Journal of HOSPITAL MEDICINE www.journalofhospitalmedicine.com

BRIEF REPORTS

''Can We Just Stop and Talk?'' Patients Value Verbal Communication About Discharge Care Plans

Marwa Shoeb, MD, Susan Eva Merel, MD*, Molly Blackley Jackson, MD, Bradley D. Anawalt, MD

Department of Medicine, University of Washington, Seattle, Washington.

BACKGROUND: Studies show that hospitalized patients often do not understand their postdischarge care plan. There are few studies about patients' preferences regarding the content of discharge care plans.

OBJECTIVE: To identify what patients view as essential elements of a post-hospitalization plan.

DESIGN: Anonymous written survey distributed on the second day of admission to internal medicine wards.

SETTING: An academic tertiary care hospital and an academic county hospital in Seattle, Washington.

PATIENTS: Two hundred English-speaking adult inpatients ≥18 years or their proxies.

RESULTS: The majority of patients (64.5%) surveyed wanted verbal discharge instructions, with only 10.5% requesting written instructions ($P < 0.0001$). One hundred percent of patients valued the following discharge instructions as essential: "when you need to follow-up with [primary care provider] PCP," "warning signs to call PCP," and "medicines to continue post-hospitalization." One hundred percent of patients wanted "a lot of information about my condition" and "test results," but only 39% wanted "a lot of information about my medications" ($P < 0.0001$). When asked to choose the most important piece of discharge instruction related to their disease, 67.5% of patients chose "lifestyle changes." One hundred percent of patients thought that personal communication between the inpatient provider and the outpatient primary care provider was "extremely important" or "essential."

CONCLUSION: Patients uniformly placed high value on: 1) verbal communication about discharge care plans; 2) information about lifestyle changes for improved health; and 3) personal communication between inpatient and outpatient providers. *Journal of Hospital Medicine* 2012;7: 504–507. © 2012 Society of Hospital Medicine

Hospital discharge can be hazardous because discontinuity and fragmentation of care increase risks to the patient. Inadequate communication has been identified as a major etiology for errors and adverse events occurring shortly after discharge.[1,2] Another potential result of a ''failed'' hospital discharge is patient dissatisfaction. Increased patient involvement in care improves health outcomes, and may improve patient satisfaction.[3] To engage patients in their care, healthcare providers must collaborate with patients to coordinate care across settings.

In this study, we sought to determine what patients and their caregivers view as essential elements of a safe and high-quality discharge process. We developed a survey with a broad range of questions related to the hospital discharge process (see Supporting Information, Appendix A, in the online version of this article). The survey included several questions derived from Project BOOST (Better Outcomes for Older adults through Safe Transitions) discharge care plans.[4]

***Address for correspondence and reprint requests:** Susan Eva Merel, MD, Department of Medicine, University of Washington, 1959 NE Pacific St, Box 356429, Seattle, WA 98195-6429; Telephone: 206-616-4088; Fax: 206-221-8732; E-mail: smerel@uw.edu

Additional Supporting Information may be found in the online version of this article.

Received: September 7, 2011; **Revised:** February 10, 2012; **Accepted:** March 4, 2012
2012 Society of Hospital Medicine DOI 10.1002/jhm.1937
Published online in Wiley Online Library (Wileyonlinelibrary.com).

METHODS

Study Design

We surveyed patients on the second day of admission to the internal medicine wards at the University of Washington Medical Center (a 450-bed tertiary care teaching hospital) and Harborview Medical Center (a 412-bed county teaching hospital) from June 1, 2010 to August 1, 2010. All patients ≥18 years old who were admitted during weekdays were considered for participation. Any potential participant unable to manually fill out the survey was offered the opportunity to use a proxy to help complete the survey. A proxy was any adult support person who was present in the room at the time the patient was approached with the opportunity to participate. Patients were excluded only if they (or their proxies) could not read English. The second day of hospitalization was chosen for several reasons: 1) to attempt to assess patients at a similar point in their hospital stay; 2) to avoid the day of discharge, as this may have introduced confounders such as patients who were actively engaged in the discharge process; and 3) to avoid the day of admission to increase the likelihood that patients would be medically stable at the time of the survey.

The Survey

The study protocol was reviewed and approved by the University of Washington Committee for the Protection of Human Subjects. All subjects gave verbal informed consent. The survey consisted of 3 sections:

demographics, questions gauging the importance of various key points in the discharge process to patients, and open-ended questions. Responses to questions used a Likert scale. Responses to open-ended questions were handwritten on the paper survey.

Statistical Analysis

The quantitative data were classified categorically and analyzed using Fisher's exact test. Three investigators (M.S., S.E.M., M.B.J.) individually reviewed and coded all written patient or proxy comments using grounded theory methodology.[5] Discrepant coding was identified and reconciled. The reconciled coded comments were aggregated into themes.

RESULTS

Demographics

We screened 240 patients or proxies and 200 completed the survey; 10.4% were ineligible due to language barrier, and 6.3% refused. Ninety-two percent of patients completed the surveys. A majority were male (62.5%), 18–59 years old (80%); spoke English as their first language (66%); were community-dwelling prior to hospitalization (59%); were followed by a primary care provider (PCP) (53%), and many had at least a 4-year-college education (45%). One hundred eighty-five surveys (92.5%) were completed by patients, and 15 (7.5%) were completed by proxies. Ninety surveys were completed at the county teaching hospital, and 110 surveys were completed at the tertiary teaching hospital. See Table 1 for detailed demographic information.

TABLE 1. Patient Demographic Characteristics

Patient age, n (%)	
18–59 yr	160 (80)
60–69 yr	30 (15)
70–79 yr	5 (2.5)
80 and older	5 (2.5)
Patient gender, n (%)	
Male	125 (62.5)
Female	75 (37.5)
Patient schooling, n (%)	
Less than high school	20 (10)
High school	50 (25)
Two-year college	40 (20)
Four-year college	70 (35)
Graduate education	20 (10)
English is patient's first language, n (%)	
Yes	132 (66)
No	68 (34)
Patient has a primary care doctor, n (%)	
Yes	106 (53)
No	94 (47)
Patient's residence before hospitalization, n (%)	
Home without home health	64 (32)
Home with home health	54 (27)
Skilled nursing facility	52 (26)
Shelter	30 (15)

Survey Results

One hundred percent of patients rated the following items as *essential* (highest category on Likert Scale): ''when you need to follow-up with primary care doctor,'' ''warning signs to call primary care doctor,'' and ''medicines to continue post-hospitalization'' (Figure 1). Patients rated the following items as less important (these items were not unanimously rated as *extremely important* or *essential*): ''treatment you received,'' ''medicines you took pre-hospitalization,'' ''importance of bringing all your medicines to follow-up appointments,'' and ''given the side effect of each medication.'' One hundred percent of patients wanted *a lot of explanation* (highest category on Likert Scale) about ''my condition'' and ''my test results.'' Only 39% of patients wanted *a lot of explanation* about discharge medications. Sixty-one percent wanted *somewhat of an explanation* about discharge medications. When asked to choose the most important piece of information, 67.5% of patients chose ''lifestyle changes.'' See Figure 1 for the relative importance of the items.

The majority of patients surveyed, 173 (86.5%), wanted verbal discharge instructions with or without written discharge instructions, with only 10.5% requesting only written discharge instructions ($P < 0.0001$). The majority of patients, 168 (84%), wanted resources to read about their medical condition, with 97 (57%) requesting brochures and 62 (36.9%) requesting Web sites. One hundred percent of patients thought that personal communication between the inpatient provider and the primary care doctor was ''extremely important'' or ''essential.''

We identified 4 major themes in our qualitative review of the patients' and proxies' comments: ''verbal communication,'' ''frustration,'' ''opacity of system,'' and ''too many physicians.'' Participant quotes related to the 4 major themes are presented in Table 2. Many participants expressed a desire for verbal, rather than written, communication at the time of discharge with their healthcare team; patients particularly requested time for verbal communication with their physician. In the frustration theme, many patients and caregivers expressed frustration that the healthcare team was not carefully listening to them. In the theme of ''too many physicians,'' many patients expressed feeling overwhelmed by the number of different doctors involved in their care; particularly at discharge, patients did not know to whom to direct questions. Finally, as part of the ''opacity of system'' theme, patient comments included concerns regarding how information will be passed to outside doctors, and that the system of communication is not clear.

DISCUSSION

Discharge is a period of transition from hospital to home that involves a transfer in responsibility from the inpatient care team to the patient and/or

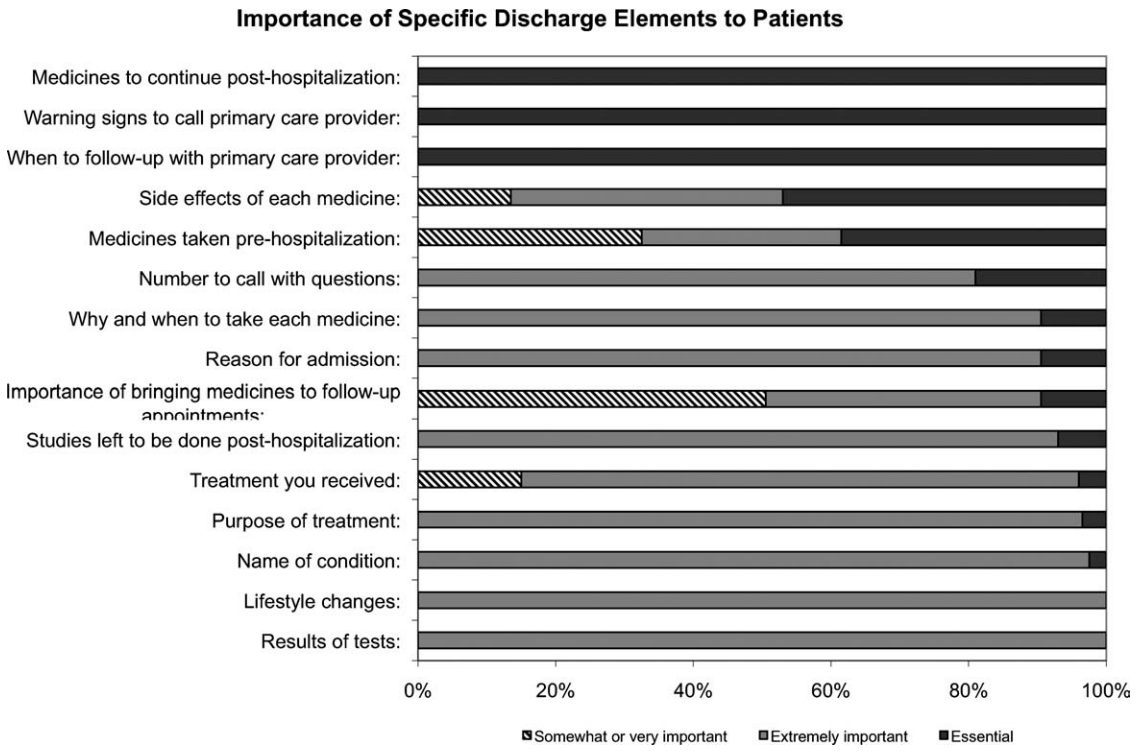

FIG. 1. Importance of specific elements of discharge instructions to patients.

TABLE 2. Major Themes From Open-Ended Comments With Patient Quotes

Verbal communication
"Can we just stop and talk? Everybody is rushing in and out."
"I just want my doctor to stop by before I go home and tell me what the plan is."
"Sometimes I feel like no one is talking to me. All they do is give me paperwork."
"I want my doctors to sit down with me before I leave the hospital and tell me exactly what I need to do so that I don't come back."
"I don't want papers, I want people. I want to talk to someone and not read my problems from a sheet of paper."
Frustration
"I wonder sometimes if anyone is listening to me . . . I seem to be part of a very elaborate organization that has its own rules and regulations and will not alter its ways.
"Why do I have to keep retelling my story? It gets tiring. I wish my story could just be told once."
Too many physicians
"I saw lots of doctors during my time here, but I didn't see them again when I was leaving."
"I see so many doctors . . . I have no idea who is in charge and who I should direct my questions to."
"I feel overwhelmed by the number of doctors I see every time I come into the hospital."
"I want my main doctor to talk to me. I get so confused when I hear from more than one doctor."
"I miss the days when my primary doctor came in to check on me. He knew exactly what I needed. Now, I meet new people every time I go into the hospital."
Opacity of system
"I wonder if all my doctors talk to each other. Sometimes, it seems like they don't."
"Who keeps track of all this information? Is there someone who will pass on what happened to me here to the outside world?"

caregivers and primary care physician. Ineffective communication, planning, and coordination of care can undermine patient satisfaction, increase adverse events, and contribute to more frequent hospital readmissions.

The patients we surveyed uniformly placed high value on verbal (more than written) communication about discharge care plans. Protected time during the discharge process for hospital staff to provide verbal recommendations to patients, especially about when they should return for follow-up, warning signs to contact PCP sooner, and medications to continue after discharge, may improve patient satisfaction.

In open-ended comments, several subjects suggested that physicians should sit down in the patient's room and provide verbal discharge instructions. Although it is well recognized that verbal communication alone has limitations and that providing patients with written instructions remains crucial, verbal reinforcement may highlight the most important instructions.

Interestingly, subjects valued information about lifestyle changes over detailed information about their medications. This may suggest that hospitalized patients are particularly receptive to information about lifestyle changes such as smoking cessation or importance of compliance with medical appointments.

Lastly, patients we surveyed value personal communication between inpatient and outpatient providers. It is plausible that this would improve transitions of care, and previous studies have suggested that direct communication between inpatient and outpatient providers occurs infrequently, with only 20% of primary care providers in 1 study reporting that they are always notified when their patient is being discharged from a hospitalist service.[6]

The themes that emerged from our open-ended questions also highlight the importance of direct verbal communication with patients and careful coordination of care with outside physicians. Because

patients may be unlikely to fully remember verbal instructions at discharge, providers may consider providing patients and family members with patient-centered written materials to take home in order to reinforce important self-care instructions. The patient comments further suggest that patients may be more satisfied, and that discharges may be smoother, if 1 or 2 physicians were always identified to the patients and their caregivers as the leaders of the care team throughout the hospital course and discharge process.

Our study had several limitations. We only surveyed patients on general medicine services, so our findings might not apply to other populations. We did not enroll participants on weekends and holidays; it is possible that this led to some bias in the enrollment of subjects. We also only surveyed patients and/or proxies who could speak and read English, and this was a fairly highly educated population, with almost half having completed 4 years of college. Finally, we relied on participant self-report for demographic information because we did not have access to the electronic medical record. This study was conducted at 2 large academic medical centers that include resident physicians in the daily care of patients; thus, these results may not be generalizable to other settings.

Effective verbal communication between physicians, outpatient providers, patients, and their caregivers about discharge care plans might improve patients' understanding of their hospitalizations, increase their satisfaction with care, and reduce readmissions. In addition, physicians should recognize that patients value advice about lifestyle interventions that might improve their health, as part of the discharge care plan. Intervention studies are necessary to test these hypotheses in large, diverse populations.

Acknowledgements

Disclosure: Nothing to report.

References

1. Moore C, Wisnivesky J, Williams S, McGinn T. Medical errors related to discontinuity of care from an inpatient to an outpatient setting. *J Gen Intern Med*. 2003;18(8):646–651.
2. Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297(8):831–841.
3. Greenfield S, Kaplan S, Ware JE Jr. Expanding patient involvement in care. Effects on patient outcomes. *Ann Intern Med*. 1985;102(4): 520–528.
4. Society of Hospital Medicine. Project BOOST, Better Outcomes for Older adults through Safe Transitions. Available at: http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/HTMLDisplay.cfm&CONTENTID=27659. Accessed August 1, 2011.
5. Strauss AC, Corbin JM. Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory. 2nd ed. Thousand Oaks, CA: Sage; 1998.
6. Pantilat SZ, Lindenauer PK, Katz PP, Wachter RM. Primary care physician attitudes regarding communication with hospitalists. *Am J Med*. 2001;111(9B):15S–20S.