

**JULIA HO, KERRY KULUSKI, ASHLINDER GILL**

## **CONTEXT**

Hospitals are under increasing pressures by governing bodies to meet mandated performance standards and fiscal targets. As a result, hospitals are incentivized by funders to discharge patients efficiently and effectively. Being discharged from hospital is a vulnerable process for patients. This period, often referred to as transitional care, is defined by the American Geriatrics Society as a “set of actions to ensure the coordination and continuity of health care as patients transfer between locations or different levels of care within the same location”. Despite a push by researchers to understand the causes and effects of poor transitions of care, gaps in knowledge currently exist about the patient experience, particularly the experience of patients with complex chronic conditions.

## **OBJECTIVES**

The purpose of this study was to determine the discharge experiences and concerns of patients with multiple chronic diseases. By addressing these concerns, the experience of care transitions could become more patient-centered.

## **METHODS**

A secondary qualitative analysis was conducted on interviews with 116 patients from a large urban rehabilitation and complex continuing care facility in Toronto, Canada. The data was drawn from a large scale mixed methods study conducted in 2011. The data analyzed was largely drawn from responses to the questions: “do you have any discharge concerns?” and “if yes, can you describe the concerns”. A NVivo software version 10 node report generated all comments in the entirety of the interviews related to concerns regarding discharge which formed the basis of the analysis. Qualitative description, a surface reading of data, was employed to provide a comprehensive summary of the data. We determined the themes inductively through a systematic process of dividing the data into meaning units, organizing the units into domains, constant comparison of meaning units to the final generation of categories or themes.

## **FINDINGS**

Three broad themes were identified: process (patient concerns prior to discharge), consequences (patient comments related to the anticipated implications of their health condition post-discharge), and needs (how patients reported concerns about post-discharge condition management). *Process*: patients expressed concerns about the logistics and process of being discharged from the hospital. More specifically, patients were concerned about the next steps in their care plan, emerging friction in the provider-patient relationship, and the fear of premature discharge. *Consequences*: the theme encompasses patient-reported implications about their health conditions post-hospital stay, as a result of leaving the comforts and security of the hospital, relocation, adverse events at home, and impact on family. *Needs*: the data captured encompasses patient concerns about their ability to manage their health condition and the availability of health care supports at home. These included availability of home care, navigating the predisability home, and ability to manage daily activities.

## **CONCLUSIONS**

This article presents a framework based on complex patients’ experiences of care transitions. At the onset of a patient admission into the hospital then continuously during treatment, providers need to facilitate clear lines of communication with patients about care planning and goal setting. Embedding our transitions of care framework at a system level would make the most impact on patient care. Funding models and accountability frameworks, which incentivize discharge processes that place patients and their families at the center, are necessary to fully serve the complex needs of the chronic disease population.