Patient Perspectives of the Hospital Discharge Process: A Qualitative Study

Kayla C Jones, MA[1],* (ID), Kirsten Austad, MD, MPH[1,2,*],
Santana Silver, MPH[1], Erika G Cordova-Ramos, MD[1,3],
Kathryn L Fantasia, MD[1,4] (ID), Daisy C Perez, MPH[5] (ID),
Kristen Kremer, MPH[6], Sophie Wilson, MA[7], Allan Walkey, MD[1,8],
and Mari-Lynn Drainoni, PhD[1,9,10]

Abstract

Care transitions after hospitalization require communication across care teams, patients, and caregivers. As part of a quality improvement initiative, we conducted qualitative interviews with a diverse group of 53 patients who were recently discharged from a hospitalization within a safety net hospital to explore how patient preferences were included in the hospital discharge process and differences in the hospital discharge experience by race/ethnicity. Four themes emerged from participants regarding desired characteristics of interactions with the discharge team: (1) to feel heard, (2) inclusion in decision-making, (3) to be adequately prepared to care for themselves at home through bedside teaching, (4) and to have a clear and updated discharge timeline. Additionally, participants identified patient-level factors the discharge planning team should consider, including the social context, family involvement, health literacy, and linguistic barriers. Lastly, participants identified provider characteristics, such as a caring and empathetic bedside manner, that they found valuable in the discharge process. Our findings highlight the need for shared decision-making in the discharge planning process to improve both patient safety and satisfaction.

Keywords

hospital discharge, patient experience, patient satisfaction, shared-decision making

Introduction

Care transitions after hospitalization are complex processes that require coordination of care and communication across multiple interdisciplinary care teams, patients, and caregivers. The high frequency of adverse events postdischarge, including avoidable readmissions[1-4] and high prevalence of patient and caregiver distress during this time, signal persistent and important gaps in quality and safety.[5,6] One measure of the quality of care transitions is patient satisfaction ratings, which are systematically

[1] Evans Center for Implementation & Improvement Sciences (CIIS), Department of Medicine, Boston University Chobanian & Avedisian School of Medicine, Boston, MA, USA
[2] Department of Family Medicine, Boston University Chobanian & Avedisian School of Medicine, Boston, MA, USA
[3] Department of Pediatrics, Boston Medical Center, Evans Center for Implementation & Improvement Sciences (CIIS), Boston University Chobanian & Avedisian School of Medicine, Boston, MA, USA
[4] Section of Endocrinology, Diabetes and Nutrition, Department of Medicine, Boston University Chobanian & Avedisian School of Medicine, Boston, MA, USA
[5] Department of Psychiatry, Boston Medical Center, Boston, MA, USA
[6] Department of Ambulatory Operations, Boston Medical Center, Boston, MA, USA
[7] Department of Quality and Patient Safety, Boston Medical Center, Boston, MA, USA
[8] Section of Pulmonary, Allergy, Critical Care and Sleep, Department of Medicine, Boston University Chobanian & Avedisian School of Medicine, Boston, MA, USA
[9] Section of Infectious Diseases, Department of Medicine, Boston University Chobanian & Avedisian School of Medicine, Boston, MA, USA
[10] Department of Health Law Policy & Management, Boston University School of Public Health, Boston, MA, USA

*Co-first author.

Corresponding Author:
Kayla C Jones, Evans Center for Implementation & Improvement Sciences (CIIS), Department of Medicine, Boston University Chobanian & Avedisian School of Medicine, 720 Harrison Ave, Boston, MA 02118, USA.
Email: kjones4@bu.edu

tracked as part of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.[7] However, quantitative data alone provide an incomplete understanding of the patient experience. To date, a handful of studies have used qualitative methods to gain a richer understanding of patient experiences during the hospital discharge process and have highlighted the importance of patients' trust in providers,[5] the quality of discharge teaching, [8,9] the involvement of caregivers,[6] the need to anticipate postdischarge challenges,[5] and patients' desire for accountability and continuity to troubleshoot these challenges.[10]

At our safety net institution, the HCAHPS survey[7] revealed possible disparities by race/ethnicity in the domain related to taking into account patient preferences in discharge planning. However, there is a lack of qualitative studies that have explored how the care transition experience may differ by race/ethnicity, despite well-documented disparities in outcomes after hospital discharge driven by socioeconomic disadvantage [11], unequal access to quality care,[12] and communication barriers.[13] As part of a system-wide effort to identify, understand, and eliminate disparities by race/ethnicity in the care we provide, we conducted qualitative interviews with a diverse group of patients regarding their perspectives on the hospital discharge process, including if and how their preferences were considered. We also sought to explore potential differences in experience by race/ethnicity.

Methods
Study Setting

This study was conducted at a large urban safety net hospital in New England. The hospital is a tertiary care academic medical center that serves a diverse low-income population, including 50% Black and 25% Latino, and 30% with limited English proficiency (LEP).

Participant Recruitment

Between July and August 2021, the hospital operations team generated a list of patients discharged in the previous 12 months who completed the HCAHPS survey by mail in either English or Spanish. The list was screened by the hospital patient experience team to identify those who rated their experience according to the discharge domains across the entire spectrum of responses (both positive and negative), focusing on those with free text comments related to discharge. From this list, participants who met the following eligibility criteria were contacted by the hospital experience team: age 18 or older, owned a telephone, and were admitted to the hospital between July 2020 and May 2021. They were contacted via telephone in their preferred language according to the electronic medical record to confirm eligibility, explain the study, and offer participation. Participant recruitment was completed when thematic saturation was reached. This project was deemed to be a quality improvement initiative by the Boston Medical Center and Boston University Medical Campus Institutional Review Board.

Table 1. Demographic and Characteristics of Participants.

Characteristics	N = 52
Race	
White	14 (27%)
Black	25 (48%)
Asian	2 (4%)
Latino	9 (17%)
Unavailable	2 (4%)
Gender	
Male	22 (42%)
Female	30 (58%)
Language preferences	
English	46 (88%)
Spanish	4 (8%)
Haitian Creole	1 (2%)
Portuguese	1 (2%)
Median length of stay	3.00 days
Average time from hospital discharge to interview	137 days

Data Collection

A semistructured interview guide was developed by the study team to elicit perspectives regarding participants' recent discharge experiences. Topics queried by the interviews are included in the Supplemental materials.

One-on-one interviews were audio-recorded and conducted via telephone in each participant's preferred language, either by an interviewer who was fluent in the language or with an interpreter, after obtaining verbal consent and were recorded with participants' permission. Participants were compensated with a $50 debit card.

Data Analysis

Interviews were professionally transcribed and translated verbatim. Data analysis was guided by the Health Equity Implementation Framework (HEIF),[14] which unites one of the most frequently used implementation science frameworks (i-PARIHS)[15] with a healthcare disparities framework.

The study team used rapid analytic methods.[16,17] Briefly, 5 team members each individually coded the first 3 transcripts and compared coding to establish consensus. Minor revisions were made to the codebook based on group consensus. The remaining transcripts were independently coded and findings along with illustrative quotes were abstracted into a summary table derived from the codebook. Summary tables were entered into a matrix to establish themes and compare results across racial/ethnic groups; comparison between racial/ethnic groups was not possible due to the small sample size.

Results
Characteristics of Participants

Participants' self-reported demographics and characteristics are provided in Table 1. A total of 52 participants were included in the final analysis, including 36 participants of

color (25 Black, 9 Latino, and 2 Asian), similar to the overall hospital population. Most participants were covered by a public insurance program and represented a mix of both medical and surgical admissions.

Overview of Themes

Participants articulated 4 desired outcomes of their interactions with the discharge planning team: to feel heard, to be included in decision-making, to be adequately prepared to care for them through bedside teaching, and to have a clear and updated discharge timeline. They also identified patient-level factors that they felt should be considered in discharge planning, including the social context, family involvement, and health literacy and linguistic barriers. Lastly, they identified provider characteristics that they found integral to achieving these desired outcomes, including a caring and empathetic bedside manner.

The themes that emerged were similar between White participants and participants of color, with examples in both groups of individuals feeling that their preferences were not adequately considered and that they were excluded from decision-making during discharge planning. However, the degree to which participants of color felt unheard or that their preferences were not considered were more extreme, including feelings of dehumanization, compared to sentiments among White participants. In addition, there was an increased emphasis among participants of color on the importance of understanding their social context in discharge planning and language-concordant discharge teaching. There were no explicit reports of perceived bias or discrimination that influenced the discharge experience.

Specific Themes

Feeling heard. Participants articulated the importance of feeling heard by their care team. Many valued when their opinion was considered in the discharge planning process:

> They heard that I wanted to go home, that it was my preference. They made sure they could arrange for oxygen at home. They took my opinion into consideration…. (PID02)

In contrast, not feeling heard produced negative perceptions of the discharge process. For example, some participants felt like they were not yet ready to go home but that the care team did not hear their concerns:

> I came home, no physical therapy, no nothing in place … And they literally were kind of like pushing me out of the door after I had three surgeries. They weren't giving me no time, I was telling them…and they were not listening or caring of what I was trying to tell them. (PID1520)

Here the participant links the concept of being unheard with not being adequately cared for by her providers.

Listening was a component of provider empathy that participants highly valued. For example, one participant who emphasized how well his discharge instructions were explained then stated "They treated me like family, like a sister or brother" (PID161).

A small number of participants felt unheard and uncared for throughout the admission, which continued into discharge planning. The most extreme examples came from participants of color. One Latino participant stated that "the discharge process was overall very poor … the whole thing is just a mess" and when asked how it could have been improved she said, "if I was taken care of better" (PID1621). Another stated, "…[they] could have treated me like a human being, not treated me like an animal" (PID1492).

Inclusion in decision-making. A key reason participants wanted to be heard is so that their opinion could be included in a collaborative decision-making process. With regard to discharge destination, some participants described accounts of decisions being made unilaterally, without including them in the process. Other participants expressed frustration with the care team not discussing additional contextual factors regarding their living situation, which may have influenced discharge destination decisions. Participants described barriers—such as stairs or not having family support—that they felt were important details often overlooked during the discharge process:

> I said, "I don't think I'll go home" because…I live with my husband only…my husband was also recovering from [a] stroke. So, I told them I was thinking I was going to rehab but somebody said, "No, you're going home." I said, "Why should I go home? Because there's nobody to help me at home." (PID63)

No White participants articulated a lack of home support as an important consideration. In fact, some noted support at home as a reason to opt for home care instead of rehab. One such participant described how she felt going to rehab was unnecessary and that the decision was not hers to make:

> She kind of made it sound like I had to go to the rehab place, that I had no choice, instead of asking me if I wanted to go. That I didn't like … And that's when I said, "No I'm going to go home." (PID46)

Here the participant is advocating for a more collaborative process of deciding her discharge location. She felt empowered to articulate her decision and was ultimately discharged home.

Preparation for self-care. Many participants felt like the care team provided them with clear discharge instructions. The information was typically provided verbally by a nurse, in addition to written information:

I think the most trusted was the nurses…because they went over the information with me like in detail, and I also looked to them throughout…. (PID13)

Here, nurses are depicted as having a more patient-facing role than doctors and physician-assistants. As such, participants often identified nurses as a trustworthy source for discharge teaching.

Participants valued teaching that ensured their comprehension. This often meant reviewing information slowly and stopping to confirm understanding:

I understand almost 100% everything. They [were] very patient, they speak very slowly, and they explained everything very slowly to me, so I understand everything. (PID03)

The vast majority of participants who had LEP referenced the appropriate use of interpreters to ensure comprehension. For example, one Spanish-speaking participant highlighted the use of an in-person interpreter to ensure she understood the care instructions:

[The discharge process was] good because they called an in-person interpreter for me, and they explained to me what I had to do and the medications I had to take. (PID1465)

Discharge processes that built confidence in participants' ability to perform self-care activities at home were also flagged as important. This required clear instructions and demonstrations with the opportunity to practice postdischarge tasks under the supervision of inpatient providers:

…they showed me how to administer [a shot] myself because I had to give it to myself for a couple of days after I got discharged…[the nurse] really built up my confidence in it, because that was just my major problem, administering my injection myself after my discharge… (PID25)

However, both White participants and participants of color reported struggles with uncertainty once at home which made self-care challenging. These challenges are often related to medication management, prescribed diet, and therapeutic devices. Participants articulated a need for more instructions on what they needed to do at home and details on who to contact with questions postdischarge. For example, one participant stated:

…what I did not understand well was about what to eat because I was [having] lot of difficulty eating [at home], and I was not functioning well at all because a lot of things I couldn't eat, but those are the questions that I had…it wasn't [until] I went to the emergency room like the third time, then they told me, each person has a special diet. (PID1453)

Another participant needed a better understanding of what was "normal" to experience postdischarge:

I wish I had known what was the reasonable amount to be expected to find in the drain on a daily basis…I told them I had anywhere from 30 milliliters…[the doctor] told me, "Oh, that's nothing." So … I didn't know … what I had was normal. (PID1131)

Clarifying discharge timeline. Many participants expressed an understanding that the discharge process is complicated and that there are unexpected factors that could delay it. Nonetheless, participants appreciated knowing the factors upon which their discharge was contingent:

…they said … if my oxygen level was fine, where it's supposed to be that I would … be discharged … I knew what to expect. I knew what they were looking for. (PID134)

Some participants were frustrated with uncertainties regarding when they would be discharged from the hospital. Overall participants—both White participants and those of color—wanted more frequent and clearer discharge timeframe expectations communicated:

The only thing that to me was kind of confusing, they couldn't really give me a time or even a ballpark in the beginning. So I wasn't sure the time I was going home and that kind of made it difficult to arrange a ride … Like the whole process wasn't clear. (PID409)

These logistics were complicated by the COVID-19 pandemic due to visitor restriction policies. Many participants expressed appreciation when nurses and physicians helped arranged transportation home.

Based on our analysis grounded in the HEIF, we created a conceptual model of patients' preferences for effective transition after hospitalization displayed in Figure 1.

Discussion

This project used qualitative methods to explore the hospital discharge experiences of a diverse group of patients served by a safety net hospital. Overwhelmingly, participants articulated the importance of feeling heard by their care team, being included in decision-making, receiving robust preparation to care for themselves after hospitalization, and being provided a frequently updated and clear discharge timeframe. Empathetic clinicians who could communicate a detailed timeline for discharge and build participants' confidence in self-care tasks, as well as assistance with transportation home, were highly valued.

These themes align with prior research on patient experience with hospital transitions of care conducted outside of the safety net setting. Mitchell et al[6] carried out interviews and focus groups with 248 patients and caregivers across 6
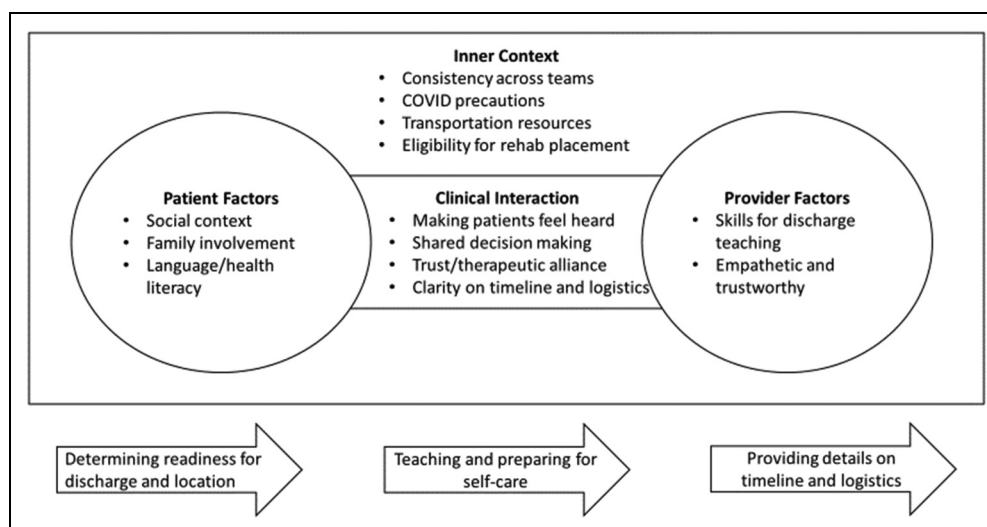
Figure 1. Conceptual model of patient preferences for transitions of care based on health equity implementation model.

health systems. They concluded that collaborative discharge planning, actionable self-care plans, and accountability for continuity of care were the most important aspects and outcomes of hospital transitions of care. Provider empathy was also identified in their work as integral to a positive experience, similar to our findings. Hospital discharge is a stressful and vulnerable time, which may explain the importance of provider empathy, especially in the safety net context where baseline stress is high. It is increasingly recognized in medicine that empathy is a teachable communication skill, rather than a personality trait, and this communication skill should be emphasized during transitions of care.[18,19]

Our findings shed light on an important gap in the literature by examining racial/ethnic differences in the discharge planning experience at our institution. We used a modified variation of the HEIF to examine multilevel drivers of health equity, including aspects of the clinical encounter, the intervention recipients, and larger societal influences.[14,20] Overall, our findings were similar when compared between participants who identify as White and participants of color. Participants of color did, however, place a greater emphasis on understanding the social context as part of discharge planning including the involvement of family in home care. Also, the most extreme examples of discontent with discharge planning came from participants of color, including a small number who felt they were treated inhumanely or that their preferences were completely ignored.

Another theme from participants of color with LEP was the need to address comprehension of discharge instruction. Miscommunication is a major driver of adverse events around the time of hospital discharge.[21,22] While comprehension may be an issue for English-proficient patients with low health literacy,[22] language barriers further increase the chances of poor communication.[23,24] In our interviews, many participants with LEP valued the use of in-person interpreters to review discharge instructions. Our sample size of participants with LEP was too small to allow us to draw further conclusions.

Promoting shared decision-making is a potential avenue to better meet patients' needs and preferences in discharge planning and promote health equity.[6,21] The benefits of shared decision-making have been identified across various fields of medicine.[25-28] While Agency for Healthcare Research and Quality's IDEAL discharge planning approach recommends including patients in the process and listening to their preferences—both key components to shared decision-making—there is little in the published literature about how to include shared decision-making during hospital discharge planning or its impact.[29] Our interviews revealed that information sharing with patients, another key step of shared decision-making, appeared to be lacking. Improved transparency and education regarding the process, especially in determining discharge destination, could help resolve dissatisfaction.

Our interviews identified several targets for quality improvement interventions. In addition to those highlighted above, our findings align with prior research showing that explicitly starting to prepare patients for self-care before the day of discharge is effective by allowing time for repeated instruction and questions.[5,30,31] Providing a combination of verbal and written discharge information helps facilitate patient comprehension. Efforts to audit and improve the quality of written discharge teaching can also be high-yield.[21,32]

Limitations

First, due to the COVID-19 pandemic, interviews were only offered via phone or Zoom,[33] limiting interviews to those who had access to a phone or computer. However, according to internal data, 85% of patients at our institution do have a phone; thus, this is unlikely to have a meaningful impact. Second, while none of our participants reported that racial/ethnic bias influenced their care, the phrasing we used in our interview guide did not directly use terms such as racism or discrimination, which may have led to underreporting. Additionally, our study design did not specify

identifying prior hospitalizations, which we recognize may potentially influence the patient-reported experience with the discharge process. Third, our strategy of recruiting from HCAHPS respondents may limit generalizability especially given differential engagement by race, ethnicity, language, and economic status.[34-36] Moreover, because our sample was limited to those who responded to HCAHPS in English or Spanish, our findings may underrepresent the communication barriers in discharge planning faced by patients with LEP. Of note, as a single-center quality improvement project our work may not be generalizable, but nonetheless offers insights into the patient experience that are likely similar at other institutions.

Conclusion

In this qualitative exploration of the discharge experience from a safety net hospital, interviews highlight the need for improved shared decision-making with patients during the discharge planning process. While our analysis adds to the existing literature by comparing experiences by race/ethnicity, nearly all of the outcomes and behaviors articulated by our participants are recognized standards of care as summarized in AHRQ's IDEAL Discharge Planning strategy.[37] Based on our findings, these benchmarks are not consistently being met at our institution. Further studies are warranted to evaluate strategies that include shared decision-making and empathy training, as well as the development and implementation of patient-facing decision aids for key choices such as discharge destination.

ORCID iDs

Kayla C Jones https://orcid.org/0000-0002-5902-159X
Kathryn L Fantasia https://orcid.org/0000-0002-2949-9568
Daisy C Perez https://orcid.org/0000-0002-9528-0062

Statement of Human and Animal Rights

All procedures in this study were conducted in accordance with the Boston Medical Center and Boston University Medical Campus Institutional Review Board-approved protocols.

Statement of Informed Consent

Verbal informed consent was obtained from the patients for their anonymized information to be published in this article.

Supplemental Material

Supplemental material for this article is available online.

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