An Integrated Model of Discharge Planning for Acutely-Ill Elderly Patients

Wells, D. L., Martin, D. K., Moorhouse, A., Craig, D., & Foley, J. M.

Abstract

Prior research has demonstrated that current discharge-related practices present resource-related and ethical problems for all those involved.

The purpose of this 9-month qualitative study was to develop a more resource efficient and compassionate discharge planning model for acutely-ill, elderly patients. The focus group interviewing method was used to elicit 99 participants' perceptions of an ideal approach to discharge planning. Focus group participants included professionals from acute-care hospitals and community organizations. Telephone interviews were also completed with 25 patients and 6 family members.

Themes identified in the analysis revealed that an ideal approach to discharge planning would incorporate seven elements. According to participants, the approach is ideal because it potentially addresses both resource utilization and ethical issues. Program evaluation of the model is underway in order to determine its effectiveness.

Because of fiscal deficits, Canadian hospitals have been undergoing "the most extensive round of reform since the inception of Medicare 25 years ago" (Hurley, Lomas, & Bhatia, 1994, p. 491) and massive restructuring. In this context, hospitals have persistently focused their discharge-planning related policies and practices on achieving quick discharge. Patients 65 years of age or over pose a challenge to this objective of hospitals. They have approximately twice as many hospital admissions and over twice as long an average length of stay as other age groups (McWilliam,1992). Moreover, although hospitalization rates in Canada (and in the U.S.) are decreasing, they are declining more slowly for the elderly, especially for those over 75 years of age (Barer, Hertzman, Miller, & Pascali, 1992). Elderly patients will continue to be major consumers of hospital services for the foreseeable future. Therefore, approaches to discharge planning for the elderly must be creative in order to contain their lengths of stay so that institutional goals concerning both cost control and quality of care can be met.

However, the literature clearly indicates a number of difficulties in the discharge planning process for elderly patients. These problems have included (a) lack of clarity around the discharge planner role and absence of cooperation and support from physicians (Feather,1993; McBride,1995; McWilliam 1992; McWilliam & Sangster,1994); (b) lack of coordination, communication, and leadership in discharge planning (Jewell,1993; McWilliam & Sangster); (c) making discharge decisions too early in the course of elderly patients' hospital stays, which forces professionals to predict the final discharge outcome without accurate information (Dill,1995; McWilliam; Wells, 1997); (d) lack of information or preparation concerning discharge teaching (Charles et al.,1994; Jewell; McBride; McWilliam & Sangster; Mistiaen, Duijnhouwer, Wijkel, de Bont, & Veeger, 1997); and (e) the frequently inaccurate assessment of patients' needs while in hospital, which meant that community professionals often had to re-evaluate and change post-discharge services (Prescott, Soeken, & Griggs,1995). These discharge-planning related issues were associated with (a) delays in discharge; (b) perceptions of an inadequate discharge plan by patients, families, and professionals; and (c) the undermining of quality resource management and quality care.

As well, the literature demonstrates a number of ethical and humanitarian concerns about the discharge planning process. It has been reported that patients and families were not systematically involved in discharge decision making, that their options concerning the discharge plan of care were limited, and that they were asked to make discharge decisions without adequate information. These problems represented ethical conflicts with respect to balancing patient self-determination or autonomy with patient best interest or safety and informed decision making (Chadwick & Russell, 1989; Dill,1995; Dubler,1988; Jewell,1993; Proctor, Morrow-Howell & Lott, 1993; Wells, 1997). Also, patient and families found the process to be distressing, as did professionals because of the drive for quick discharge (Abramson, 1988; Brown,1990; Coulton, Dunkle, Chow, Haug, & Vielhaber,1988; Jewell; McWilliam,1992; McWilliam & Sangster, 1994; Proctor, Morrow-Howell, Albaz, & Weir, 1992; Wells). Proctor et al. (1993) reported that delayed discharge, in-hospital mortality, and less than adequate post-discharge care were the consequences of these varied problems.

Intervention studies of discharge planning for elderly patients that involves a discharge planner who has explicit responsibility for planning and uses a standardized protocol have indicated such positive effects on organizational outcomes as (a) increased numbers of patients discharged home (Evans & Hendricks, 1993); (b) fewer readmissions (Evans & Hendricks; Haddock, 1994); fewer total days rehospitalized (Naylor et al., 1994; and (c) lower

charges for acute-care total hospital costs (Naughton, Moran, Feinglass, Falconer, & Williams, 1994; Naylor et al.). In addition, these interventions resulted in increased patient and family satisfaction and fewer unmet treatment needs post discharge (Haddock; Soskolne & Auslander, 1993). Equivocal results were reported with regard to total length of stay (Evans & Hendricks; Haddock; Naughton et al.; Naylor et al.).

However, to date, discharge planning interventions have not explicitly addressed issues about the efficiency of the discharge planning process itself, such as the timing of decision making and best use of professional resources, together with the management of ethical issues, such as patient autonomy and informed decision making. Nor has a Canadian study examined the redesign of discharge planning practices. Therefore, we conducted this study to develop a model of discharge planning for the elderly that potentially would maximize efficiency and ensure an ethical discharge process, which in turn could support hospital imperatives about cost containment and high quality care. We undertook the research anticipating the reality that hospitals would continue to experience constricting budgets, ongoing organizational restructuring, and a largely elderly patient population.

METHODS

Study Design

Both focus group and telephone interviews were used in this qualitative study, which was approved by the Human Subjects' Review Committee at the University of Toronto and by all 5 of the participating hospitals' research ethics committees. The focus group approach produces data that offer insights into participants' perceptions about products, services, or opportunities (Krueger, 1994). Because so little was known about the contribution of everyday, practice-based processes to outcomes related to the efficient use of resourses and the management of ethical problems in discharge planning, we believed that the perceptions of professionals (hospital and community based) directly involved in those practices could help us develop an improved approach. As well, patients who had been discharged from hospital and/or a family member received a telephone interview in order to elicit their perceptions of discharge planning. Demographic data about the study participants were collected at the time of the focus groups and telephone interviews.

The primary research question we asked participants was, "What are your perceptions of an ideal approach to discharge planning?" To help participants think about an ideal approach, we asked them to speculate on (a) the most important goals to be achieved; (b) who should be involved, how, and why; (c) strategies to achieve the goals; and (d) what barriers might interfere with achieving an ideal approach and how these may be overcome.

Sampling Procedure and Sample

Our study involved major subgroups of acute-care hospitals in Greater Metropolitan Toronto (GMT). A total of 5 hospitals were selected on the basis of the following characteristics: (a) size; (b) urban or suburban setting; (c) community acute or fully-affiliated teaching hospital status; and (d) whether the age of the population and utilization of hospital services reflected a large number of elderly persons relative to the rest of GMT. As well, none of the 5 selected hospitals was slated to be closed or significantly altered in direction, as indicated in the Final Report of the MTDHC Hospital Restructuring Committee (MTDHC, 1995). All 5 hospitals offered orthopaedic, general medical and surgical, and cardiology services, which were the services of interest because the majority of elderly patients are admitted to them (MTDHC). The 5 hospitals approached agreed to participate in the study.

As well, 20 community advocacy and health and social service organizations in Metropolitan Toronto, which are regularly involved in acute-care hospital discharge-planning activities, were contacted by the investigators and invited to take part in the study. The organizations approached offered services, which included non-profit housing; nursing, social work, and other professional assistance; as well as, legal advice. Fourteen of the organizations agreed to participate.

Using a letter of introduction describing the research, a contact person at each of the participating hospitals and community advocacy and service organizations selected focus group participants according to the following criteria: (a) they were directly involved in discharge planning as a practitioner, administrator, or advocate; (b) their medical service(s) was one of those of interest in the study; (c) they had time to be interviewed; and (d) they were willing to participate. A total of 99 persons attended the focus groups; 85 came from the 5 hospitals and 14 from the community organizations. They included physicians, administrators, nurses, occupational and physical therapists, social workers, home care coordinators, a pharmacist, a chaplain, a speech pathologist, a dietician, and a respiratory therapist. The average number of years worked in their respective professions was 17.6 years. They had worked an average of 10.4 years at their respective hospital, and they spent an average of 13 hours/week on discharge planning. Participants from the community organizations were administrators. Their average number of years in the profession was 17.5. They had worked at the organization an average of 7 years and spent an average of 12.5 hours/week on discharge-related issues. All participants provided written informed consent to participate in the focus groups.

Within a week of the patients' discharges, the hospital contact persons provided researchers with the names of those patients, and the family member most involved in the discharge, who had given their verbal consent. A total of

88 names were obtained. The investigators then contacted the patients and/or family members by phone and invited them to participate in a face-to-face or telephone interview. A total of 25 patients and 6 family members agreed to a telephone interview, which constituted their consent. The mean age of the patients was 76 years, while that of the family members was 64.3 years. The majority of patients were female, as were the family members. Half the patients were married, and half were widowed. Although they represented a number of diverse cultural groups, most were Canadian born. The majority were living independently prior to admission and returned home at discharge.

Data Collection Procedures

Sixteen focus groups were conducted, ranging in size from 3 to 14 participants. All focus groups were held at a private location and moderated by a research assistant familiar with group processes; the sessions were tape recorded. The moderator began the groups with a welcome and overview of the study, and then proceeded to the more formal interview process, guided by the research questions. One of the investigators attended the focus groups to observe and record field notes in relation to the discussion.

The telephone interviews conducted with patients and family members occurred at a time convenient to the participants. The interview was directed by the research questions. Data from the telephone interviews were hand recorded as close to verbatim as possible.

Data Analysis

Data from the focus groups and telephone interviews were entered into The Ethnograph, a computer software program for the analysis of qualitative data (Seidel, Kjolseth, & Seymour, 1988). The analysis proceeded in two steps. First the data were read, and topics identified in the data were used to develop and apply a coding system to the unstructured data. Second, the codes and their corresponding segments of data were grouped by theme, and the themes were elaborated following Krueger's (1994) principles of analysing focus groups.

The research team drafted a model of discharge planning that was based on the seven dominant themes that emerged. The model thus constituted seven elements that reflected the typical or common way in which the participants responded to the research questions. It was reviewed with several of the focus group participants and adjusted in response to their feedback.

RESULTS

Participants suggested that, together, the seven elements they identified as critical to discharge planning represented an ideal approach to that planning. The model was termed integrated by the researchers because participants believed that all seven elements were necessary; that is, no one element on its own was thought to be sufficient to achieve the best process of discharge planning. Subjects believed that this ideal approach to discharge planning potentially could be cost and time efficient and could ensure a safe and durable discharge acceptable to professionals, patients and families, and the hospital. Figure 1 shows the model and its seven elements.

Element 1: The Patient Is at the Centre of the Discharge Planning Process

The study participants believed that the patient must be at the centre of discharge planning as both a key participant and a resource in discharge planning. As a key participant, the patient would assume an active role in the process and, ultimately, be the final decision maker. That is, the health care professionals would assess and provide options based on their expertise from which the patient may choose the option that best meets his or her values and needs. As a resource to the health team, the patient would provide input into the identification of discharge goals and required services. The most important objectives to be attained by placing the patient at the centre of discharge planning were articulated as the active and continuous involvement of patients in informed decision making.

Element 2: Discharge Planning Is Directed by a Discharge Manager

From the participants' viewpoint, a discharge manager is required to oversee and participate in the entire discharge planning process from the pre-admission to post-discharge of the patient. That is, she or he would (a) gather relevant data from health care professionals, patients, and families; (b) facilitate timely and appropriate referrals; and (c) maintain the primary communication link between health care professionals, patients and families, and community services, if necessary. Thus, the discharge manager would bear responsibility for the negotiated matching of needs with services.

The participants claimed that the involvement of a discharge manager constituted *the strategy* most likely to accomplish several objectives of an ideal approach to discharge planning. These goals were expressed as (a) making the best use of scarce resources, (b) ensuring that accurate information was shared among professionals and with patients and families, (c) determining congruence among participants regarding discharge-related goals and the definition of patients needs, and (d) promoting a quick discharge. It was thought that the discharge manager could be a nurse, social worker, or other hospital-based health professional. However, she or he must have advanced knowledge about the care of elderly patients in order to assume, and succeed in, the role.

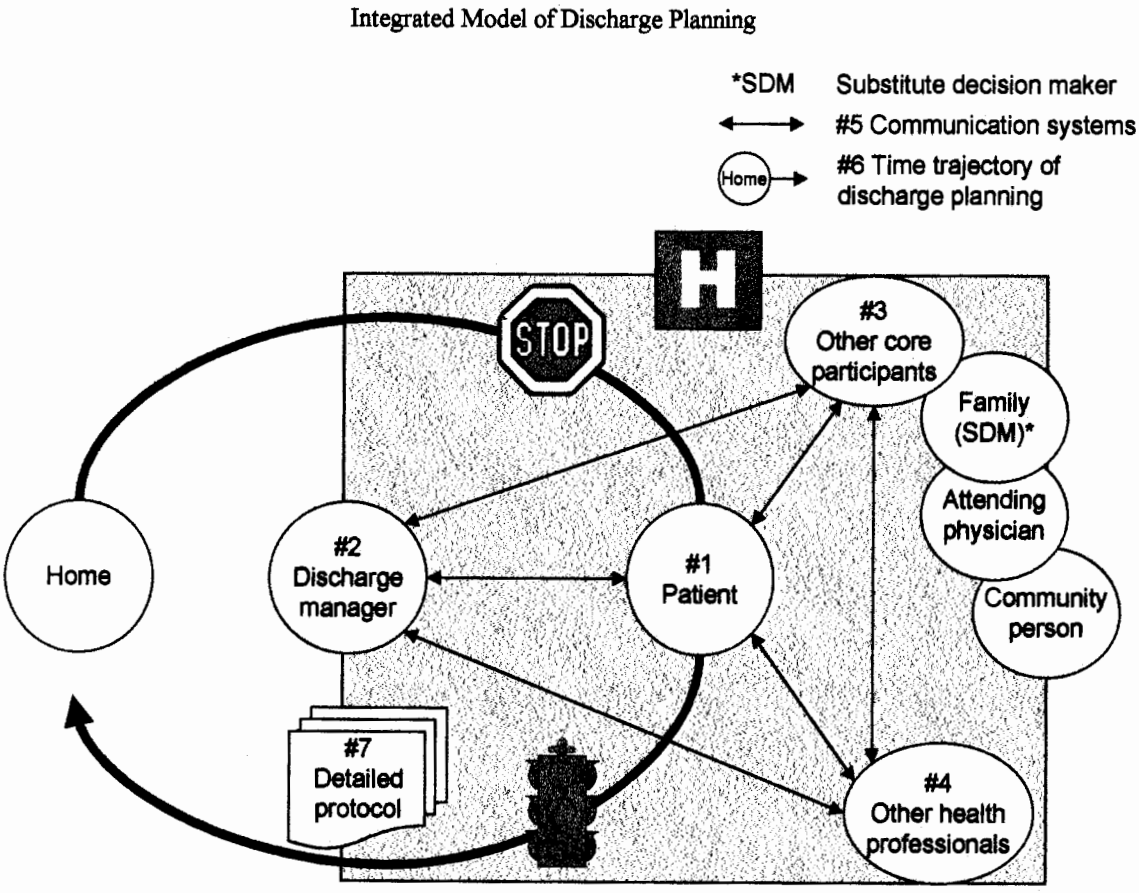

Figure 1. An integrated model of discharge planning for acutely-ill elderly patients.

Element 3: Family Members, the Attending Physician, and a Community Professional Are Core Participants in Discharge Planning

Along with the patient and discharge manager, family members, the attending physician, and a community professional were identified by the study participants as the other core participants in discharge planning. Family members would be involved with the agreement of the patient and supply information regarding the patient's history and the discharge-related goals and needs of both patient and family. As well, the family members may be able to help with any footwork related to the patient's discharge. If the patient is incapable of participating in discharge planning, a substitute decision maker (SDM), who may or may not be a family member, must also be a core participant. The family member's active involvement was expected to enhance the accuracy of discharge plans and the family's commitment to the post-discharge care of the patient, and to reduce the risk of patient readmission.

Attending physicians must be core participants in discharge planning because they hold accountability for the admission, discharge, referrals, and general medical management of their patients. In hospital care today, physicians also have financial responsibility to closely monitor the costs of patient care. Therefore, physicians need to ensure that physician-related forms are completed on time, discharge dates and the discharge location are determined in agreement with other core participants, and adequate time is given to plan a safe and durable discharge. Situating the physician in a core position supported another element of an ideal approach to discharge planning, namely, the closer link of that planning with the clinical care of the patient (see element 6).

A community person is the final core participant in discharge planning. This person could be the family physician or a member of a community organization who either was involved in providing services to the patient and family prior to admission or would be involved in providing services at discharge. The community person could supply

information about the pre-admission status of the patient and relevant community services, help determine the appropriateness of proposed discharge goals and location, and/or ensure the timely implementation of community services after discharge. Participants insisted that the full participation of appropriate community- based persons in discharge planning was critical to the continuous flow of information between the hospital and community, and to the patient's timely discharge.

Element 4: Other Health Professionals Are Involved in Discharge Planning Only as the Need Arises

The participants suggested that, other than core participants, other health professionals should be involved in discharge planning only as the need arises. These professionals could provide discipline-specific expert assessments concerning the needs of the patient and family. The discharge manager should bear responsibility for organizing the interaction between appropriate health professionals and the core participants in planning. Involving other health professionals only as the need arises would ensure that their time and energy were not wasted.

Element 5: Well-Working Communication Systems Are in Place to Support Discharge Planning

Well-working communication systems are fundamental to the discharge planning process. Ideal systems would include (a) systematic and continuous communication between patient, family, and providers, and between the hospital and community organizations; (b) open and equal sharing of information among participants; (c) the coordination of communication and information gathering and sharing by one person; (d) the use of standardized forms/records for patient assessments and discharge plans, a summary of each being made available to the patient at discharge; and (e) development of a computerized information system to facilitate the flow of information within the hospital and between hospital and community, which would reduce the need for a community person to be physically on site at the hospital during discharge planning. Well-working communication systems were said to be necessary to achieve trust and rapport among the participants in discharge planning, suitable and accurate assessment and discharge plans, and the judicious use of scarce resources.

Element 6: The Time Trajectory of Discharge Planning and the Patient's Clinical and Social Situations Are Linked

The participants proposed a time trajectory of decision making in discharge planning. The process would begin with gathering information about the patient's clinical and social situations, setting goals and expectations about the discharge plan, and estimating a discharge date. However, participants cautioned about making and acting upon any decisions too early in the course of the patient's hospitalization. A "wait and see" period (the stop-sign in Fig.1) was deemed necessary in order to avoid making mistakes in discharge plans if the patient's clinical course or social situation changed. In order to be accurate, final decisions about the discharge must be closely linked with a clear understanding of the patient's ultimate social circumstances and clinical condition (as opposed to situations at admission or early in treatment phases), which normally develop later in the patient's hospital stay (the go-light in Figure 1). This entwinement would also allow for other important objectives to be met, that is, that the patient be discharged when medically ready, that appropriate supports be in place at discharge, that an acceptable discharge location had been chosen, and that efficient use had been made of professionals' time.

Element 7: A Detailed Protocol Facilitates Discharge Planning

The participants argued that a protocol would be critical to implement the discharge planning model. This protocol would include an outline of time-phased activities related to information gathering and the development of discharge plans to be undertaken (a) prior to admission, at admission, and early in the hospitalization; (b) during the mid-period of the patient's hospital stay; (c) when discharge is imminent (within 48 hours of discharge); and (d) after discharge. It was thought that this detailed guide for discharge planning, as opposed to generic standards and broad-based hospital guidelines or policies, would more effectively and efficiently direct the activities of those involved.

DISCUSSION

The seven-element model of discharge planning developed in this study is significant for two reasons. First, it is based on the perceptions of persons directly involved in day-to-day discharge planning, namely professionals, patients and families, rather than on those of hospital administrators or professionals who are less actively involved. Persons closest to the actual practice may be those most able to identify key problems and to generate new and creative solutions. Such information, in turn, may be of use to researchers, policy and program decision makers, and professionals in the refinement of a practice, such as discharge planning.

Second, the model addresses many of the concerns identified in current and past discharge planning processes. Specifically, it may ameliorate the lack of clarity around the discharge planner role, the absence of cooperation and support from physicians, and the lack of coordination, communication, and leadership in discharge planning. In particular, the elements of the model related to the designation of a single discharge manager, the inclusion of the physician as a core participant, and the presence of well-working

communication systems may redress these problems.

As well, untimely decision making and inaccuracies in the decisions made, which frequently have been noted in prior research as dilemmas in the discharge planning process, may not arise as issues in our model. Closely linking discharge decision making to the patient's clinical and social situations over the course of the hospital stay may ensure a discharge plan that truly reflects the patient's circumstances. Moreover, if the patient is located at the centre of the process and if patients, families, and professionals are systematically involved in discharge planning throughout the patient's hospital stay, patient autonomy and informed decision making may be promoted, and some of the distress participants have been reported to experience during discharge planning may be mitigated.

The literature has linked the problems associated with past and current discharge planning practices to delays in discharge, perceptions of inadequate plans by all those involved, and the undermining of quality resource management and quality care. More recent innovative models of discharge planning in the U. S. that incorporated standardized protocols and the use of a discharge planner have revealed increased satisfaction with planning for patients and families and savings for the hospital, for example, in terms of fewer readmissions and fewer total days rehospitalized. However, the models tested in prior research have not explicitly incorporated mechanisms to ensure the efficient timing of decision making, the efficient deployment of professionals' and families' time and energy in discharge planning, and the autonomy and informed decision making of patients and families. These additional features are included in our model. Nevertheless, it remains to be determined whether or not the integrated model proposed by participants in this study is both resource efficient and ethically sound. Currently, some of the authors are investigating both the process and outcome effects of the model in the acute-care hospital setting in a funded, program evaluation study by using case comparisons and relatively large samples. It should be possible to generalize the findings across similar settings.

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Authors

Donna L. Wells, RN, PhD is Assistant Professor, Faculty of Nursing and Member, Joint Centre for Bioethics, University of Toronto.

Douglas K. Martin, PhD is Research Associate, Joint Centre for Bioethics, University of Toronto.

Anne Moorhouse, RN, PhD is Clinical Nurse Specialist, Markham Stouffville Hospital, Markham, Ontario.

Dorothy Craig, RN, MScN is Professor Emeritus, Faculty of Nursing, University of Toronto.

Julie M. Foley, MSW, is Executive Director, Scarborough Community Care Access Centre.

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