RESEARCH ARTICLE

Pairing Transitional Care Rounding and Post-Discharge Follow Up Strategies to Improve Patient Understanding of Care Instructions

Lisa Romano, M.S.N., R.N., Barbara Davis, M.A., Lyndsey Lord, M.B.A., R.N., Nate Sternberg, Krisha Patel, M.P.H.

ABSTRACT

There are numerous factors that can impact a patient's understanding of care instructions when transitioning from the hospital setting to home. This retrospective data analysis measured the effect of bundling interventions – a transitional care round and post-discharge outreach call – on patients' ability to understand information to care for themselves safely post-discharge. The results showed that patients who received both a transitional care round and a post-discharge outreach call had fewer questions about aspects of their care plan compared to those who only received a post-discharge outreach call. It was determined that further research is required to understand how pairing the aforementioned interventions impact hospital readmission rates.

KEYWORDS

Transitions of Care, Transitional Care Rounding, Post-Discharge Follow Up

INTRODUCTION

Transitioning a patient from hospital to home is an extremely complex and multifaceted process. In addition to the amount of information a patient and family are challenged to absorb regarding new medications, follow up care, and clinical symptoms, Social Determinants of Health (SDH) may also play a significant role in a patient's recovery. SDH vary among patient populations and include items such as family support systems, financial stability, ability to comprehend written and verbal instructions, and physical safety in the home.[1]

While these issues are not clinical in nature, they can have a profound effect on the ability of a patient to understand information and care for themselves safely post-discharge. Although patients may be more comfortable at home with the support of family and friends and away from the stresses of a hospital or post-acute setting, for some, this transition becomes challenging and may result in critical gaps in care.

Some healthcare processes are based on an evidence-based bundle of interventions to reduce the risk of complications and support improved care. While not comparable to other bundles in terms of complexity, pairing two interventions across a care process, such as the transition to home, can help coordinate care and maximize the ability to proactively resolve patient issues.

CHALLENGES TO PATIENT COMPREHENSION OF CARE INSTRUCTIONS

There are various challenges throughout the discharge process that can impact the degree to which patients leave the hospital with an adequate comprehension of their care instructions. This may involve many stakeholders sharing critical pieces of information that can easily be misinterpreted by patients and/or their caregivers. Other challenges, such as those related to SDH and health literacy, are well-documented issues that can affect recovery following an inpatient stay. Additionally, changes in reimbursement have led to decreased Length of Stay (LOS), which may also impact patients' time to digest and understand the care plan.

In light of these challenges, the purpose of this study was to assess the impact of pairing the transitional care round and outreach call as a way of assessing patient understanding of care instructions as measured by their questions.

THE STUDY

The transitional care round consists of a final review of the personalized discharge plan, including home care needs, durable medical equipment, transportation, follow-up appointments, care instructions, and signs and symptoms to monitor. The post-discharge outreach call confirms that this plan has been effectively carried out and assesses if the patient has remaining questions that can be immediately addressed.

To test this hypothesis, CipherHealth studied the effectiveness of implementing these complementary strategies: transitional care rounding and post-discharge outreach. A retrospective data analysis was completed of three CipherHealth clients that used both of these interventions. The facilities studied included six community-based hospitals located throughout various geographic regions across the United States.

STUDY APPROACH

The analysis included 5,609 patients over a 6-month period. All patients included in the analysis received an outreach phone call after leaving the hospital. During outreach calls, patients were asked about their understanding of their care instructions and medications, which are known risk factors for readmission. In response to the questions, patients could press a button on their keypad to indicate that they had a question, triggering a call back from a care team member to address their concerns and resolve the issues.

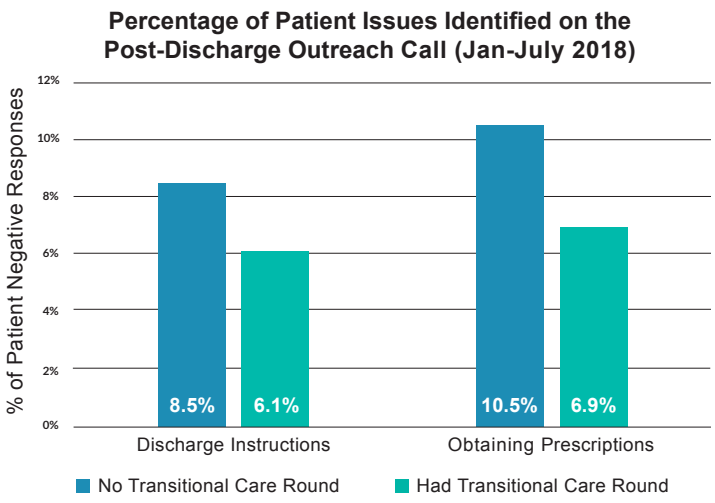
A subset of the total population also had a transitional care round conducted during their acute hospital stay. During the transitional care round, clinicians asked patients about their understanding of their instructions for home, including symptoms or problems to monitor and an understanding of their medications.

CipherHealth performed a 2 sample z-test, and a p-value of 0.4483 was calculated, thereby ensuring comparability between the two patient cohorts. Following that analysis, CipherHealth compared the patients' inquiries into discharge instructions and medications by grouping patients who received both interventions to those patients who had only one intervention.

RESULTS

CipherHealth's retrospective data analysis identified that for patients who received only an outreach call post-discharge, 8.5% had questions about their instructions for recovery at home and 10.5% had issues obtaining prescriptions. In comparison, for patients who received both a transitional care round and an outreach call, 6.1% had questions about their instructions for recovery at home and 6.9% had issues obtaining prescriptions.

Patient Group	Sample Size n=	Patients who had questions about discharge instructions	Patients who had questions about obtaining prescriptions
Patients who received a transitional care round	1061	65 (6.1%)	73 (6.9%)
Patient who did not receive a transitional care round	4548	387 (8.5%)	476 (10.5%)



This review suggests that supplementing discharge teaching with both a focused transitional care round and post-discharge outreach is an effective way to support a patient's healing journey. This process allows patients multiple opportunities to request clarification or additional education from their caregivers and providers, as well as providing patients the necessary time to review and process their discharge instructions.

FUTURE ANALYSIS

More analysis is needed to test the hypothesis that patients who receive both a transitional care round and an outreach call are less likely to be readmitted. Review of the literature identifies four key factors in preventing readmission. One of those factors is the patient knowing whom to contact after discharge if there is a problem.[2] This element is included in the required set of information hospitals share with patients at discharge as the care team reviews signs and symptoms to monitor at home. Patients in our study demonstrated understanding of their discharge instructions, and if there were questions, they were able to seek immediate help.

Based on the data in this retrospective study, pairing a transitional care round with an outreach phone call reduces patient questions. This case study demonstrates the impact of pairing strategies for patients who are transitioning to home. Further analysis is needed with a larger sample size, longer study period, and correlation to readmission rates to further assess impact.

REFERENCES

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