


Hospital Discharge Planners Need More Information When Referring Patients to Home Health Care: Insights From the Coronavirus Disease 2019 Pandemic

Jun Li¹ , Thomas Jeffers², Babatope Ogunjesa³ and Minakshi Raj³

¹Department of Public Administration and International Affairs, Maxwell School of Citizenship and Public Affairs, Syracuse University, Syracuse, NY, USA. ²Jeffers Design & Development, Zeeland, MI, USA. ³Department of Kinesiology and Community Health, College of Applied Health Sciences, University of Illinois Urbana-Champaign, Urbana-Champaign, IL, USA.

Health Services Insights
Volume 16: 1–10
© The Author(s) 2023
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/11786329231211093



ABSTRACT: Hospital discharge planners play an important role in helping patients choose appropriate home health care. However, during the COVID-19 pandemic, they may not have had enough information to make the best decisions for their patients. A study of 58 discharge planners from Michigan hospitals found that 90% of them wanted information about the quality of home health agencies and whether they were prepared for COVID-19. However, only about 20% had this information readily available. The study also found that discharge planners varied in how they incorporated quality information. Some did not incorporate any quality information at all, while others provided it to patients without explaining its significance. Only about 25% of discharge planners helped patients interpret different sources of information. These findings suggest that hospital discharge planners had an unmet need for quality information, and they also provided limited assistance to patients. This may have led to some patients receiving suboptimal care. Thus, we proposed that hospital discharge planners need more information about the quality of home health agencies. Discharge planners should be more transparent about the quality of information they have, and they should help patients interpret it.

KEYWORDS: Post-acute care, discharge planning, quality, hospital quality, coronavirus, care transitions

RECEIVED: June 23, 2023. **ACCEPTED:** October 12, 2023.

TYPE: Original Research

FUNDING: The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This project was supported by the Walter J. McNerney Award from the University of Michigan, Department of Health Management and Policy (Dr Li, Dr Raj). The funding organizations had no role in the design and conduct of the study; collection, management, analysis, and interpretation of

the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication. No conflicts of interest disclosures are applicable.

DECLARATION OF CONFLICTING INTERESTS: The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

CORRESPONDING AUTHOR: Jun Li, Syracuse University, 314 Lyman Hall, Syracuse, NY 13244, USA. Email: jli208@syr.edu

Introduction

Patients have long struggled with identifying high-quality post-acute home health care.^{1,2} Post-acute home health care services may include nursing for pharmacologic and non-pharmacologic interventions; occupational therapy to maintain functional capacity; and physical therapy to help patients recover from illness and maintain independence.³ Even though high-quality home health care may lead to decreased hospitalizations and lower costs, quality in the sector varies greatly.⁴ Home health care quality, as commonly measured by how well an agency helps patients manage daily activities, treats symptoms and wounds, prevents harm and hospital use, vary substantially by geography and for racial-ethnic minority populations.^{4,5} In recent years, the coronavirus disease 2019 (COVID-19)¹ pandemic has brought safety to the forefront of quality, and made it increasingly difficult for patients to identify safe options,⁶⁻⁹ and a substantial proportion of clinically vulnerable patients have delayed care due to concerns about safety with regards to infection.¹⁰

The hospital discharge planner, often a nurse or social worker, plays an important role in guiding where patients receive post-acute care.^{1,2} Discharge planners arrange post-acute referrals, identify potential service options, and assist patients in selecting providers,¹¹ with an overarching goal of

ensuring continuity of care as patients transition across settings and minimizing adverse events following discharge.¹² Studies show that effective discharge planning can decrease medical errors, hospital use, and nonadherence to post-discharge care regimens.¹³⁻¹⁵ US federal regulations require a hospital provide patients with a list of home health agencies in the patients' geographic location. Since November 2019, the Centers for Medicare and Medicaid Services (CMS) has further required US hospitals to provide quality information to patients for better discharge planning.¹⁶ This requirement speaks to the important role of discharge planning in helping patients navigate the care continuum.

Ideally, discharge planners would provide information tailored to patients' needs and concerns.¹⁷ Yet prior literature suggests that discharge planners have incomplete information about the quality of home health agencies and provide insufficient guidance to patients.¹ For instance, discharge planners often lacked a mechanism to receive patient feedback regarding home health care quality after patients left and many were unaware of publicly available sources of objective quality measures such as those produced by the CMS.¹ Given new challenges brought forth by the pandemic, whether discharge planning practices were sufficient in assisting patients in choosing home health care is unknown.



Our objective was to understand discharge planning needs and practices during the pandemic. In this mixed-methods study, we surveyed and interviewed 58 hospital discharge planners from 27 hospitals in Michigan. We sought to understand discharge information needs, what information were used to inform referrals, and the extent to which they helped patients identify high-quality home health options.

Analysis Strategy

We employed a multi-stage mixed methods study design.¹⁸ We first surveyed discharge planners to understand the availability and usefulness of quality and COVID-19 safety information for referrals to home health (Appendix 1). Next, we interviewed discharge planners to understand how they gathered, used, and presented quality information to patients. Finally, we drew upon interview findings to develop a second survey to quantify key themes and patterns in processes, facilitators, and barriers found in the interviews.

Participants

We collected data from June 16, 2020, through September 1, 2020, on a convenience sample of discharge planners, who were employed at general, acute care hospitals in the Michigan Value Collaborative (MVC). The MVC is a coalition of 87 hospitals representing 89% of acute care hospitals in Michigan with an explicit focus on improving quality of care.

The MVC sent an initial email to representatives from each of the 87 member hospitals on June 16, asking them to disseminate our initial survey to discharge planning staff within their institutions. We fielded the first survey online via Qualtrics from June 16 to August 7 and obtained responses from 58 discharge planners representing 27 hospitals. At the end of the survey, respondents were prompted to indicate their interest in participating in a follow-up interview and/or survey.

We then conducted all 11 semi-structured, one-on-one telephone interviews from July 13–August 11. The goal of the interview was to capture a variety of perspectives. We developed the interview protocol based on findings from the first survey (Appendix 2). Main topics included: (1) descriptions of home health quality from the interviewee's perspective, (2) interviewee's process of gathering and presenting information on home health referral options to patients, and (3) interviewee's procedures for assessing COVID-19 safety among home health agencies.

One member of the study team with extensive with qualitative research experience trained the second researcher with expertise in health administration to conduct all 11 interviews from July 13–August 11, which were typically 30 to 45 minutes in length. Interviewers were randomly assigned interviewees based on availability; if multiple interviewees worked within the same health system, they were assigned a different interviewer to minimize potential for bias. Despite our orientation

toward capturing various perspectives rather than reaching saturation, we found that saturation was reached for our topic areas of interest whereby there was no new information collected from interviews.¹⁹

All interviews were audio recorded and transcribed using the professional audio-to-transcription service, Rev. We used a deductive approach to coding and content analysis. (Appendix 3).²⁰ Since we were particularly interested in discharge planners' (1) information needs, (2) engagement with available information, and (3) role and responsibilities in assisting patients in identifying high quality home health care options, our codebook reflected these areas and aligned with our interview framework. In the first iteration, we coded for themes broadly related to information needs, engagement with available information, and responsibilities in assisting patients. Three study team members reviewed all transcripts and were randomly assigned to code 3 to 4 transcripts deductively as "primary coder" and an additional 3 to 4 transcripts as a "secondary coder." Then, we inductively developed subcodes to describe and reflect specific processes, attitudes, or concerns discharge planners expressed within the larger areas of information needs, engagement with information, and role and responsibilities in assisting patients.^{21,22} We created a spreadsheet of codes and 3 members of the study team proposed emergent subcodes based on coding of 4 interviews as either primary or secondary coder. The study team met once a week to discuss and form consensus around subcodes, after which the study team completed coding of all transcripts. Ultimately, all transcripts were coded twice, and double coding followed by meetings to establish consensus were used for reliability. Any discrepancies were discussed and resolved by all coders.

In our second round of surveys, fielded from August 3–September 1, we collected responses from 16 discharge planners (Appendix 4). This survey reflected themes and sub-themes identified in the interviews and focused on the discharge planner's (1) definition of high-quality home health care, (2) process of collecting and incorporating quality information for referrals, (3) presentation of referral options. We used secondary data to provide additional context on the study participants' working environments (Appendix 5).

Participants provided written consent for the survey and verbal consent for recording interviews and to publish deidentified results. Respondents received a \$10 gift card for each survey completed. Interviewees received \$25 for completing an interview.

Results

Characteristics of survey respondents and interviewees

Our first-survey data comes from 58 discharge planners representing 27 hospitals (Table 1). Most survey respondents had day-to-day discharge planning responsibilities (91%) and worked at the hospital for at least 1 year (93%). Most were

Table 1. Overview of samples of hospital discharge planners in Michigan.

	FIRST SURVEY	INTERVIEW	SECOND SURVEY
Number of respondents	58	11	16
Number of hospitals	27	9	9
Number of respondents per hospital, median (p25, p75)	1 (1, 3)	1 (1, 3)	1 (1, 1)
Survey respondent characteristics			
Tenure at hospital			
<1 year	7%	10%	7%
1-5y	32%	40%	53%
5+ years	61%	50%	40%
Has discharge planning duties	91%	93%	90%
Has administrative duties	53%	33%	40%
Confident home health agencies can keep patients safe from COVID-19	82%	87%	80%
Typical number of options presented to patients at discharge			
<6 home health agencies	-	33%	19%
6 to 10 home health agencies	-	33%	38%
11 to 20 home health agencies	-	17%	25%
21+ home health agencies	-	17%	19%
Hospital characteristics			
Case-mix index, mean (SD)	1.72 (0.24)	1.71 (0.29)	1.60 (0.26)
Teaching	86%	81%	82%
IPPS	40%	13%	36%
For-profit ownership	9%	6%	9%
Rural			
Large urban	9%	18%	6%
Other urban	75%	55%	63%
Rural	16%	27%	31%
Size			
<50 beds	14%	27%	31%
50-199 beds	21%	18%	13%
200-399 beds	33%	27%	31%
400+ beds	36%	27%	25%
Hospital has COVID-19 positive patients	96%	93%	100%
Hospital assesses home health for COVID-19 readiness	65%	47%	20%
County characteristics			
COVID-19 prevalence as of June 2020			
COVID-19 cases, mean (SD)	1747 (2607)	3025 (3915)	1139 (1690)
% in bottom quartile of cases in state	0%	0%	0%

(Continued)

Table 1. (Continued)

	FIRST SURVEY	INTERVIEW	SECOND SURVEY
% in second quartile of cases in state	9%	9%	6%
% in third quartile of cases in state	19%	18%	50%
% in top quartile of cases in state	72%	73%	44%
% Medicaid eligible patients, mean (SD)	22.19% (3.27)	24.23% (2.12)	22.22% (3.39)
Hierarchical Condition Categories per person, mean (SD)	1.03 (0.05)	1.04 (0.04)	1.02 (0.03)

Authors' analysis using publicly available Medicare and Michigan.gov data and survey data collected from 6/16/2020 to 9/1/2020. IPPS=Medicare Inpatient Prospective Payment System. Among the 58 first survey respondents, 40 expressed an interest in the follow-up survey, 22 expressed an interested in the interview, 6 individuals participated in both the interview and second survey.

Table 2. Useful information and their availability during discharge planning for patients referred to home health care.

	INFORMATION USEFUL (% OF SURVEY RESPONDENTS)	INFORMATION READILY AVAILABLE (% OF SURVEY RESPONDENTS)
Overall quality among home health agencies		
Reputation	98	34
General quality	91	60
COVID-19 quality among home health agencies		
Availability of personal protective equipment	90	18
Currently treating COVID-19 positive patients	90	23
Have COVID-19 safety protocols	88	21
Can contain COVID-19 spread	78	16
Staff training in infection control	72	12

Authors' analysis using first survey data collected from 6/16/2020 to 8/7/2020. N=58 survey respondents. Information marked as "useful" if respondents reported that the information was useful to have or that patients asked about the information at least sometimes during the discharge planning process.

employed at a teaching hospital (86%), in an urban setting (84%), and at an institution with at least one potential COVID-19 patient (96%). Approximately 65% incorporated some type of COVID-19 safety assessment of home health agencies as part of the referral process. Most (80%) felt fairly or very confident that agencies could keep their patients safe.

The 11 interviewees in our sample were employed at 9 hospitals. These hospitals were generally like hospitals in the first survey sample, although there were some slight differences. For instance, the hospitals averaged a case-mix index of 1.60 (SD=0.60) in the interview sample (vs 1.72 [SD=0.24]), had about 22.22% (SD=3.39) of patients that were Medicaid eligible (vs 22.19% [SD=3.27]); and about 73% of interviewees worked in hospitals located in geographies that were in the top quartile of COVID-19 cases in the state (vs 72%). Only 20% of the interviewees assessed potential home health agencies for COVID-19 safety of as part of the referral process compared to 65% in the first survey sample. A larger share of respondents worked at hospitals with fewer than 50 beds (27%vs 14% in first survey sample) and at hospitals located within a large urban geographic core-based statistical area (18%vs 9%) (Table 1).

Finally, 16 discharge planners representing 9 hospitals responded to the second survey. Fewer respondents in this sample incorporated COVID-19 safety assessments when making referrals (47%vs 65%), and fewer worked at hospitals located in the top quartile of COVID-19 prevalence (44%vs 72%).

Information utility and their availability

We sought respondents' views about various information's utility and availability for discharge planning to home health in the initial survey (Table 2). We gaged utility based on either if respondents believed that the information would be useful for discharge planning or if it was information asked by patients. We found that high-utility information was mostly unavailable. More than 90% of respondents in the initial survey reported high utility of having information on home health agencies' reputation and general quality, but only 34% and 60% of survey respondents had such information readily available.

The mismatch between information utility and availability with respect to agencies' COVID-19 readiness was worse. Only about 20% of survey respondents had information on whether

home health agencies had access to personal protective equipment and whether the agencies were treating COVID-19 patients; yet 90% of respondents considered this information to be high utility. Other information related to COVID-19 had similar high discrepancy rates: 88% of respondents found having information regarding whether the agencies had COVID-19 safety protocols to be useful but only 21% had the information readily available, 78% of respondents found having information regarding whether the agencies can contain COVID-19 spread to be useful versus 16% had the information readily available, and 72% found having information on whether agencies had staff trained in infection control to be useful but only 12% had the information readily available.

The interview findings also indicate that patients and discharge planners wanted more information about agencies' quality as related to COVID-19. One interviewee noted: "People get funny about people in their home, especially now." "How can I protect myself? How are they protecting me? Are they wearing masks? What PPE are they using? How can I know that they're not going to bring me something when I'm already compromised?" (Figure 1)

Most discharge planners struggled to provide answers to their patients. As noted by one interviewee: "It's harder for us, I think, to have the hands-on information of what actually happens in the home. Really, none of the home health agencies have provided us with, hey, this is what we're doing to protect patients. I think we just make the assumption, and maybe this is irresponsible, and we need to have more conversations." (Figure 1)

Discharge planners in our second survey estimated that 28% of their patients referred to home health had asked questions about COVID-19 (Figure 1). However, they only had COVID-19 readiness information on 24% of agencies that typically served their patients.

Perceptions of quality and likely sources of information for assessing home health quality

Despite an overall dearth of information, discharge planners were confident of the quality across home health agencies, including their COVID-19 readiness. Our first survey indicates that 82% of discharge planners were fairly or very confident that home health agencies could keep their patients safe from infection (Table 1). The typical information source for discharge planners in determining this were anecdotal. Most (86%) reported relying on communication with agencies, 43% from professional networks, and 34% on feedback from patients. Only 26% relied on reports generated by state, federal, insurer, or non-profit entities.

In interviews, we explored the potential explanations for why discharge planners were likely to believe, with little to no evidence, that home health agencies could keep patients safe during the pandemic. This confidence appeared to be based on whether agencies' were willing to accept patients—a proxy for agencies' safety—rather than data driven assessments. Several

interviewees noted that early in the pandemic, many agencies were requiring stringent COVID-19 diagnostics data, and in other cases, agencies stopped taking referrals. One interviewee noted "They've gotten a lot better because they got on board and got the PPE and trained their staff, from what I understand. I don't know, really, how much training they've gotten, but they seem a little bit more confident in the accepting of referrals and not requiring the testing." (Figure 2).

Like the other samples, the typical sources of information interviewees relied upon to assess COVID-19 safety among agencies came from communications with agencies (89%) as opposed to systematic reports generated by reliable third parties (21%) (Figure 2). Interviewees who discussed this further found that communicating with agencies directly provided up-to-date information with greater detail afforded through questions and additional description. With direct communication, agency representatives could provide interviewees with greater information about the number of patients with Covid, updates about availability of PPE, and evolving considerations.

The dominant view among the second survey sample was also that home health agencies could keep patients safe from COVID-19 (87%) (Figure 1). Approximately 69% of the 16 second survey respondents characterized home health agencies to vary somewhat in their quality (Figure 2).

Hospital discharge planners defined quality in home health care differently, however. Most defined a high-quality agency to be one that visits the patient soon after a hospital discharge (88%), returns the patient to their prior levels of functioning (69%), keeps patients out of the hospital setting (63%), responds to referral requests from the discharge planner in a timely manner (56%), and is proactive in COVID-19 readiness and safety (56%). Other aspects, such as whether the agency has high Medicare Home Health Star Ratings (31%) and can track patients across settings (6%), were viewed as less important (Figure 2).

Respondents to the second survey also identified anecdotal information as the most likely source for assessing home health quality even though anecdotal information was incomplete (Figure 2). For instance, 94% would use feedback from returning patients, but they only had such information on 15% of their patients.

Incorporating home health care quality into the discharge planning process

Using quality information to compile home health options. Our interview findings suggest that discharge planners varied in how they incorporated quality, and for many, quality was not considered while compiling home health options. One interviewee explained: "Basically we have a list of home care facilities in the area. I have not had personal experience with them. We're not allowed to recommend any. So, a lot of times, I go in and talk to the patient, see if they've ever had home care before, if they were happy with their services, we'll order that one. If they're not, then I provide

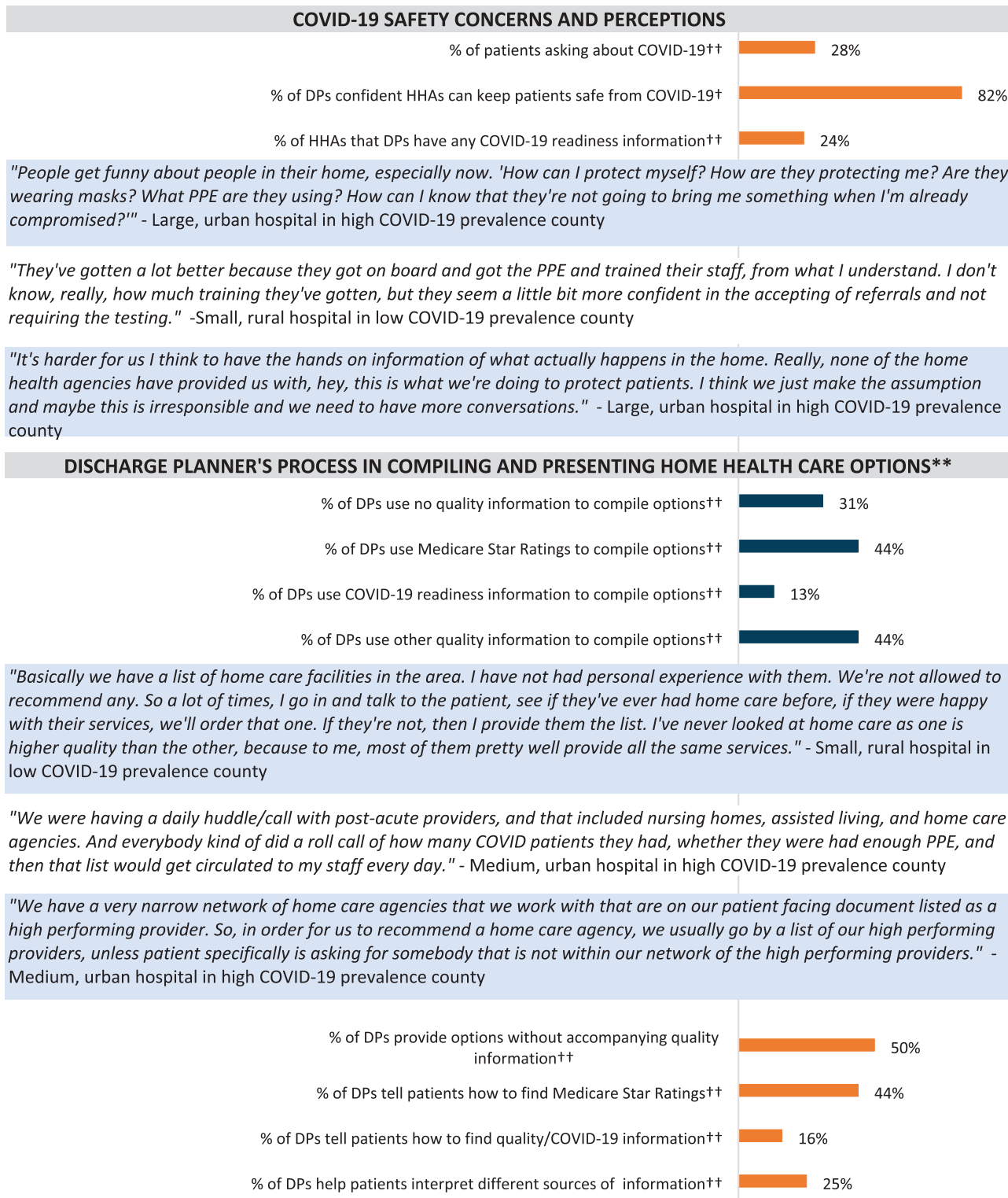


Figure 1. Discharge planners' views on home health safety and how quality information was incorporated in practice.
 † Results from first survey among the second survey sample (N=16 out of 58 first survey respondents), †† Results from second survey (N=16 survey respondents), N=11 interview participants. Authors' analysis using survey data collected from 8/3/2020 to 9/1/2020 and interview data collected from 7/13/2020 to 8/11/2020. **19% of discharge planners present <6 home health options, 38% of discharge planners present 6 to 10 home health options, 25% present 11 to 20 home health options, and 19% present 21 + home health options to patients during the referral process.

them the list. I've never looked at home care as one is higher quality than the other, because to me, most of them pretty well provide all the same services." (Figure 1)

Four out of 11 discharge planners interviewed used an organization-wide approach to incorporate quality in compiling options. *"We have a very narrow network of home care*

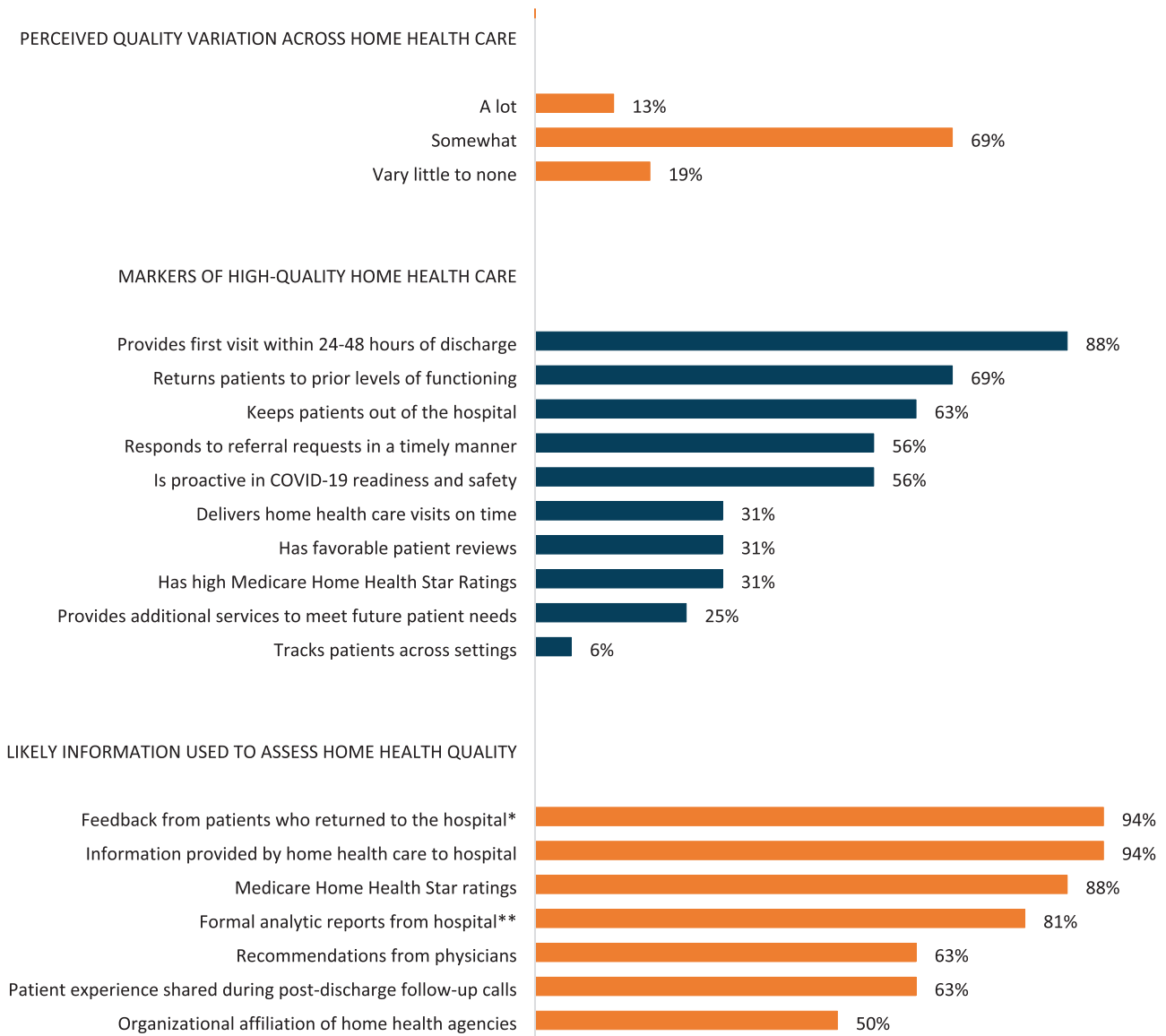


Figure 2. Michigan discharge planners' perceptions of home health quality and their preferred information for assessing quality. Authors' analysis using second survey data collected from 8/3/2020 to 9/1/2020. N= 16 survey respondents. * Survey respondents reported having follow-up information on their patients 15% of the time. ** 69% of survey respondents reported having hospital analytics to identify patient readmissions or emergency department use.

agencies that we work with that are on our patient facing document listed as a high performing provider. So, in order for us to recommend a home care agency, we usually go by a list of our high performing providers, unless patient specifically is asking for somebody that is not within our network of the high performing providers.” (Figure 1)

To overcome limited information on COVID-19 readiness, 3 hospitals in our interview sample convened post-acute care providers to exchange COVID-19 readiness information. As one interviewee described “We were having a daily huddle call with post-acute providers. . . And everybody kind of did a roll call of how many COVID patients they had, whether they were had enough PPE, and then that list would get circulated to my staff every day.” (Figure 1)

More than a third of respondents to the second survey did not incorporate any quality information in drawing the list of options for patients (Figure 1). Only 13% of discharge planners

reported incorporating COVID-19 readiness among agencies in compiling the list of options for patients. Others in our second survey used Medicare’s Home Health Star Ratings information (44%) or other sources of quality information (44%) in streamlining referral options.

Presenting quality information to patients. Our second survey results indicate that 50% of surveyed discharge planners did not provide any accompanying quality information along with the list of home health options. In some cases, the lists were large (Figure 1). More than a third of respondents typically presented 6 to 10 agencies and 19% of survey respondents typically presented at least 21 options (Table 1).

Others provided verbal information: 44% of the second survey respondents informed patients how to find Medicare Home Health Star Ratings, 16% directed patients to other quality and COVID-19 safety information (eg, a home health

representative). Only about 25% helped patients interpret different sources of information about quality.

Discussion

We set out to assess discharge planners' information needs, the information they used to inform referrals, and the extent to which they assisted patients in identifying high-quality home health care options. We found an overall unmet need for quality information among discharge planners. These needs were more pronounced when helping patients identify home health agencies capable of safely providing care during COVID-19. While some hospitals had access to more comprehensive information, others had to rely on unvalidated assumptions about home health agencies. Additionally, only half of discharge planners presented home health options with accompanying quality information and only a quarter assisted patients in interpreting various sources of information.

Our study suggests that discharge planners were largely unequipped with accessible information to help patients understand COVID-19 exposure risk. Fewer than a quarter of discharge planners had readily available information on agencies' COVID-19 competencies, and on average, they only had information on 24% of agencies serving their patients. This is particularly concerning, given that discharge planners report a third of their patients referred to home health having questions on COVID-19. The transfer of patients from hospital to home healthcare is a pivotal moment in healthcare management, requiring a comprehensive exchange of information to ensure seamless continuity of care.^{23,24} Even without complications of COVID-19, researchers have expatiated the significance of effective communication and information sharing between hospital discharge planners, home health care providers, patients, and their families.²⁵⁻²⁷ These studies reveal that inadequate information provided during the referral process can result in harmful outcomes, including hospital readmissions and compromised patient safety. Our study highlights the need for improved information exchange and communication in the referral process from hospital to home health care.

Our study also corroborates other findings that discharge planning practices at some hospitals may be insufficient.^{1,28} Numerous studies have documented the importance of patient-centered care during the transition from hospital to home health care.²⁹⁻³¹ When patients are empowered with knowledge and involved in their care, they are more likely to comply with treatment plans, resulting in improved health outcomes.³²⁻³⁴ Yet our study found that a substantial proportion of discharge planners did not incorporate quality when compiling home health care options, despite quality being an important factor for patients.^{1,35} Like older studies conducted prior to the pandemic,^{1,28,36} we found that discharge planners presented large lists of options to patients. Even after CMS' requirement for hospitals to include quality information during discharge planning, we found that half of respondents did not present any

accompanying quality information. Given that patients are asked to choose a post-acute care provider while they are ill,² large choice sets with limited support create unnecessary barriers for patients.

There are several ways to improve the referral process. First, CMS should improve its data capabilities and become more agile in addressing information needs during emerging health emergencies. Providing publicly accessible information would aid discharge planners in understanding the reality of COVID-19 readiness among post-acute providers, and address patient concerns directly. This could also alleviate variations and inequities in the current information gathering process. At the time of data collection, health care systems were under immense pressure and faced severe constraints in resources.³⁷ As we found in this study, some hospitals convened post-acute providers in their service area to gather information, but not all hospitals have the infrastructure or the resources to do so. For patients who are not treated by proactive hospitals, the lack of systematic information would only exacerbate disparities.

Second, CMS should strengthen incentives for hospitals to stay informed of patient status after discharge. For example, CMS could reward hospitals that conduct post-discharge follow-up with patients. Patient feedback was rated as one of the most likely sources of information by discharge planners to assess home health quality, yet, follow-up information was unavailable for most patients. Without comprehensive follow-up information, hospitals are unlikely to know whether quality was consistent with their expectations or whether their patients received home health care at all.³⁸

Finally, hospitals could improve how they present information to patients. Medicare Home Health Star Ratings are publicly available,³⁹ and including this easily accessible information, alongside the list of options may ease patients' cognitive burden and minimize inequities across patients with varying abilities to seek additional information.²

Limitations

Our findings are based on a voluntary convenience sample in Michigan and may not be generalizable to other contexts. While a convenience sample may not be representative, given the quality-improvement engagement of MVC hospitals, our sample is likely to represent the upper bound in terms of discharge planners' availability of quality information and the extent to which they used the information. Moreover, Michigan is similar to the rest of the United States in the number of hospital beds per 1000 people,⁴⁰ per capita hospital spending, and per capita home health care spending.⁴¹

Conclusion

Our results highlight the importance of having a robust information system to support patients in the transition from

the hospital to home, which has become especially important during the COVID-19 pandemic, but also relevant for future health emergencies. Frequently occurring influenza outbreaks, for instance, exert considerable burden on older and clinically vulnerable populations and health care systems each year.⁴² Policymakers should leverage existing quality information, provide infection control readiness data on home health agencies, and incentivize proactive discharge planning practices at hospitals to ensure that patients have equitable and necessary support to make informed decisions.

Acknowledgements

We thank the Michigan Value Collaborative for disseminating our first survey. We also thank the Department of Health Management and Policy at the University of Michigan for awarding us the Walter J. McNerney grant that enabled this research.

Author Contributions

All authors have made substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work. All authors have substantially contributed to drafting the work or revising it critically for important intellectual content. All authors have given final approval of the version to be published. Finally, all authors agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Ethics Approval and Consent to Participate

The study was given permission with exemption by the University of Michigan Institutional Review Board. Additionally, we administered informed consent to participants at all stages of the study. Participants provided written informed consent for the survey and verbal consent for recording interviews, and to publish deidentified results. All methods were carried out in accordance with relevant guidelines and regulations.

ORCID iD

Jun Li  <https://orcid.org/0000-0002-7829-0752>

Supplemental material

Supplemental material for this article is available online.

REFERENCES

- Baier RR, Wysocki A, Gravenstein S, et al. A qualitative study of choosing home health care after hospitalization: the unintended consequences of 'patient choice' requirements. *J Gen Intern Med.* 2015;30(5):634-640.
- Kothari P, Guzik J. *Health Care Provider Perspectives on Discharge Planning: From Hospital to Skilled Nursing Facility*; 2019.
- Brody AA, Guan C, Cortes T, Galvin JE. Development and testing of the Dementia Symptom Management at Home (DSM-H) program: an interprofessional home health care intervention to improve the quality of life for persons with dementia and their caregivers. *Geriatr Nurs.* 2016;37(3):200-206.
- Wang Y, Spatz ES, Tariq M, Angraal S, Krumholz HM. Home Health Agency performance in the United States: 2011-15. *J Am Geriatr Soc.* 2017;65(12):2572-2579.
- Fashaw-Walters SA, Rahman M, Jarrin OF, et al. Getting to the root: examining within and between home health agency inequities in functional improvement. *Health Serv Res.* 2023; 1-13:1475-6773. doi:10.1111/1475-6773.14194
- Barnett ML, Grabowski DC. Nursing homes are ground zero for COVID-19 pandemic. *JAMA Heal Forum.* 2020;1:e200369. doi:10.1001/jamahealthforum.2020.0369
- Grabowski DC, Mor V. Nursing home care in crisis in the wake of COVID-19. *JAMA.* 2020;324(1):23-24.
- Grabowski DC, Joynt Maddox KE. Postacute care preparedness for COVID-19 Thinking ahead. *JAMA.* 2020;323(20):2007-2008.
- Tumlinson A, Altman W, Glaudemans J, Gleckman H, Grabowski DC. Post-acute care preparedness in a COVID-19 world. *J Am Geriatr Soc.* 2020;68(6):1150-1154.
- Czeisler MÉ, Marynak K, Clarke KEN, et al. Delay or avoidance of medical care because of COVID-19-related concerns - United States, June 2020. *MMWR Morb Mortal Wkly Rep.* 2020;69:1250-1257.
- Buffin D, Selekmán J. Discharge planning for children requiring mobility and orthotic devices. *J Pediatr Surg Nurs.* 2020;9(3):88-91.
- Patel PR, Bechmann S. *Discharge Planning*. StatPearls Publishing; 2023. Accessed September 19, 2023. <https://www.ncbi.nlm.nih.gov/books/NBK557819/>
- Bajorek S, McElroy V. *Discharge Planning and Transitions of Care*. Published online September 7, 2019. Accessed September 19, 2023. <https://psnet.ahrq.gov/primer/discharge-planning-and-transitions-care>
- Readmissions and Adverse Events After Discharge. Published online September 7, 2019. Accessed September 19, 2023. <https://psnet.ahrq.gov/primer/readmissions-and-adverse-events-after-discharge>
- Re-Engineered Discharge (RED) Toolkit. Accessed September 19, 2023. <https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html>
- Centers for Medicare and Medicaid Services (CMS). Medicare and Medicaid programs; revisions to requirements for discharge planning for hospitals, critical access hospitals, and home health agencies, and hospital and critical access hospital changes to promote innovation, flexibility, and improvement in P. *Fed Regist.* 2019;84:51836-51884.
- Sefcik JS, Nock RH, Flores EJ, et al. Patient preferences for information on post-acute care services. *Res Gerontol Nurs.* 2016;9:175-182.
- Nastasi BK, Hitchcock J, Sarkar S, et al. Mixed methods in intervention research: theory to adaptation. *J Mix Methods Res.* 2007;1(2):164-182.
- Guest G, Bunce A, Johnson L. How many interviews are enough?: an experiment with data saturation and variability. *Field Methods.* 2006;18(1):59-82.
- Gilgun JF, ed. Grounded theory, deductive qualitative analysis, and social work research practice. In: Fortune AE, Reid WJ, Miller RL Jr. eds. *Qualitative Research in Social Work*. 2nd ed. Columbia University Press; 2013;107-135.
- Boyatzis RE. *Transforming Qualitative Information: Thematic Analysis and Code Development*. Sage Publications; 1998.
- Vaismoradi M, Turunen H, Bondas T. Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nurs Health Sci.* 2013;15(3):398-405.
- Kwame A, Petrucka PM. A literature-based study of patient-centered care and communication in nurse-patient interactions: barriers, facilitators, and the way forward. *BMC Nurs.* 2021;20(1):158.
- Morey T, Scott M, Saunders S, et al. Transitioning from hospital to palliative care at home: patient and caregiver perceptions of continuity of care. *J Pain Symptom Manag.* 2021;62(2):233-241.
- Tyler N, Planner C, Byrne M, et al. Developing Best Practice Guidance for discharge planning using the RAND/UCLA appropriateness method. *Front Psychiatry.* 2021;12: 789418
- Xiao S, Tourangeau A, Widger K, Berta W. Discharge planning in mental healthcare settings: a review and concept analysis. *Int J Ment Health Nurs.* 2019;28(4):816-832.
- Hofmeyer A, Clare J. The role of the hospital liaison nurse in effective discharge planning for older people: perspectives of discharge planners. *Contemp Nurse.* 1999;8(3):99-106.
- Tyler DA, Gadbois EA, McHugh JP, et al. Patients are not given quality-of-care data about skilled nursing facilities when discharged from hospitals. *Health Aff.* 2017;36(8):1385-1391.
- Steele Gray C, Tang T, Armas A, et al. Building a digital bridge to support patient-centered care transitions from hospital to home for older adults with complex care needs: protocol for a co-design, implementation, and evaluation study. *JMIR Res Protoc.* 2020;9(11):e20220
- Bokhour BG, Fix GM, Mueller NM, et al. How can healthcare organizations implement patient-centered care? Examining a large-scale cultural transformation. *BMC Health Serv Res.* 2018;18(1):168.
- Grover S, Fitzpatrick A, Azim FT, et al. Defining and implementing patient-centered care: an umbrella review. *Patient Educ Couns.* 2022;105(7):1679-1688.
- Gómez-Velasco DV, Almeda-Valdes P, Martagón AJ, Galán-Ramírez GA, Aguilár Salinas CA. Empowerment of patients with type 2 diabetes: current

- perspectives. *Diabetes. Metab Syndr Obes Targets Ther.* 2019;12:1311-1321. doi:10.2147/DMSO.S174910
33. Bailo L, Guiddi P, Vergani L, Marton G, Pravettoni G. The patient perspective: investigating patient empowerment enablers and barriers within the oncological care process. *Ecancermedicalscience.* 2019;13:912. doi:10.3332/ecancer.2019.912
 34. Amin S, Soliman M, McIvor A, Cave A, Cabrera C. Understanding patient perspectives on medication adherence in asthma: a targeted review of qualitative studies. *Patient Prefer Adherence.* 2020;14:541-551.
 35. Shugarman LR, Brown J. *Nursing Home Selection: How Do Consumers Choose?* Vol. 1. Findings from Focus Groups of Consumers and Information; 2006.
 36. Gadbois EA, Tyler DA, Mor V. Selecting a skilled nursing facility for postacute care: Individual and Family Perspectives. *J Am Geriatr Soc.* 2017;65:2459-2465. doi:10.1111/jgs.14988
 37. Blumenthal D, Fowler EJ, Abrams M, Collins SR. Covid-19 - implications for the health care system. *New Engl J Med.* 2020;383(15):1483-1488.
 38. Li J, Qi M, Werner RM. Assessment of receipt of the first home health care visit after hospital discharge among older adults. *JAMA Netw Open.* 2020;3(9):e2015470
 39. Centers for Medicare & Medicaid Services. Home health star ratings. Published 2018. Accessed March 7, 2018. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQI-HomeHealthStarRatings.html>
 40. Kaiser Family Foundation. Hospital Beds per 1,000 Population by Ownership Type. Published 2020. Accessed October 10, 2020. <https://www.kff.org/other/state-indicator/beds-by-ownership/?activeTab=map&timeframe=0&selectedDistributions=total&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
 41. Kaiser Family Foundation. Health Care Expenditures per Capita by Service by State of Residence. Published 2020. Accessed October 10, 2020. <https://www.kff.org/other/state-indicator/health-spending-per-capita-by-service/?currentTimeframe=0&selectedDistributions=hospital-care-home-health-care&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
 42. Langer J, Welch VL, Moran MM, et al. High clinical burden of influenza disease in adults aged ≥ 65 years: can we do better? A systematic literature review. *Adv Ther.* 2023;40(4):1601-1627.