

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 discharge⁵ 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 hospitalists⁷ 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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Hospital discharge " key steps. Staff should: 1 Explain and provide information about the discharge process in a format you can understand and engage with, soon after admission. 2 Start discharge planning once you have a diagnosis and treatment plan. Ask about and take account of your home circumstances, involving you (and your carer or family as appropriate) at all stages. Ask what post-discharge support the hospital provides and whether they provide aids for use in the short term, to help with mobility or ensure your safety, if you need them. You have a right to an assessment by your local authority where it appears you may have needs for care and support. Being discharged from hospital. Each hospital has its own discharge policy. You should be able to get a copy from the ward manager or the hospital's Patient Advice and Liaison Service (PALS). Once you're admitted to hospital, your treatment plan, including details for discharge or transfer, will be developed and discussed with you. A discharge assessment will determine whether you need more care after you leave hospital. You should be fully involved in the assessment process. With your permission, family or carers will also be kept informed and given the opportunity to contribute. If you need help putting your views across, an independent advocate may be able to help. Find out about getting back to normal after an operation. What's meant by minimal or complex discharge? Project BOOST from the Society of Hospital Medicine focuses on day of hospital discharge with phone call follow-up 2-3 days later 13 . The Care Transition Program TM focuses on empowering seniors and improving their selfmanagement skills with the use of home nurse visits or transition coaches and phone call follow-up. ... Seniors frequently struggle during the transition home following an acute hospitalization resulting in frequent rehospitalizations. Studies consistently show a lack of comprehension of discharge instructions. To determine the frequency of low cognition at hospital discharge among community dwelling seniors and the changes in cognition that occur one month following hospitalization. Understanding Hospital Discharge Planning. Many older family members may have special needs that develop as a result of a health condition for which they have been hospitalized. Some older individuals need daily care after being discharged from the hospital. Families and caregivers need to be aware of these issues and prepared to provide coordinated care for their loved one after he or she leaves the hospital. What is hospital discharge planning? Hospital discharge planning is crucial to ensuring that your aging loved one receives the post-hospital care needed to regain his or her health.