EDITORIAL

BOOSTing the Hospital Discharge

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Hospitalists recognize the importance of the care transition from the inpatient setting to the outpatient setting, despite being described as causing a divorce between inpatient and outpatient care.[1] If you do not believe this, just glance at the table of contents for this issue of the *Journal of Hospital Medicine*, which has 5 reports on research about various aspects of the hospital discharge transition complemented by an eloquent story of how a hospitalist facilitated the care coordination of one family's matriarch.[2] An accompanying editorial proposes that hospitalists embrace the need of patients and their caregivers for care coordination.[3] Thankfully, a growing number of academic hospitalists are focusing their efforts on identifying problems in the process and evaluating potential interventions to optimize it.

The hospital discharge process commonly has been an afterthought, concluding a typically intense experience for patients, some of whom may have begun the episode of hospitalization near death. After diagnostic evaluations and treatments, a patient has achieved stable enough status to be discharged home, and the inpatient physician has signed off with a simple "may go" in the written orders. The physician may feel absolved of responsibility as he expects the nurses to take care of instructions and to find transportation home for the patient. Unfortunately, this experience often is consistent with Webster's definition of discharge: "to relieve of a charge, load, or burden … unload … release from an obligation." Some patients may feel like a Nolan Ryan fastball flying out of the hospital, but with no one to catch them.

Recognizing how the hospital discharge transition to home can be a perilous process fraught with failure,[4] we laid out a research agenda for transitions of care. We are gratified to see the robust response from researchers published in this issue of the *Journal of Hospital Medicine*. The studies range from the description of a new tool to assess patients' mobility before discharge[5] to evidence that the length of stay is prolonged (ie, delayed discharge) when the discharge diagnosis differs from that made on admission.[6] Chen and colleagues analyzed the timing of discharge during the day and found that the duration of the discharge process was influenced by the need for consultation or a procedure prior to discharge; this finding is not surprising to practicing hospitalists. We agree with their conclusion that broad institutional efforts will be needed to facilitate the process. Hospitalists are part of a system and must engage the entire team to improve efficiency.

O'Leary and fellow hospitalists[7] at Northwestern Memorial Hospital focused on creating a better discharge summary within their electronic health record with the aim of improved overall quality of the summaries and, just as important, timely completion. Despite some research indicating that absence of adequate communication between primary care providers and inpatient medical teams is not associated with adverse clinical outcomes,[8] other research has demonstrated that it does affect outcomes and probably affects rehospitalization rates.[9,10] Moreover, another article in this issue describes a project undertaken at Baylor Health Care System (Dallas, TX) that demonstrated a reduction in emergency department visits and readmissions within 30 days post-discharge among high-risk elderly medical patients when a targeted care bundle was used.[11] The results from this intervention, which consisted of medication counseling/reconciliation by a clinical pharmacist, condition-specific enhanced discharge planning by a care coordinator, and phone follow-up, confirm recent results from 2 similar studies.[12,13] These studies provide support for the idea that straightforward changes in the discharge process can improve patient outcomes.

Today in the United States, hospitalists likely care for the majority of hospitalized older patients.[14] We strongly encourage them to use evidence-based approaches to optimize the discharge process in their hospitals, and fortunately, clear guidance is available. Because of generous funding from the John A. Hartford Foundation, Project BOOST (Better Outcomes for Older Adults Through Safe Transitions) is mentoring 30 hospitals in an effort to implement the BOOST toolkit and improve their discharge transition processes.[15] Another cost-effective method involves the use of transition coaches to help the most vulnerable older patients with complex care needs.[16] This approach is now being implemented by more than 100 healthcare organizations worldwide.[17]

Heartened by these exciting initiatives, we applaud the Society of Hospital Medicine's collaboration with the American College of Physicians, the Society of General Internal Medicine, the American Geriatrics Society, and the Society of Academic Emergency Medicine to produce a consensus policy statement on transitions of care that provides guiding principles for transitions both into and out of the hospital.[18] Soon, all hospitalized patients and their caregivers may receive robust education prior to discharge, confirmation of their understanding with the teach-back approach, medication reconciliation, and clear instructions for follow-up, and the patient's primary care provider will be aware of all that has happened. Patients should expect nothing less than hospitalists ensuring their seamless transition from hospital to home.

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