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Fall 12-15-2017

# A Roadmap for the Journey Home - A Supplemental Tool Guiding Patients from Hospital to Home

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**A Roadmap for the Journey Home – A Supplemental Tool Guiding Patients from Hospital  
to Home**

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### **Abstract**

Centers for Medicare and Medicaid (CMS) have recognized readmission rates as a public health problem. CMS incentivizes hospitals to reduce readmission rates and reduce payments for hospitals with high readmission rates (Berry et al., 2013). Patient education and discharge planning are associated with decreased readmission rates. I gained fieldwork experience at Children's Health System of Texas in Dallas. Children's Health, a pediatric non-profit, is the 8th largest pediatric health care provider in the U.S. Prior to discharge patient education occurs on topics related to their diagnosis, plus patients are provided discharge instructions including their diagnosis, medications, and simple instructions for the patients to continue care at home. With current discharge practice, patients and their parents report feeling partially prepared for the transition from hospital to home. I created a supplemental discharge tool, also called a journey map, and piloted the discharge tool by meeting with patients and parents to help them understand the tool. The tool is provided with a survey to gather patient feedback. The survey questions measure qualitative and quantitative data to assess the tool's efficacy. The feedback will influence tool revisions. The tool is used during an inpatient admission and is divided into seven topics: hospital, care, medicine, follow-up, home care needs, and home. Each topic provides question prompts to help patients and their parents understand if they are ready to take ownership for their care. The tool is distributed to patients on a general pediatrics floor with an average length of stay between one to two days. Future research implications include reviewing the readmission rates of patients who used the journey map. There is potential to create diagnosis specific discharge tools for specialties like Neurosurgery. Policy implications include exploring reimbursement rates determined by CMS and may impact National Patient Safety Goals by Joint Commission.

## **I. Introduction**

Healthcare facilities are faced with increasing pressure to reduce medical costs and improve patient outcomes. Although it may seem counterintuitive that lowered costs are linked to improved healthcare, a focus on decreasing readmission rates has the potential to do so. The Center for Healthcare Quality and Payment Reform (CHQPR) says reducing hospital readmissions is one of the best ways to reduce healthcare costs quickly while improving patient care. Centers for Medicare and Medicaid (CMS) have recognized readmission rates as a public health problem. CMS incentivizes hospitals to reduce readmission rates and reduces payments for hospitals with high readmission rates (Berry et al., 2013). A readmission occurs when a person is admitted to a hospital after being discharged from an earlier hospitalization within a certain time period; CMS defines the time period within 30 days. For the purpose of this project, the definition provided by CMS was used. Readmission rates are an indicator of the quality of care received.

Berry et al. (2013) notes a gap in knowledge regarding pediatric readmissions. In pediatrics, the 30-day unadjusted readmission rate for all hospitalized children as surveyed among 72 pediatric hospitals nationally is 6.5% (Berry et al., 2013). The noted readmission rate varied widely depending on the condition and hospital, showing adjusted rates as high as 28.6%. In addition to CMS addressing readmission rates as a public health problem, the Pediatric Quality Measures program established by the Children's Health Program Reauthorization Act has identified readmission rates as a primary initiative.

Patient education and discharge planning are associated with decreased readmission rates. University of Texas Medical Branch (UTMB) defines patient education as an individualized, systematic process designed to effect change in behavior with the purpose of increasing patient

comprehension of diagnosis and increase in participation self-management of health care needs. Discharge planning is a process with the goal of improving the coordination of services after discharge from the hospital by considering the patient's needs within their community as defined by Katikireddi and Cloud (2008). It is vital that patients are educated about their diagnosis and capable of identifying resources to assist in their care. Prior to discharge there are many opportunities for effective education to increase a patient's understanding of their diagnosis, which leads to decreased readmission rates. Holland et al. studied the effects of utilizing a screening tool to identify patients who could benefit a plan for discharge earlier in their hospital admission. Depending on the diagnosis early discharge planning can assist with decreasing hospital length of stay (Holland et al., 2015). Decreased hospital length of stay contributes to positive health outcomes. Per Noyes, Brenner, Fox, and Guerin (2014), prolonging the discharge process does not provide patients any potential health benefits and increases patient's exposure to potential harm. Edwards, O'Toole, and Wallis (2017) identified effective discharge planning allows pediatric patients to have positive health outcomes at home; it was found that use of an effective discharge plan allowed 27 children to be successfully discharged to home. Wesseldine, McCarthy, and Silverman (1999) studied the efficacy of discharge planning to reduce readmission rates among pediatric patients diagnosed with acute asthma. With patient education provided by healthcare providers, the likelihood of readmission rates significantly decreased. Furthermore, the intervention group was also significantly less likely to present to the Emergency Department and less likely to present problematic asthma to during primary care visits (Wesseldine, McCarthy, and Silverman, 1999).

Comparing this public health problem against the ecological model, public policy identifies readmission rates as a public health issue and aims to decrease rates. This CMS

initiative is relatively new with minimal longitudinal data to support a downward trend of lowered readmission rates in pediatrics. Lack of data has not discouraged healthcare facilities to focus on this public health issue. An increasing number of pediatric facilities are addressing this public health problem through increased patient education by researching best practices and effective discharge tools. However, pediatric healthcare facilities are not collaborating enough with one another and adult facilities to reduce readmission rates. If healthcare entities worked together to share processes, discharge planning elements, practices, and tools that reduce readmission rates, healthcare overall would benefit by implementing shared resources instead of creating their own individual process. The combination of an effective discharge tool to facilitate increased patient education is the purpose for this semester's capstone project.

## **II. Scope of the Project**

I gained fieldwork experience at Children's Health System of Texas located in Dallas. Children's Health is the 8<sup>th</sup> largest pediatric health care provider in the U.S. As a private, non-for-profit the organization strives to achieve its mission to make life better for children. In 2016, Children's Health cared for 278,708 unique patients through inpatient admissions, outpatient clinic visits, primary care physician visits, home care visits, and therapeutic services. With 616 licensed beds, 1310 medical and dental staff, 7800 employees, and over 50 specialty and subspecialty programs, Children's Health serves children in the north Texas region.

Children's Health strategic priorities include People, Quality, Efficiency, and Growth. A focus on population health ensures patients are adequately equipped to lead healthy lives outside of the walls of this healthcare facility, which calls for increased quality of healthcare delivery leading to improved quality of life for patients. My project focused on an enhanced discharge education tool. With a more educated patient population, there is hope for a more involved, accountable, and healthier population leading to decreased readmission rates.

Currently, patients are educated on specific topics related to their diagnosis prior to discharge. Also, patients are provided discharge instructions including their diagnosis, medications, and simple instructions for the patients to continue care at home. With current discharge practice, patients and their parents are not fully prepared for the transition from hospital to home. Often patients do not know enough about healthcare to have the ability to ask informed questions, such as confirming if medications can be picked up from a standard pharmacy or a compound pharmacy. This gap in knowledge



led to the creation of a discharge journey map. The Director of Patient Education had been provided anecdotal evidence that patients felt partially prepared for discharge. She called together randomly selected parents of patients who were admitted to create a focus group. She facilitated a conversation with the focus group seeking to understand what parents believe they needed to feel prepared for discharge. The participants asked for a simple, easy to follow, one-page resource to helping understand what was happening during their admission.

The focus group feedback guided the creation of the discharge journey map. The journey map is a tool to use once admitted into the hospital throughout the entire inpatient admission and for review at home. A patient will use the tool during admission by reading the question prompts then use the tool after discharge at home by reviewing answers provided during admission. Use of one tool throughout an admission assists with consistency of topics discussed and simplifies the admission into seven general topics.

I worked as a Training Consultant for Children's Health. For this project, I created the supplemental discharge tool, Appendix A. The tool was designed with the purpose of increasing awareness to fill in any educational gaps patients may have. Throughout this fieldwork assignment, I had the opportunity to implement different public health competencies especially communication and working with an inter-professional team, as listed in Appendix B.

After the tool was created, it was time to pilot the tool among admitted patients. At the beginning of the pilot, the Director of Patient Education and I distributed the tool and met with patients and their families to help them understand how and when to

use the tool. The discharge tool was also provided with a survey for patients to provide feedback. I collected the surveys and compiled surveys data collected up to date; surveys are still being completed and collected currently. The survey results will enhance the discharge journey map by incorporating patient and parent feedback.

### **III. Public/Population Health Impact: Findings and Significance**

**Results.** This fieldwork placement resulted in the creation of one supplemental discharge tool for general pediatric admissions. This tool is meant to be used throughout an inpatient admission to prompt questions and write down answers, which will help patients prepare for discharge. Healthcare is very confusing to understand; the processes and delivery of care vary from facility to facility. Use of medical terminology exacerbates this confusion. This can make healthcare encounters overwhelming for patients. Additionally, some patients and their parents may not know enough about health care to ask the right questions. The tool is designed to address gaps in vocabulary. The tool is broken down into seven topics: hospital, care, medicine, follow-up, home care needs, and home. Under each of the topics, there are question prompts to help patients and their parents understand if they are ready to take ownership for their care; questions prompts are not written with medical jargon but with vocabulary suited for a 4<sup>th</sup> grade reading level. The question prompts are written in plain language as statements to check off on the map if he/she agrees with the statement. If there is disagreement, hopefully the patient will feel empowered enough in their care to ask their providers about the topic. For example, a statement related to the topic Medications is “I know which side effects to watch for and who to call, if needed.” If a patient is unsure, they can ask about medication side effects and the proper contact. As those topics are brought up throughout their admission, they can read the question prompts or write down related notes under the topic header. Furthermore, the tool also provides an area for patients to write down information such as contact information and a list of helpful questions.

This journey map is currently provided to all patients on one of the general pediatrics floors, C9, where hospitalists practice. Participants included the patients and parents / legal

guardians of admitted pediatric patients. To kick-off the pilot, the Director of Patient Education and I provided the journey map and survey to participants then explained the pilot and how to use the tool. After clinical staff had the chance to observe us explain the tool to patients, they began to take ownership of providing the tool and survey as part of their workflow. The Director of Patient Education set that expectation that clinical staff would incorporate distribution of the tool and survey as part of their workflow to pilot the tool.

Along with the discharge journey map, patients were provided a survey. This survey asked questions measuring qualitative and quantitative data to assess the efficacy of the supplemental discharge tool. Currently data is being collected from all participants who are English-speaking and willing to complete the survey. The tool and survey will be provided to all patients admitted to C9 consistently for an annual quarter with no maximum number of patients to be recruited. After the quarter, data will be analyzed to determine next steps.

The qualitative data collected provides a forum for patients and their parents / legal guardians to provide any additional feedback that might not be addressed by the quantitative questions. The question related to qualitative data is “Please list any other comments or suggestions.” Quantitative analysis focused on rating the efficacy of the supplemental discharge tool. The questions related to quantitative data include:

- I. Does the title match the tool? The title of the tool is called *Partner with Us: Your Child’s Journey Home*.
- II. Is the journey map easy to read and understand?
- III. Does the material help me understand the journey?
- IV. Does the material use words that I understand or explain medical words?
- V. Are the pictures are easy to read and understand?

VI. Do you think journey map will help other patients and families?

**Implications.** After data collection has occurred. The data will be used to refine the tool according to patient and parent feedback. Next, the Marketing department will review and revise to ensure brand consistency. Afterwards, a translator in the Language Access Services department will translate the document into Spanish. This will result in a one-page, front and back, English and Spanish discharge journey map. The data gathered is only from one general pediatric inpatient unit with an average length of stay between one to two nights. This data is only related to patient and parent perception of readiness for their transition home. Future research implications include assessing the tools efficacy by looking for a correlation between this discharge tool and lowered readmission rates for general inpatient admissions. Reviewing the readmission rates of the patients who have been provided a journey map and identifying a potential correlation between readmissions within 30 days after discharge can achieve this.

From a program perspective implications include revising the journey map based on patient feedback and the possibility of developing a series of disease specific supplemental tools to assist patients during their hospital admission and their transition from hospital to home. If the tool proves to facilitate the transition from the hospital to home for general pediatric admissions, variations may be created for patients admitted to specialty units. It is imperative to collect data from other units with varying lengths of stay and different diagnoses. Data collected from these areas can influence the creation of disease-specific journey maps. The general admission journey map could be used as the foundation for tailored discharge tools in units such as Hematology / Oncology, Nephrology, Neurosurgery, NICU / PICU, and Cardiology. Another research implication includes observing the effects of supplemental discharge tools for patients with longer lengths of stay or specific diagnoses.

There are also policy implications such as exploring reimbursement incentives for general pediatric inpatient admissions and reviewing penalties for pediatric hospitals with high readmission rates determined by CMS. If supplemental tools and education decrease readmission rates, they may impact National Patient Safety Goals by Joint Commission.

#### **IV. Conclusion**

This project attempted to improve the transition from a hospital admission to home by using a supplemental discharge tool referred to as a discharge journey map. Literature supports that patient education throughout a hospital admission assists patients with their transition back home. It has been proven that earlier education in a patient's admission can have a positive impact as seen by Wesseldine, McCarthy, and Silverman's (1999) study; this study showed that targeted patient education led to patients being less likely for readmission or Emergency Department visits and less likely to present problems during primary care visits.

Patient education can traditionally be thought of as an individual conversation or series of fragmented conversations with patients and families accompanied with handouts. Patient education can be transformed into an on-going conversation while using a supplemental discharge tool to document notes and ensure every patient is consistently given the same information to assist with the transition home. This resulted in the creation of a discharge journey map, a one-page handout that allows patients and families to fill it out as they continue throughout their admission and after discharge at home. The tool is provided to patients at the beginning of their admission with the hope that the tool helps patients understand what is happening during the admission that will provide deeper knowledge of how to manage any additional care once home. The tool also provides question prompts for patients and their parents to address any potential knowledge gaps.

The public health impact of this project is local to specific inpatient floors within Children's Health in Texas and provides a broad impact for future research. The results show the discharge journey map helps patients and their parents understand their admission in an easy to read and understand manner. The surveys show that patients and their parents believe this tool

will help other admitted children. Research should be conducted to evaluate the efficacy of patient education tools to assist patient preparedness for care outside of the walls of a healthcare facility. Additionally research should review the role of this particular patient education tool in regards to readmission rates within 30 days of discharge.

The implications of this project are broad and can apply to all 40 locations of Children's Health System of Texas, the state, and the country. Regarding local impact, this can positively improve patients' transition to home by being fully prepared to take of themselves. The discharge tool can be tailored to other areas outside of general inpatient admission to assist other patients who receive care from Children's Health. There other implications include an impact on pediatric reimbursement and the possibility of this type of patient education tool becoming a part of the National Patient Safety Goals by Joint Commission.



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## **Appendices**

Appendix A: Discharge Journey Map

# Partner with Us: Your Child's Journey Home

Your child's doctors and nurses start planning for your child's journey home while they are in the hospital. Use this journey map as a guide to help you partner with us in getting you and your child home safely.

Hospital	Care	Medicine	Follow Up	Home Care Needs	Ride Home	Home
<ul style="list-style-type: none"> <li><input type="checkbox"/> My child was in the hospital because _____.</li> <li><input type="checkbox"/> My child's main hospital doctor is _____.</li> <li><input type="checkbox"/> I was a part of the planning for my child's care and discharge.</li> <li><input type="checkbox"/> My child's might go home from the hospital on _____.</li> <li><input type="checkbox"/> I plan to take my child to Dr. _____ when they get sick at home.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> I can care for my child's personal needs when we go home (diaper change, bathing, feeding, playing/activity)</li> <li><input type="checkbox"/> I can care for my child's health care needs at home (illness, medicine, nutrition, feeding tube, trach).</li> <li><input type="checkbox"/> I know what problems to watch for at home, what to do for them, and who to call, if needed.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> I know what my child's medicines are, where to get them, and how to give them.</li> <li><input type="checkbox"/> I know what side effects to watch for and who to call, if needed.</li> <li><input type="checkbox"/> I know my pharmacy hours and if they can fill my child's medicines.</li> <li><input type="checkbox"/> My child does not need medicine.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> My child's follow-up appointment(s) are scheduled before we go home, if needed.</li> <li><input type="checkbox"/> I have my child's follow-up appointments saved in my phone or calendar.</li> <li><input type="checkbox"/> I am signed up for MyChart to help me partner with my child's doctor and nurses after we leave the hospital.</li> <li><input type="checkbox"/> I know how to get my child's test results, if needed.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> I have what I need at home to care for my child (medicine, supplies, equipment).</li> <li><input type="checkbox"/> I know to call my child's case manager, for any issues with home care at _____.</li> <li><input type="checkbox"/> My child's home orders have been reviewed before leaving the hospital (therapies, medicines, feedings, supplies).</li> <li><input type="checkbox"/> I know how to call my child's Home Health/Supply company. _____</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> I have a ride home from the hospital for my child once they are ready.</li> <li><input type="checkbox"/> Our ride home is available at these times:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Morning (8:00 am – 12:00 pm)</li> <li><input type="checkbox"/> Afternoon (12:00 pm – 4:00 pm)</li> <li><input type="checkbox"/> Evening (4:00 pm – 8:00 pm)</li> </ul> </li> <li><input type="checkbox"/> I will need a ride home.</li> <li><input type="checkbox"/> I have my child's car seat.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> My doctor or nurse answered all my questions about my child before leaving the hospital.</li> <li><input type="checkbox"/> I feel ready and prepared to care for my child at home.</li> <li><input type="checkbox"/> I know who and when to call if my child has problems.</li> <li><input type="checkbox"/> My child's regular doctor at home knows about my child being in the hospital.</li> </ul>
<p><b>Notes:</b></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>			<p><b>Helpful Questions:</b></p> <ul style="list-style-type: none"> <li>I don't have a doctor to take my child to when they are sick at home, who can help me?</li> <li>What must I learn to be able to take care of my child at home?</li> <li>What should I look for to know if my child is getting better or worse? If my child looks worse, who should I call?</li> <li>Can someone help me with insurance questions? How much will my child's medicines cost?</li> <li>What is MyChart and why should I sign up for it?</li> </ul>			

### Appendix B: MPH Program Competency Inventory

Competency	Description of How Each Was Achieved
<p><b>1.</b> Select quantitative and qualitative data collection methods appropriate for a given public health context</p>	<p>I contributed to the distribution of a survey that asks quantitative and qualitative data regarding a specific education discharge tool called a Journey Map for pediatric patients and their legal guardians.</p>
<p><b>2.</b> Interpret results of data analysis for public health research, policy, or practice</p>	<p>I collected the surveys distributed to patients and families then compiled the data; data is currently being collected. The qualitative and quantitative data allows us to understand what patients and families expect from a discharge tool and how to improve the tool to better suit their needs.</p>
<p><b>3.</b> Design a population based policy, program, project, or intervention</p>	<p>I created a discharge tool to assist patients and their families transitioning from hospital admission to home. This tool is designed to help patients and families be prepared for their discharge from the hospital.</p>
<p><b>4.</b> Communicate audience-appropriate public health content, both in writing and through oral presentation</p>	<p>I created the discharge tool with the guidance of the Director of Patient Education. Working alongside this director, we spoke with internal staff about the tool regarding expectations of distribution, collection of tool surveys, and resources for additional Journey Maps and surveys. Additionally, I spoke with patients and their caretakers about the tool and survey.</p>
<p><b>5.</b> Perform effectively on inter-professional teams</p>	<p>During this project, I have worked with the Director of Patient Education, physicians, the charge nurse, inpatient RNs, and Health Unit Coordinator. I communicated professionally with all groups to achieve the project goal.</p>