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Engaging Patients at Hospital Discharge

I first met G.M. (a pseudonym) a year ago during a hospitalization for a flare of his Crohn's disease. At the age of 26, he had accrued nearly 400 hospital days in more than 10 institutions—ranging from academic to community medical centers from the East Coast to the West Coast. He had been admitted and discharged more than 25 times and endured several surgeries, intermittent struggles with chronic pain and depression, and mishaps due to poor discharge planning. He referred to discharge as the most chaotic time of hospitalization, a comment that prompted a memorable discussion.

He began by describing the emotions he felt when first told about being discharged, using words such as *fear* and *helplessness*. He repeatedly talked about the lack of planning and anticipation of discharge as well as the frustration of watching a system that required fixing. Speaking with tremendous emotion and insight, he also pointed out the discharge experiences that maintained his trust and faith in the system. The conversation then shifted to his mother, who pointed out that her experiences as the caretaker were quite different than her son's. She was equally passionate and genuine in trying to characterize the hospital discharge process.

The conversation was so moving that I asked G.M. and his mother to jot down their thoughts on discharge as well as participate in a multidisciplinary patient safety conference. The following are excerpts from our conversation, their letters, and the conference.

THE PATIENT'S VIEW

You never go into the hospital wanting to stay there, but you also worry tremendously about adjusting back to home life. In my case, I was often on heavy pain medications with a PCA (patient-controlled analgesia), so the transition to orals always created a source of stress, particularly when the transition happened right at discharge. I've had a number of experiences when they told me I was going home, stopped the PCA, and then simply sent me on my way. Nothing is worse than being discharged from the hospital, spending the car ride home doubled over in pain, and then not being able to get pain meds from the pharmacy until the next day. On the other hand, I've had discharges that were better anticipated, so I could participate in the process. This made all the difference in the world. I don't think people realize that when you're on a PCA right up to discharge, you're not really in a state to receive counseling, education, or instructions about follow-up plans—I was just trying to get better.

Many times, I knew I was getting close to discharge, but I often

The author thanks G.M. and his mother for candidly sharing their thoughts and feelings about the discharge process. He also thanks Erin Hartman, MS, for her invaluable editorial assistance in preparing this manuscript. The patient safety conference described was part of the Triad for Optimal Patient Safety (TOPS), a project funded by the Gordon & Betty Moore Foundation.

didn't see anyone owning the process. Information would be fragmented or inconsistent, and while I may have been "ready" for discharge, I wasn't "prepared" for discharge. This was a combination of paperwork being incomplete or being left to arrange my own follow-up appointments after getting home. When you're sick and depressed, you fall through the cracks of the system. You just don't have the resolve to make things happen.

Ultimately, a well orchestrated discharge prepared me to be independent on some level. I felt comfortable and ready for life outside the hospital. I didn't feel helpless because I was only responsible for getting well—not for arranging my follow-up appointments, ensuring the home care nurse was coming by, and confirming that my primary doctor knew what was going on. In these situations, there was always a discharge planner serving as a patient advocate of sorts. I also can't imagine what I would have done if I didn't have my mom with me all the time. She's my mom, my advocate, and my caretaker and I don't know how patients survive without someone like that.

HIS MOTHER'S VIEW

I wasn't the sick and helpless one but rather the one who was expected to make it all happen: keep tabs on the medications, understand the details of the discharge plan, and ultimately manage the execution of care postdischarge. In the majority of cases when we had a "bad" discharge experience, it was because the goals were confused. It became about the "bed" that was needed for the person still sitting in the emergency department. They may not have realized it, but we fully understood the tension, and we very much felt it during the spotty discharge communications. Safety for the patient being discharged seemed to fall off the radar.

The goals of the process must be clear. In "good" discharges, caregivers clearly outline the transition plan, transfer records to the outpatient physicians, and arrange referrals to specialists as needed. Perhaps equally important is addressing the patient's emotional state for discharge. This isn't about convincing us that he's safe to go home, but a simple acknowledgement of the difficult transition—particularly after a long hospitalization—goes a far way in providing reassurance and decreasing fear and anxiety. If the issue is always one about beds and cost, I would think someone would figure out that a "good" discharge prevents readmissions, which would have to be a cost-effective investment.

DISCUSSION

The voice of the patient (or family member) is incredibly powerful. Rather than having a trainee present a case history to illustrate teaching points, it is sometimes more meaningful and instructive to let patients tell their own stories. We invited G.M. and his mother to discuss their discharge experiences at a multidisciplinary patient safety conference. There, representative members of the discharge team (eg, house staff, attending, bedside nurse, pharmacist, and discharge planner) responded to their comments and discussed their roles in the discharge process. Ultimately, the patient and his mother taught us the most about what we can do to improve a process fraught with complexity and the potential for errors: communicate and work better as a team.

G.M. and his mother listened to each of the "experts" discuss the tasks they must complete to ensure a smooth discharge. Each provider expressed how committed they were to safe discharges, yet all of them shared how easy it is for one to go awry. They knew their individual roles, but all relied on each other to make the process complete—highlighting that communication failures frequently lead to poor discharge experiences for patients. Engaging patients in the process should not transfer ownership of discharge to them (ie, making them responsible to ensure we do our jobs), though our patient and his mother presented several examples of how they owned the process because it was clear no one else did.

Evaluating our hospital discharge systems must include identifying methods to improve communication with outpatient providers, ensuring medications are available to patients on discharge, and providing written instructions (including follow-up appointments) to patients before they leave the hospital. G.M. and his mother remind us that the best systems still need to engage patients, make them an active part of the discharge process (rather than an outcome of it), and never underestimate what patients suffer through emotionally prior to discharge.

Providers often feel uneasy when having to explain to patients that they no longer require hospitalization and perhaps avoid emotional engagement in those discussions because of the fear that some patients may become upset about a planned discharge. Communicating with patients about discharge plans should be handled with the same

compassion, patience, and skill as delivering bad news. Patients entrust their lives to our clinical decision making, and abandoning this trust just as they leave the hospital is an unintended message that our patient and his mother perceived during their poor discharge experiences.

In my practice, I frequently include trainees in bedside discussions with patients and families, both to illustrate how important these conversations are and to model skills I was taught during my training. I now use discussions about discharge as a specific bedside teaching moment as well, hoping to impress on trainees the overriding message shared by G.M. and his mother: do not forget to

engage patients in a process that is designed for them rather than to them.

Many physicians remain dedicated to improving hospital systems, but perhaps we should all be including our patients more in quality improvement activities and hospital committee work, as they provide perspectives not easily captured by administrative data and run charts.

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