the VHA; however, with 70% of veterans also receiving care from civilian clinics, this can be a challenge (Vaughan et al., 2018). TCPs support veterans via a multidisciplinary approach in the process of obtaining optimal healthcare outcomes. To date, TCPs have been poorly acknowledged among civilian care providers and therefore put veterans at an undue risk for readmission. If this poor awareness continues, the health status of veterans will continue to prove costly, both materially and physically. Therefore, the use of TCPs by civilian providers, in support of optimal healthcare outcomes among veterans demands further consideration.

Purpose

The purpose of this IR is to raise the awareness of TCP use among clinicians in civilian settings to improve the healthcare outcomes of veterans. Veterans face challenges because of

poor utilization of TCPs by clinicians in civilian healthcare settings. TCPs must be acknowledged among healthcare providers in VHA and civilian settings to address the challenges of the veteran population. The IR reveals studies regarding TCPs and their impact on veteran healthcare outcomes when used by clinicians in civilian settings. Veterans are at risk of readmissions without effective collaborative efforts among the VHA and civilian clinicians when implementing transitional care.

Given the concern for poor health outcomes among veterans, it is imperative that TCPs are acknowledged and utilized (Libbon et al., 2019). TCPs should include a multimodal approach. A multimodal approach to the transition of care includes patient education, medication reconciliation, and multidisciplinary care coordination, supporting the most optimal outcomes for the veteran population (Libbon et al., 2019). The IR examined poor utilization of TCPs by clinicians in civilian healthcare settings and revealed the need for raised awareness about the benefits of TCPs to ensure optimal veteran healthcare outcomes.

Review Questions

The integrative review addressed the following: For veterans in a civilian healthcare setting, does participation in TCPs impact healthcare outcomes as compared to veterans who are not in a TCP?

The following questions focused the review:

1. What standardized care coordination practices are available to support collaborations between VHA and civilian clinicians for effective TCP utilization?
2. What guidelines support the effective use of TCPs implemented by civilian clinicians?

3. What guidelines aim to solidify practices that align with providing safe and effective healthcare outcomes for veterans in TCPs?

Goals of the Project

The goals of this project included:

1. To provide an IR of the research related to the use of TCPs for veterans among civilian clinicians, examine the challenges veterans face with transitions of care, and demonstrate the strategies civilian clinicians can employ to improve healthcare outcomes for veterans in TCPs
2. To provide evidence-based recommendations to inform policy and practice
3. To recommend priorities for future research and program development

Inclusion and Exclusion Criteria

To ensure that the information covered by the IR is current, the inclusion criteria was established to ensure that publications reviewed ranged from 2016 to 2021. The review did not use any unpublished dissertations. Further inclusion criteria included the availability of reports in full text and written only in English. Practice settings of all types, veterans from all branches of services, and all types of healthcare providers were further included in the search criteria. The age and gender of veterans were not a factor in the inclusion or exclusion process. The population samples included all ethnicities and races of veterans to maintain a broad base of participants from various service branches (Army, Navy, Air Force, Marines, Coast Guard). Toronto and Remington (2020) found that explicit inclusion criteria prevent the influence of confounding variables. Studies associated with VHA, and civilian settings were considered based on the topic of interest, raising the awareness of TCP use among civilian clinicians for the

optimal healthcare outcomes of veterans. The measurable outcome reflects how raising the awareness of TCP use among civilian clinicians effects the healthcare outcome of veterans.

Identifying the primary and secondary target audiences will permit generalizations and ultimately support the goal for all readers of the IR to develop insight on the value of TCP utilization among civilian clinicians (Toronto & Remington, 2020). Identifying a target audience in research synthesis is complicated, according to Cooper (1998). The ability to reference targets that support the results and generalization of the studies were noted (Cooper, 1998). The target audience for this IR was civilian healthcare providers. The secondary audience was veterans.

Table 1

Inclusion and Exclusion Criteria

Inclusion	Exclusion
Publication from 2016-2021	Publication prior to 2016
Full text reports	Literature not available in full text
All types of practice settings	Literature written in a foreign language
Reviews written in English language only	Non-healthcare facilities
Health care providers	Non-veterans
Veterans (All branches of service)	Dissertations
Peer-reviewed articles	Non-research articles (fact sheets)

Conceptual Framework (Whittemore & Knafl)

An IR is a specific review method that summarizes past empirical or theoretical literature to understand better a particular phenomenon (Whittemore & Knafl, 2005). Developed by Harris Cooper (1998) and modified by Whittemore and Knafl (2005), the IR incorporates a wide range

of purposes: to define concepts, to review theories, to review evidence, and to analyze the methodological issue of the topic of interest. The IR synthesizes diverse findings and provides a framework for future research and practice. It highlights the current state and measures the quality of evidence in the literature (Toronto & Remington, 2020). The conceptual model, as defined, provides focus, rationale, and a tool for integration and interpretation of information (Moran et al., 2017).

The framework, the Preferred Reporting Items for Systematic Reviews, and Meta-Analyses (PRISMA) Statement, guided this IR (see Appendix D). This framework was used to organize the literature into various categories utilizing the Melnyk Level of Evidence Pyramid (see Appendix C). The framework includes the problem formulations stage, the literature search, the data evaluation stage, the data analysis stage, and the presentation stage (Cooper, 1998). This IR offers a union of different discoveries on TCPs and presents the present evidence quality, nature of proof, gaps in writing, and future strides for exploration and practice (Toronto & Remington, 2020). When conducting an IR, variables, triggers, stakeholders, and dissemination must be explained as well (Toronto & Remington, 2020). The conceptual and operational meaning of variables are vital in decreasing ambiguity in the IR.

PRISMA served to support the framework of this IR and a flow diagram that illustrates the selection process of literature used for the IR (Toronto & Remington, 2020) is included. Furthermore, the IR followed a systematic approach as described by Toronto and Remington (2020) to ensure transparency and rigor. PRISMA facilitated complete and transparent reporting of the IR (Page et al., 2021). The 27-item checklist and flow diagram help in the illustration of the IR. It also provided a reference for the quality of the reporting. Although PRISMA is not a quality assessment tool, it may be used for critical appraisal.

This IR was completed based on the Cooper (1998) conceptual framework, which was later modified by Whittmore and Knafl (2005) for IRs. This approach combines a substantive strategy for a rigorous and complete review of literature. The Doctor of Nursing Practice (DNP) supports the integrative approach to the review of literature. The collection, analysis, and integration of research findings will improve the awareness and understanding of TCPs in civilian healthcare settings for veterans and will inform nursing practice in supporting optimal healthcare outcomes. This approach will display the scholarship of the DNP and demonstrate the importance of identifying the “overlooked mission” to raising the awareness of TCP use among civilian clinicians to support optimal healthcare outcomes for veterans. The IR framework was based on the five-stage process of Whittmore and Knafl (2005). The following stages were brought to realization: problem identification stage, literature search stage, data evaluation, data analysis, and presentation of results (Toronto & Remington, 2020).

Problem Identification Stage

Identifying a problem and the purpose of a review are the first steps in any review (Whittmore & Knafl, 2005). This IR addressed the need for TCP use in civilian healthcare settings to support optimal healthcare outcomes for veterans. There are significant consequences associated with high readmission rates of veterans in the civilian provider healthcare sector. For veterans with many chronic diseases and complex therapy regimens, high-quality transitional care is especially vital. Veterans are likely to receive care from a variety of clinicians and move around within health care settings regularly. According to a growing body of evidence, they are vulnerable to care breakdowns and thus have the greatest need for transitional care services.

Literature Stage

Search strategies are critical to the review process to support enhanced rigor and complete unbiased results (Whittemore & Knafl, 2005). The specific focus was raising awareness for the use of TCPs among civilian clinicians to improve the healthcare outcomes of veterans. Whittemore and Knafl noted that obtaining all the relevant literature on a problem can be challenging. A comprehensive literature search aims to attain the maximum number of eligible primary sources using multiple strategies. This review used a table of evidence to organize data in a meaningful way to ensure consistency of information from all resources. This table of evidence consisted of the study purpose, sample information, methods, study results, level of evidence, study limitations, and usefulness to support a change (see Appendix A).

The search strategy for the review included a comprehensive, computer-assisted search of the Cochrane Library, PubMed, Medline, National Guideline Clearinghouse, Google Scholar, and the Cumulative Index of Nursing and Allied Health Literature (CINAHL) from 2016 to 2021. Keywords and phrases used for the search included transition and care management program, transition program, transitional health care programs, transitional care, civilian healthcare settings, VHA healthcare settings, and veterans. The IR revealed 35 peer-reviewed articles. The systematic literature review included articles related to TCPs, veterans, care management programs, and transitional care.

Two articles were categorized as systematic reviews (Ayele et al., 2021; Liss et al., 2019). Nine case studies (Ayele et al., 2019; Benzer et al., 2020; Bingham et al., 2019; Burke et al., 2019; Libbon et al., 2019; Lovelace et al., 2016; Miller et al., 2019; Rinne et al., 2017; Vaughan et al., 2018), one pilot study (Libbon et al., 2018), and two quality improvement projects (Libbon et al., 2019; Miller et al., 2019) were included in the review based on the topic

of interest. Three of the articles were categorized as qualitative (Crytzer et al., 2019; Etchin et al., 2021; McCreight et al., 2019). Cohort studies consisted of six articles (Eh et al., 2020; Kind et al., 2016; Miller et al., 2020; Rottman-Sagebiel et al., 2018, Schlosser et al., 2020; Wray et al., 2019).

Target Audience. Identifying a target audience in research synthesis is complicated, according to Cooper (1998). The target audience for this IR was civilian healthcare providers. The secondary audience was veterans. The secondary population for this review was veterans in TCPs compared to veterans without referrals to TCPs. The primary and secondary audience permitted generalizations, with the goal for the readers of the IR to develop insight regarding the value of TCPs by civilian clinicians among veterans supporting optimal health outcomes. The age and gender of veterans were not a factor in the inclusion or exclusion process. The population samples of the literature included any ethnicities and races of veterans to maintain a broad base of participants from various service branches (Army, Navy, Air Force, Marines, Coast Guard).

Inclusion. Publications dated from 2016-2021 were included to ensure current date of information and research was applied. The research did not include unpublished dissertations. Further inclusion criteria included the availability of reports in full text, practice settings of all types, and reviews written only in the English language.

Exclusion. The search excluded articles dated prior to the year 2016. Additional exclusions were literature not available in full text and written in a foreign language, non-veterans, unpublished dissertations, and non-research articles.

Setting. Studies associated with VHA, and civilian settings were considered based on the topic of interest.

Data Evaluation Stage

The process of conducting an analysis is extraordinarily complex due to the variety of studies involved and the data collected from different methodologies (Whittemore & Knafl, 2005). This makes it difficult to analyze the data. Aside from case studies, other studies such as cross-sectional studies were also included in the analysis (Whittemore & Knafl, 2005). It is particularly important that the literature is evaluated properly when the research designs are different from those used in other studies. It is more challenging to define the quality of the literature when primary sources are not necessarily empirical. The most important aspect to consider when it comes to the quality of the literature is the authenticity of the sources. If the report is theoretical, then other methods should also be considered. It is at this stage that the data are organized, coded, categorized, and summarized into a coherent interpretation and conclusion (Whittemore & Knafl, 2005).

Quality criteria instruments can be helpful when determining the quality of primary sources (Whittemore & Knafl, 2005). The PRISMA checklist served as a quality criteria instrument to evaluate the quality of sources (see Appendix D). Another quality instrument used for the IR was the Melnyk Pyramid (Melnyk & Fineout-Overholt, 2015), which allowed for the scoring of reports from I to VII based on level of evidence (see Appendix B). Level I includes systematic reviews of controlled trials; level II is a randomized controlled trial; level III is a

controlled trial (non-randomized); level IV is a cohort or case-controlled study; level V is a systematic review of descriptive studies; level VI is a single descriptive study; and level VII is expert opinion.

Data Analysis Stage

It is at this stage that the data are organized, coded, categorized, and summarized into a coherent interpretation and conclusion (Whittemore & Knafl, 2005). As one of the most difficult stages of the IR, this stage has the most potential for error. In this stage categories, distinguishing patterns, themes, relationships, and variations are identified and displayed for the reader.

Initially, extracted data are compared item by item so that similar data are categorized and grouped together (Whittemore & Knafl, 2005). The IR will recast, combine, reorganize, and integrate sources to recreate new knowledge regarding the topic. The goal of the data analysis stage is to provide an unbiased analysis of the primary sources. It also aims to create a comprehensive synthesis of the evidence. According to Whittemore and Knafl (2005), data analysis is compatible with varied data from multiple methodologies.

Arranging, coding, and categorizing is difficult because of the many forms of research. As a result, a constant comparison strategy employed in qualitative designs applies to IRs between data sources. The approach was systematic and consisted of data reduction, data display, data comparison, and conclusion drawing and verification (Whittemore & Knafl, 2005). The purpose of these processes was to provide clear information on the studies and results associated with the topic of raising awareness of TCPs use among civilian clinicians to improve healthcare outcomes for veterans.

Constant Comparison Method. This method allowed the reviewer to convert data into categories and led to the identification of patterns, relationships, and themes (Whittemore &

Knafel, 2005). Extracted data were compared item by item and groupings were compared to facilitate further analysis and synthesis. For this IR, iterative comparisons were continually made between data sources to allow for constant comparison, and conclusion drawing and verification (Whittemore & Knafel, 2005).

Data Reduction. Data reduction was divided into two phases. The first phase determined a classification system for managing the data via subgroups. Each level of evidence represents sequential analysis, considering chronology, setting, sample characteristics, and participants' experiences. The next phase involved extracting and coding data into a manageable framework. The framework was compiled into a matrix and supported comparing primary resources on specific issues, variables, and data characteristics (Whittemore & Knafel, 2005).

Data Display. The extracted data were converted into a chart to support comparison across all primary resources for the identified subgroups. The data served as a starting point for interpretation. The matrix was displayed in a chart to provide a visual portrayal of the writing assembled and utilized in the IR.

Data Comparison. The data comparison step is an iterative process of examining displays of primary source data to identify patterns, themes, and relationships (Whittemore & Knafel, 2005). This IR provides a conceptual map that consists of the defined variables and similar variables so that patterns and relationships between variables were depicted easily. An important aspect to remember is that the strategies of data comparison are continuously evolving, and transparency is necessary when discussing methods used in the data analysis stage (Toronto & Remington, 2020). Data comparison supports the drawing of conclusions with rigorous analytic activities.

Conclusion Drawing and Verification. Higher levels of abstraction are found in this final phase of data analysis. Generalizations from each subgroup are reflected, along with identification of commonalities and differences. Whitemore and Knafl (2005) suggested that conclusions and conceptual models that emerge be revised and verified to include as much data as possible. The conclusion phase maintains that conflicting evidence is challenging when the evidence presented is compelling. Conflicting evidence is often an indicator for additional research (Whitemore & Knafl, 2005). After the subgroup analysis, the synthesis of elements and conclusions are complete. A new paradigm of primary sources and all subgroups are included into a holistic depiction of the topic of interest. Records kept during the entire data analysis process ensured that analytical honesty and process transparency were considered (Whitemore & Knafl, 2005).

Presentation of Results

The presentation of the results phase in an IR is pivotal in displaying explicit details from sources and evidence to support conclusions, according to Whitemore and Knafl (2005). The results of an analysis are presented in a table or diagram, which supports the conclusions and provides a new understanding of the subject (Whitemore & Knafl, 2005). The various limitations of the review are also highlighted. This process additionally involves communicating the implications for practice, policy, and research. This IR project was divided into three different types of presentations: a table, a flowchart, and concept maps. The table shows the various information sources that support the findings (see Appendix A), and the systematic approach used during the literature search is displayed in the flowchart (see Appendix D).

The concept maps also depict the multiple themes that were identified (see Figure 1), as well as the types of TCPs that were found in the study (see Figure 2). The process of conducting

an analysis is particularly challenging due to the variety of studies involved and the data collected from different methodologies. The data collected during the IR supports the need for more research to understand the topic and improve practice to support devising guidelines for TCP utilization by civilian providers. It also provides a valuable contribution to the development of health policy.

Figure 1

Transitional Care Programs

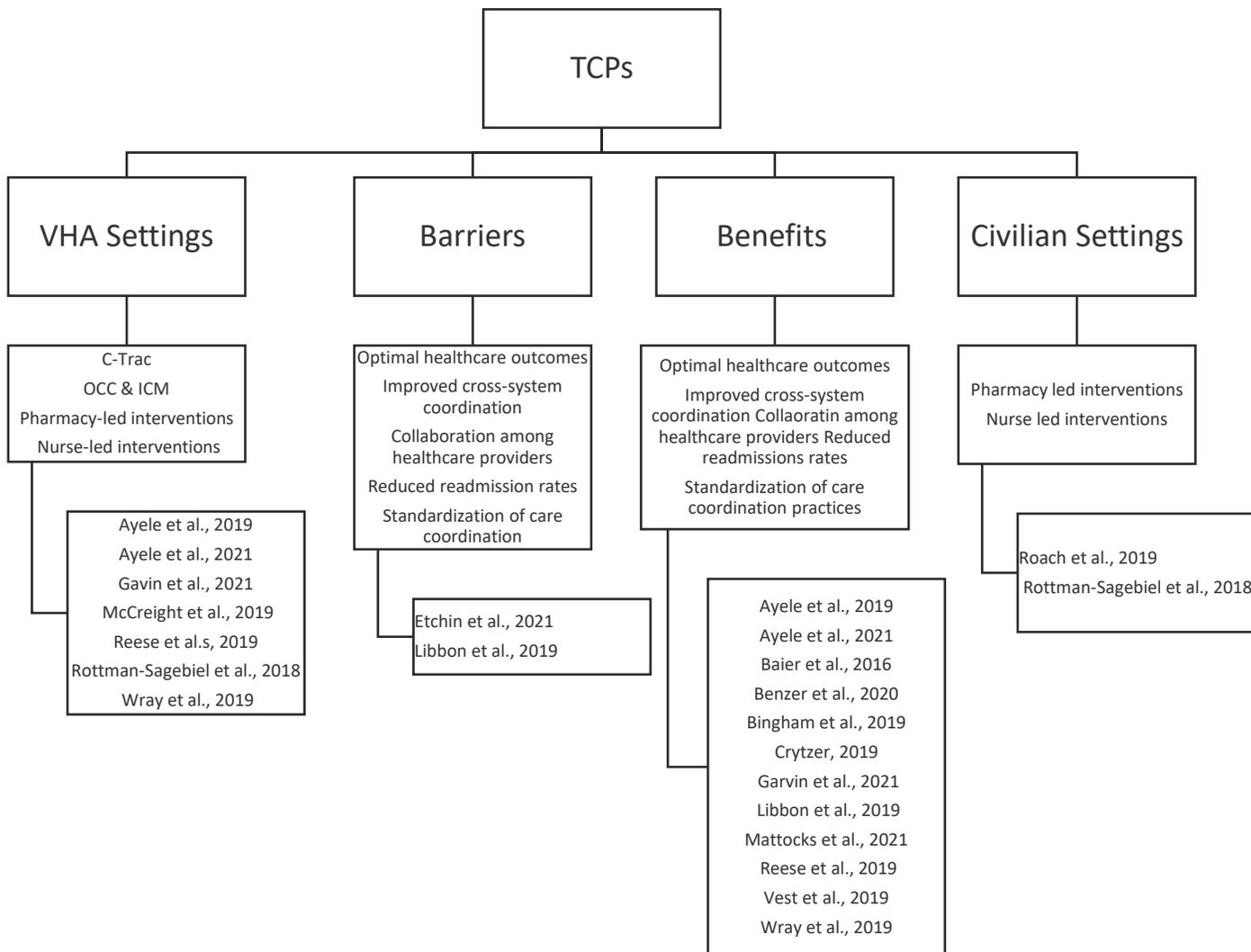
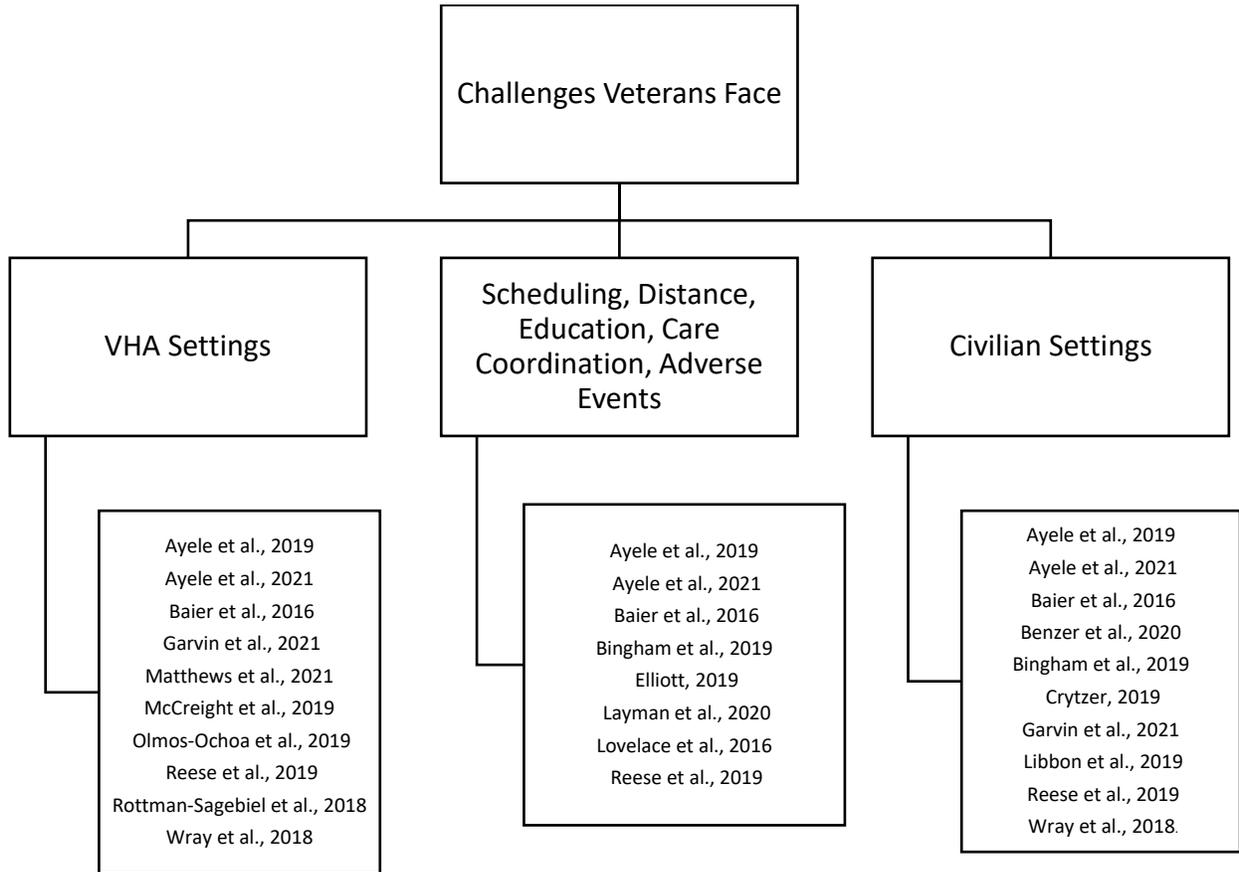


Figure 2

TCPs Civilian Healthcare



SECTION TWO: SEARCH STRATEGIES

Search Organization and Reporting Strategies

IRs are described by Whitemore and Knafl (2005) as contributing to a deeper understanding of the subject by including experimental and non-experimental research in a review and addressing many purposes simultaneously. Consideration must be given to the way that different types of studies are combined and integrated to form conclusions when they use different research methods. The need for all types of literature reviews has become more evident as the need for evidence-based practice (EBP) initiatives have also increased. For these reasons the literature search must be comprehensive, organized, and clearly reported (Toronto & Remington, 2020).

Search Strategy

The Cochrane Library, Nursing & Allied Health Database (ProQuest), OVID Technologies, Inc. (OVID) Medline, Cumulative Index of Nursing and Allied Health Literature (CINAHL) Plus with full text, and Health Source were used to search for literature related to the topic. Keywords and phrases relevant to this topic included transition and care management program, transition program, transitional health care programs, transitional care, veterans transitional care, veteran readmissions, VHA readmissions, civilian healthcare, and non-VHA healthcare. A preliminary search of English-language articles published in the last five years, resulted in 254 articles for review. The search was then further refined by including articles in full text. Further refinement led to the review of 35 articles shown in the literature matrix (see Appendix A). Each study included in the literature matrix includes reference, study purpose, sample characteristics, methods, study results, level of evidence, study limitations, and rationale for using the article to support a change.

Melnyk Pyramid. The Melnyk Pyramid provides a system for sorting studies according to the likelihood that the evidence will answer the clinical question (see Appendix C). The levels range from one to seven, with no studies excluded based on their level. Studies with various levels can offer valuable insight. Level I is meta-analysis of randomized controlled trials; level II consists of one or more randomized controlled trials, while level III is a controlled trial without randomization. An example of level IV would be a case-control or cohort study, and level V includes systematic reviews of descriptive and qualitative studies. Level VI involves a single descriptive or qualitative analysis, and finally, level VII, includes expert opinion.

PRISMA Statement. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) supports the framework. PRISMA aims to support the reporting guidelines for systematic reviews that reflect advances in methods to identify, select, critically appraise, and synthesize studies (Page et al., 2021). The flow diagram reports the selection process of literature used for this IR (Toronto & Remington, 2020), which is found in Appendix D. PRISMA is comprised of a checklist of 27 items to illustrate the information flow (Page et al., 2021).

Terminology

Documentation of the search process and terms used to conduct the search are essential to ensure rigor and transparency (Toronto & Remington, 2020). This IR was guided by the review questions and search terms were adjusted as needed to produce relevant results. The search terms included: transition and care management program, transition program, transitional health care programs, transitional care, veterans transitional care, veteran readmissions, VHA readmissions, civilian healthcare, and non-VHA healthcare. Boolean phrases (e.g., OR, AND, NOT) were utilized as needed to expand or limit the search of literature based upon inclusion and exclusion

criteria. Consultation with a research librarian further refined the search and ensured the inclusion of relevant articles.

Limitations

Several limitations were noted in this IR. One limitation is the use of a single reviewer. A single reviewer could affect the accuracy of the results. Another issue that was noted was the implementation of a search strategy that involved only one researcher. The scope of the search was exceptionally large, and it was challenging for the reviewer to identify the most appropriate articles for the review due to the volume of literature. It was also noted that the terms used in the search might have led to overlooking some studies related to TCPs. The PRISMA and the Melnyk Pyramid were used to screen the articles for eligibility, but these systems demonstrated some differences. This issue led to the inclusion of some studies that were not eligible for review but did offer some insight pertaining to the topic of interest. This could have affected the internal validity of the results.

SECTION THREE: MANAGING THE COLLECTED DATA

The IR included articles related to TCPs, veterans, care management programs, and transitional care in VHA and civilian healthcare settings. The systematic and comprehensive search yielded 35 articles with variations ranging from level one to level six on Melnyk's Pyramid of Evidence (Melnyk & Fineout-Overholt, 2015). Two of the studies were systematic review of randomized controlled trials (Ayele et al., 202; Liss et al., 2019); one study was a randomized control trial (Alper et al., 2021); four studies were control trials without randomization (Baier, 2016; Benzer et al., 2020; Layman et al., 2020; Roach et al., 2019); 20 were cohort studies (Ayele et al., 2019; Bingham et al., 2019; Burke et al., 2019; Burke et al., 2020; Cordasco et al., 2019; Eh et al., 2020; Kind et al., 2016; Libbon et al., 2019; Lovelace et

al., 2016; Mattocks et al., 2019; Mattocks et al., 2021; McCreight et al., 2019; Miller et al., 2019; Miller et al., 2020; Miller et al., 2021; Rinne et al., 2017; Rottman-Sagebiel et al., 2018; Schlosser et al., 2020; Wallace et al., 2018; Wray et al., 2019); four studies were systematic reviews of qualitative studies (Crytzer, 2019; Garvin et al., 2021; Olmos-Ochoa et al., 2019; Reese et al., 2019); and four were single qualitative or descriptive studies (Elliott, 2019; Etchin et al., 2021; Miller et al., 2021; Vest et al., 2019). These articles supported the problem statement that addressed the issue of TCPs being poorly acknowledged among civilian care providers and therefore put veterans at an undue risk for readmissions. The articles also support TCP use, outcomes related to the use of TCPs, veterans and their vulnerability related to high readmission rates, and the impact civilian settings have on veteran health outcomes.

PRISMA Flow Diagram

Data analysis was presented utilizing PRISMA. PRISMA supports a flow diagram methodology (see Appendix D). The flow diagram starts with the number of articles identified from the initial search. There were 254 articles screened for the IR. Further refinement led to 35 articles (see Appendix D). The 35 articles were selected for the IR and are displayed in the literature matrix (see Appendix A).

SECTION FOUR: QUALITY APPRAISAL

After collecting and organizing the data, a quality appraisal was required. This process was systematically carried out to evaluate the relevance and value of the literature (Toronto & Remington, 2020). It involved selecting the most relevant and reliable literature and applying exclusion and inclusion criteria. The selected literature was evaluated according to the IR's review questions to ensure relevancy, which guided the IR process. While maintaining rigor, the author considered the strengths and weaknesses of the studies concerning the methodology.

Besides ethical approval, the quality of an evaluation also includes the approval of an Institutional Review Board (IRB). Institutional approval was obtained through the Liberty University IRB (see Appendix E). To ensure an understanding of the importance of protecting human subjects in research, the project researcher and project Chair completed the Collaborative Institutional Training Initiative (CITI) training (see Appendix B). The data search for the IR regarding TCPs, and their utilization by VHA and civilian settings was complete according to the description by Toronto and Remington (2020).

According to the description supplied by Toronto and Remington (2020), the data search for the IR was complete. The search was considered complete when the search strategy had been modified by adding relevant terms based on citations relevant to the topic; new searches contained no new and unique results; and searches on the high-profile authors of the topic did not reveal new citations.

Source of Bias

The quality of studies published increases when reductions in the number of studies are affected by bias. This issue can also affect the credibility of the review. It is crucial that the researchers thoroughly investigate the various sources of bias in the studies. For instance, publication bias can occur when a study is not published; therefore, a professional librarian was consulted to guide the researcher for this type of literature. The IR further considers qualitative concept components as transferable, credible, and dependable to prove the IR findings' trustworthiness. Note that gray literature was not utilized to support the topic of interest. According to Toronto et al. (2020), gray literature includes unpublished papers, such as dissertations, white papers, and theses.

Internal Validity

The internal validity of a study focuses on the believability of its findings. If there is bias in the individual studies selected for the IR, this will affect the validity of the entire study. The clinical questions and the problem statement are the basis for the IR. Each study was chosen based on the type of research, the limitations of the study, and the potential bias that could affect its validity. The studies reflect clinician use of TCPs for veterans; however, the research is lacking when discussing the actual utilization of TCPs among civilian clinicians for veterans. The studies offered further insight to devise themes of interest for the IR. These themes included barriers to caring for veterans in civilian settings, strategies for improving veteran care and TCP use, and challenges veterans face without effective TCPs.

Appraisal Tool

The appraisal of literature is not always straightforward and can be very inconsistent. There is no ideal method for assessing the quality of literature for an IR (Toronto & Remington, 2020). In nursing, various tools are used to evaluate the quality of the literature. One of these is the Melnyk Level of Evidence (LOE) Pyramid, which is a tool that focuses on the most critical quality of the literature. This LOE is noted in Appendix C. There were two-level I studies, five-level III studies, 20 level IV studies, four-level V studies, and four-level VI studies that supported the IR. The strength of the research evidence is moderate, as 35% of the studies were rated as level one, two, or three on Melnyk's Pyramid (see Appendix A).

Reporting Guidelines

Guidelines for reporting demonstrate how the IR proposal becomes written to eliminate bias within the final review. The guidelines also acknowledge the importance of the iterative process of the IR. In 2020, Toronto and Remington noted that the quality of information

collected using preferred reporting items and meta-analyses increases the implementation of the PRISMA guidelines (see Appendix D). The 27-item checklist critically appraises the literature through a flowchart.

Applicability of Results

The appraisal results for each study are displayed in the matrix. The IR contributes to understanding problems and the development of solutions when the applicability of results is recognized (Whittemore & Knafl, 2005). The themes identified for this IR were analyzed to determine the applicability of the results addressing the phenomena of interest. The main themes identified were the barriers in civilian settings, strategies for improving TCP use, and challenges veterans face without effective TCPs. The IR revealed themes to raise awareness related to the use of TCPs among civilian healthcare clinicians for veterans.

Barriers in Civilian Settings

The complexity of the health risks faced by military veterans has raised concerns about their poor health outcomes. It is important that civilian healthcare providers are knowledgeable about these individuals' unique needs, which can often lead to barriers in care delivery (Crytzer, 2019). When patients receive care from the VHA and civilian settings, they often experience issues with coordinating their care due to the lack of information exchange and the system that relies on patients to coordinate their care (Benzer et al., 2020). The lack of coordination and the poor delineation of responsibilities among healthcare clinicians within civilian settings affects the level of care demonstrated to the veteran population. Therefore, enhancing communication among these providers and their patients is essential to improving care transitions and outcomes (Baier et al., 2016).

Additionally, the transfer of medical records from VHA providers poses a significant barrier to the civilian clinician's ability to provide care safely and effectively for the veteran (Benzer et al., 2020). The lack of continuity in care provision will hinder the effectiveness of TCPs for veterans. Most healthcare in the U.S. is considered fragmented, as many clients have different providers across several systems of care. While it is desirable to have care across settings, evidence shows that this type of care can lead to less efficient and less safe care (Eh et al., 2020). Veterans often receive dual-use care provision, which is when veterans receive care from healthcare facilities and civilian providers. Although advocated, this care provision often leads to challenges in veteran care (Pope et al., 2018).

Strategies for Improving TCP Use

The VHA has developed various strategies and resources that help facilitate safe transitions to minimize poor health outcomes, via TCPs. One of the most important factors that healthcare providers need to consider when it comes to improving the use of TCPs is the understanding of their patients' complex healthcare needs. Civilian clinicians can improve the use of TCPs among veterans by understanding the veteran's socioeconomic status, medical history, and military experiences. Through the acknowledgement of these experiences, the veteran and provider can work collaboratively towards optimal healthcare outcomes. For example, one particular study in the literature noted a pharmacy-led TCP that assisted veterans in receiving follow-up care after hospital discharge (Lyman et al., 2020). This program supported collaboration and communication to best understand the veteran's healthcare status. Utilizing TCPs has proven to best support optimal healthcare outcomes for veterans. Another reviewed study revealed that patients who receive comprehensive post-discharge care, including

instructions on self-care and medications, have fewer chances of experiencing adverse events (Ayele et al., 2020).

Understanding Veteran Demographics. Providing practical, culturally competent care for service members is essential for civilian clinicians. Deployment, combat exposure, and military-specific environmental exposures create a set of health needs unique to the veteran population (Vest et al., 2019). Despite the various advantages of having a civilian healthcare provider, it is still challenging for them to communicate with the needs of veterans effectively. Therefore, the clinician must develop an understanding of the diverse healthcare requirements affecting the veteran population. Civilian providers must identify veteran experiences and their healthcare needs to identify military-related health sequelae to provide appropriate care.

Communication. Despite the positive effects of increased access to care, there is still a gap in the care coordination between healthcare systems. This issue is often the result of a lack of or ineffective communication between systems of care (Koufacos et al., 2022). Aside from being able to provide the necessary care, one of the most common issues healthcare providers encounter when it comes to communicating with veterans is the lack of information on health history, discharge summaries, and referrals (Schlosser et al., 2020). According to Schlosser et al., the key factors that can improve the coordination of care between civilian and VHA providers are the availability of the information they need to provide adequate care. Other areas of concern regarding lack of communication include getting care authorized, communicating with a specialist, the review of discharge summaries, and ensuring timely medication renewals (Schlosser et al., 2020).

Challenges Facing Veterans

Poor coordination between providers and patients is often the cause of costly and recurring hospital readmissions. Despite the increasing attention given to the quality of care, little is known about the perspectives of providers and patients on the various aspects of rehospitalization. Veterans have various challenges associated with using TCPs across healthcare settings. Knowledge gaps and deferred power, difficulties navigating the health care system, and complex psychiatric and social needs are some areas where veterans may experience poor health outcomes when not involved in TCPs. Veterans face difficulty in recalling the multiple healthcare providers assigned as care providers. Challenges are also noted when having to transition between various healthcare systems. The situation is especially worrisome when transitioning between VHA and civilian healthcare settings. Patients with fragmented care are more likely to experience higher rates of hospitalization and worse clinical outcomes. They are also more prone to higher costs associated with healthcare. Veterans are especially vulnerable to this issue as they are more likely to have multiple health insurance plans and providers (Rinne et al., 2017).

SECTION FIVE: DATA ANALYSIS AND SYNTHESIS

According to Whittmore and Knafl (2005), data analysis in research reviews is done by carefully classifying, labeling, and describing the information collected from primary sources, ensuring the findings are thoroughly integrated and presented in a unified manner. A data analysis aims to provide an unbiased and comprehensive analysis of the available information. It also involves developing a synthesis of the evidence. The analysis and synthesis will provide the stage to address TCP use among civilian clinicians for veterans to support optimal healthcare outcomes. This stage included data reduction, display, and comparison. Among the themes

identified were barriers to caring for veterans in civilian settings, strategies for improving veteran care and TCPs use, and challenges veteran face without effective TCPs.

Data Analysis Method

The goal of an IR is to create a deeper understanding of the topic by identifying the various facets of the data used to develop a new concept or framework for understanding the phenomenon of interest. The data analysis process is beneficial for the researcher and helps increase the knowledge of the subject. A data matrix is also helpful in providing a structure to the presentation of the results. This matrix type displays the citation, study purpose, sample characteristics, methods, study results, level of evidence, study limitations, and evidence to support a change (see Appendix A). The creation of a review matrix is essential in data analysis. Creating a matrix deconstructs individual literature sources into essential elements (Toronto & Remington, 2020).

For this IR, a constant comparison method was used. A constant comparison method is a broad-based approach that combines qualitative and quantitative methods to create systematic categories. The analysis starts by acknowledging the objective of the IR, which is to create a better understanding of the topic (Toronto & Remington, 2020). The goal of an analysis is to create a new framework for understanding the phenomenon of interest. This process involves analyzing the collected data and developing a new concept or framework that will help improve the knowledge of the subject. In addition to being able to analyze the data, the process also involves constant comparison to identify new themes that supported the study.

Synthesis

The process of synthesis is a complex and creative process that involves identifying and developing new sources. It can lead to a new understanding of a topic or a new model (Toronto

& Remington, 2020). Knowledge from the literature was synthesized into a significant, value-added contribution to new knowledge on the use of TCPs by civilian healthcare clinicians. The literature supports raising the awareness of using TCPs by civilian clinicians to support the most optimal healthcare outcomes for veterans. Although synthesis is a process that involves the creation of a new concept, analysis is different from synthesis since it focuses on the deconstructing of a phenomenon into its themes (Toronto & Remington, 2020).

The themes identified for this IR were barriers to caring for veterans in civilian settings, strategies for improving veteran care and TCP use, and challenges veterans face without effective TCPs. The author aimed to create new models and perspectives for the topic of interest through critical analysis. The strength of the research evidence was found to be moderate, as 35% of the studies were rated as level one, two, or three on Melnyk's Level of Evidence Pyramid (see Appendix A). This IR's results support the need to raise the awareness of TCP use among civilian clinicians for veterans. The literature revealed no devised standards or guidelines in the use of TCPs among veterans in civilian health care settings. Supplemental research confirmed that TCPs supported readmission rates, but there was little information specific to the veteran population regarding use in civilian healthcare settings (Agency for Healthcare Research and Quality [AHRQ], 2019). The results of this IR support the need to devise standards and guidelines that support the topic of interest.

Types of Barriers

The results of this IR project revealed that there are various barriers that prevent effective use of TCP in civilian settings (Burke et al., 2019). Burke et al. noted that one of the most significant barriers to understanding the quality of care that veterans receive, or need is the lack of information about the services available to them in both the VHA and civilian settings.

Barriers to effective TCP implementation are demonstrated across the VHA and civilian settings during care coordination for veterans (Ayele et al., 2019). Information exchange between the VHA and civilian settings significantly hinders effective TCPs and continuity of care for veterans. The VHA and other healthcare providers should consider new delivery models that can help expand veterans' access to healthcare and treatment outside the VHA setting. These include training more providers in the healthcare requirements facing the veteran population, as well as the value of TCPs for this population.

Organizational Barriers. Availability and communication are a key factor in the effectiveness of TCPs across healthcare settings (Ayele et al., 2021). Lack of organizational buy-in from civilian clinicians and healthcare staff reduces the opportunity of supporting optimal healthcare outcomes for veterans. Other factors such as the complexity of the patient population and lack of institutional commitment to TCP utilization was also noted. The key to improving the quality of care for patients is collaboration within and beyond the organization. This can be accomplished through the development of effective care transitions programs, financial restrictions, and the recruitment of staff members committed to ensuring optimal healthcare outcomes.

Logistical Barriers. Most veterans are accustomed to receiving healthcare from VHA settings; however, through partnerships within civilian settings, the opportunity for receiving care from various provider settings has become a standard process for veterans (Schlosser et al., 2020). Besides the recruitment of staff members, the development of effective care transitions programs and the implementation of strategies geared toward improving the quality of care for patients are important factors for healthcare organizations to consider. These include the

establishment of a comprehensive TCP and the development of effective communication and collaboration within and beyond the organization.

Social Barriers. Veterans are skeptical about the efficacy of treatment and are often reluctant to try it. They also feel that seeking help could be seen as a sign of weakness. Other cultural and personal concerns can also prevent veterans from seeking help. Veterans, especially those affected by mental health conditions, are reluctant to seek help for healthcare outside the VHA settings due to the stigma associated with mental health disorders. Veterans receiving care across multiple healthcare systems should be able to receive effective care coordination to avoid experiencing adverse effects. This can be accomplished through the identification and treatment of social determinants of health (Ayele et al., 2021).

Strategies for Utilization

Veterans face challenges of optimal health outcomes due to poor utilization of TCPs by clinicians in civilian settings; therefore, acknowledging the lack of utilization is imperative to practice change (Libbon et al., 2019). The approach needs to involve how to increase the knowledge among the care providers (Libbon et al., 2019). Today's veterans are more prone to experiencing mental and physical symptoms that can last for decades. It is therefore important that they receive the necessary care coordination and treatment to improve their health. This can be done through the implementation of an interprofessional approach that includes multiple health services (Crytzer, 2019). Bingham et al., (2019) revealed the implementation of multiple communication systems and bundling of various interventions has led to the creation of more comprehensive care plans for veterans.

Strategies for Effective Coordination

The VHA MISSION Act of 2018 promotes veterans' access to civilian healthcare, requiring increased coordination (Olmos-Ochoa et al., 2019). Additional strategies for coordination consist of nurse-led interventions, pharmacy-led interventions, and the development of readmission programs affecting continuity of care (Miller et al., 2020). In 2017, scheduling and communication problems with the VHA delayed needed care for many veterans. As a result, the number of potentially unsafe prescriptions has increased (Schlosser et al., 2019). Two studies conducted by the VHA revealed that the need for systems-based solutions to support the coordination of care for patients with complex chronic conditions is growing (Cordasco et al., 2019).

The veteran also plays a role in care coordination. Education of health needs, communication among clinicians, and transportation to and from appointments are approaches to care in which the veteran can actively participate while collaborating with the healthcare teams. Raising the awareness of TCP use among clinicians in civilian settings to improve the healthcare outcome of veterans must incorporate strategies of communication and collaborations among providers across the spectrum of care for veterans. As a result of their study, Bingham et al. (2019) concluded that a multidisciplinary approach with an emphasis on communication systems was the most effective strategy for addressing the needs of veterans.

SECTION SIX: DISCUSSION

This IR aimed to raise awareness of the use of TCPs among civilian clinicians to support optimal healthcare outcomes for veterans. Challenges veterans encounter with care transitions and how civilian clinicians can improve health outcomes through TCP utilization also guided the review. The IR addresses the various gaps in the knowledge and practice of TCP utilization among civilian clinicians in healthcare settings for the veteran population to support optimal

outcomes. The IR revealed numerous studies that suggested the need for collaboration between the VHA and civilian healthcare organizations to implement TCPs among the veteran population (Benzer et al., 2020; Cordasco et al., 2019; Libbon et al., 2019; Lovelace et al., 2016; Mattocks et al 2019; Miller et al., 2019,2021; Schlosser et al., 2020; Vest et al., 2019). Although the implementation of TCPs in the VHA is successful, further studies are needed to confirm its effectiveness in other settings. High-quality transitional care prevents patients from experiencing poor outcomes, such as hospital readmissions. It can also help minimize the risk of experiencing adverse events (Rottman-Sagebiel et al., 2018).

This IR synthesized information answering the following questions:

1. What standardized care coordination practices are available to support collaborations between VHA and civilian clinicians for effective TCPs?
2. What guidelines support the effective use of TCPs implemented by civilian clinicians?
3. What guidelines aim to solidify practices that align with providing safe and effective healthcare outcomes for veterans in TCPs?

Standardized Care Coordination

The IR revealed that care coordination between civilian and VHA clinicians needs to be supported with standards and guidelines to ensure the effective utilization of TCPs. The VHA coordinates care for all veterans, regardless of their medical conditions, with civilian providers across various service intensities (Cordasco et al., 2019). Care coordination ensures that patients receive the best possible care and are satisfied with their experience. Outcomes are improved by coordinating care and reducing costs. Rinne et al. (2017) revealed that many veterans have delays in service related to missed or duplicative experiences, resulting in challenges that impact their care.

Many of the issues civilian and VHA clinicians encountered during the dual care process included the lack of communication regarding medication updates, lab results, and imaging results (Schlosser et al., 2019). These findings support the need for systems-level solutions to improve care coordination for those with complex chronic conditions (Rinne et al., 2017). VHA is working with various stakeholder groups to establish a comprehensive approach to care coordination of practices. The focus of the approach centers on developing and testing systems-level solutions such as the Patient Information Management (PIM) system, improving care quality, and reducing veterans' cost of care (Cordasco et al., 2019).

Evidenced-Based Practices for TCPs

Evidence-based practice (EBP) care transition interventions are vital for TCPs to improve veteran healthcare outcomes. EBP includes patient education, patient-aligned care teams (PACTs), medication management, and follow-up care. Although the VHA setting remains effective in this area of TCPs, civilian healthcare settings require additional capabilities for successfully utilizing TCPs for veterans to improve healthcare outcomes. Coordination of care is a critical component of healthcare delivery that involves multiple individuals working together effectively.

This process can involve exchanging information and resources between multiple healthcare providers. The VHA is a leading example of how care coordination can improve healthcare quality (Olmos-Ochoa et al., 2019). Interventions such as Coordinated Transitional Care (C-TraC) capture processes that track the veteran's movement across the care coordination process reviewed by a multidisciplinary team. The VHA's C-TraC program is a low-cost program that supports veterans transitioning from a hospital to a community-based care facility. It utilizes hospital-based case managers and nurses, as well as in-depth post-hospital telephone

contact, to help patients and their caregivers navigate the various steps of the transition. The program reduced 30-day rehospitalizations at one facility by over 30% (Kind et al., 2016).

Effective Practice Guidelines for TCPs

The VHA has practical practice guidelines for veteran care. However, studies that address practice guidelines among civilian clinicians regarding TCPs used for veterans' care are limited. Several of the studies revealed the effectiveness of TCPs among civilian clinicians related to civilian patients (Baier et al., 2016; Bingham et al., 2019; Eh et al 2020; Layman et al., 2020; Miller et al., 2020; Roach et al., 2019). TCPs provide in-home or telephonic follow-up, with focused support during the immediate post-hospital period, improving patient safety and reducing hospitalizations (Lovelace, 2019). To improve veterans' care, a pilot program, VETSTEPS, was developed. In this program, best practices and procedures were combined to improve the performance of the hospital (Wray et al., 2019).

Most studies identified nurses as the key individuals involved in implementing the program (Elliott, 2019). Nurses can also identify the needs of their local military veterans and refer them to other healthcare providers. The TCP's intention is to bridge the gap between primary care providers and patients discharged from hospitals or nursing homes. It involves providing them with the necessary support and resources to follow up with their patients. The lack of communication and effective decision-making among healthcare providers are some of the factors that can lead to patient safety gaps during transitions of care. This issue is especially prevalent in ambulatory care facilities. Communication and participation in a shared decision-making process are some factors that can prevent patients from experiencing safety gaps during a transition of care. Preparing for a safe and effective transition of care can help a facility improve

the quality of its services. It can also help prevent errors and improve communication between patients, their care partners, and other healthcare providers.

Implications for Practice

An IR can be pivotal in shaping the future direction of a topic of interest. Implementing TCPs among civilian healthcare clinicians can support optimal healthcare outcomes for veterans. To provide high-quality healthcare to our military veterans, interprofessional teams should work with the VHA to address the health concerns of veterans. As the number of veterans in the U.S. continues to grow, it is important that healthcare providers work together to address the needs of veterans to provide the best possible care. One of the most effective ways to do this is by having nurses working in community settings (Crytzer et al., 2019). The complexity of the health risks veterans face and the various factors affecting their quality of life raise concerns about the potential for poor outcomes. Since many seek care outside the VHA system, healthcare providers must be aware of the unique needs of these individuals (Crytzer et al., 2019).

Issues civilian and VHA clinicians encountered during the dual care process included the lack of communication regarding medication updates, lab results, and imaging results. Patients in VHA and civilian settings risk experiencing adverse events and costly and time-consuming rehospitalizations. The IR revealed sufficient evidence to change practice in support of collaborations between VHA and civilian clinicians to support optimal healthcare outcomes for veterans by using TCPs. Interventions must target the specific health needs of veterans at risk for suboptimal health outcomes. VHA and civilian health settings should continue to explore possibilities with clinically focused TCPs, such as local pharmacies and nurse-led initiatives, to address the significant costs associated with poor outcomes, including readmissions. More

research is needed to determine if TCP use among civilian clinicians in support of optimal healthcare outcomes will impact metrics for quality, including readmission reduction.

This IR revealed several points of discussion to disseminate:

1. TCPs require a multimodal approach to impact the veteran population's complex health issues (Ayele et al., 2021).
2. There is a critical need for veterans and civilian clinicians to become aware of the barriers to effective use of TCPs in civilian healthcare settings (Ayele et al., 2019).
3. There is ample literature regarding TCPs; however, there are limitations in finding a practical approach to care coordination across multiple healthcare settings (Alper et al., 2021; Cordasco et al., 2019; Miller et al., 2019; Olmos-Ochoa et al., 2019; Rinne et al., 2017).
4. The lack of a collaborative practice process between VHA and civilian clinicians in healthcare settings to support the health outcomes of veterans must be addressed (Miller et al., 2019; Pope et al., 2018; Rinne et al., 2017).
5. Standards and practice guidelines for using TCPs in civilian healthcare settings, do not currently exist.

Dissemination

The dissemination of results is the culmination of a scholarly project (Melnik & Fineout-Overholt, 2015). Without effective communication, the information gathered will not provide the necessary value to the public. A well-designed and executed dissemination plan will ensure that the results are communicated to a targeted audience and encourage further studies (Toronto & Remington, 2020). Measuring the project's success also helps improve the quality of the information. This process may be conducted through various methods and tools, such as online

databases and paper publishing. The findings, objectives, audience, user needs, dissemination methods, resources, and barriers should be considered.

Findings

The findings of the IR to be considered for further dissemination include:

1. Establishing effective collaboration among VHA and civilian clinicians in support of TCPs facilitates better health outcomes for veterans (Roach et al., 2019).
2. Addressing fragmented care processes of veterans during care coordination within civilian settings (Mattocks et al., 2021).
3. Identifying effective TCP use by civilian clinicians to improve healthcare outcomes for veterans (Roach et al., 2019; Wallace et al., 2018).
4. Acknowledging the barriers civilian clinicians face in identifying and implementing TCPs for veterans (Vest et al., 2019).

Objectives

In disseminating review findings, clear descriptions of search techniques, analysis, appraisal, and synthesis methods will enhance methodological quality (Toronto & Remington, 2020). The dissemination of this IR's findings aims to raise awareness of TCPs among civilian clinicians for veterans to ensure optimal healthcare outcomes. Designing and implementing a comprehensive strategy for improving the quality of civilian healthcare settings for veterans will be influenced by the experiences of those who use the VHA system. Objectives include: describing the TCPs available for veterans in VHA and civilian settings, challenges veterans face when TCPs are not supported within civilian settings, and factors contributing to the utilization of TCPs by civilian clinicians.

Audience

Effective communication across the spectrum of health care is beneficial for disseminating the IR findings. The stakeholders' interest in raising awareness of TCP use among civilian clinicians affects veterans' health outcomes and supports communication with VHA providers and healthcare systems. Many stakeholder groups can be involved in addressing the issue of TCPs among civilian clinicians for veterans. Stakeholders include providers, nurse care coordinators, case managers, hospital resource teams, and community-based resources. The audience will be able to incorporate collaboration, communication, education, and information to enhance TCPs for veterans in various healthcare systems. In addition, board members and health systems administrators are responsible for the organization's sustainability and quality of its operations; therefore, they would also be a respective audience. Other stakeholder groups, such as social workers and managers, are critical to ensuring TCP utilization in support of optimal veteran health outcomes.

User Needs

The dissemination of the findings gears toward meeting the needs of the various stakeholder groups. The communication efforts aim to provide the audience relevant and meaningful information about the topic of interest (Toronto & Remington, 2020). The dissemination method must keep the audience's attention and provide value and meaning to users; users must see the relevance and weight of the IR and compel them to seek more information on the topic (Toronto & Remington, 2020). Dissemination efforts must incorporate the users most relevant to the topic, providers, nurse care coordinators, case managers, hospital resource teams, and community-based resources. A few users might require high clarification of

IR foundation, methodology, and discoveries, while others may need a quick outline or abstract of the IR.

Methods

Methods to disseminate information in a healthcare system and community includes conferences, podium presentations, publications, poster presentations, news media, and social media (Toronto & Remington, 2020). The appropriate presentation method will provide additional discoveries shared with key stakeholders regarding the awareness of TCPs among civilian clinicians for veterans and their effects on health outcomes. For this IR, the results will be disseminated through various means to include a journal publication submission and a poster presentation at a nursing conference.

Resources

After identifying the objectives, audience, and methods to be used with dissemination, the skills and resources required for the dissemination need to be identified (University of Regina, 2011). Grants are an example of funding resources that could be used to disseminate the IR findings. The VHA and civilian settings will provide an effective platform to display research findings related to the topic of interest. Through the author's affiliation with Army Nurse Corps and various nursing organizations, resources to support the dissemination of the IR findings are a matter of collaborating with the VHA and civilian settings. This dissemination will be shared through abstract or podium presentations that discuss the review findings to raise the awareness of TCP use by civilian clinicians among veterans to support optimal healthcare outcomes.

Barriers

One of the most common barriers that can prevent the successful dissemination of the findings is the lack of support from the healthcare systems regarding the topic of interest. The

lack of provider understanding of specific healthcare issues related to the veteran population is a barrier to consider. Many veterans have multiple conditions and providers, and many are receiving a portion of their care in the community, which will only grow as recent legislation expands options for private care (Cordasco et al., 2019). Having multiple care providers could lead to competing priorities in either health system.

Conclusion

The number of veterans is increasing. As a result of growing numbers, there is a need to consider social support, to include the healthcare of this complex populace. This IR provides a review of literature regarding the use of TCPs; specifically with the goal of addressing the gap regarding TCP usage by civilian clinicians. TCPs work in support of optimal healthcare outcomes. Most often acknowledged in the VHA care system, TCPs support collaboration and communication to ensure coordinated care provision for veterans. There are several noted TCP models in the literature with documented outcomes related to quality, specifically readmission.

Veterans often return to the hospital as a result of failed care transitions; this proves costly physically and financially. This IR revealed studies regarding the impact of TCPs, and further suggested a need to address TCP utilization among civilian healthcare providers to support optimal healthcare outcomes. There are currently no standards or guidelines specific to the use of TCPs by civilian clinicians in support of veterans. The review provided important insight to barriers, as well as strategies to consider with implementation. There is clearly an overlooked mission—TCP utilization in civilian healthcare settings is critical to consider, ensuring optimal veteran healthcare outcomes.

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Appendix A

Evidence Table

Name:

Clinical Question:

Author (year)	Study Purpose/Objective(s)	Design, Sampling Method, & Subjects	LOE*	Intervention & Outcomes	Results	Study Strengths & Limitations
Alper E, O'Malley TA, Greenwald J. (2021). Hospital discharge and readmission. <i>UpToDate</i> . https://www-uptodate-com.ezproxy.liberty.edu/contents/hospital-discharge-and-readmission?search=A%20patient-centered%20transitional%20care,%20case%20management%20program:%20Taking%20case%20management%20to%20the%20streets%20and%20beyond.%20&sectionRank=3&usage_type=default&anchor=H25&source=machineLearning&selectedTitle=5~150&display_rank=5#H25	Examines hospital discharge, details elements of the process that can increase risk of readmission and reveals interventions to improve safety.	Older, high-risk patients with various areas hospitalization, discharge, telephonic follow-ups, and methods to reduce readmissions	Level 2, randomized controlled trial (Melnyk, & Fineout-Overholt, 2015)	Systematic review of 43 studies, 16 randomized trails,	Of the 16 randomized trails, 5 out 16 demonstrated significant decreases in admission rates.	Because of the diversity in interventions, patient populations, and outcomes, the measured outcomes could not be identify based on the specific intervention or impact.
Ayele, R. A., Lawrence, E., McCreight, M., Fehling, K., Glasgow, R. E., Rabin, B. A., Burke, R. E., & Battaglia, C. (2019). Perspectives of clinicians, staff, and veterans in transitioning veterans from non-va hospitals to primary care in	To understand the barriers and facilitators to care continuum for	70 participants involved in transitional care for veterans in civilian healthcare settings. Participates	Level 3, Control Trail (no randomization) (Melnyk,	Perceptions from the participants were ineffective care process across	A qualitative assessment using semi-structured interviews with	This study is acceptable for use for the study proposal objectives. Barriers and facilitators are helpful in designing effective

<p>a single va healthcare system. <i>Journal of hospital medicine</i>, 14(3), E1–E7. Advance online publication. https://doi.org/10.12788/jhm.3320</p>	<p>veterans transitioning from civilian to VHA care settings.</p>	<p>included 23 VA and 29 civilian clinicians and staff members, of which 18 veterans with recent discharges from civilian hospitals.</p>	<p>& Fineout-Overholt, 2015)</p>	<p>the healthcare systems. Four themes were generated to effect smooth transitions and improved care coordination</p>	<p>clinicians, staff, and patients is used.</p>	<p>interventions for transitional care.</p>
<p>Ayele, R., Liu, W., Rohs, C., McCreight, M., Mayberry, A., Sjoberg, H. Kelley, L., Glasgow, R., Rabin, B. & Battaglia, C. (2021). VA care coordination program increased primary care visits and improved transitional care for veterans post non-va hospital discharge. <i>American Journal of Medical Quality</i>, 36(4), 221-228. doi: 10.1177/1062860620946362.</p>	<p>The Community Hospital Transitions Program (CHTP) intervention was developed to address challenges veterans face post non-VA hospitalization.</p>	<p>Veterans discharged from non-VA hospitals</p>	<p>Level 1, Systematic Review. (Melnyk, & Fineout-Overholt, 2015)</p>	<p>A qualitative assessment was conducted using the PRISM</p>	<p>Demonstrated that veterans received timely follow-up after hospitalization.</p>	<p>Unmeasured confounders were evident based on lack of data. Due to limited data, the study may not be generalizable for non-VA facilities. The study can be used to support change. The purpose provided insight on the strategies non-VA hospitals use regarding veterans' readmissions.</p>
<p>Baier, R. R., & Trivedi, A. N. (2016). For hospital readmissions, hindsight is not 20/20. <i>Journal of General Internal Medicine: JGIM</i>, 31(11), 1270-1271. https://doi.org/10.1007/s11606-016-3821-0</p>	<p>Identifying factors that contribute to patients' readmission and prevention strategies.</p>	<p>PCPs, admitting and discharging physicians</p>	<p>Level 3 - Controlled trial (no randomization). (Melnyk, & Fineout-Overholt, 2015)</p>	<p>Survey questions presented to providers regarding patient discharge strategies</p>	<p>All PCPs, (admit or discharge) have important, but different reason for readmissions</p>	<p>The study can support the change in terms of looking through the lens of civilian healthcare settings regarding readmissions. However, it does not refer or relate to veterans</p>

<p>Benzer, J., Gurewich, D., Singer, S., McIntosh, N., Mohr, D., Vimalananda, V. & Charns, M. (2020). A mixed methods study of the association of non-veterans affairs care with veterans' and clinicians' experiences of care coordination. <i>Medical Care</i>, 58(8), 696-702. doi: 10.1097/MLR.0000000000001338.</p>	<p>The study is to determine the experiences of patients and clinicians with care coordination across the VA and civilian system of care.</p>	<p>National survey of VA health records was completed April – Sept 2016. Patient self-reporting and clinician interviews completed may-Oct 2017. Patients with DM2 and CVA or mental health comorbidities was sampled. Observational mix-method with patient and clinical interviews</p>	<p>Level 3 Control trial (no randomization) (Melnyk, & Fineout-Overholt, 2015)</p>	<p>Observational mix-method with patient and clinical interviews</p>	<p>Veterans in both VA and civilian care reported worse experiences versus VA only patients. Clinicians reported adverse clinical decision-making experiences.</p>	<p>Due to observational design, casualization is not established. Sampling is not broad. The study was unable to distinguish between civilian systems used. In addition, nonrandom sample used. The study provided good insight into the limitations of civilian hospital settings regarding veterans care coordination and the potential for poor outcomes.</p>
<p>Burke, R. E., Canamucio, A., Glorioso, T. J., Barón, A. E., & Ryskina, K. L. (2019). Transitional care outcomes in veterans receiving post-acute care in a skilled nursing facility. <i>Journal of the American Geriatrics Society (JAGS)</i>, 67(9), 1820-1826. https://doi.org/10.1111/jgs.15971</p>	<p>The purpose was to measure adverse outcomes in veterans transitioning from a hospital setting to skilled nursing facility (SNF). Both VA and non-VA</p>	<p>Veterans, aged 65 years or older, who were acutely hospitalized and discharged to an SNF</p>	<p>Level 4, Cohort and Case Studies (Melnyk, & Fineout-Overholt, 2015)</p>	<p>Retrospective observational study reviewing hospital records</p>	<p>Four in five veteran transitions (81.7%) occurred entirely outside the VA system.</p>	<p>Information that allowed for reasons of discharge to a SN was unavailable. No standard definition of terms and is not generalizable.</p> <p>The study does provide evidence suitable for change. The study identifies veterans and the utilization of both VA and civilian hospital settings for comparison.</p>

	hospitals and SNFs were used.					
Burke, R. E., Canamucio, A., Glorioso, T. J., Barón, A. E., & Ryskina, K. L. (2020). Variability in transitional care outcomes across hospitals discharging veterans to skilled nursing facilities. <i>Medical Care</i> , 58(4), 301-306. https://doi.org/10.1097/MLR.0000000000001282	Evaluate variability in transitional care outcomes within the VHA and civilian healthcare setting. Identify characteristics of high-performing and low-performing hospitals	Veterans age 65 or older hospitalized with acute issues in a VHA or civilian hospital setting. Subsequently discharged to a skilled nursing facility.	Level 4 Case and Cohort studies (Melnyk, & Fineout-Overholt, 2015)	Retrospective observational study	Variability in hospital outcomes was significant. No hospital in the study was associated with an adverse event. High or low, few identifications	The variability in post-acute exist is unknown. Also, that was no way to identify performing hospital. The study will support the proposal. The study revealed, good outcomes is more than likely to be responsive to transitional care interventions. Able to understand and support TCPs for patient/veterans
Cordasco, K. M., Hynes, D. M., Mattocks, K. M., Bastian, L. A., Bosworth, H. B., & Atkins, D. (2019). Improving care coordination for veterans within va and across healthcare systems. <i>Journal of General Internal Medicine</i> , 34(Suppl 1), 1–3. https://doi.org/10.1007/s11606-019-04999-4	Recommendations on care coordination strategies are discussed in this supplement.	Three workgroups.	Level 4, Case control/Cohort study (Melnyk, & Fineout-Overholt, 2015)	Systematic review of theoretical frameworks	Recommendations based on theoretical frameworks to better understand care coordination across different systems of care	Theoretical frameworks provided for the information discussed in the article. The basis of care coordination and the effect on veterans is discussed in the article, therefore, it will support change

<p>Crytzer, M. L. (2019). Caring for military veterans in the community: An interprofessional approach. <i>Journal of Community Health Nursing</i>, 36(2), 57-64. https://doi.org/10.1080/07370016.2019.1583839</p>	<p>The study focus is on caring for veterans in a community setting</p>	<p>Review of the implementing interprofessional care for veterans within a civilian setting.</p>	<p>Level 5 Literature studies (Melnyk, & Fineout-Overholt, 2015)</p>	<p>Literature review</p>	<p>The research found that interprofessional collaboration enhance healthcare outcomes for veterans</p>	<p>Specific civilian healthcare facilities were not included in the research. The research will support change. Identifying the need of interprofessional care supports good healthcare outcomes for veterans.</p>
<p>Elliott, B. (2019). Civilian nurses' experiences caring for military veterans. <i>Home Healthcare Now</i>, 37(1), 36-43. doi: 10.1097/NHH.0000000000000709.</p>	<p>The study revealed how nurses identified differences in caring for veterans versus non-veterans</p>	<p>Nurses who cared for veterans</p>	<p>Level 6, Single descriptive or qualitative study (Melnyk, & Fineout-Overholt, 2015)</p>	<p>A mixed-methods approach, using both exploratory descriptive and qualitative descriptive components</p>	<p>The study found although some nurses screen for veterans status, there is still a need for further education to improve cultural competence on veteran population</p>	<p>The study only focused on nurses and the number of participants makes for bias results. The study adds insight into the role nurses play in civilian hospitals regarding the care of veterans. This study will support the project.</p>
<p>Eh, K. X., Han Ang, I. Y., Nurjono, M., & Shiow Toh, S. E. (2020). Conducting a cost-benefit analysis of transitional care programs: The key challenges and recommendations. <i>International Journal of Integrated Care</i>, 20(1), 5-5. https://doi.org/10.5334/ijic.4703</p>	<p>Perspective paper describes the approaches used in estimating the total costs of a bundle of</p>	<p>An academic care center review of cost-analysis of transitional care programs.</p>	<p>Level 4, Case Study (Melnyk, & Fineout-Overholt, 2015)</p>	<p>A case study of lessons learned in conducting a cost-benefit analysis of transitional</p>	<p>The study acknowledges the importance of TCPs on improving patient outcomes,</p>	<p>The main point was regarding the cost-analysis of TCPs with little insight on the process of implementation The study adds to the review of how TCPs improves patient outcomes.</p>

	transitional care service.			care program in Singapore	however, the cost-analysis of TCPs requires further review.	
Etchin, A., LaCoursiere-Zuccherro, T., McDannold, S. & McInnes, D. (2021). Dual use of Department of Veterans Affairs and community healthcare: Homeless veterans' experiences, perspectives, and perceptions. <i>Journal of the American Association of Nurse Practitioners</i> , 33(11), 991-998. doi: 10.1097/JXX.0000000000000551.	Explores the homeless population of veterans seeking care within and outside the VHA system	Homeless veterans (n=21) conducted focus groups interviews	Level 6, descriptive study (Melnyk, & Fineout-Overholt, 2015)	This is a descriptive phenomenological study	Veterans' healthcare concerns and needs appeared difficult to meet. However, veterans voiced better care within civilian settings versus that of the VHA.	Was not general to all veterans, just the homeless population. The study will support the need to improve veteran-centered care access and care requirements
Garvin, L., Pugatch, M., Gurewich, D., Pendergast, J. & Miller, C. (2021). Interorganizational care coordination of rural veterans by veterans affairs and community care programs. <i>Medical Care</i> , 59, S259-S269. doi: 10.1097/MLR.0000000000001542.	A review was conducted to examine the interorganizational care coordination initiatives between the VA and community partners in	Peer-reviewed articles that provided original quantitative and qualitative research of interorganizational care coordination efforts for rural Veterans receiving care between the VA	Level 5 - Systematic review of descriptive & qualitative studies (Melnyk, & Fineout-Overholt, 2015)	Systematic review using PRISM guidelines (PRISMA) guidelines consisting of 2 electronic databases (PubMed and Embase) searches for	Included articles provided examples of initiatives that improved or impeded rural health care delivery.	The inclusion process only consisted of rural veterans and those using civilian facilities. There was also a limitation in related studies due to search terms. The review provided examples of initiatives to enhance care coordination among veterans in VA and civilian healthcare systems. This

	caring for rural Veterans	and Community Care settings.		articles published between January 2009 and May 2012		review will add to the support for change.
Greenstone, C. L., Peppiatt, J., Cunningham, K., Hosenfeld, C., Lucatorto, M., Rubin, M., & Weede, A. (2019). Standardizing care coordination within the department of veterans affairs. <i>Journal of General Internal Medicine: JGIM</i> , 34(Suppl 1), 4-6. https://doi.org/10.1007/s11606-019-04997-6	The review discussed standardizing care coordination across various healthcare settings.	VA implementation of a standardized tool assesses Veterans' risk for care coordination failures in the community. A standardized care coordination plan note is utilized, and new referral and authorization systems ensure that critical components of the care plan are followed up appropriately	Level 3 Controlled Trials (no randomizations).	Quality/Initiative implementation /improvement	Achieving High-quality care coordination system across the Veterans. OCC Care Coordination Model and CC&ICM	Editorial without specific medical requirements of study group identified. The article would prove helpful based on implementation of care coordination initiative
Kind, A., Brenny-Fitzpatrick, M., Leahy-Gross, K., Mirr, J., Chapman, E., Frey, B. and Houlahan, B., (2016). Harnessing protocolized adaptation in dissemination: Successful implementation and sustainment of the veterans affairs coordinated-transitional care program in a non-veterans affairs hospital. <i>Journal of the American Geriatrics Society</i> , 64(2), pp.409-416.	The objective project was to adapt a transition model that is specific to civilian healthcare settings.	The local, multidisciplinary key stakeholder group and the UWHC C-TraC leadership	Level 4 - Case-control or cohort study (Melnyk, & Fineout-Overholt, 2015)	Review study of the implementation process of a change model	The pilot program met the organization's goal of the C-TraC invention for transitional care.	A good-fidelity C-TraC program that was feasible and sustained in a non-VA setting. The implementation of a care coordination model generated in the VA system and having the ability to successfully integrate in a civilian system add value to how civilian hospitals

						can provide quality transitional care.
<p>Koufacos, N. S., May, J., Judon, K. M., Franzosa, E., Dixon, B. E., Schubert, C. C., Schwartzkopf, A. L., Guerrero, V. M., Traylor, M., & Boockvar, K. S. (2022). Improving patient activation among older veterans: Results from a social worker-led care transitions intervention. <i>Journal of Gerontological Social Work, 65</i>(1), 63–77. https://doi.org/10.1080/01634372.2021.1932003</p>	<p>The study examined the response of social worker-led CTI would be effective in helping to empower veterans by improving their levels of patient activation as they navigate dual healthcare systems.</p>	<p>Veterans ages 65 and older who was enrolled in primary care at two VA healthcare and also received care from healthcare services at a non-VHA facility within the past two years.</p>	<p>Level 1, Clinical Trials</p>	<p>Clinical trial to measure the intervention of social worker led CTI for veterans discharged from non-VA facilities from Mar 2016 to Jan 2020. Intervention</p>	<p>The changes in the care transitions for veterans from non-VA facilities resulted in a significant increase in the activation levels of these individuals. It also revealed that these changes affected the quality of care.</p>	<p>Sample size too small. The study will be helpful in supporting a change. The study demonstrates how the intervention improves outcomes based on TCPs.</p>
<p>Layman, S. N., Elliott, W. V., Regen, S. M., & Keough, L. A. (2020). Implementation of a pharmacist-led transitional care clinic. <i>American Journal of Health-System Pharmacy, 77</i>(12), 966-971. https://doi.org/10.1093/ajhp/zxaa080</p>	<p>The study describes a pharmacist-led transitional care clinic (TCC) for high-risk patients with recent</p>	<p>A retrospective review of 2016 TCC data for 114 COPD and HF patients.</p>	<p>Level 3 - Controlled trial (no randomization) (Melnyk, & Fineout-Overholt, 2015)</p>	<p>A retrospective review was conducted.</p>	<p>A pharmacist-led TCC effectively reduced readmissions and prevented medication-related</p>	<p>Limited study group participants. Utilizing pharmacists as midlevel Practitioners increased access to care after discharge and improved patient outcome, therefore this research will add to the change.</p>

	hospitalization or was seen in the emergency department (ED).				problems for high-risk patients who were hospitalized or seen in the ED.	
Libbon, J. V., Austin, C. M., Gill-Scott, L. C., & Burke, R. E. (2019). Improving the transition of care process for veterans hospitalized at non-vha facilities. <i>Journal for Healthcare Quality: Promoting Excellence in Healthcare</i> , 41(2), 68–74. https://doi.org/10.1097/JHQ.000000000000000159	The goal was to improve transitions of care for Veterans hospitalized at a nearby community hospital back to the VHA using a robust quality improvement process.	Veterans hospitalized at civilian facilities and received primary care through VA facilities	Level 4 - Case-control or cohort study (Melnyk, & Fineout-Overholt, 2015)	A pilot quality improvement intervention,	The study demonstrated improvement in transitional care of Veterans	Content specific and not widely applicable. The study was unable to demonstrate how the intervention effected readmission rates. This study will add value to the change. The results of an intervention that shows results can validate additional research.
Liss, D. T., Ackermann, R. T., Cooper, A., Finch, E. A., Hurt, C., Lancki, N., Rogers, A., Sheth, A., Teter, C., & Schaeffer, C. (2019). Effects of a transitional care practice for a vulnerable population: A pragmatic, randomized comparative effectiveness trial. <i>JGIM: Journal of General Internal Medicine</i> , 34(9), 1758–1765. https://doi.org/10.1007/s11606-019-05078-4	The aim of the study is to evaluate the effects of a transitional care practice (TC) following discharge. The study addressed the medical	Adults discharged from an initial emergency room visits or inpatient hospitalization	Level 1, Systematic review, randomized controls (Melnyk, & Fineout-Overholt, 2015)	Pragmatic, randomized comparative effectiveness trial	The primary outcome was a two-fold. Indicator of death or readmissions within 90 days of discharge. Secondary outcomes	Study could not differentiate between planned and avoidable readmissions. Outcome data was from one institution only. Although randomization occurred, some factors were imbalanced. The study provided results that evaluated transitional care in civilian settings

	psychosocial needs of patients				included hospitalization over 180 days after initial discharge.	However, the subjects were not veterans. Despite the non-veterans inclusion, the study will still add value to the subject of the proposal.
Lovelace, D., Hancock, D., Hughes, S. S., Wyche, P. R., Jenkins, C., & Logan, C. (2016). A patient-centered transitional care, case management program: Taking case management to the streets and beyond. <i>Professional Case Management</i> , 21(6), 277-290. https://doi.org/10.1097/NCM.0000000000000158	The aim of the study is to examine the impact of the McGuire VAMC TCP on Veteran ED and hospital utilization and costs.	346 Veterans was a part of the study 2013-2014. Veterans that were discharged following inpatient care and having more than two	Level 2 Controlled trial (no randomization) (Melnyk, & Fineout-Overholt, 2015)	Retrospective review of the medical records of 346 veterans.	Veterans who obtained transitional care programs demonstrated a decrease (67%) in hospital admissions and a (61%) decrease in ED visits in the 90 days following participation in this program	The study lacked the ability of measuring veterans' health outcomes. The study would add support to the proposed project. The evaluation cost, utilization and transitional care program impact on veterans were discussed. To aid in the comparison between transitional care programs in the civilian sector.
Low, L. L., Vasanwala, F. F., Ng, L. B., Chen, C., Lee, K. H., & Tan, S. Y. (2015). Effectiveness of a transitional home care program in reducing acute hospital utilization: A quasi-experimental study. <i>BMC health services research</i> , 15, 100.	Evaluation of a transitional home care program operated by the Singapore General Hospital	262 Patients enrolled into the program in a tertiary hospital in Singapore	Level 3, controlled trial (no randomization) (Melnyk, & Fineout-	Used a quasi-experimental study with pre and post design methods.	Patients had a significant reduction in readmission, 52 and 53% respectively within a 3-	Patients were used as the control group. Reductions in readmission amount the participants demonstrates the research would support the change.

<p>https://doi.org/10.1186/s12913-015-0750-2</p>			<p>Overholt, 2015)</p>		<p>and 6-month timeframe.</p>	
<p>Mattocks, K. M., Cunningham, K., Elwy, A. R., Finley, E. P., Greenstone, C., Mengeling, M. A., Pizer, S. D., Vanneman, M. E., Weiner, M., & Bastian, L. A. (2019). Recommendations for the evaluation of cross-system care coordination from the va state-of-the-art working group on VA/Civilian care. <i>Journal of General Internal Medicine: JGIM</i>, 34(S1), 18-23. https://doi.org/10.1007/s11606-019-04972-1</p>	<p>Summarized and synthesized vital literature to recommendati on of cross-system care coordination.</p>	<p>Greater than 50 VA researchers, program directors, clinicians, and policy makers</p>	<p>Level 4, Case study/Cohort study (Melnyk, & Fineout-Overholt, 2015)</p>	<p>Literature synchronizatio n of findings from a workgroup</p>	<p>Identified barriers and limitations veterans face with care coordination .</p>	<p>The study was conducted as an evaluation of literature and workgroups examining specific aspects of care coordination. The study would add value to the proposal in that insight received from stakeholders are important to understanding the need of transitional care programs for veterans.</p>
<p>Mattocks, K. M., Kroll-Desrosiers, A., Kinney, R., Elwy, A. R., Cunningham, K. J., & Mengeling, M. A. (2021). Understanding VA’s use of and relationships with community care providers under the mission act. <i>Medical Care</i>, 59(Suppl 3), S252–S258. https://doi.org/10.1097/MLR.0000000000001545</p>	<p>The study aims to understand the community care partners the VA associates with. Also, to identify areas with the needed for such partnerships and to identity the various challenges in working with</p>	<p>VA directors was used to conduct a nationwide survey to explore needs, challenges, and expectation of community care networks.</p>	<p>Level 4, Case study/Cohort study (Melnyk, & Fineout-Overholt, 2015)</p>	<p>Emailed invitations were sent to 170 VA medical centers to conduct the survey.</p>	<p>The study found the challenges VA providers and community care network face when providing care to veterans. Timely payments from VA and wait times for veterans among the few.</p>	<p>Representation of the larger population of VA was not provided. Only the perspectives of the VA directors were obtained. The evidence can be useful in the current project. The relationship between VA and community care facilities will aid in establishing the effective partnership strategies to better serve veterans.</p>

	community providers.					
<p>McCreight, M. S., Gilmartin, H. M., Leonard, C. A., Mayberry, A. L., Kelley, L. R., Lippmann, B. K., Coy, A. S., Radcliff, T. A., Côté, M. J., & Burke, R. E. (2019). Practical use of process mapping to guide implementation of a care coordination program for rural veterans. <i>JGIM: Journal of General Internal Medicine</i>, 34(1), 67–74. https://doi.org/10.1007/s11606-019-04968-x</p>	<p>The study employed and studied process mapping as a tool for assessing site context prior to implementation of the transitions nurse program (TNP), a new care coordination program.</p>	<p>Front-line staff, including VA providers, nurses, and administrative staff from five VA Medical Centers and nine rural Patient-Aligned Care Teams</p>	<p>Level 4, Case control/Cohort study (Melnyk, & Fineout-Overholt, 2015)</p>	<p>Collection of data from interviews, direct observation and group sessions obtained from staff members of the VA during January-March 2017</p>	<p>Observational qualitative study guided by the Lean Six Sigma approach to evaluate care coordination program.</p>	<p>Unlikely to be generalizable due to variations in the processes. Because the studied outlined process to guide implementation of care coordination programs, it would add to the content of the proposed study.</p>
<p>Miller, C. J., Shin, M., Pugatch, M., & Kim, B. (2021). Veteran perspectives on care coordination between veterans affairs and community providers: A qualitative analysis. <i>The Journal of Rural Health</i>, 37(2), 437-446. https://doi.org/10.1111/jrh.12526</p>	<p>The aim of this study is to investigate the perspectives of veteran based on the challenges in care coordination between the VHA and civilian providers in rural areas.</p>	<p>51 veterans from various age, gender, and geographical</p>	<p>Level 6, Descriptive / Qualitative study (Melnyk, & Fineout-Overholt, 2015)</p>	<p>Qualitative semi structured interviews with directed content analysis to guide analysis from a previous study</p>	<p>As with the previous study, veterans noted challenges with coordination of care due to staffing, geography, and lack of some services.</p>	<p>Limited number of interviews across the geographical locations. Limited generalizability. The study can add evidence to the proposed project. The experiences from veterans and the challenges faced when dealing with care coordination add to the relevancy of the project.</p>

<p>Miller, D., Ramsey, M., L’Hommedieu, T. R., & Verbosky, L. (2020). Pharmacist-led transitions-of-care program reduces 30-day readmission rates for Medicare patients in a large health system. <i>American Journal of Health-System Pharmacy</i>, 77(12), 972–978. https://doi.org/10.1093/ajhp/zxaa071</p>	<p>This report describes the growth and development of the Pharmacy Transitions of Care (PTOC) program at a Florida health system.</p>	<p>Medicare core-measure patients with 30-day readmission rates.</p>	<p>Level 4, Case study/Cohort study (Melnik, & Fineout-Overholt, 2015)</p>	<p>Review of a retrospective reconciliation assessment</p>	<p>Clinical pharmacists improved Patient outcomes through effective medication reconciliation processes. And has been incorporated successfully in all hospitals within the system and sustain a reduction in all-cause 30-day readmission rates</p>	<p>Challenges included patient capture, patient engagement, physician buy-in, and EMR Capabilities. The adaptability of this program to other health systems and hospitals will add value to the proposed project.</p>
<p>Miller, L. B., Sjoberg, H., Mayberry, A., McCreight, M. S., Ayele, R. A., & Battaglia, C. (2019). The advanced care coordination program: A protocol for improving transitions of care for dual-use veterans from community emergency departments back to the veterans’ health administration (VA) primary care. <i>BMC Health Services</i></p>	<p>The Advanced Care Advanced Coordination (ACC) pilot program aims to address the gaps in care coordination</p>	<p>Eligible participants to include veterans with access to both VA and civilian emergency departments. The annual numbers of participants will be between 250-300</p>	<p>Level 4, Case study/Cohort (Melnik, & Fineout-Overholt, 2015)</p>	<p>A quality improvement study conducted by the Advanced Care Coordination (ACC)</p>	<p>The ACC program is an ongoing quality improvement (QI), program to provide longitudinal</p>	<p>Staff notification is required, therefore may not be reported when veterans access services. Sustainability due to cost, limiting staffing to provide information. The quality improvement program will support the current project</p>

<p><i>Research</i>, 19(1), 734-734. https://doi.org/10.1186/s12913-019-4582-3</p>	<p>between the VA and civilian emergency department. The focus is on the veteran’s social determinants of health (SDOH) to facilitate Veterans’ transitions.</p>	<p>veterans including staff for both facilities.</p>			<p>care coordination to dual use veterans for 90 days.</p>	<p>proposal. Addressing the dual use of healthcare facilities by veterans and the challenge of sustainment is important to the research.</p>
<p>Olmos-Ochoa, T., Bharath, P., Ganz, D. A., Noël, P. H., Chawla, N., Barnard, J. M., Rose, D. E., Stockdale, S. E., Simon, A., & Finley, E. P. (2019). Staff perspectives on primary care teams as de facto “hubs” for care coordination in va: A qualitative Study. <i>Journal of General Internal Medicine: JGIM</i>, 34(Suppl 1), 82-89. https://doi.org/10.1007/s11606-019-04967-y</p>	<p>To identify and understand the challenges and factors of care coordination encountered by the staff of a Patient-Aligned Care Team (PACT) in a VHA Clinic</p>	<p>Telephone interview with staff, frontline managers and, primarily nurse managers prior to study implementation</p>	<p>Level 5, Systematic review/Descriptive study (Melnyk, & Fineout-Overholt, 2015)</p>	<p>Qualitative study using semi-structured formative evaluation interviews.</p>	<p>Challenges were identified in coordinating care across the different levels of care in VHA and outside the VHA. Challenges in resources were also noted</p>	<p>Small number of interviewees, quality of care could not be addressed. The study would be appropriate for the project. It outlines the need for additional research to effectively enhance care coordination for veterans as it relates to staff involvement.</p>
<p>Pope, C. A., Davis, B. H., Wine, L., Nemeth, L. S., Haddock, K. S., Hartney, T., & Axon, R. N. (2018). Perceptions of U.S. veterans affairs and community</p>	<p>This study explores perceptions of VA and non-</p>	<p>VHA and civilian healthcare providers from various healthcare settings.</p>	<p>Level 3 Controlled Trials (no</p>	<p>Twenty VA and 11 non-VA providers participated in</p>	<p>Overall, VA and non-VA providers had similar</p>	<p>Various providers were interview, thus less generalizable nationally. Validation of observation</p>

<p>healthcare providers regarding cross-system care for heart failure. <i>Chronic Illness</i>, 14(4), 283–296. https://doi.org/10.1177/1742395317729887</p>	<p>VA healthcare providers caring for Veterans with heart failure (HF) of dual use veterans.</p>		<p>randomization).</p>	<p>semi-structured interviews, which were analyzed using parallel qualitative content and discourse analysis.</p>	<p>ranges of perceptions regarding Veteran knowledge of HF and their motivations for dual use.</p>	<p>is lacking. e study discusses use of both VA and non-VA providers in attempting to understand how both functions regarding care of veterans with HF.</p>
<p>Rinne, S. T., Elwy, A. R., Bastian, L. A., Wong, E. S., Wiener, R. S., & Liu, C. (2017). Impact of multisystem health care on readmission and follow-up among veterans hospitalized for chronic obstructive pulmonary disease. <i>Medical Care</i>, 55 (Suppl 1, 7), S20-S25. https://doi.org/10.1097/MLR.0000000000000708</p>	<p>The study is to examine the association of use of non-VA outpatient care with 30-day readmission and 30-day follow-up among veterans admitted to the VA for COPD</p>	<p>A total, 20,472 Medicare-eligible veterans admitted to VA hospitals for COPD during October 1, 2008, and September 30, 2011.</p>	<p>Level 4, Case Control/Cohort Study (Melnik, & Fineout-Overholt, 2015)</p>	<p>A retrospective cohort study using VA data and Medicare claims</p>	<p>Non-VA care produce no association between readmission for no cause, however, COPD readmissions for both dual care and Medicare only veterans increased use readmission. Medicare-only outpatient care was lower in</p>	<p>Non-VA outpatient care was based on Medicare claims only and was unable to identify other sources of care. The study would be useful for the project proposed. The difference in Medicare only and dual use Veterans can provide vital insight into the challenges experienced and identify strategies beneficial for both groups.</p>

					follow up rates	
Rottman-Sagebiel, R., Cupples, N., Wang, C. P., Cope, S., Pastewait, S., Braden, H., MacCarthy, D., Conde, A., Moris, M., Gonzalez, E.-Y., & Espinoza, S. (2018). A pharmacist-led transitional care program to reduce hospital readmissions in older adults. <i>Federal Practitioner: For the Health Care Professionals of the VA, DoD, and PHS</i> , 35(12), 42–50.	A meta-analysis of 19 studies that evaluated the effectiveness of pharmacy led medication reconciliation interventions at the time of a care transition	Standardized questionnaires used for patients in TCPs.	Level 4, Case control/Cohort study (Melnyk, & Fineout-Overholt, 2015)	Nonresearched quality improvement project	26% lower odds of readmission within 30 days of discharge compared with that of the control group	Patient admission was restricted to one hospital and was not a randomized control trail. Risk for bias was identified. This study will add to the proposed changed with the identification of an effective TCPs which is pharmacy-led.
Schlosser, J., Kollisch, D., Johnson, D., Perkins, T., & Olson, A. (2020). VA-community dual care: Veteran and clinician perspectives. <i>Journal of Community Health</i> , 45(4), 795-802. https://doi.org/10.1007/s10900-020-00795-y	The study sought to better understand both the experience both veterans and clinicians have when care is provided simultaneously in both VA and community settings.	Veterans using both VHA and civilian healthcare settings.	Level 4 Case study/Cohort study (Melnyk, & Fineout-Overholt, 2015)	Mixed methods exploratory study to included focus groups and surveys from veteran clinicians.	Limited information sharing among VA and civilian clinicians. Multiple issues were reported when veterans used both VA and civilian clinicians.	Limitations of this study include modest sample size, limited female veteran participation and limitation with only using two states. Direct insight from veterans and clinicians will support the change.
Vest, B. M., Kulak, J. A., & Homish, G. G. (2019). Caring for veterans in U.S.	The purpose of this	10 Participants were recruited to	Level 6, Qualitative	Semi-structured	Study results identified	Larger sub-sample than the primary sample of

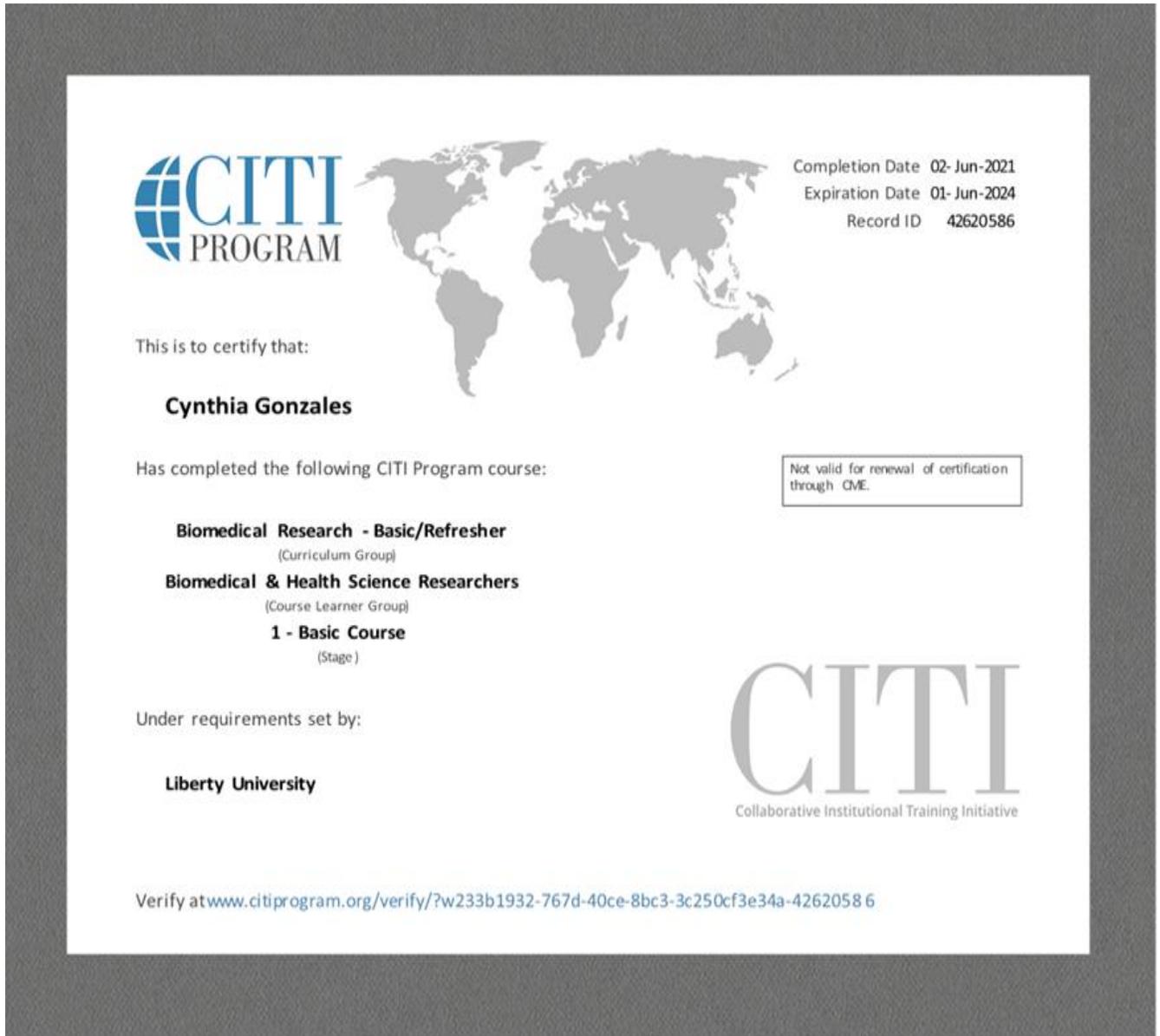
<p>civilian primary care: qualitative interviews with primary care providers. <i>Family Practice</i>, 36(3), 343–350. https://doi.org/10.1093/fampra/cmz078</p>	<p>research was to qualitatively assess, barriers to providing care as described by non-VA primary care Providers. the training providers perceive as most useful and the tools and translational processes they think would be most valuable in increasing military cultural competency.</p>	<p>participate in qualitative interviews, based on a larger quantitative survey study of 102 participants.</p>	<p>study (Melnyk, & Fineout-Overholt, 2015)</p>	<p>qualitative interviews, with 10 non-VA primary care providers.</p>	<p>barriers related to non-VA providers’ ability to care for veterans among their patients. Also, demonstrated mechanisms for improving recognition of veterans in civilian health care settings.</p>	<p>participants, resulting in more providers from academic practices. Small number of practice providers, limiting the thematic capacity identified. This study would provide valuable insight into the topic of the proposal. It reflects on barriers experienced by civilian providers and methods used to combat these barriers.</p>
<p>Wray, A. M., Hoyt, T., Welch, S., Civetti, S., Anthony, N., Ballester, E., & Tandon, R. (2019). Veterans engaged in treatment, skills, and transitions for enhancing psychiatric safety (VETSTEPS). <i>Psychiatric Rehabilitation Journal</i>, 42(3), 277–283. https://doi.org/10.1037/prj0000360</p>	<p>This article aims to examine VETSTEPS impact on treatment follow-up rates and</p>	<p>Veterans with mental health admissions and follow up care.</p>	<p>Level 4 Case study/Cohort study (Melnyk, & Fineout-Overholt, 2015)</p>	<p>A retrospective program data from a pilot critical time intervention intended to gather coded veteran</p>	<p>Preliminary, the results concluded that the VETSTEPS program may be an effective</p>	<p>No standardized process was in place. Limited numbers of veterans included in the study was noted. The study demonstrated improved outcomes for veterans,</p>

	veteran readmissions.		treatment and diagnostic data from the electronic health record. Information was gathered from the psychiatric history and physicals	bridging critical time intervention.	which is the aim of the proposed study.	
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*Note: Melnyk’s Level of Evidence (LOE) Pyramid is required for appraising the level of evidence. This appendix is formatted in landscape orientation.

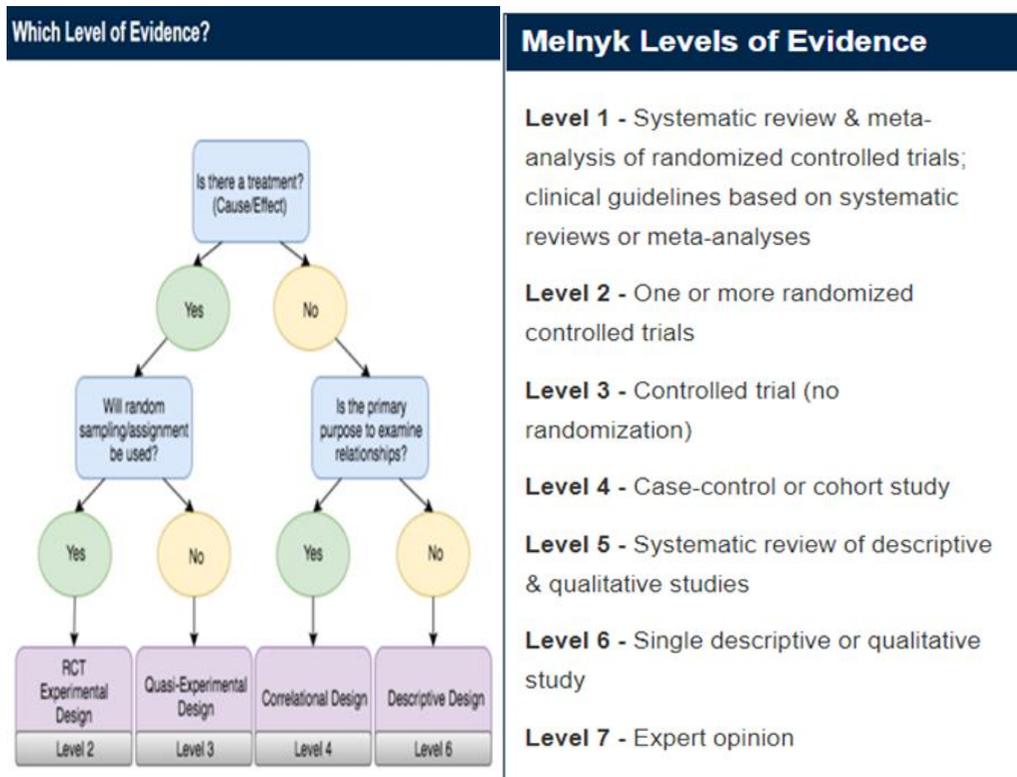
Appendix B

CITI Training Certificate



Appendix C

Melnik Levels of Evidence

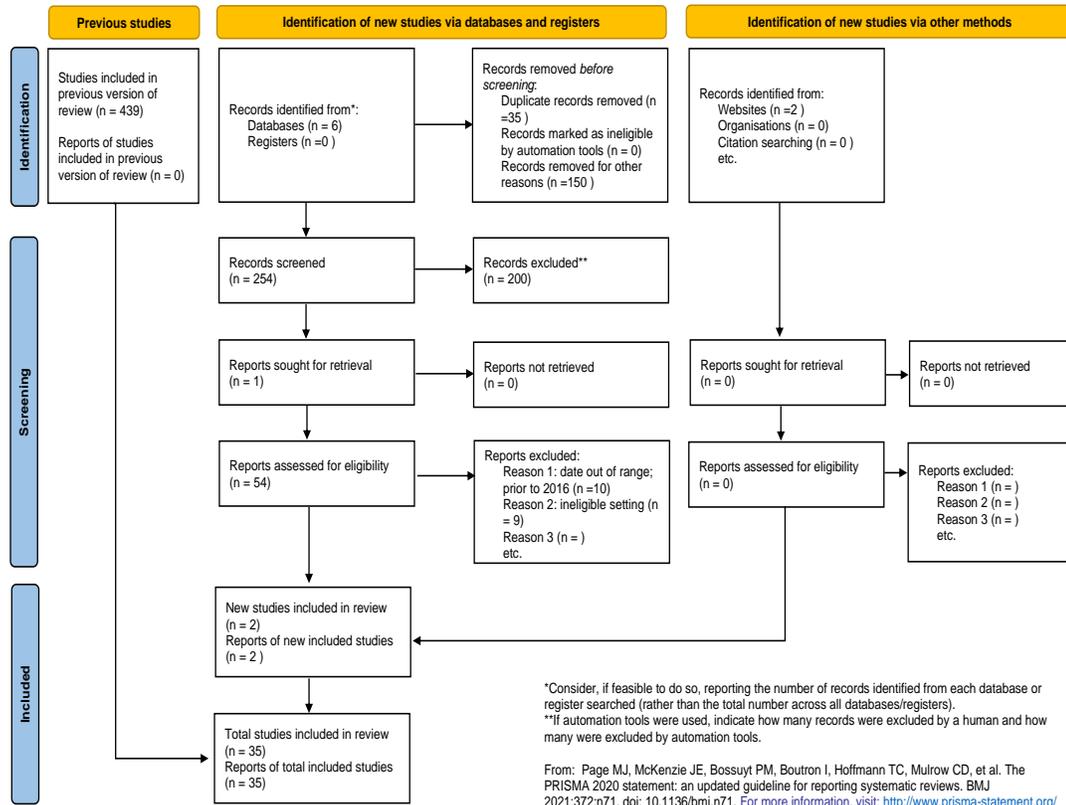


Modified from:

Melnik, B.M. & Fineout-Overholt, E. (2015). "Box 1.3: Rating system for the hierarchy of evidence for intervention/treatment questions" in *Evidence-based practice in nursing & healthcare: A guide to best practice (3rd ed.)* (pp. 11). Philadelphia, PA: Wolters Kluwer Health

Appendix D

PRISMA



Appendix E**IRB Letter****LIBERTY UNIVERSITY.**
INSTITUTIONAL REVIEW BOARD

May 23, 2022

Cynthia Gonzales
Dana Woody

Re: IRB Application - IRB-FY21-22-1065 The Overlooked Mission-Transitional Care Programs for Veterans in Civilian Settings: An Integrative Review

Dear Cynthia Gonzales and Dana Woody,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study does not classify as human subjects research. This means you may begin your project with the data safeguarding methods mentioned in your IRB application.

Decision: No Human Subjects Research

Explanation: Your study is not considered human subjects research for the following reason:

(1) It will not involve the collection of identifiable, private information from or about living individuals (45 CFR 46.102).

Please note that this decision only applies to your current application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued non-human subjects research status. You may report these changes by completing a modification submission through your Cayuse IRB account.

Also, although you are welcome to use our recruitment and consent templates, you are not required to do so. **If you choose to use our documents, please replace the word *research* with the word *project* throughout both documents.**

If you have any questions about this determination or need assistance in determining whether possible modifications to your protocol would change your application's status, please email us at irb@liberty.edu.

Sincerely,

G. Michele Baker, MA, CIP
Administrative Chair of Institutional Research
Research Ethics Office