

Evidence Based Nursing Interventions for Reducing Hospital Readmissions and Improving Patient-Centered Healthcare Outcomes

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Abstract

Hospital readmissions within 30 days of discharge represent a critical indicator of fragmented care coordination and suboptimal transitional care, imposing substantial clinical and financial burdens on healthcare systems globally. This study synthesizes evidence-based nursing interventions designed to reduce hospital readmissions and improve patient-centered outcomes. The paper examines theoretical frameworks, particularly Orem's Self-Care Deficit Nursing Theory, which provides the conceptual foundation for transitional care programs that address patients' therapeutic self-care demands during the vulnerable post-discharge period. Validated risk stratification tools, including the Transitional Care Model screening criteria and Project BOOST's 8Ps Assessment, enable targeted identification of high-risk patients. Systematic analysis of established transitional care models demonstrates that intensive, nurse-led interventions including the Transitional Care Model (13-48% readmission reduction), Project RED (30% utilization reduction), and Project BOOST (2-6% readmission reduction) significantly improve post-discharge outcomes when implemented with fidelity. The Teach-Back method emerges as a critical educational strategy, with meta-analyses demonstrating reduced readmission odds (OR=0.40, 95% CI: 0.17-0.94) through iterative comprehension

verification. Clinical evidence reveals that structured physical and occupational therapy significantly reduces 30-day readmissions (OR=0.84, $p=0.005$), while combined home visits and telephone follow-up decrease heart failure readmissions by 36% (RR=0.64, $p<0.01$). Patient experience metrics, including HCAHPS scores, demonstrate strong correlation with nursing care quality ($R^2=0.90$). This review concludes that multifaceted transitional care programs integrating risk stratification, structured education, multidisciplinary follow-up, and continuous quality monitoring constitute the most effective approach to reducing hospital readmissions and advancing patient-centered healthcare delivery.

1. Introduction

Hospital readmissions represent a critical metric for evaluating the quality, safety, and systemic efficiency of contemporary healthcare delivery systems. Unplanned readmissions within the immediate post-discharge phase serve as indicators of fragmented care coordination, gaps in provider accountability, and suboptimal patient preparation during the transition from acute care settings back to the community (Naylor et al., 2011). From a clinical perspective, the transition from an inpatient acute unit to the home is a highly vulnerable period characterized by rapid shifts in therapeutic plans, complex medication adjustments, and a lack of direct clinical supervision. Consequently, patients frequently experience medication-related adverse events, unexpected functional decline, and preventable disease exacerbations that necessitate urgent rehospitalization (Hansen et al., 2011).

The systemic and financial scale of hospital readmissions is profound. In the United States, nearly one in five Medicare beneficiaries representing approximately 2.6 million older adults is readmitted within 30 days of discharge, costing the healthcare system an estimated \$15 to \$26 billion annually, of which up to \$17 billion is spent on avoidable readmissions (Jencks et al., 2009). On a global level, demographic shifts are compounding these challenges; for example, within the European Union, the population aged 65 years and older is projected to reach 29.1% by 2080, with the fraction of individuals over 80 years expected to double. This aging trajectory inevitably escalates the prevalence of complex, multi-morbid conditions, which heavily strains acute care facilities and intensifies the demand for effective transitional care systems (World Health Organization, 2021).

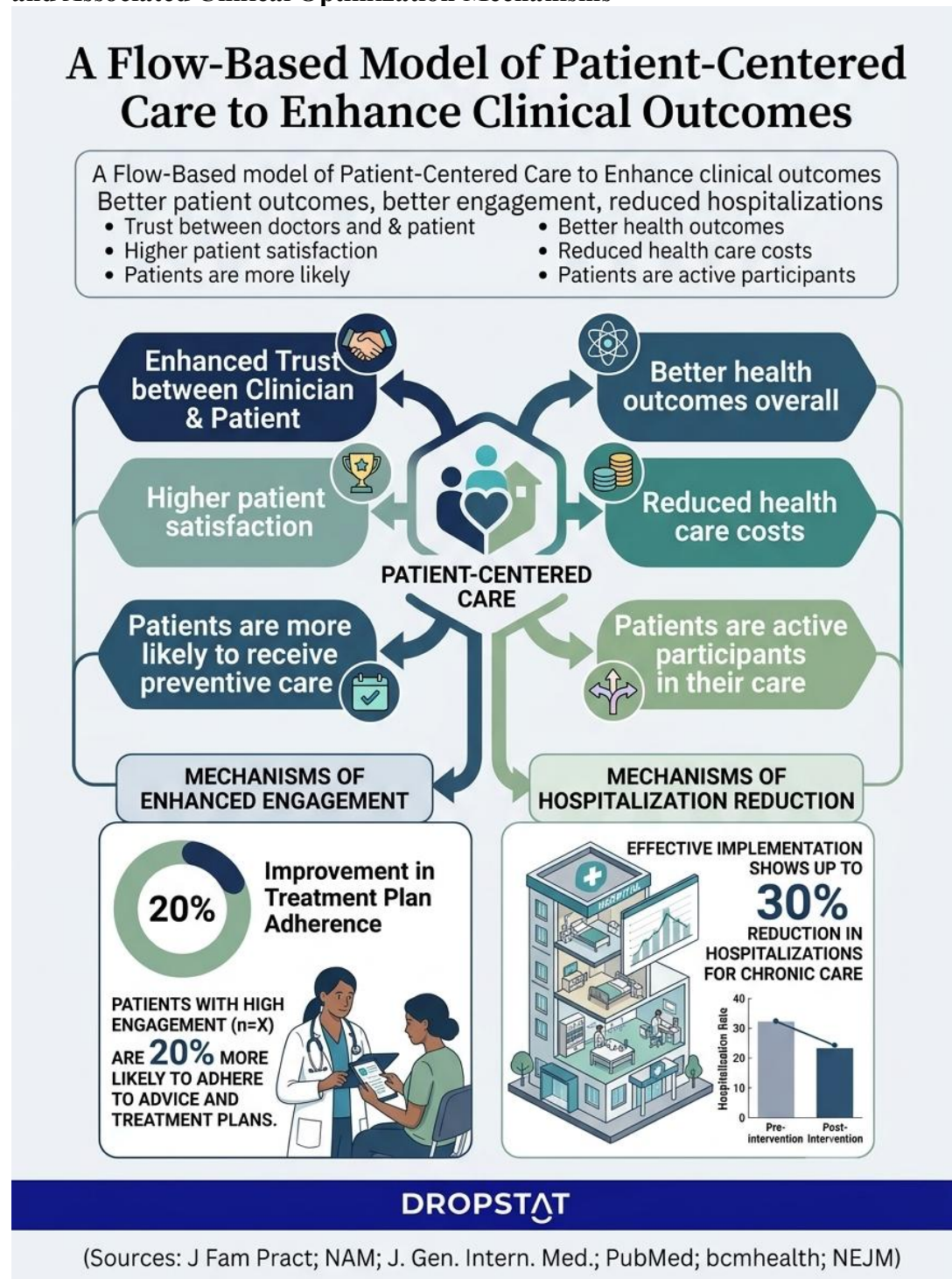
In response to these unsustainable clinical and financial pressures, federal and international policies have transitioned from volume-based to value-based healthcare reimbursement structures. The Hospital Readmissions Reduction Program (HRRP), enacted under the Patient Protection and Affordable Care Act, penalizes acute care hospitals by reducing their base operating payments by up to 3% if they exhibit higher-than-expected 30-day Risk-Standardized Readmission Rates (RSRRs) for highly prevalent conditions (Porter, 2010). These targeted conditions include acute myocardial infarction, chronic obstructive pulmonary disease (COPD), heart failure (HF), pneumonia, coronary artery bypass graft (CABG) surgery, and elective primary total hip and knee arthroplasties. To evaluate hospital performance, the Centers for Medicare & Medicaid Services (CMS) calculates the Excess Readmission Ratio (ERR), defined as the ratio of predicted-to-expected unplanned readmissions for each target condition (CMS, 2024).

$$ERR = \frac{\text{Predicted Readmissions}}{\text{Expected Readmissions}}$$

Under the 21st Century Cures Act, hospitals are divided into five distinct peer groups based on their proportion of dual-eligible (Medicare and Medicaid) patients to ensure that safety-net institutions which manage highly complex, socioeconomically vulnerable patient mixes are compared against peer-group medians rather than a national average (Forster et al., 2003).

To bypass these strict tracking parameters and avoid financial penalties under the HRRP, some healthcare systems have increased their reliance on "observation status". Because observation status is billed as outpatient care under Medicare Part B, these encounters do not count as inpatient admissions and therefore do not trigger 30-day readmission risk tracking. However, this shift severely impacts the patient experience by increasing out-of-pocket expenses and altering post-discharge nursing support (Kansagara et al., 2011).

Figure 1: Conceptual Flow-Based Framework of Patient-Centered Care (PCC) and Associated Clinical Optimization Mechanisms



2. Theoretical Foundations of Transitional Care

To ensure clinical efficacy, nursing-led transitional care interventions must be structured upon rigorous theoretical foundations that guide clinical assessment and workflow design. Dorothea Orem's Self-Care Deficit Nursing Theory provides a highly applicable conceptual framework for designing and executing care transition programs

(European Commission, 2021). Orem's grand theory is constructed upon three interrelated sub-theories: the theory of self-care, the theory of self-care deficit, and the theory of nursing systems. At the core of this framework is the concept of *self-care agency*, which represents the acquired power and capability of individuals to initiate and perform actions to maintain their life, health, development, and general well-being (Kripalani et al., 2007).

During acute hospitalization or the immediate post-discharge phase, patients frequently experience a severe clinical imbalance. The physical and cognitive demands of recovering from surgery, managing a new acute diagnosis, or coping with a chronic disease exacerbation termed the *therapeutic self-care demand* temporarily or permanently exceed the patient's internal *self-care agency*. This state of imbalance is defined by Orem as a *self-care deficit*, which clinically justifies and necessitates professional nursing intervention (Zuckerman et al., 2016).

Orem outlines five primary methods of assistance through which nurses can intervene: acting or doing for others, guiding others, supporting another, providing an environment that promotes personal development, and teaching another. Based on these methods, the nurse designs a specialized *nursing system* that transitions from wholly compensatory (total nurse care) to partly compensatory (shared care) and ultimately to a *supportive-educative system* (Coleman et al., 2006).

3. Pre-Discharge Risk Stratification and Assessment

The proactive identification of patients at high risk for post-discharge care failures is a critical first step in designing targeted transitional nursing systems. Rather than applying intensive, resource-heavy transition resources universally, hospitals must utilize validated, evidence-based screening tools to stratify patients at risk of readmission (Coleman et al., 2004).

The Transitional Care Model (TCM) utilizes ten standardized hospital discharge screening criteria developed through randomized clinical trials to identify high-risk older adults. These criteria focus on chronic comorbid burden, functional limitations, cognitive status, and healthcare utilization history, noting that the presence of two or more criteria significantly heightens the probability of a poor post-discharge transition (Leppin et al., 2014).

In parallel, the Society of Hospital Medicine's Project BOOST utilizes the "8Ps Risk Assessment" tool to identify specific risk domains and deploy targeted, risk-specific nursing interventions. The eight risk factors under this framework encompass problems with medications, psychological symptoms, principal diagnosis, physical limitations, poor health literacy, poor social support, prior hospitalizations, and palliative care (Society of Hospital Medicine, 2014).

Beyond general screening scores, recent clinical research has highlighted the predictive power of nursing-sensitive process indicators during acute hospitalization. In a case-control study of adults hospitalized with chronic heart failure, researchers demonstrated that specific clinical indicators such as in-hospital falls, a lack of fall-risk identification at admission, poor knowledge of prescribed medications, polypharmacy (defined as the prescription of four or more discharge medications), and complex medication dosing schedules are independent predictors of 30-day rehospitalization (Dharmarajan & Krumholz, 2014).

Conversely, the documented receipt of structured, nurse-led discharge education was associated with a significantly lower likelihood of readmission, establishing structured education as an actionable nursing intervention. To assist clinicians in stratifying patients, Table 1 synthesizes these validated risk-screening elements and clinical predictors (Gonçalves-Bradley et al., 2022).

Table 1. Standardized Risk Assessment and Nursing-Sensitive Predictors of Hospital Readmissions

Assessment	Core Risk Factors &	Targeted Assessment
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Tool / Indicator Source	Screening Criteria	Parameters & Clinical Logic
TCM Discharge Screening Criteria	• Age $\geq$ 80 years. • Multiple active comorbidities ($\geq$ 3 diagnoses). • Frequent recent utilization ($\geq$ 2 admissions in past 6 months or 1 in past 30 days). • Chronic cognitive impairment (dementia, delirium history).	• Cognitive evaluations using Mini-Cog, MoCA ($<$ 26), CAM, or Six-Item Screener ($\leq$ 3). • Assessment of active social support and functional limitations.
Project BOOST 8Ps Assessment	• Problems with medications (polypharmacy). • Psychological symptoms (depression). • Principal diagnosis (HF, COPD, Stroke). • Physical limitations (frailty, deconditioning). • Poor health literacy (understanding barrier). • Poor social support (isolation). • Prior hospitalizations. • Palliative care needs.	• Universal screening at admission to map risk-specific clinical pathways. • Coordinates multidisciplinary teams (pharmacy, therapy, social work) to mitigate identified risks.
Nursing-Sensitive CHF Predictors	• In-hospital falls during index stay. • Unidentified fall risk at admission.	• Quantitative predictors of 30-day readmissions. • Emphasizes fall-prevention strategies and medication reconciliation as primary clinical

	• Poor subjective knowledge of prescribed medications. • Discharge polypharmacy (≥ 4 medications). • Complicated or frequent dosing schedules.	targets.
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4. Systematic Review of Established Transitional Care Models

To standardize care transitions and mitigate post-discharge care failures, health systems have evaluated several structured transitional care models. These models employ dedicated transition providers, typically nurses or case managers, who serve as clinical leaders of the transition team (Naylor et al., 2018).

Figure 2: Taxonomy of Contemporary Evidence-Based Nursing Practice (EBNP) Domains and Core Sub-Specialties



4.1. The Transitional Care Model (TCM)

The Transitional Care Model (TCM) is an intensive, advanced practice nurse-led intervention that provides comprehensive inpatient planning and post-discharge home follow-up for high-risk older adults. The heart of the model is the Transitional Care Nurse (TCN), who coordinates care across the entire acute and post-acute episode, ensuring relational and informational continuity. The TCN designs an evidence-based plan of care during hospitalization, conducts a home visit within 24 to 48 hours of discharge, provides ongoing telephone support seven days a week, and accompanies the patient to their first primary care follow-up visit (Hirschman et al., 2015).

4.2. Project RED (Re-Engineered Discharge)

Project RED is a standardized, hospital-based discharge planning program designed to reduce post-discharge all-cause readmissions and emergency department visits. Led by

a "Discharge Advocate" (clinical nurse), Project RED is built upon twelve discrete, mutually reinforcing components, including obtaining language assistance, arranging follow-up medical appointments, and completing medication reconciliation (Hansen et al., 2013).

A central feature of the model is the visual, patient-centered After Hospital Care Plan (AHCP), which outlines clinical information in simplified language. This is reinforced by a follow-up telephone call from a pharmacist or clinical nurse within 48 to 90 hours post-discharge. Clinical evaluations demonstrate that Project RED reduces subsequent 30-day hospital utilization by 30%, showing its high effectiveness in diverse, low-income, and safety-net patient populations (Ribeiro et al., 2021).

4.3. Project BOOST (Better Outcomes for Older Adults through Safe Transitions)

Project BOOST is a comprehensive multidisciplinary quality improvement framework focused on streamlining clinical workflows, reducing medication errors, and preparing patients and family caregivers for discharge. By incorporating the 8Ps risk screening, patient-centered written discharge instructions (Patient PASS and the Discharge Patient Education Tool [DPET]), and structured follow-up calls, Project BOOST provides clinical units with actionable tools to improve transitions. Multicenter clinical trials have shown that participation in Project BOOST leads to a consistent, statistically significant 2% to 6% reduction in overall 30-day readmission rates (Jack et al., 2009).

4.4. Surgical and Palliative Transition Care

While transitional care is frequently studied in chronic medical populations, systematic reviews demonstrate its clinical impact in surgical and palliative cohorts. In post-surgical populations, a systematic review of transitional care interventions demonstrated that discharge planning programs reduce readmissions by 11.5% to 23% (Moka et al., 2025).

Additionally, patient education interventions reduce surgical readmissions by 14% to 23.5%, primary care follow-up reduces readmissions by 8.3% for high-risk post-operative patients, and home visits achieve a 4% to 7.69% reduction. In seriously ill patients requiring a palliative approach, a systematic review and meta-analysis of randomized controlled trials (Di Nitto & Durante) demonstrated that transitional care interventions lead to small-to-moderate improvements in symptoms (Standardized Mean Difference [SMD] = -0.39, 95% CI: -0.74 to -0.04) and health-related quality of life (SMD = 0.20, 95% CI: 0.08 to 0.33) (Freitag et al., 2026).

However, no statistically significant differences were observed in mortality, functional status, or caregiver burden compared to standard care, highlighting that the primary value of palliative care transitions lies in symptom control and comfort rather than life extension (Mozzarelli et al., 2026).

Table 2. Systematic Comparison and Quantitative Outcomes of Transitional Care Models

Model / Program Pathway	Primary Target Population	Core Nursing & Clinical Components	Quantitative Efficacy & Statistics
Transitional Care Model (TCM)	Chronically ill, high-risk older adults (≥ 65 years) with complex comorbidities.	• Led by APN/TCN. • In-hospital planning, home visits within 48 hours, and weekly phone contact. • Spans an average of	• 13% to 48% reduction in 90-day readmissions. • Consistent improvement in functional autonomy and quality of life.

		1 to 3 months.	
Project RED	General adult inpatient populations, particularly in safety-net settings.	• Led by a Nurse Discharge Advocate (DA). • Delivery of the After Hospital Care Plan (AHCP). • Follow-up call by a pharmacist within 48 hours.	• 30% reduction in 30-day hospital utilization (readmissions + ED visits). • Average cost savings of \$412 per patient.
Project BOOST	High-risk adult patients, with a focus on older medical populations.	• Multidisciplinary quality improvement toolkit. • Employs the "8Ps Risk Assessment" and Patient PASS. • Mentorship-driven clinical workflow redesign.	• 2% to 6% reduction in 30-day hospital readmissions. • Correctly predicts over 90% of unplanned readmissions.
Surgical Transitions Pathway	Adult populations undergoing high-risk surgical procedures.	• Standardized post-surgical discharge planning. • Targeted home visits, patient education, and early follow-up.	• Discharge planning reduces readmissions by 11.5% to 23%. • Patient education reduces readmissions by 14% to 23.5%.
Palliative Transitions Pathway	Seriously ill patients requiring a supportive/palliative approach.	• Multi-component transition planning. • High focus on post-acute symptom monitoring and medication reconciliation.	• Improves post-discharge symptoms (SMD = -0.39, $p < 0.01$). • Improves health-related quality of life (SMD = 0.20, $p = 0.09$).

5. Evidence-Based Nursing Educational Strategies: The Teach-Back Method

The clinical success of any transitional care program depends on the educational methodology used by nurses during discharge planning. Traditional patient education,

which often relies on the passive delivery of written discharge handouts, is highly ineffective. Research indicates that patients remain confused about their healthcare plans upon returning home, immediately forgetting approximately half of the clinical information presented to them during discharge, with nearly 50% of what is recalled being incorrect (Kessels, 2003). This retention gap is exacerbated by low health literacy, cognitive deconditioning, and systemic anxiety, which compromise the patient's self-care agency and lead to home medication errors (Berkman et al., 2011).

The Teach-Back method, also known as "show me" or "closing the loop," is an evidence-based, interactive communication strategy that addresses this challenge. In a structured teach-back protocol, the nurse breaks complex clinical information into small, manageable components. After explaining each component using clear, non-jargonized terminology, the nurse asks open-ended, non-threatening questions that require the patient or family caregiver to repeat or demonstrate the information in their own words. If a gap in comprehension is identified, the nurse immediately clarifies and reteaches the concept, continuing this cycle until the patient demonstrates complete understanding (Horwitz et al., 2013).

To enhance the teach-back method, clinical teams have integrated structured, disease-specific assessment scales. For example, the TIME tool is a structured instrument associated with improved understanding of medication side effects and a higher satisfaction with nursing education (White et al., 2013).

In chronic heart failure cohorts, clinical care bundles combine teach-back with the Dutch Heart Failure Knowledge Scale (DHFKS) and dietary sodium intake assessments. Research shows that implementing this structured care bundle leads to a statistically significant improvement in heart failure knowledge levels ($p > 0.001$), a significant reduction in post-discharge dietary sodium intake scores ($p < 0.001$), and improved completion of critical nutrition and pharmacy referrals (Riegel et al., 2021).

Analyzing the quantitative evidence reveals a clinical distinction between short-term behavior and long-term healthcare utilization. In a prospective, two-arm randomized controlled trial evaluating discharge education using the teach-back method in heart failure patients, the intervention group showed significant improvements at 7 days post-discharge across self-care maintenance ($F = 11.597$, $p = 0.001$), symptom perception ($F = 20.173$, $p < 0.001$), self-care management ($F = 7.205$, $p = 0.009$), and self-care efficacy ($F = 4.210$, $p = 0.043$). However, this specific short-term trial observed no statistically significant differences in 30-day unplanned healthcare utilization, including readmissions and emergency department visits (Lin et al., 2020).

In contrast, systematic reviews and meta-analyses pooling multiple long-term clinical trials demonstrate that discharge education using the teach-back method significantly reduces overall hospital readmission rates (Odds Ratio [OR] = 0.40, 95% CI: 0.17–0.94) (Talevski et al., 2020).

This divergence suggests that while educational interventions rapidly empower individual self-care agency and behavioral compliance, translating these cognitive gains into sustained reductions in healthcare utilization requires a longer, continuous follow-up period (Ha Dinh et al., 2016).

Furthermore, research indicates that simply utilizing the teach-back method does not automatically guarantee high patient satisfaction. A statistically significant correlation between teach-back use and patient satisfaction with discharge teaching. This lack of association was attributed to a lapse in nurse adherence to proper teach-back steps over time, or incomplete provider training (such as training only 65% of clinical staff), highlighting the need for continuous quality audits, thorough staff training, and regular clinical feedback (Hodges et al., 2020).

Table 3. Efficacy of Nurse-Led Educational Interventions and Knowledge Assessments

Educational	Target	Intervention	Quantitative
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Tool / Scale	Population	Mechanics	Outcomes & Statistics
Teach-Back Method (TBM)	Chronic illness cohorts (Heart Failure, Diabetes).	• Iterative, closed-loop verification of understanding. • Use of open-ended, jargon-free questions.	• Reduces heart failure-related readmissions (OR = 0.40, 95% CI: 0.17–0.94). • Enhances self-efficacy ($p = 0.043$) and self-care ($p = 0.001$).
Dutch Heart Failure Knowledge Scale (DHFKS)	Hospitalized patients with Congestive Heart Failure.	• Standardized baseline and post-discharge knowledge testing. • Integrates sodium restrictions and dietitian referrals.	• Significantly increases disease-specific knowledge ($p > 0.001$). • Reduces dietary sodium scores post-discharge ($p < 0.001$).
TIME Tool	General adult inpatient medication education.	• Visual and interactive medication teaching tool. • Focuses on side effects and indications for therapy.	• Increases comprehension of medical side effects. • Significantly correlates with higher patient satisfaction scores.

6. Clinical Interventions: Mobility, Physical Therapy, and Follow-Up Protocols

To optimize post-discharge outcomes, health systems must implement targeted clinical interventions during the hospital stay and immediately following discharge. A comparative analysis of physical deconditioning and post-discharge support protocols reveals a clear clinical distinction between early mobilization and structured physical therapy (Coleman et al., 2004).

6.1. Early Mobilization vs. Structured Physical Therapy

In patients hospitalized for pneumonia, a systematic synthesis of clinical trials shows that *early mobilization* (defined as moving to an upright position on the first day of hospitalization, in-bed cycling, or booklet exercises) does not reduce post-discharge readmissions. A meta-analysis of three randomized controlled trials showed no statistically significant differences in 30-day readmissions (OR = 0.78, 95% CI: 0.52–1.17, $p = 0.22$) or 90-day readmissions (OR = 0.76, 95% CI: 0.53–1.10, $p = 0.14$) between early mobilization and standard care (Tamura-Lis, 2013).

In contrast, structured physical and occupational therapy (PT/OT) interventions delivered during hospitalization show a significant protective effect against rehospitalization. Retrospective cohort studies show that pneumonia patients receiving more than six PT/OT visits during their stay have a significantly lower 30-day readmission or death risk (adjusted OR = 0.86, 95% CI: 0.75–0.98, $p = 0.03$) compared to those with no visits (Tamura-Lis, 2013).

Similarly, patients receiving at least 0.5 hours per day of physical therapy exhibit a decreased 30-day all-cause readmission rate (adjusted OR = 0.65, 95% CI: 0.43–0.98, $p = 0.02$). When pooling randomized controlled trials and retrospective studies, structured PT/OT interventions are associated with a significant 16% reduction in 30-day hospital readmissions (OR = 0.84, 95% CI: 0.75–0.95, $p = 0.005$) (Hesselink et al., 2012).

This divergence reveals a critical clinical distinction: while simple mobilization during an acute inpatient stay does not alter post-discharge vulnerability, structured occupational and physical therapy programs that actively rebuild functional tolerance and independence significantly reduce post-acute mortality and readmission rates (van der Wal et al., 2005).

6.2. Home Visits and Telephonic Outreach Protocols

Following discharge, the timing and combination of nursing follow-up interventions are key factors in clinical safety and readmission reduction. Outpatient nursing care can be technical, educational, or managerial. Evidence suggests that a single, isolated post-discharge intervention is less effective than a multi-component transitional care strategy (Hansen et al., 2011).

A systematic review and meta-analysis of randomized controlled trials focusing on heart failure populations demonstrated that combining home visits with follow-up telephone contact reduces the risk of hospital readmissions by 36% (Relative Risk [RR] = 0.64, 95% CI: 0.54–0.75, $p < 0.01$) and reduces mortality by 35% (RR = 0.65, 95% CI: 0.50–0.85, $p < 0.01$) compared to usual care (Zuckerman et al., 2016).

To optimize these clinical outcomes, the first post-discharge home visit should occur within 7 to 14 days of discharge, with telephone follow-up initiated at least weekly for a minimum of 30 days. The clinical value of telephone outreach is further supported by a prospective study of patients discharged home from acute care settings. Patients contacted by a registered nurse within 72 hours of discharge showed a 1.2% absolute decrease in 30-day readmissions (9.8% vs. 11.0% in the historical cohort), with disease-specific reductions observed in congestive heart failure (14.3% down to 9.1%), COPD (20.0% down to 13.4%), and pneumonia (14.9% down to 14.0%) (Kansagara et al., 2011).

Furthermore, patients contacted within the critical 24-to-48-hour post-discharge window were 1.2 times less likely to be readmitted than those who could not be reached (readmission rates of 6.8% vs. 8.2%, respectively; $p = 0.005$). These findings indicate that transitional care interventions are most effective when they are highly intensive, last at least one month, and target patients who are systematically screened as high-risk (Forster et al., 2003).

7. Patient-Centered Experience Metrics and Policy Implications

In value-based healthcare, hospital performance is evaluated using both clinical readmission rates and patient-reported experience scores. The HCAHPS survey publicly reports patient perceptions of hospital care, which directly impacts hospital reimbursement and market reputation (Leppin et al., 2014).

7.1. HCAHPS Survey Metrics

The HCAHPS survey consists of 22 core items evaluating key aspects of the patient experience. Of these, several domains are directly nursing-sensitive, including nurse communication, staff responsiveness, medication communication, and discharge information. Because nurses have continuous, direct interaction with patients, the quality of nursing care represents a critical driver of overall HCAHPS performance. Satisfying patient perceptions in nursing domains significantly increases the probability of a hospital achieving a high overall HCAHPS rating (Moka et al., 2025).

Quantitative analysis shows that nursing care quality has a 90% coefficient of determination on overall patient satisfaction, with nurse clinical competence, cognitive ability, and communication skills serving as the key drivers (Talevski et al., 2020).

To optimize these scores, clinical units utilize targeted, nurse-led interventions. The implementation of structured "nursing rounds" (including hourly rounding and 4P rounds targeting Pain, Personal hygiene, Positioning, and Placement of personal items) has been shown to improve HCAHPS scores while reducing patient-initiated call light usage and complaints regarding staff behavior by 43% (Mozzarelli et al., 2026). Furthermore, the utilization of dedicated "discharge nurses" has been shown to raise discharge domain scores from the 22nd to the 76th percentile. Post-discharge phone calls conducted by clinical nurses are also effective, often identifying and resolving critical post-discharge care discrepancies (Freitag et al., 2026).

Conclusion

This comprehensive review establishes that evidence-based nursing interventions are central to reducing hospital readmissions and improving patient-centered healthcare outcomes. The synthesis of theoretical frameworks, validated assessment tools, and structured transitional care models demonstrates that effective readmission reduction requires a multifaceted, theoretically grounded approach rather than isolated interventions. Orem's Self-Care Deficit Nursing Theory provides a robust conceptual foundation, guiding nurses in assessing patients' self-care agency and implementing appropriate nursing systems that progressively transition patients from wholly compensatory to supportive-educative care. The systematic analysis reveals that successful transitional care programs share several critical components: systematic risk stratification using validated screening criteria, intensive nurse-led discharge planning with structured education utilizing the Teach-Back method, coordinated multidisciplinary follow-up combining home visits and telephone outreach, and continuous quality monitoring. The quantitative evidence consistently demonstrates that when these elements are integrated and implemented with fidelity, significant reductions in 30-day readmissions ranging from 13% to 48% can be achieved across diverse patient populations. A particularly important finding is the distinction between short-term educational gains and sustained healthcare utilization reduction. While the Teach-Back method rapidly improves patient knowledge and self-care behaviors, translation into reduced readmissions requires extended follow-up periods and continuous reinforcement. The evidence also highlights that physical therapy and structured follow-up protocols, rather than simple mobilization, provide meaningful protection against readmission. Furthermore, the integration of patient-reported experience metrics, particularly HCAHPS scores, reinforces the dual value of nursing interventions in simultaneously improving clinical outcomes and patient satisfaction. The strong correlation between nursing care quality and overall satisfaction ($R^2=0.90$) underscores the central role of nurses in value-based healthcare delivery. Policy implications are substantial, as healthcare systems must prioritize investment in transitional care infrastructure, including advanced practice nursing roles, structured education programs, and post-discharge follow-up protocols. The Hospital Readmissions Reduction Program's financial penalties create compelling incentives for hospitals to adopt these evidence-based interventions. However, the shift toward observation status as a strategy to avoid readmission tracking raises concerns about patient financial burden and access to post-discharge nursing support, necessitating policy refinement. Future research should focus on optimizing intervention components for specific populations, evaluating cost-effectiveness across diverse healthcare settings, and identifying strategies to sustain intervention fidelity over time. Additionally, the integration of technology-enhanced transitional care, including telehealth monitoring and mobile health applications, warrants investigation as a means to extend nursing reach and improve post-discharge support. Ultimately, this review confirms that nursing-led transitional care represents a high-impact, cost-effective strategy to address the persistent challenge of hospital readmissions. By implementing comprehensive, evidence-based transitional care programs, healthcare systems can achieve the dual

goals of improving patient outcomes and advancing value-based, patient-centered healthcare delivery.

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