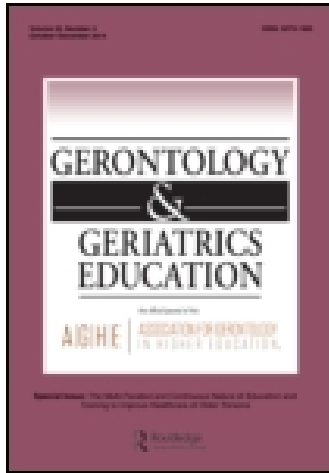


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Hospital to Home: A Geriatric Educational Program on Effective Discharge Planning

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Hospital to Home: A Geriatric Educational Program on Effective Discharge Planning

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There has been increased attention on the needs of the burgeoning older adult population, with focus on the limited education and training experiences available in geriatric care. Older adults transitioning between levels of care often require increased attention, and the American Geriatrics Society (AGS) Task Force on the Future of Geriatric Medicine has encouraged greater training opportunities be provided to better understand the needs of this population. The Hospital to Home Program is one model of geriatric training emphasizing many of the AGS recommendations. Through qualitative analyses of 51 internal medicine residents' reflections, the authors report how this educational program is meeting the above need and share how Hospital to Home is enhancing residents' skills in creating a safe discharge for geriatric patients and their families.

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KEYWORDS biopsychosocial needs, discharge, geriatric training, medicine residents

INTRODUCTION

As the geriatric population rapidly grows, there is an increased need for physician education regarding the unique needs of this group. This population frequently presents with multiple comorbid conditions, with impairment in cognition and ability to perform activities of daily living (Osthega et al., 2000), and often has limited access to care (Naylor, 2003). The Hospital to Home Program aims to provide education in these areas, in an effort to positively influence residents' care for older adults in the discharge process. The purpose of this article is to study the learning that has occurred in this decades-long training program through qualitative data collected from the residents who participated in the Hospital to Home Program from 2009 to 2012.

Resident Education in Geriatric Discharge Planning

The discharge process for older adults is complex and often marked by complications and vulnerabilities (Kripalani, Jackson, Schnipper, & Coleman, 2007). During this critical transition, there are multiple biopsychosocial stressors that can occur, including changes in medications and new caregiving demands placed on families. Such challenges are worsened by inadequate education, poor communication, and poor coordination of care (Bull, Hansen, & Gross, 2000). Patients and family members frequently report dissatisfaction surrounding the discharge process, with approximately one third of patients expressing that they have left the hospital with unmet needs (Naylor, 2003). Furthermore, 20% of geriatric patients discharged from an inpatient stay will be readmitted within 30 days (Jencks, Williams, & Coleman, 2009), with nearly one third of those readmissions considered preventable (Oddone et al., 1996). Such readmissions can cause patients and their families tremendous distress and significant cost to hospitals.

In an effort to respond to the needs of geriatric patients and increase safe transitions, recommendations have been made by the American Geriatrics Society (AGS) Task Force on the Future of Geriatric Medicine (Besdine et al., 2005). Recognizing that most physicians will receive geriatric training only in the context of core training, the AGS Task Force suggested that ample opportunities be provided in medical school and postgraduate training to ensure competence in geriatric care. Although there are certainly challenges to providing this type of education, geriatric training is enhanced when residents are exposed to models of care in at least one setting, see

patients through transitions of care, and engage in interdisciplinary work (Thomas et al., 2003). Furthermore, it has been suggested that residents who have the opportunity to conduct a home visit have great opportunity to learn about the unique aspects of geriatric care, as they can increase their awareness of the environmental limitations and hazards of home safety, and understand the patient's functional status in their own context (Hayashi et al., 2007). Despite the presumed benefits of such learning opportunities, there is limited literature documenting program evaluation of interdisciplinary teaching efforts in geriatric medicine education (Leipzig et al., 2002).

Hospital to Home

The Hospital to Home Program is one innovative model that addresses some of the AGS Task Force geriatric medicine competencies (Besdine et al., 2005). The program, initially described by Matter et al. (2003), provides individual instruction for first-year internal medicine residents about transitional care from an acute hospitalization to home for older adults. Residents conduct comprehensive, videotaped interviews with hospitalized patients for whom they are not providing direct care. Real-time observation and feedback from a behavioral health postdoctoral fellow is provided; this process encourages residents to consider a broad range of biopsychosocial matters, though the level of prompting varies based on individual resident skill and awareness. Residents are asked to consider the patient's functional status, social supports, and environmental factors that will either support or hinder a safe discharge. They then communicate the patient's concerns and/or needs to a social worker or other treatment team members as appropriate. A home visit is subsequently scheduled within 4 to 5 days of discharge; the home interview is also videotaped.

Residents then present video segments and informational slides at a case conference to educate their peers (including residents in family medicine, medicine/pediatrics, and medical students), who we hope learn vicariously about discharge planning for geriatric care. The video creates a shared learning experience that allows the residents to "show" rather than describe the patient experience. After the resident presents the hospital portion of the experience, the other residents predict how the patient will function at home. The home visit video gives them instant feedback about how the patient actually transitioned to the home setting. By the time a resident completes training he or she has presented at one Hospital to Home session and attended between three to seven additional sessions. As we have progressed with this program, we have subjectively observed that the upper-level residents who also engaged in the program as first-year residents often make insightful comments about the situations being depicted, demonstrating persistence of what they learned from their participation.

The objective of the current study was to assess first-year internal medicine residents' learning experience through the above program.

METHOD

Participants

Since 2001, nearly 200 internal medicine residents have participated in the Hospital to Home Program. To evaluate and subsequently enhance the program, in 2009 residents were asked to explicitly report their "learning points" as part of the presentations provided to their peers. Residents were asked to include a slide that outlined the learning points that were most meaningful, would influence their future approach to discharge planning, and altered their understanding and/or approach to a biopsychosocial/systems model of care.

Between 2009 and 2012, 68 internal medicine first-year residents participated in the Hospital to Home Program. Not all residents completed the program following the protocol; a range of learning opportunities have been offered based on residents' needs and patient availability including multiple hospital visits, only home-visits, and in some instances follow-up with patients via telephone (see Table 1). The results presented consider all first-year residents who participated during this 3-year period, with the awareness that the experiences outlined in Table 1 were likely instructive in different ways. For example, though a telephone interview does not let residents assess the environmental factors of the home, postdischarge communication has helped residents understand barriers faced by many geriatric patients upon return to their own settings.

Qualitative Analyses

In this study, the authors evaluated the residents' "learning point" slides; residents were made aware at the outset of their one-to-one training with the biopsychosocial fellow that information gathered from this educational experience might also be disseminated for more widespread learning.

TABLE 1 Formatting of Educational Experience

Item	<i>n</i>	%
Hospital interview only	13	19.12
Home interview only	3	4.41
Two interviews	52	76.47
Hospital and home	48	70.59
Hospital on two occasions	2	2.94
Hospital and telephone	2	2.94

Informed consent (beyond the above mentioned notification) was not attained for this retrospective program evaluation. The Institutional Review Board at the university where this program evaluation was conducted approved this study as exempt. Of those residents who completed the program, 17 did not document their learning points in a fashion that allowed for review; some simply included a slide that stated “Things Learned” but did not incorporate detailed information that could be assessed.

For the 51 residents who provided greater detail, each learning point was assessed and categorized. In the initial analysis, one investigator reviewed the learning points utilizing principles of grounded theory, letting meaning derive from the data and generating preliminary codes based on the occurrence of themes. This process resulted in 23 different points reflecting a range of educational topics, from “patient acknowledgement of loss of independence” to “reliability of patient report when cognition is under question.”

An additional investigator then reviewed these 23 items; through joint review of the learning points, the two investigators achieved consensus that a second iteration of coding would aid in the clear identification of the primary themes. One investigator then organized the emergent themes into six main subject areas, presented below; the second investigator then reviewed these groupings and consensus was established that theoretical saturation had been reached. Inter-rater reliability was not calculated. The remaining authors reviewed the final six thematic areas and provided confirmation that they capture the breadth of resident statements in their conference presentations. These groupings were based on the authors’ assessment of overlapping ideas that reflected broader themes being considered by residents. For example, 14 residents explored the environmental factors that influenced recovery, whereas eight reflected on how systems might create barriers to recovery; these items were considered conceptually similar and condensed into the broader category of recovery.

To make certain trustworthiness (Miles, Huberman, & Saldana, 2013) was established, (a) learning points were submitted in a fashion that encouraged personal, meaningful contemplation of the interview process; (b) learning point slides were separated from resident presentations and deidentified to ensure anonymity; (c) data were triangulated by comparing documented learning points to residents’ recorded remarks made to patients about their learning experiences (which precipitated the request for the learning points slide); and (d) accepted strategies were utilized in the organization of themes, including clustering.

As noted above, video data were reviewed to assess residents’ remarks on the educational process made directly to patients that also reflected their learning points, though these were not directly included in the data analyses. Of note, anonymity of residents could not initially be maintained for the latter portion of this review, as their voice and sometimes their person were

captured on film; therefore, statements made by residents that were thought to be relevant to this program evaluation were transcribed, deidentified, and aggregated into a single file. Additionally, as this was a retrospective analysis of their learning points, many residents had already completed the program and there was no longer any tie to their educational evaluations. Quotes in written and verbal format that demonstrated the central themes were noted and included below.

RESULTS

Analysis of learning points revealed that most residents (51.0%) were focused on one to two main points. However, in some cases there were up to five points that residents articulated to their peers (Table 2). Learning points revealed six major categories that residents were interested in: patient recovery, aging (ranging from successful aging to issues of incapacity), the role of social supports, communication, patients' roles as members of their treatment team, and resources available to patients.

Resident-Identified Learning Points

Patient recovery. The majority of residents focused on recovery with increased awareness of the obstacles and the aides to this process. For some, their observations were specific to the barriers to recovery that existed within the patients' home environment such as stairs to enter a home. Others observed that the patient had roles and responsibilities that might impede recovery, most frequently noting that the identified patient was the caregiver to someone equally or more ill. Residents also documented increased awareness of the larger context, reflecting on the systemic barriers to health maintenance, and exploring issues related to medication expense

TABLE 2 Number of Learning Points (LPs) and Themes

Item	<i>n</i>	%
Number of LPs		
1 LP only	13	25.49
2 LPs	13	25.49
3 LPs	17	33.33
4 or more LPs	8	15.69
Themes		
Recovery	39	76.47
Aging	20	39.23
Social support	17	33.33
Communication	16	31.37
Patient role	15	29.41
Resources	8	15.69

and transportation services. One resident's final written learning point was, "Remember to think about the larger system when you are frustrated."

Aging (un)successfully. A moderate number of residents documented increased learning about the aging process. Some noted increased attention to the negative effects of aging, with focus on changing cognition and the impact of decline on the reliability of patient report. This also led some to reflect on the role others (e.g., family and friends) play in the interviewing process. Others had the opposite experience, learning that "aging" does not imply "incapacitated," and that there are many models of successful aging. One resident stated,

It was very refreshing to see a patient who had such a great perspective on life and on age. So often we hear patients saying "I'm this old," and it is better to define a patient as a whole rather than based on an age or a number.

Additionally, some explored patients' perspectives on what it means to be a "geriatric" patient; a few observed that when patient and physician perceptions of aging differ, rapport might decline and expectations about treatment and approach to care might not align.

Social support. When learning points were about social support, residents considered family influence in establishing a safe discharge and ensuring opportunity for recovery. Some articulated increased awareness that family input in medical interviews was equally relevant to the patient's input and that families serve as providers' "first-line observers." They also recognized that perceived supports were often more important than actual supports. As an example, some explored how patients positively responded to geographic distance between themselves and their caregivers when they were aware that family would be available if necessary. Residents also identified the role of friendship in patient safety and recovery following discharge; one wrote, "Friends can be a tremendous source of support in the absence of strong family ties."

Communication. Some residents described the role of communication in patient care, approaching this from one of two standpoints: (a) the use of nonverbal communication and touch with patients, and (b) the role and influence of technology on the communication process. Regarding nonverbal communication, residents identified that this form of communication was important to the health and well-being of their patients. For some, it was as basic as remembering to make eye contact and to share their name and role as they entered the room. For others, it was recognizing that using touch could convey empathy and warmth.

Those who reflected on technology were often prompted to do so by the patients they interviewed. Patients observed that computers and electronic medical records limited interpersonal interactions with their physicians.

Residents described a shift in their approach in computer-use when with patients; specifically, some indicated this would prompt them to relocate the computer to allow for increased eye contact while still taking advantage of this important tool. One asked the following question, "How accepting and understanding is the aging population of our use and reliance on technology to communicate and practice medicine?"

Patients as team members. Others were interested in how patients serve as active participants in their own treatment team. One resident suggested, "Encourage ownership of care and pursue care that aligns with the patient's future goals." For many, interest in this topic seemed spurred by the patients' initiation of dialogue on this matter. Patients sometimes informed residents that they wished to be integrated into the care team and did not want to defer to providers' medical knowledge; in some instances, these patients challenged their providers. Residents subsequently explored how this might reflect cohort differences, and some suggested this might represent the changing face of geriatric medicine. Others explored the feelings that this stirred in them as providers, indicating it could be frustrating to be challenged or to have their authority questioned. Despite such frustrations, residents were also positive in their reflections on this subject. One wrote, "Empower patients to be their own advocates."

Resources to enhance overall care. Residents also reflected on the role of resources in patient care and discharge. Some noted increased need to educate themselves on what materials and resources were available to more effectively use them in patient care. As an example, three residents in the last year were unaware that the hospital offered a manual on the nature of knee replacement surgery that includes a detailed outline and timeline about recovery; all three were educated about this particular resource by the patients they were interviewing and privately expressed frustration that they did not successfully utilize such tools in their patient care. One wrote, "Patient education is an important part of the physician-patient encounter to help alter patient health behaviors, improve health status and increase awareness on available health resources." Furthermore, one noted that patients sometimes benefit from the availability of written materials to fully understand the nature of what is verbally explained, writing, "sometimes you need to spell it out." Despite this, others noted that more resources do not ensure success in patient care and/or discharge.

Increased Insight: The Patient Is a Whole Person

Although the majority of residents did not explicitly reflect on the holistic needs of patients, some (9.8%) included learning points about the need to conceptualize patient care from a biopsychosocial perspective. Five residents recognized that the patients' environment and other psychosocial factors

were just as meaningful as the diagnosis given during hospitalization. As an example, one resident noted,

When this patient was discharged, no one ever asked him about the availability of transportation to appointments in the future. We got him home and then. . . ? We have to be aware that patients are more than a diagnosis and their treatment will extend beyond medical management of a single problem.

DISCUSSION

In sum, the Hospital to Home Program is a unique model of geriatric training that meets most of the recommendations of the AGS Task Force (Besdine et al., 2005), allowing residents to see patients through transitions and engage in interdisciplinary approaches to care. Resident learning on such matters is perhaps best articulated by a resident who stated, "So much of geriatric care is about safety, functional status, and social supports. Changes are a bigger deal; having a good discharge plan as early as possible is important to make the transition as smooth as possible." As noted, however, some challenges have been faced in providing consistent implementation of this program to residents, which are most frequently related to patients' availability. Despite this, the learning points demonstrate that residents are leaving this educational program with a variety of ideas about geriatric care and discharge. Through the Hospital to Home Program our residents are heightening their skills as communicators and collaborators, and thinking about the broader, biopsychosocial needs of their geriatric patients.

Residents' self-reflection demonstrates how they are exploring and understanding the psychosocial needs of geriatric patients and their families through the discharge process. It is our hope that with increased awareness of these learning points, the residents come to have greater appreciation for the complexity of discharge planning, and that through presentations to their peers that others also come to think critically about the qualities that make older adults a diverse group with unique needs. When one resident was asked what he had learned from this training, he responded, "The hospital is almost like a factory sometimes. We have to get patients out and bring more patients in." Later in the course of this project, he discussed how this educational process reminded him that sometimes "good" medical care is provided by "slowing down."

Although there are benefits to this educational program, there are also limitations to this study. First, for those residents who did not document their learning points, there is no way of assessing what they are gaining from participating in this program. Furthermore, some might argue that their lack of feedback suggests that these individuals truly did not benefit

from the program. Second, as noted in the program design, the behavioral health postdoctoral fellow assists residents in exploring the biopsychosocial themes that emerge in the interview process; we therefore cannot ensure that learning points are not repetition of the feedback provided though we do hope that residents' documentation of the information is a reflection of their consideration of such matters. Third, the structure of the program has not involved any form of follow-up assessment. Subsequently, we currently have no ability to monitor or measure the long-term benefit of this educational program and whether residents continue to implement steps to improve discharge that they recommend at the time of their presentations.

Efforts to expand this educational program are subsequently occurring as methods to measure its long-term benefits are increased. Additionally, attending physicians are being asked to follow the same educational protocol to improve geriatric care. The hope is that by expanding efforts to all providers, there will be ongoing attention paid to geriatric patients' and their families' needs and that readmission rates can simultaneously be reduced. Future program evaluation would also benefit from evaluating whether this learning has a direct impact on readmission rates.

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