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Improving Post-Discharge Engagement of Mental Health Patients in the Veterans Affairs South Texas Healthcare System

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IMPROVING POST-DISCHARGE ENGAGEMENT FOR MENTAL HEALTH PATIENTS IN THE VETERANS AFFAIRS SOUTH TEXAS HEALTHCARE SYSTEM

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Nneoma Anyanwu

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Abstract

Discharge from a hospital is a high-risk period for mental health patients, as 20% experience an adverse event within 30 days of discharge. Poor discharge engagement can lead to complications for recovery, which include an increased risk for readmissions, longer length of stay, increased risk for suicide, and death. Hospital stays cost the United States $377.5 billion dollars per year; there is pressure for hospitals, health plans, and providers to examine the admission and discharge processes to improve healthcare delivery, transition of care, and patient health outcomes. At a South Texas VA, 67.66% of mental health patients attended all their discharge appointments, far below the VA's national benchmark of 85%.

To improve post-discharge engagement, an interdisciplinary, quality improvement project was conducted on the inpatient mental health units at one of two VA hospitals in South Texas from May 2023 through July 2023. A review of literature identified best practices regarding the discharge of mental health patients as engagement of patients, families, and/or support persons; clinician communication along the transition of care, administration of long-acting injectables, and the utilization of Peer Support Specialists (PSS). After 11 weeks of implementation, data on 62 inpatient charts showed a 3% increase in PSS referrals and an overall 5% increase in post-discharge engagement for FY-23 Quarter 3. The results of the project promote quality care by increasing knowledge on evidence-based practices that support effective discharge planning. Results may also ameliorate the potential adverse events experienced by mental health patients post-discharge and decrease healthcare costs.

Keywords. discharge, mental health patients, continuity of care, community, engagement

Improving Post-Discharge Engagement for Mental Health Patients in the Veteran's Affairs South Texas Healthcare System

Statement of the Problem

Hospital discharge is a complex and challenging process for healthcare professionals, patients and their families (Wong et al., 2020). The Veteran's Affairs (VA) South Texas medical facility is facing challenges in successfully having mental health patients attend their scheduled follow-up appointments post discharge. The VA's national benchmark for post-discharge engagement (PDE) of mental health patients is 85%. Currently, the VA South Texas hospitals' PDE-1 score is 67.66%. This means that only 67.66% of mental health patients attend all their scheduled follow up appointments within 30 days of discharge. This is problematic, not just for the VA but for the community at large. Research conducted between 2005 and 2015 indicates that 17% of people who completed suicide had been recently discharged from an inpatient setting (Tyler et al., 2019). To ensure safety and better management of psychiatric patients, the PDE-1 metric stipulates that mental health patients admitted to any inpatient psychiatric service are required to have a minimum of three follow up appointments within 30 days of discharge. Patients identified as high risk (those who have recently attempted suicide) are required to have four follow up appointments within 30 days of discharge.

Appointments can be held on a variety of platforms: virtually, telephonically or in person with the scheduled provider. The facility offers a same-day walk-in clinic, which is open Monday through Friday during normal business hours for mental health patients in the event they miss their appointment. However, despite the current measures in place, patients are not attending their appointments as scheduled. Failure to attend discharge appointments as required places this vulnerable patient population at in increased risk for injury (Burke et al., 2013).

Regular attendance at discharge appointments are necessary to deliver cost effective, safe and timely care (Burke et al., 2013). When patients do not attend their appointments, they experience a reduction in quality of life and can further complicate their care (Snyderman et al., 2014). As recent statistics show, healthcare is one of the fastest and largest industries in the world. Enhancing discharge engagement is imperative to our nation's healthcare system and overall economy because poor transitions of care from the hospital to the community cost an estimated $44 billion dollars annually (Dreyer, 2014).

Background and Significance

The business of healthcare is evolving towards a patient-centered, value-based model that requires healthcare organizations to be accountable for both cost and quality of care (Teisberg et al., 2020). This model, supported by the Institute for Healthcare Improvement, promotes coordination of care across settings and collaboration between providers to assure that healthcare is safe, efficient, and cost-effective (American Case Management Association, 2023).

The identification of the PDE-1 metric as an area of focus was executed through the hospital's stakeholders to include various directors, healthcare administrators, mental health providers, and nursing managers within the VA South Texas healthcare system. Several process improvement initiatives were initiated to address the PDE-1 metric because it has been consistently below the national benchmark of 85% and trending downward in comparison to the previous fiscal year. If left unaddressed, the VA South Texas healthcare system could lose revenue from appointments that are lost due to no-shows. The Centers for Medicare and Medicaid Services (CMS) can also deny reimbursement to the VA for indicators of poor transition of care, which includes but is not limited to frequent readmissions, longer length of stays, and so on (National Committee for Quality Assurance, 2023). Furthermore, no-shows

decrease access to care, as patients who need mental health appointments have to wait for a future date for an evaluation.

The effects of poor post-discharge engagement negatively impact the community at large as functional consequences include loss of employment, missed wages, and decreased contributions to society (Lemke et al., 2017). Poor discharge engagement also negatively impacts mental health patients' quality of life by placing them at increased risk for self-harm, suicide, relapse of illicit substances, or readmission (Smith et al., 2020). Hospitals have been under pressure from CMS to improve their transition of care of patients. In 2012, CMS established the Hospitals Readmissions Reduction Program, which reduces Medicare payments to hospitals with excessive readmissions (Resnik, 2018).

Organizational Assessment

A variety of factors have been identified at the VA South Texas hospital as contributory to poor post-discharge engagement of mental health patients. Walkthroughs and interviews consistently revealed a lack of staff education and knowledge on the extent of the problem around discharge engagement. The inpatient mental health staff also lacked knowledge as to the potential consequences of poor discharge engagement for the hospital, the patients, their families, and the community at large. Additionally, the staff harbored negative attitudes and feelings towards the hospital's current policies around the discharge process. Negative attitudes adversely influenced patient outcomes, employee productivity, and healthcare workers' engagement (Layne et al., 2019). Finally, underutilization of essential resources, as well as a lack of standardization with the unit's processes, were observed as opportunities for improvement.

Nurses played an integral role in the discharge process by coordinating care and providing timely communication with key stakeholders (Bajorek & McElroy, 2020). However,

on the inpatient mental health units, nursing involvement was relegated to tasks such as the removal of identification bracelets, obtaining signatures, stripping beds, and securing transportation. Nursing staff did not have an active role in preparing patients for discharge. The responsibility for discharging patients was primarily left to the social workers and mental health providers. The current practice did not ensure that mental health patients were educated in their own care nor that they received pertinent information early and throughout their stay.

It was also observed that communication between inpatient and outpatient mental health professionals did not occur during the patient's hospital stay. Once the patient was discharged into the community, he/she was assigned to one of 15 clinics within the VA for follow up. Many patients ended up getting lost in the transition and did not return for their appointments. Effective discharge planning requires a multidisciplinary, coordinated approach that places the patient and their families at the center (Ong et al., 2021). Discharge appointment attendance increases when communication between inpatient and outpatient healthcare team members occurs prior to discharge. Patients who have follow up shortly after hospital discharge are less likely to be readmitted to the hospital (Snyderman et al., 2014).

Additionally, the inpatient mental health providers did not routinely assess mental health patients to determine whether they met criteria for a long-acting injectable (LAI). There was variance observed with the screening of patients for LAIs and its administration. The variance was attributed to provider preference and the patient's overall circumstances. According to the American Psychiatric Association (APA, 2013), the administration of a LAI prior to discharge promotes treatment adherence. Another article concluded that the administration of a LAI prior to discharge decreases substance relapse and hospital readmissions by 20-30% (Lachaine et al., 2015).

The engagement of family and/or support persons in the discharge process was not the standard practice for all members of the healthcare team. During the planning phase, I observed patients to have a passive role. Patients were given future appointments without any education on why it was necessary. These appointments were provided to them by the nurse at discharge without first assessing whether they could attend. Family members were only contacted for historical data and collateral information to assist with formulation of the treatment plan. In order for discharge planning to be effective, it has to be an interactive process between the patient, his/her family or support persons, and the healthcare team (Ong et al., 2021). According to Haselden et al. (2019), leveraging patient's families or support persons improve treatment adherence and post-discharge attendance at follow-up appointments. Furthermore, the engagement of patients with the establishment of follow-up appointments prior to hospital discharge increases the likelihood of patients attending their appointments (Burke et al., 2013).

The hospital's Peer Support Specialist (PSS) program was not utilized due to a lack of provider awareness and training on who and how to enter referrals, as well as staffing shortages. An effective PSS program is based on peers (individuals who have undergone treatment successfully) providing knowledge, shared experiences, and emotional, social, or practical resources to patients in recovery. PSSs provide emotional support and can act as a bridge between the providers and patients. The incorporation of a PSS into the discharge planning is a cost-effective way to promote treatment adherence and support discharge from hospital to community (Gillard et al., 2020).

Additionally, the organizational assessment revealed that upon discharge from the inpatient units, the practice was to dispense a 7-14-day supply of discharge medications to the patient. This practice posed a threat to the patient's overall treatment and safety if their

prescription ran out without their having attended a follow-up appointment for laboratory analyses and ongoing medication management. Other areas for practice improvement included ensuring that medical support attendants (MSAs) were entering the required number of appointments appropriately and within the designated timeframe of 30 days.

Readiness for Change

At large, the organization demonstrated a readiness for change through the engagement of various stakeholders in leadership positions, providers, and support staff. In fall 2022 (after the reporting of FY-22 Q3 data became available), the project was designated as a Lean Six Sigma Green Belt Process Improvement project and was launched in October 2022. The purpose of the Green Belt project was to identify the root causes of the ongoing problem and implement effective measures to better engage mental health patients upon discharge, thereby bringing the PDE-1 metric closer to the VA's national benchmark of 85%.

However, at the unit level, readiness for change was much more diminished, particularly among the nursing staff. Conflicting attitudes from nursing staff and medical providers uncovered the belief that there was not much area for improvement. Many claimed to have understood the scope of the problem but not believe that changes to their current practice would truly make a difference. When questioned more about their beliefs, many felt that the systems processes were cumbersome for the patients. Many also harbored the belief that patients preferred being readmitted via the emergency department as an easier alternative for them.

Project identification

Purpose

The purpose of this DNP project WAS to improve post-discharge engagement of mental health patients discharged from the adult inpatient (male/female) psychiatric units at a VA medical facility in South Texas. The goal of this project WAS to increase the South Texas VA

healthcare system's PDE- 1 metric to 85% (or higher) by August 2023. This was accomplished by facilitating evidence-based practices and implementing interventions to increase mental health patient's engagement within 30 days of discharge, thus promoting patient and family centered, high quality care.

Objectives

- Educate 100% of unit leadership, mental health providers, nursing staff, and unit secretaries on the background and importance of the DNP project by May 1, 2023.
    1. Staff would be educated on the PDE-1 metric and the background of the problem.
    2. Staff would be educated on the AHRQ resources and tools. The intent was to improve awareness on the scope of the problem and promote involvement of healthcare team members towards improving the discharge process. Staff would be educated and provided literature on the efficacy and safety of continuity of care for mental health patients discharged within 30 days.
    3. By May 1, 2023, 100% of all inpatient mental health patients have 3-4 follow-up appointments established within 30 days prior to discharge from the inpatient units.
- By July 1, 2023, 100% of mental health inpatients have a support person or family member identified for adequate engagement in the discharge planning process.
    1. Patient families or support persons be engaged to provide reinforcement on the treatment plan through psychoeducation and emotional support.
    2. All mental health inpatients be educated on the AHRQ's Taking Care of Myself: A Guide for When I Leave the Hospital and the AHRQ discharge checklist, and be provided a copy upon admission (Appendices B-I).

- By July 1, 2023, 100% of all mental health patients have an enhanced discharge plan in place. This consists of interdisciplinary communication between the inpatient and outpatient mental health teams to streamline care and promote patient continuity of care.
- By July 1, 2023, medication reconciliations be conducted by admitting providers to ensure that 100% of all mental health inpatients who are chronically psychotic, or determined to be a high risk for suicide are ordered a suitable LAI instead of an oral prescription prior to discharge for mood stabilization and treatment compliance.

Anticipated Outcomes

Anticipated outcomes of the project were:

- entering the correct number of required patient appointments upon discharge;
- enhanced communication between inpatient and outpatient providers and nursing staff;
- increased patient attendance at follow up appointments post-discharge;
- increased screening and ordering of long-acting injectable medications instead of oral antipsychotics;
- decreased readmissions; and
- decreased encounters in the emergency department.

Summary Strength of Evidence

Family and Support Person Engagement

Research has demonstrated both short-term and long-term benefits for engaging family and support persons in the care of patients suffering from mental health illnesses (Lemke, 2017). Family engagement in the discharge processes can lead to better outcomes, such as fewer relapses, longer duration between relapses, reduced hospital admissions, shorter inpatient stays, and improved compliance with medication and treatment plans (Ong et al, 2021). In an article by

Haselden et al. (2019), family involvement during psychiatric hospitalizations, or refusal to be involved, has also been associated with post-discharge medication adherence or nonadherence, respectively. Implementation of best practices involves collaborative teamwork and cultivation of human connection to help patients safely navigate the gap between care settings (Waring et al., 2014).

According to AHRQ, discharge from hospital to home requires the successful transfer of information from clinicians to the patient and family to reduce adverse events and prevent readmissions through treatment adherence. Led by the American Institutes for Research Institute for Patient and Family-Centered Care and Joint Commission, the AHRQ has developed multiple resources to help hospitals develop effective partnerships with patients and their families with the goal of improving multiple aspects of hospital quality and safety. Resources include The Guide to Patient and Family Engagement in Hospital Quality and Safety, and the IDEAL discharge planning overview, process, and checklist. According to the AHRQ (n.d.), facilities that have implemented the IDEAL discharge planning experienced an improvement in Consumer Assessment of Health Providers and Systems hospital survey scores and a reduction in readmissions by 32%.

Enhanced Discharge Plan: Communication

According to Schnipper et al. (2021), providers, along with nursing staff, play an integral role in the discharge process and the provision of timely communication with key stakeholders, which is necessary to ensure smooth transitions of care. The transition of care from hospital to community represents a vulnerable period for patients. According to Patel & Landrigan (2019), the current health care environment increases the potential for communication errors at discharge, due to shortened length of stays, frequent turnover of medical providers, and transfer

of patient care between and within large care teams. Effective execution of a patient's treatment plan requires interdisciplinary collaboration of providers and nursing staff along the patient's transition continuum. Smith et al. (2020) concluded that collaborative discussions among inpatient and outpatient providers are significantly associated with patient attendance at outpatient mental health follow up appointments. Ultimately, the evidence suggests that a well-managed transition of care and communication between providers can improve patient safety and quality of care (Patel & Landrigan, 2019).

Peer Support Specialists

Peer support services offer hope and empathy, and foster respectful relationships that are built on shared experiences and trust; this is critical, particularly in a stigmatized population. Peer support encompasses a wide range of activities and interactions between patients who share similar experiences, diagnoses, mental health conditions, and/or substance use disorders. This mutuality between a PSS and a patient in/or seeking recovery promotes connection, and inspires hope and adherence to the patient's treatment plan (Gilliard et al., 2020). Gillard et al. (2020) reported that adding a PSS to the treatment plan improves "activation" in terms of the patient's knowledge, skills, and attitudes. A PSS can also benefit patients' families by helping to destigmatize mental health illness. PSSs can also work with families to provide moral and emotional support (Shalaby & Agyapong, 2020).

Screening for Long-Acting Injectable Administration

Readmission rates for patients with mood disorders are higher than any other mental health condition, with 15% readmitted within 30 days of hospital discharge and up to 22.4% of patients with schizophrenia being readmitted (Health Catalyst, n.d.). LAIs allow for better treatment compliance by delivering slow steady concentrations of medication into the

bloodstream over a two to 24-week period (Vonderhaar & Snyder, 2020). In a 12-month trial conducted by the Journal of American Medical Association, the relapse rate of 86 patients with first-episode schizophrenia was 33% among those taking oral antipsychotics versus 5% among those receiving LAIs (Subotnik et al., 2015). Vonderhaar & Snyder (2020) concluded that LAI medications were shown to increase adherence to treatment regimens and reduce readmissions (Vonderhaar & Snyder, 2020). Additionally, Pietrini et al. (2016) revealed that patients who were switched from oral antipsychotic to a LAI showed significant improvements in health-related quality of life, better functioning in almost all areas of living, and adherence to treatment plans, in contrast to patients on oral antipsychotic medications.

Theoretical and Conceptual Framework

The theoretical framework used to guide this project was Hildegaurd Peplau's *Theory of Interpersonal Relations*. Hildegaurd E. Peplau (1909-1999) was born in Pennsylvania and was an American nurse known as the "Mother of Psychiatric Nursing" (Gonzalo, 2023). She became the first published nursing theorist following Florence Nightingale. Peplau's theory of interpersonal relations is defined as an interpersonal, therapeutic process that takes place when professionals specifically educated to be nurses engage in therapeutic relationships with people who need health services. Peplau identified three phases: orientation, working, and termination. Peplau theorized that nurse-patient relationships must pass through all three phases to be successful (Hagerty et al, 2017).

During the brief orientation phase, hospitalized patients realize they need help and attempt to adjust to their current (and often new) experiences. Peplau (1997) theorized that nurses must quickly establish a therapeutic relationship with respect, courtesy, and compassion as the foundation of the relationship.

The next phase is the working phase, which accounts for most of the nurse's time with patients. In this phase, the nurse conducts assessments about patients to use during teaching and when contributing to the interdisciplinary plan of care (Peplau, 1997). During the working phase, the nurse becomes more familiar with their assigned patients, and the patients begin to accept their nurse as a health educator, resource person, counselor, and care provider.

Peplau (1997) believed that when nurses practice "nondirective listening" they facilitate an increase in the patient's awareness of their feelings regarding their changing health. This therapeutic form of communication allows nurses to provide reflective and nonjudgmental feedback to patients to help them clarify their thoughts.

The last phase is the termination phase, also known as discharge planning (Peplau, 1997). The success of the termination phase is dependent on how well patients and nurses navigate the prior two phases (orientation and working phases). The main part of the termination phase occurs when nurses teach patients about symptom management and recovery in the community. Nurses contribute enormously to the patient's experience (Hagerty et al., 2017). Interdisciplinary healthcare team members (e.g., nurses, social workers, providers) are leveraged to improve post-discharge engagement and transition back to community (Peplau, 1991).

Peplau's theory of interpersonal relations supports the goals and objectives of this DNP project in many ways. When discharge care is well coordinated, initiated early, and backed by evidence-based practices, patients and their families feel supported as they transition from hospital to community. As patients and healthcare professionals navigate each phase of the process, knowledge is attained, equating to empowerment. This interdisciplinary and collaborative practice enhanced the likelihood of post-discharge attendance and scheduled follow up appointments.

The conceptual framework used to guide this project was the John Hopkins Evidenced Based Practice Model. The John Hopkins Evidenced Based Practice Model is a three-phased approach referred to as the PET process: practice question/problem, evidence, and translation (Dang, et al., 2022). The first phase consists of the Principal Investigator identifying a problem by identifying a patient population, interventions, clinical setting, and outcome (PICO). The second phase includes a literature search and evidence appraisal for strength and quality. In phase three, the findings are synthesized and recommendations for improvement in practice are developed (Dang et al., 2022).

Methods

A quality improvement project to improve post-discharge engagement for mental health patients discharged to the community was implemented at a VA medical facility in South Texas. A project description was submitted to the Institutional Review Board at the University of Texas and given a Non-Regulated Research determination. Additionally, approval to implement the project was obtained from the organization's key stakeholders, including Chief of Inpatient Psychiatric Services, Chief of Inpatient Psychiatric Nursing Services, Lead Social Worker, Lead PSSs, and unit nurse managers. In this quality improvement project, all families and/or identified support persons were included in the population. No contact was made with the patients who declined to have family or support person involvement with their care, and this was annotated in the patient's electronic chart.

Setting

Macrosystem

The South Texas VA medical facility was situated in a robust medical center in San Antonio (zip code 78229) and served more than 114,000 veterans across South Texas. The

medical facility was one of two medical facilities under the South Texas Veterans' healthcare system. The facility had a 24-hour emergency department and provided a wide variety of healthcare services, including mental health, women's health, LGTBQ+ care, prosthetics and rehabilitation, nephrology, dental services, treatment for spinal cord injury, bone marrow transplant, and more. The South Texas healthcare system serviced 15 locations, two medical facilities, and 13 community-based outpatient clinics, with one mobile clinic. The South Texas Veterans Health Care system was one of the leading healthcare systems serving veterans in the VA Heart of Texas Health Care Network. An innovative center within the Veterans Integrated Service Network (VISN 17), it included medical centers in Texas and New Mexico.

Microsystem

A microsystems assessment was conducted at a South Texas VA medical facility, inpatient mental health units from October 2022 through December 2022. The mission of the South Texas Veterans Mental Health Services was to "improve the mental health and quality of life of our veterans by providing appropriate, compassionate, quality care using a veteran-centered, holistic approach. On occasion, proudly serves the local active-duty population." The inpatient units were a closed unit and had 19 beds on the male wing and six beds on the female wing, totaling 25 beds. Each unit provided four 15-minute fresh air breaks and various types of group therapy throughout the day.

Population

The mental health inpatient population comprised both adult male and female housed on separate, locked units. The inpatients presented with mental health diagnoses, including but not limited to depressive disorders, posttraumatic stress disorder (PTSD), psychotic disorders (e.g., schizoaffective disorder, schizophrenia), bipolar disorder, and substance use disorders. The

microsystems assessment revealed several opportunities for improvement. There was minimal communication between the inpatient and outpatient mental health teams regarding the treatment plans for discharged patients. Smith et al. (2020) found that patients were more likely to attend their post-discharge appointments when their inpatient provider discussed their care with their outpatient provider prior to discharge.

Project Interventions

Staff Training

The staff in both the inpatient units were trained on the facilities PDE-1 metric score, and the purpose and goals of the DNP project. Additionally, training was provided from AHRQ and associated tools and resources. Training was conducted with all staff during shift change, morning huddles, on an individual basis, and via electronic mail until all were educated on the project objectives and goals. The presentation was also sent via electronic mail to the assistant nurse manager for staff to use as a reference. To encourage active participation and to prepare the patients for discharge, AHRQ Discharge Checklists were included in patient admission packets. Staff were educated on the purpose of "Taking Care of Myself: A Guide for When I Leave the Hospital" and instructed to disseminate to all patients upon admission, and to review with patients throughout their inpatient stay.

Two separate meetings were held with the PSSs (management and staff) to discuss the plan forward with the integration of the PSS program into the mental health inpatient sectors and how to generate referrals. I was also educated on the PSS program and provided resources to reinforce training with members of the healthcare team. PSS program training was also provided to medical providers on Team A to increase their awareness and knowledge regarding the ordering of referrals. The lead PSS also educated the mental health providers from Team A on

how to place referrals in the hospital's computerized patient record system (CPRS). My contact information was shared with all parties in the event there were additional questions or concerns.

Individual training was also conducted with the lead social worker and the three inpatient social workers assigned to inpatient mental health services to discuss the necessary collaborative effort needed to improve post discharge engagement. Training was executed in 2 days.

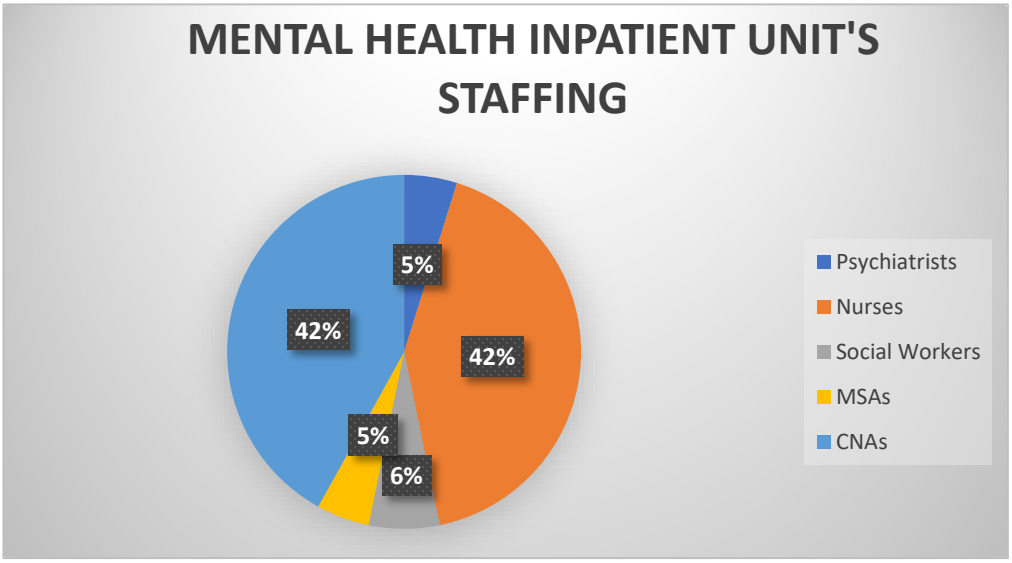
Physicians were educated on all aspects of the DNP project as well as their specific roles as it pertained to improving the transition of mental health patients from hospital to community through the utilization of peer support specialists, screening patients for LAIs as opposed to oral antipsychotics, and family/support person engagement. Physicians were educated on their role with the discharge process as well as the overall benefits to improved discharge engagement. The presentation was first conducted in person with the attending physician, followed by the resident interns and medical students. The providers reviewed the information and documented in the CPRS that family engagement and psychoeducation was performed. If a patient declined to list a family member/support person, or accept a LAI, this too was annotated in the patient's chart. Due to limited PSS resources, efforts for data collection were concentrated on the mental health providers assigned to medical Team A.

The key to success in implementing the interventions were the social workers, peer support specialists, and mental health providers at the VA. From the beginning, the staff demonstrated an understanding of the problem that the VA is currently facing and the ramifications, if left uncorrected. Additionally, in the beginning of the project the staff demonstrated a willingness to participate in interventions to enhance health care delivery and improve patient outcomes. From the inception of the project, this quality improvement project was designed to better meet the needs of mental health patients being discharged and identify

areas of weaknesses to improve post-discharge engagement. Collectively, most of the staff demonstrated a readiness for change and a positive and receptive outlook on the project and specified interventions.

Figure 1

Demographics on Mental Health Inpatient Staffing Make-Up



Note: From employee records (data collected from Nursing Management)

Patient, Family, and Support Person Engagement and Psychoeducation

There were three psychiatrists assigned full time to the inpatient mental health units. Each psychiatrist had his/her own social worker and a team of residents and medical students assigned to their team. They collectively worked together to ensure stabilization of the mental health patients from the moment they were admitted up until their discharge. Each team was educated on evidence-based practices and current literature supporting enhanced discharge engagement of mental health patients. Utilizing the IDEAL Discharge planning, overview and checklist, the provider's teams were educated on the principles of family/support person engagement and the key components to include during family psychoeducation: Describing what life at home will be

like; Medication review; Discussion on adverse effects and signs/symptoms to return to hospital; Explanation of labs/ tests results; and Follow up appointments dates/times. An opportunity for questions were provided and all demonstrated a good understanding and a willingness to support. Training was provided to all three psychiatrists via Microsoft Teams during their monthly scheduled provider meetings. Training to the residents and medical students assigned to Team A was performed face-to-face. Training for psychiatrists and subordinates spanned 2 days.

Increase Communication Between Outpatient and Inpatient Providers

This objective was not met due to the lack of support and lack of logistics between nursing management on both the inpatient and outpatient side. The initial recommendation was that, upon discharge, the inpatient nurse would escort the patient upstairs to the outpatient clinic to give a report to the mental health outpatient clinics. In the event the nurse was unable to leave the unit a phone call would be made to the charge nurse assigned to where the patient would receive outpatient care. However, due to the tempo of the inpatient unit, short staffing, and lack of inpatient nurse management support, this objective for communication between settings was suspended. An alternate objective, increasing peer support specialist referrals, was included to improve post-discharge engagement.

Peer Support Specialists

The VA currently only has 14 PSSs, which are utilized mainly in the outpatient clinics within the health care system. The mental health providers have not been placing PSS consultants because they were not fully educated on the availability of the service as a resource. This was compounded by the fact that PSSs were not involved in the discharge treatment plan. A total of three PSSs were educated on the DNP project goals and were asked to participate in the weekly interdisciplinary meetings. PSS attendance is essential to establish in discharge planning;

their attendance in the meetings provided them with the opportunity to familiarize themselves with the patients and obtain baseline information to follow up with when discharged. Once additional PSSs are hired by the VA, one PSS can be permanently assigned full time to the inpatient mental units to fully support the provider-referral process. For this project, one PSS was assigned to follow psychiatrist's Team A and attend their interdisciplinary weekly huddles on Thursdays. This was allowed for the project duration until an additional PSS could be hired full time.

Evaluation and Screening for LAI Suitability

Conducting medical reconciliations is a standard practice or technique used by healthcare providers and pharmacists to gather a complete and accurate list of patient's prescriptions and home medications and remedies (Redmond et al., 2018). Medication reconciliations are performed to identify discrepancies in drug regimens in different levels of care, settings, or points in time to inform prescribing decisions and ultimately keep the patients safe. Given the efficacy associated with LAIs in comparison to oral psychiatric medications, the medical teams were educated on the importance of screening for the suitability of LAIs and offering LAIs as a first line treatment for long term mood and psychotic disorders. Attitudes surrounding the prescribing of LAIs were explored to identify misconceptions and promote rapport and trust with patients so that they understood that the prescriptions were appropriate and safe. Of the 62 audited patients' charts admitted under provider A medical team, 100% of all eligible psychotic patients were screened for suitability of a LAI versus oral medication. In the event a patient declined to take a LAI, the providers offered an oral medication instead and annotated this accordingly in the patient's chart.

Table 1

Outcome Measures

Outcome Measure	Defined	Source	Implementation	Data Collection
Knowledge base of staff on unit	# of staff who attended training	Staff Attendance Record	April 15, 2023	Through August 2023
Documented screening for Long Acting Injectable	Screening and medication reconciliation by attending psychiatrist.	EMR-CPRS	July 01, 2023	Through August 2023
Engagement of Family; Comprehensive Discharge planning w/ 4 follow up appointments.	Documentation of family involvement in discharge planning	EMR-CPRS	July 01, 2023	Through August 2023
Interdisciplinary collaboration among inpatient and outpatient mental health teams	Documentation of SBAR from inpatient team to outpatient team	EMR- CPRS	July 01, 2023	Through August 2023

Note. From data collected at VA Audie L. Murphy inpatient Mental Health Units for the periods spanning October 2022-April 2023.

Ethical Considerations

This quality improvement project presented no risks to the patient population. Careful effort and planning in the execution of this project was key, so as to avoid any ethical dilemmas or concerns. I underwent a full indoctrination to be credentialed to have access to the VA's

medical record keeping systems. I completed a 4-hour mandatory training on patient privacy and earned a certificate of completion. I received a PIV card, which was password enabled for access and review of patients' medical records, all of which was done in accordance with HIPPA guidelines. With all patient interactions, I introduced myself as a student, and all contact with families was at the sole discretion of the consenting patient. Patients' records were all numerically coded, kept locked on site, and abbreviated without identifiable information.

Organizational Barriers

Stakeholders

After meeting with the inpatient nursing management staff, the DNP was told that it would not be possible to execute Objective 3, to have an inpatient nurse provide a report to the outpatient nursing staff. The nursing manager said that the nurses on the floor could not leave the unit with a patient because that would be a safety risk to the remaining staff. Additionally, it was explained to me that the inpatient nursing staff is very busy, and it would not be advisable to add another task to their day-to-day nursing operations. Nursing management also did not support the nurse's full involvement with the dissemination of discharge tools and resources from the AHRQ, as it was a responsibility traditionally held by social workers and providers.

Systems Processes

During the implementation of the DNP project there were a few barriers related to systems at the VA South Texas hospital. On the unit, there was no full-time MSA permanently assigned to the inpatient mental health units. The MSAs are staffed from the hospital-wide float pool. This made unit-wide training on the establishment of patient appointments inconsistent and challenging. The process in which the patients were given discharge instructions was not effective, as the patients are not included in the discussion on dates and times for follow up.

After the provider placed the order for discharge, the MSA booked the required appointments, printed the appointment slip, and handed the paperwork over to the nurse to give to the patient prior to leaving the unit. Patients were not consulted on whether those days would work with their personal schedule. Furthermore, the inpatient mental health unit prohibited visitation. Therefore, although not ideal, the engagement took place primarily over the phone.

Organizational Facilitators

DNP Project Mentor

The DNP project mentor was identified as a key facilitator in the successful implementation of the DNP project. From the start, the DNP project mentor was very knowledgeable about the VA healthcare system and provided historical data and additional context to the extent of the problem. Over the duration of the DNP project, the DNP project mentor was highly regarded among the staff and was a reliable resource for me and paved the way forward for collecting information and providing key introductions to key personnel and stakeholder meetings.

Social Workers

The inpatient social workers were the backbone of the discharge process and worked tirelessly towards ensuring adequate transition of care following discharge. Their support of the DNP project was made very clear on day one. They were receptive to all recommendations and agreed with the need for improvement on the previous longstanding discharge process.

Peer Support Specialist

Another facilitator of the DNP project's success was the PSS. Given the limited number of PSSs, they understood the importance of re-engaging with mental health inpatients. Their

ongoing training efforts, patience, and collaboration with interdisciplinary health care team members was instrumental in the attainment of the DNP project goals and objectives.

Psychiatrist

The inpatient psychiatrist on medical team A was highly supportive of the DNP project's objectives, goals, and interventions. The medical team A provider allowed me to follow her team and observe the interaction processes between the providers and the mental health patients and agreed to have her team serve as the inaugural team for the inclusion of a PSS.

Results

Objective 1: Staff Education

The project objective of training 100% of the inpatient mental health staff (e.g., unit clerks, nursing staff, medical staff, social workers) by May 1, 2023, was partially achieved. Although 100% of staff was trained on the project's goals, objectives, and purpose, training continued beyond May 1, 2023, with the remainder of staff training completed by May 5, 2023. The objective was largely met due to the use of various teaching modalities. Staff huddles during shift changes, PowerPoint training, and leveraging of swing shift nursing staff helped execute training with maximal participation. Variances in the staff's schedules (e.g., paid time off, vacation, sick leave) and my schedule, along with the needs of the patients and unit, conflicted with completion of training by the initial deadline.

When devising a plan for project implementation, it was originally anticipated that inpatient mental health staff could be trained during a 30-minute educational training session at various training times and days. However, nursing management said that the tempo of the floor did not support nursing staff attendance at the training. An alternative approach was to meet the nursing staff at shift changes during morning huddles however, training was brief due to the

demands of patient care. Additional training (e.g., PowerPoint slides, resources) was submitted to the assistant nurse manager for dissemination to the entire nursing staff. Training of the psychiatrists was provided virtually via Microsoft Teams at the monthly mental health providers' meeting. Training slides were included on the agenda and therefore made available to all VA south Texas mental health providers in the event they were not able to attend the Microsoft Teams meeting. This type of training was easier to execute because the time had already been built into the provider's schedule, unlike the nursing staff, where meetings are seldom held if at all.

Table 2

Breakdown of Inpatient Staff Attendance at Training

Staff	*Training Day 1*	*Training Day 2 (Make up)*	*Total*
Psychiatrists	*2*	*1*	*3*
Nursing	*12*	*14*	*26*
CNAs	*12*	*14*	*26*
Social Workers	*4*	*0*	*4*
MSA	*3*	*0*	*3*

Note. From attendance records (data collected on inpatient unit attendance).

I educated the nursing staff regarding observations from microsystem assessment as well as on recommendations for quality improvement. Education included reminders on how to discuss discharge appointments dates, times, and locations with the patient to ensure adherence to treatment plan and follow up. The nursing staff were also educated on the importance of providing a rationale on the number of discharge appointments to the patients. Good comprehension and verbalization were demonstrated with every nursing staff member.

Objective 2: Patient, Family, and Support Person Engagement

The goal of 100% of patient, family, and support person engagement was not attained. As chart audits revealed, 94% of patients had family/support person contact and engagement. Although 94% of patients were contacted, full engagement utilizing the AHRQ resources was limited. Findings revealed that shortly after project implementation, nursing staff compliance was low regarding the dissemination of the AHRQ resources and tools. Therefore, patient, family, and support person engagement were lower and not accounted for. This was largely attributed to the lack of enforcement from the inpatient nurse managers. Despite buy-in and support from stakeholders and leaders, the inpatient nursing managers cited "lack of time" and "heavy workloads" as reasons for not fully engaging patients, families, and support persons in the discharge process utilizing the recommended AHRQ tools and resources. The nursing staff also stated that they did not receive sufficient training on the tools and reported a lack of clear delineation of roles. As one staff member asked, "Who is responsible for doing what, exactly? Nursing, psychiatrists, or social workers?"

Objective 3: Increase PSS Referrals

At the VA, peer support supervision was an important factor in ensuring the overall effectiveness of the program by providing formal and informal training, EMR progress note monitoring, time and resource management, clinical supervisor input, and constructive feedback to the PSS, ensuring they were providing care that was in the very best interest of the patient's recovery. Patients who are ideal candidates for peer support services are those who are not severely mentally ill, dealing with chronic conditions, and consent to services.

Prior to project implementation, referrals to PSSs were not consistently placed by providers. On May 8, 2023, once the three inpatient psychiatrists and medical teams (comprising

medical students and residents) received education and training on the DNP project's goals, objectives, and overall purpose, compliance and willingness to place referrals to PSSs increased from 0% to 3%. Upon review of the 62 chart audits that were conducted on Team A, there were 18 eligible patients who were not placed for referral. Documentation did not specify as to the reasons for the lack of referral placement, which possibly stemmed from provider oversight, patient refusal, or inconsistency among providers. Follow-on education is recommended to ensure continuity in training and documentation of medical providers, as residents and medical students rotate on various clinical schedules throughout the calendar year. Additionally, the VA has implemented efforts to increase the number of PSSs available and to dedicate at least one to the inpatient units full time. As of August 2023, a PSS has been incorporated into the patient's daily treatment plan, weekly every Tuesday, and meets with the patients for introductions, overview of services offered, and review of expectations following discharge. The project also allowed for the inclusion of a PSS in the weekly interdisciplinary discharge (IDT) meetings. Results indicated that there was a 97% attendance rate at weekly IDT meetings, with the 3% absences noted very early during the implementation phase. Due to the limited number of PSSs available, the sole PSS followed provider A's team of patients for the duration of the project. On August 1, 2023 direct observations of the PSS group, questions were raised to patients receiving PSS services, and feedback largely conveyed that the PSS was a great adjunct to the patient's mental health treatment plan and would aid with post-discharge engagement.

Objective 4: Evaluate Patients for Long Acting Injectables Administration

Objective 3's goal that 100% of eligible patients will be evaluated for suitability and tolerability of LAIs was largely successful and met. Buy-in from providers was largely present, as many were already familiar with the latest recommendations on best practices from the American Psychiatric Association on the appropriate inpatient management of chronically

psychotic patients with severe mental illnesses. Providers incorporated standardization in the screening of patients and offered LAI as a first line treatment option for chronically psychotic patients. Given the demographics of the patient population, 56% of patients admitted under inpatient psychiatric services had a psychotic disorder. Over the 11 weeks of the DNP project timeline, chart audits revealed that 92% of patients were placed on a LAI versus receiving oral medication. My observations of the provider intake process revealed that 100% medication reconciliation was conducted and documented in CPRS. The reasons for not electing a LAI were documented in CPRS; the reasons for not taking a LAI were largely due to patient preference as opposed to provider omission.

PDE-1 Score

In Fall 2022, during DNP project assessment and planning, the hospital initiated a working group to help increase engagement of mental health patients at discharge. At the time, post-discharge engagement (PDE-1) metric was 67.66%. The FY-23 Quarter 1 PDE-1 remained relatively unchanged at 67.71%. The Quarter 2 PDE-1 metric had improved slightly to 69.3%. The result from FY-23 Quarter 3 was 72.72%, which revealed a 5.06% increase in the PDE-1 metric from the inception of the project. The PDE-1 metric for Quarter 4 remains pending.

The goal of increasing the PDE-1 metric to 85% or higher by August 2023 was not met; however, quarterly results in the PDE-1 metric have been trending upward since the inception of the DNP project. FY-23 Quarter 3 results accurately capture the DNPs project's performance, as they correlate with the DNP project timeline of interventions.

Figure 2

Continuity of Care Composite: PDE-1 Data Chart

% Inpatient and residential MH discharges with outpatient MH care engagement within 30 days post-discharge. Measure includes Cerner data from FY22Q4 onwards	pde1 Cerner*	(V17) (671) San Antonio, TX HCS	67.66%	67.71%	69.3%	72.72%

Discussion

Limitations

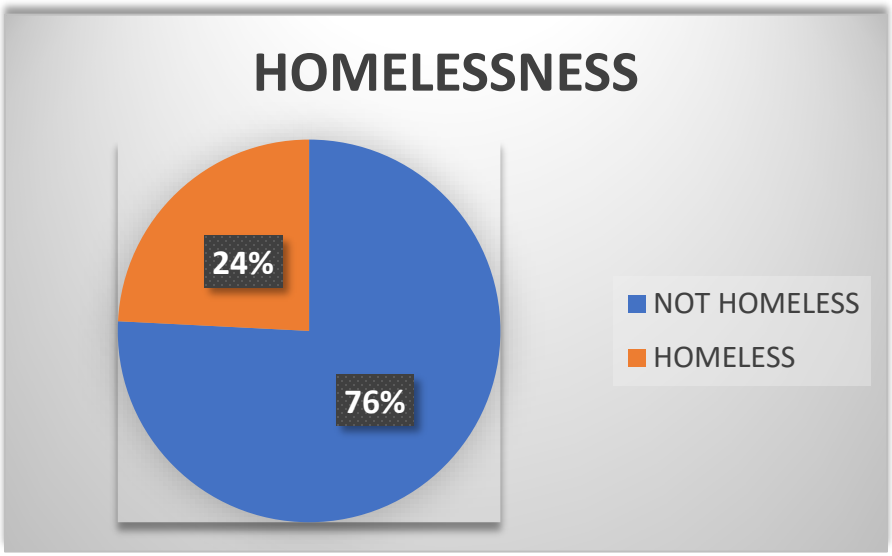
The most notable limitation was that some of the mental health patients admitted to the inpatient units did not provide a family or support person in their chart as a point of contact. The factors were attributed to fractured familial relationships or prolonged periods of minimal or no contact with family/support persons. Other factors included serious mental illnesses and conditions (e.g., acute psychosis and/or intoxication from substance use) whereby patients were unable to articulate e a functional contact number to contact family/support person. Therefore, staff were unable to include the family or support person with discharge engagement.

Homelessness was another limitation of the project, as it represented approximately 25% of the mental health inpatient population on both the male and female units. Patients who were homeless were more likely to become disengaged after discharge and seek hospital admission through the emergency department during times of interpersonal hardships, physical illnesses, and inclement weather. This problem was compounded, as they were without a phone or reliable mode of transportation. Consequently, this made it difficult for engagement, particularly for homeless patients, because once the patient was discharged from the facility, there was no means

of contact for follow up and reminders. Patients suffering from homelessness were not excluded from the data collection, which impacted results on engagement post-discharge.

Figure 3

Homeless Demographics of Patient Population



The attitudes of some staff members could be described as pessimistic, or non-supportive of initiatives associated with the project. Although staff agreed that family engagement and an early and interactive discharge process was necessary, many still felt as though the patients would remain non-compliant with treatment plans and still use the emergency department and readmissions as the sole and primary method to get medication management and various resources. Additionally, inpatient nursing management did not support nursing staff involvement in patient and family engagement. They felt as though this was a provider and social worker responsibility. Management also expressed that the nursing staff were very busy, stretched thin, and that having them teach patients on the Taking Care of Myself at Home Guide from the AHRQ would be an extra stressor, with lack of consistency in implementation.

Another limitation stemming from the training of staff was the rotation schedule of the medical students and the residents. Prior to project implementation, the medical students and residents assigned to impatient psychiatric services were trained on the DNP projects goals, objectives, and interventions. During project implementation, as part of their medical training, the residents rotated to other clinical areas and there was a lack of compliance with project goals. Furthermore, the unit clerks were not permanently assigned to inpatient psychiatric services. The hospital rotated them to various units in the hospital from a resource pool. There was inconsistency in adhering to DNP projects goals (e.g., obtaining demographic data on patients and family, inclusion of AHRQ discharge resources in admission packets, ordering follow up appointments within 30 days as appropriate).

The biggest limitation stemmed from the fact that there were a limited number of PSSs at the VA hospital. Therefore, a PSS could not be assigned to the inpatient unit on a full-time basis. Because of the lack of incorporation of the PSSs in the treatment plan of inpatients, they were not being referred to the services nor were they being followed in the outpatient network. To mitigate the shortage of PSSs, we focused on utilizing their services to one provider for the duration of the project. At the beginning of the project, they were invited to attend IDT huddles and began following patients once discharged. Additionally, the turnover of medical students and residents in rotation interfered with referral placement. Many of the residents and medical students rotated on various schedules unique to their program and year group. Additionally, new interns and residents arrived to the unit on July 1, 2023, which negatively impacted the placement of referrals as many of the new medical students and residents were not well versed on the DNP project objectives and process.

This PSS service has proved to be beneficial with the engagement of mental health patients and increasing post discharge attendance. It is my hope that more funding and allocation of resources are made available to have a PSS available to provide support to the inpatient units on a full-time basis.

Recommendations

During the project implementation, to improve quality of care and engagement after discharge, and reduce preventable readmissions, it is recommended that ongoing education and training be held on the units to ensure that all nursing staff, including MSAs, are aware of the hospital-wide problem with post-discharge engagement. Data and updates to the PDE-1 metric should be shared with all staff on a monthly or quarterly basis to encourage adherence to evidence-based practices and increase knowledge on resources that support patient and family engagement upon discharge. Training on the utilization of resources from organizations such as the AHRQ, like the Transition from Hospital to Home: IDEAL Discharge Planning Tools engage patients and family for preparing for discharge to home.

Additionally, it is recommended that funds should be allocated to hire a full time PSS to be assigned to inpatient mental health services for ongoing referrals and outpatient follow-up. PSSs provide a diverse and broad level of support by engaging in shared experiences with the patient, leading to trust and engagement. PSSs can provide a wide range of ongoing support for many mental health patients, including older adults, youth/adolescents, individuals with disabilities, and patients with substance use disorders. In two concurrent studies, a significant increase in quality of life, satisfaction, reduction of rehospitalization rates, and reduction in the number of hospital days were recorded when adding PSSs to the patient's treatment plan (Shalaby & Agyapong, 2020).

Furthermore, additional funds should be allocated towards the acquisition of a full-time discharge coordinator. A discharge coordinator is primarily responsible for the planning and coordination of patient discharges from the hospital. He or she works with patients, families, and hospital staff to ensure that all discharge planning needs are met and that patients are discharged in a timely and safe manner. A discharge coordinator can alleviate some of the responsibilities of the nurses on an inpatient mental health unit by ensuring that the discharge process happens early, and that the family/support person engagement is occurring. They can also work closely with social workers and mental health providers to ensure that all necessary resources are addressed prior to leaving the hospital. Lack of adequate care coordination can result in increased healthcare costs, which can be incurred through increased length of stay, increased/unnecessary use of resources, returns to the emergency department, or readmissions to the hospital (Bajorek & McElroy, 2020). The primary goal of care coordination is to ensure that the patient receives the highest level of quality care possible. The more complex and fragmented the needs are, the greater the need for care coordination.

Assigning full time core MSAs to the inpatient mental health units will help to reduce variance in the way patients' appointments are scheduled. Additionally, it is recommended that patients are involved with the establishment of follow-up appointments to ensure there are no unforeseen schedule conflicts that might impede attendance at discharge appointments. It is also recommended that nursing management revisit their restriction on outside visitors to the inpatient unit. This restriction was put in place during the COVID-19 pandemic; however, all other units allow outside visitors. Allowing for visitors will directly support the patient in their recovery and reinforce discharge teaching. A particular focus along the continuum of care is the coordination of resources and services provided by a healthcare organization to meet the ongoing needs of

patients. This includes referrals to appropriate community resources and leveraging other members of the healthcare team to include the patient's primary care manager, other healthcare/ nongovernmental organizations, and community services. Mental health inpatients have very complex needs and present with a variety of complex medical and psychosocial needs and need a care manager directing their outpatient care, starting with admission. Care coordination is important to support the patient in their ability to manage their own care processes to include attendance at follow-up appointments once discharged.

Sustainability

Sustainability of the DNP project interventions is possible for the VA South Texas medical facility and efforts are currently ongoing beyond the DNP project to improve discharge engagement. To maximize the improvement of the interventions beyond the project timeline, leaders and various stakeholders must leverage their platform and continue to emphasize the importance of comprehensive discharge planning for patients discharged from inpatient mental health services. Advocating for additional funding for various positions to include a full-time PSS, an RN discharge coordinator, and a nurse educator will be essential towards standardizing the discharge process and improving communication between inpatient and outpatient services.

The nurse educator is vital to the sustainability of the DNP project's objectives as he/she will provide ongoing training for the staff in the discharge planning process. The training provided will ensure successful implementation and compliance with best practices, including AHRQ discharge resources. Ongoing training will alleviate anxiety and negative attitudes towards change, as a majority of nursing staff felt as though they needed more time and training to be comfortable. Lastly, hiring a full-time auditor to assess the quality of discharge process is

paramount in the identification of gaps in the delivery of care. Auditors and quality managers can provide consistent feedback to the nursing staff in real time for sustainability of the DNP project.

Implications for Practice

The implementation of the specified interventions enhances the current provider's practice and sets the patients up for successful discharge engagement. Healthcare team members who are educated on the importance of engagement of patients, family, and support persons with the discharge process can better support patients and their family with successfully navigating their transition from an inpatient hospital setting to the community. For nurse practitioners, conducting thorough health and physical assessments along with medication reconciliations are a large part of clinical duties while serving specific patient population. Thoroughly evaluating all chronically psychotic patients to determine suitability and safety for prescribing LAIs has the propensity to improve treatment adherence, post-discharge follow up attendance, and the patient's overall quality of life. Advanced practice registered nurses are directly responsible for managing the care of patients. It is their legal duty to uphold the principles of biomedical ethics, which includes beneficence and non-maleficence. They owe it to their patients to deliver high quality care every time, using the latest evidence-based practices and recommendations. Failure to do so can lead to poor patient outcomes and cause irrevocable harm to the community at large. Incorporating the outlined objectives and associated interventions will increase post-discharge engagement of mental health patients, thereby improving patient health outcomes. Furthermore, successful implementation of this DNP project will reduce healthcare costs through better utilization of hospital resources. This DNP project has wide-ranging applicability not just for patients assigned to the VA South Texas Healthcare System but also for mental health patients globally.

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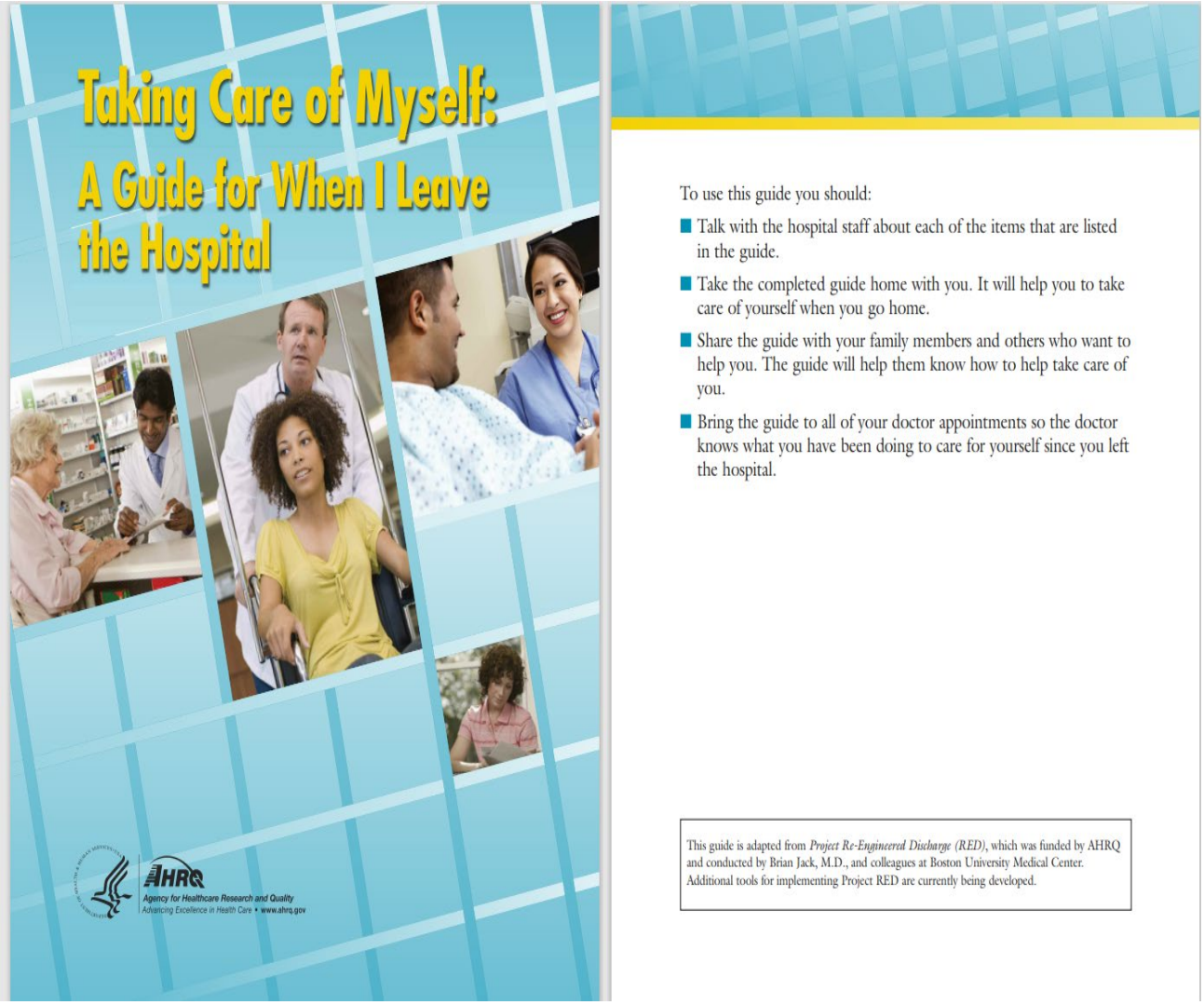
Appendix A

Staff Training Plan

Project Objectives	Content Outline	Method of Instruction	Time Spent	Method of Evaluation
Understand the importance of improving post discharge engagement	- Review current PDE-1 Score and VA benchmark - Impact of poor discharge engagement on MH patients and community at large.	Presentation/Discussion/ Question & Answer	5 mins	Teach back, verbalization
Understand the evidence base practice recommendations on improving post discharge engagement	- Explain the benefits of patient, family, and support person engagement - Discuss PSS as a resource and its advantages. - Review APA's recommendations on LAIs for the management of chronically psychotic patients.	Presentation/Discussion/ Question & Answer	5 mins	Teach back, verbalization
Understand each individual role in preparing patients for discharge and communicating and reinforcing the appointments with families	- Describe individual roles in increasing engagement (e.g., facilitating appointments, usage of AHRQ resources and involvement of families, placement of referrals, etc.).	Presentation/Discussion/ Question & Answer	15-20 mins	Teach back, verbalization

Appendix B

AHRQ Taking Care of myself at Home guide pgs 1-2.



Taking Care of Myself:
A Guide for When I Leave the Hospital

AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

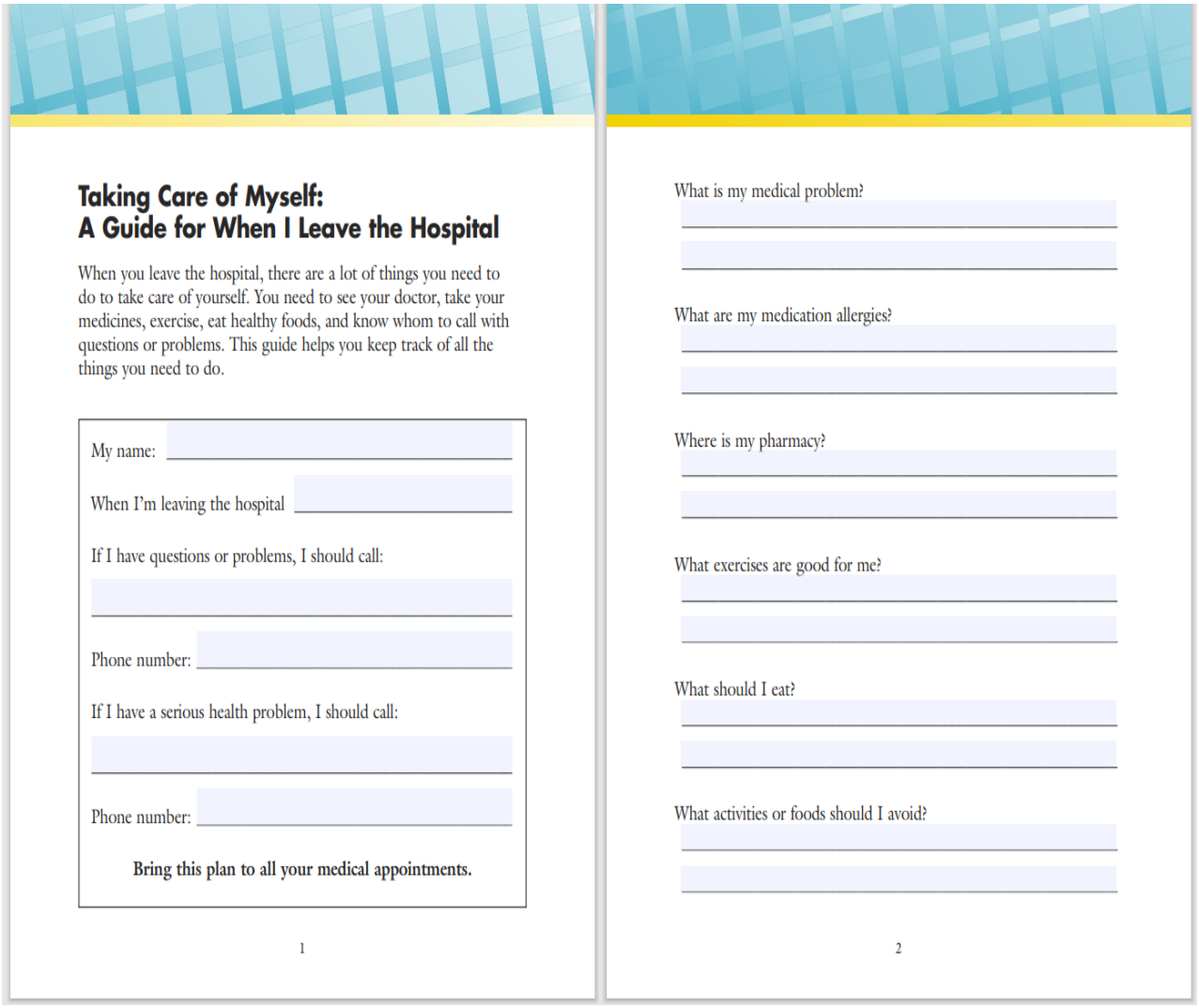
To use this guide you should:

- Talk with the hospital staff about each of the items that are listed in the guide.
- Take the completed guide home with you. It will help you to take care of yourself when you go home.
- Share the guide with your family members and others who want to help you. The guide will help them know how to help take care of you.
- Bring the guide to all of your doctor appointments so the doctor knows what you have been doing to care for yourself since you left the hospital.

This guide is adapted from *Project Re-Engineered Discharge (RED)*, which was funded by AHRQ and conducted by Brian Jack, M.D., and colleagues at Boston University Medical Center. Additional tools for implementing Project RED are currently being developed.

Appendix C

AHRQ Taking Care of myself at home guide pgs. 3-4.



Taking Care of Myself:
A Guide for When I Leave the Hospital

When you leave the hospital, there are a lot of things you need to do to take care of yourself. You need to see your doctor, take your medicines, exercise, eat healthy foods, and know whom to call with questions or problems. This guide helps you keep track of all the things you need to do.

My name: _____

When I'm leaving the hospital _____

If I have questions or problems, I should call:

_____

Phone number: _____

If I have a serious health problem, I should call:

_____

Phone number: _____

Bring this plan to all your medical appointments.

1

What is my medical problem?

_____

_____

What are my medication allergies?

_____

_____

Where is my pharmacy?

_____

_____

What exercises are good for me?

_____

_____

What should I eat?

_____

_____

What activities or foods should I avoid?

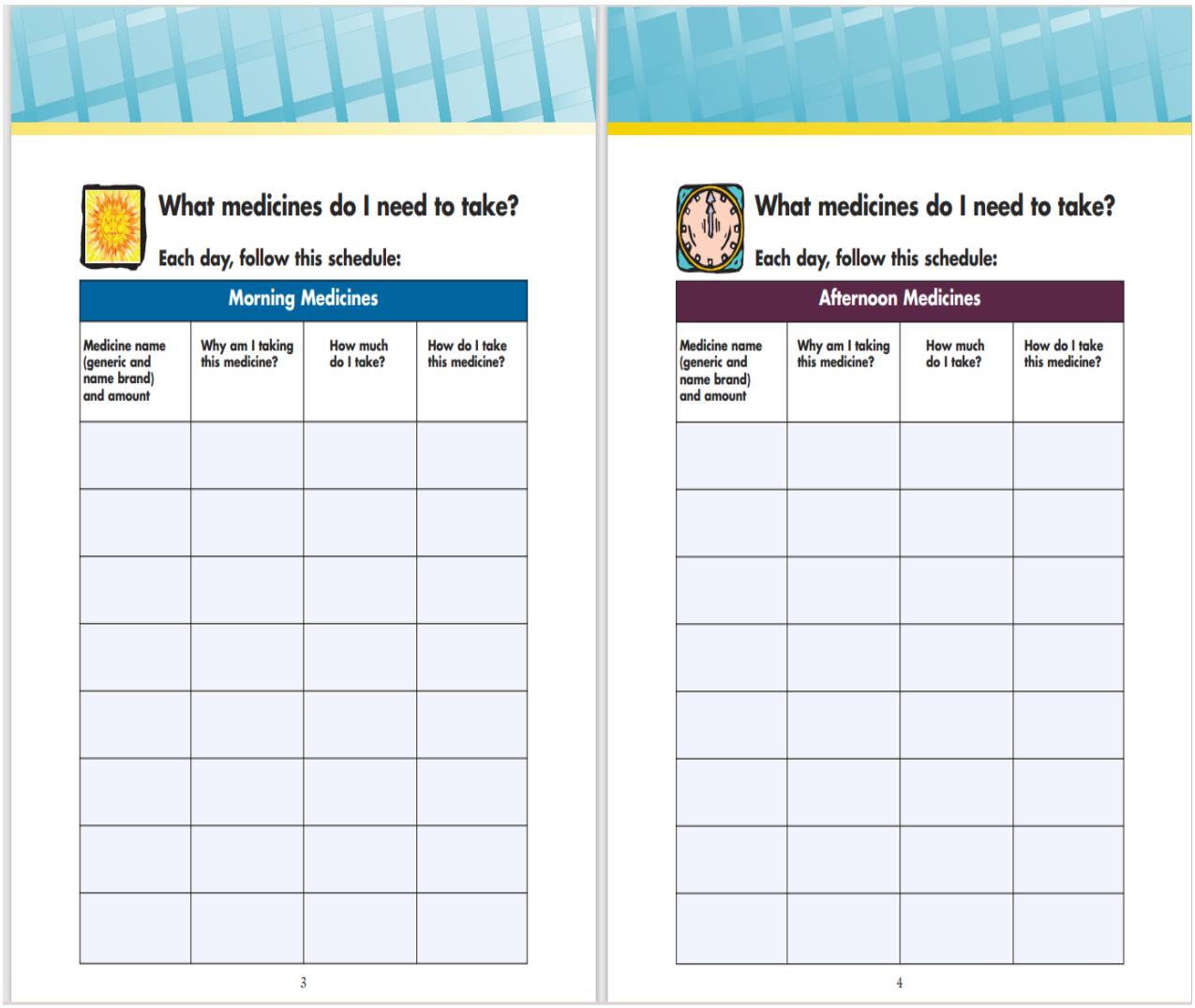
_____

_____

2

Appendix D

AHRQ Taking Care of myself at Home guide pgs. 5-6.



What medicines do I need to take?

Each day, follow this schedule:

Morning Medicines

Medicine name (generic and name brand) and amount	Why am I taking this medicine?	How much do I take?	How do I take this medicine?

3

What medicines do I need to take?

Each day, follow this schedule:

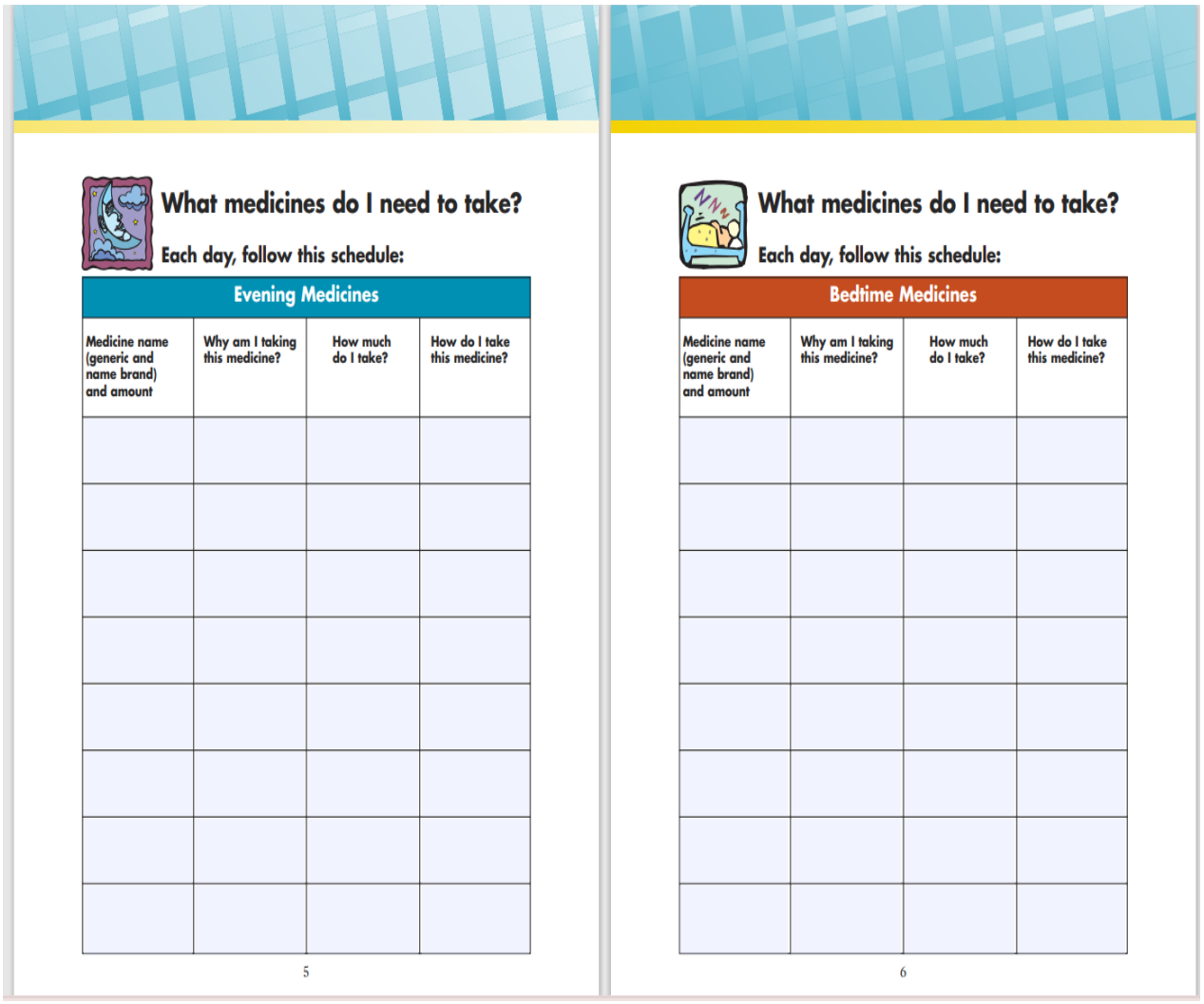
Afternoon Medicines

Medicine name (generic and name brand) and amount	Why am I taking this medicine?	How much do I take?	How do I take this medicine?

4

Appendix E

AHRQ Taking Care of myself at Home guide pgs. 7-8.



What medicines do I need to take?

Each day, follow this schedule:

Evening Medicines

Medicine name (generic and name brand) and amount	Why am I taking this medicine?	How much do I take?	How do I take this medicine?

5

What medicines do I need to take?

Each day, follow this schedule:

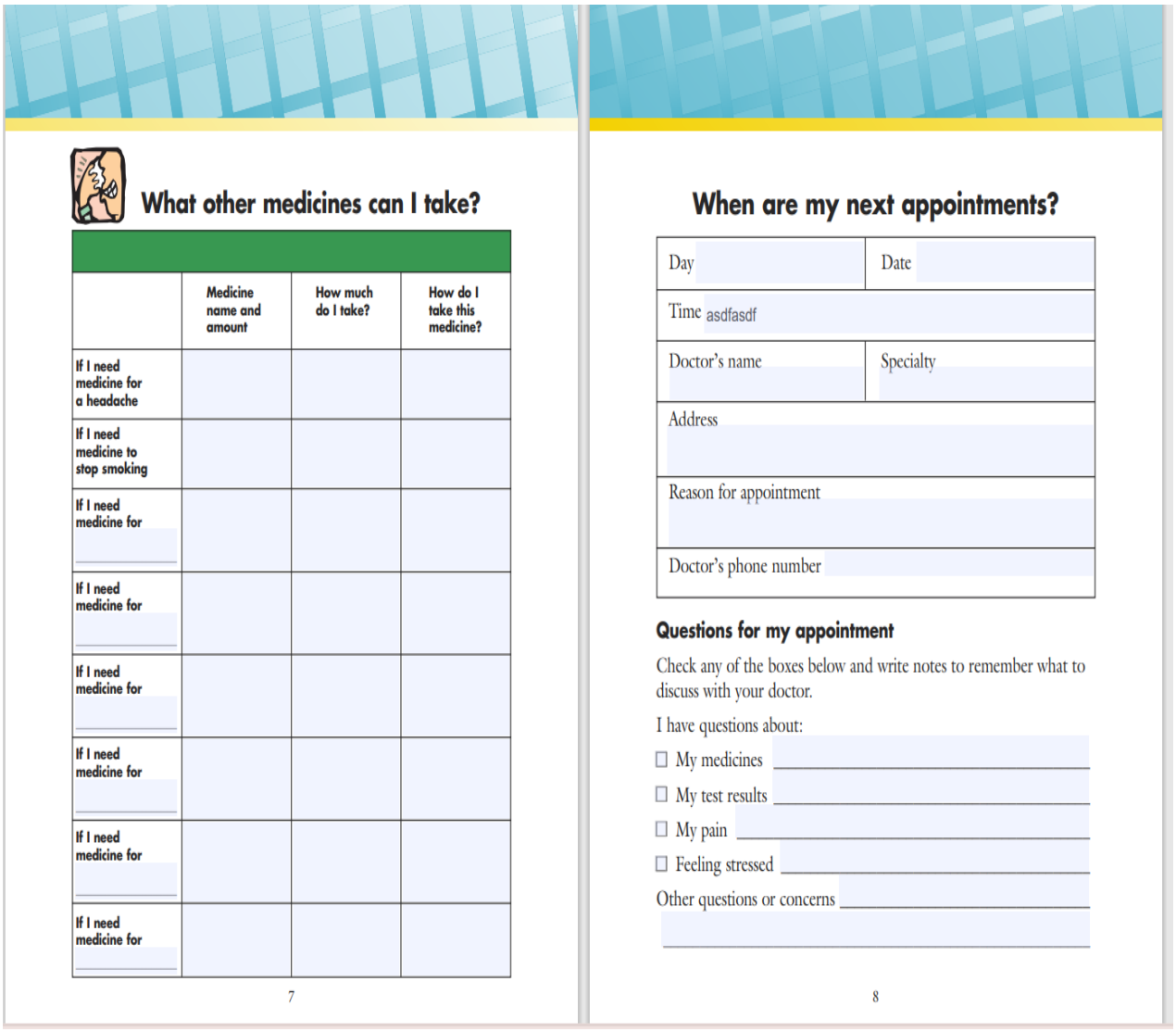
Bedtime Medicines

Medicine name (generic and name brand) and amount	Why am I taking this medicine?	How much do I take?	How do I take this medicine?

6

Appendix F

AHRQ Taking Care of myself at Home guide pgs. 9-10.



What other medicines can I take?

	Medicine name and amount	How much do I take?	How do I take this medicine?
If I need medicine for a headache			
If I need medicine to stop smoking			
If I need medicine for _____			
If I need medicine for _____			
If I need medicine for _____			
If I need medicine for _____			
If I need medicine for _____			
If I need medicine for _____			

7

When are my next appointments?

Day	Date
Time asdfasdf	
Doctor's name	Specialty
Address	
Reason for appointment	
Doctor's phone number	

Questions for my appointment

Check any of the boxes below and write notes to remember what to discuss with your doctor.

I have questions about:

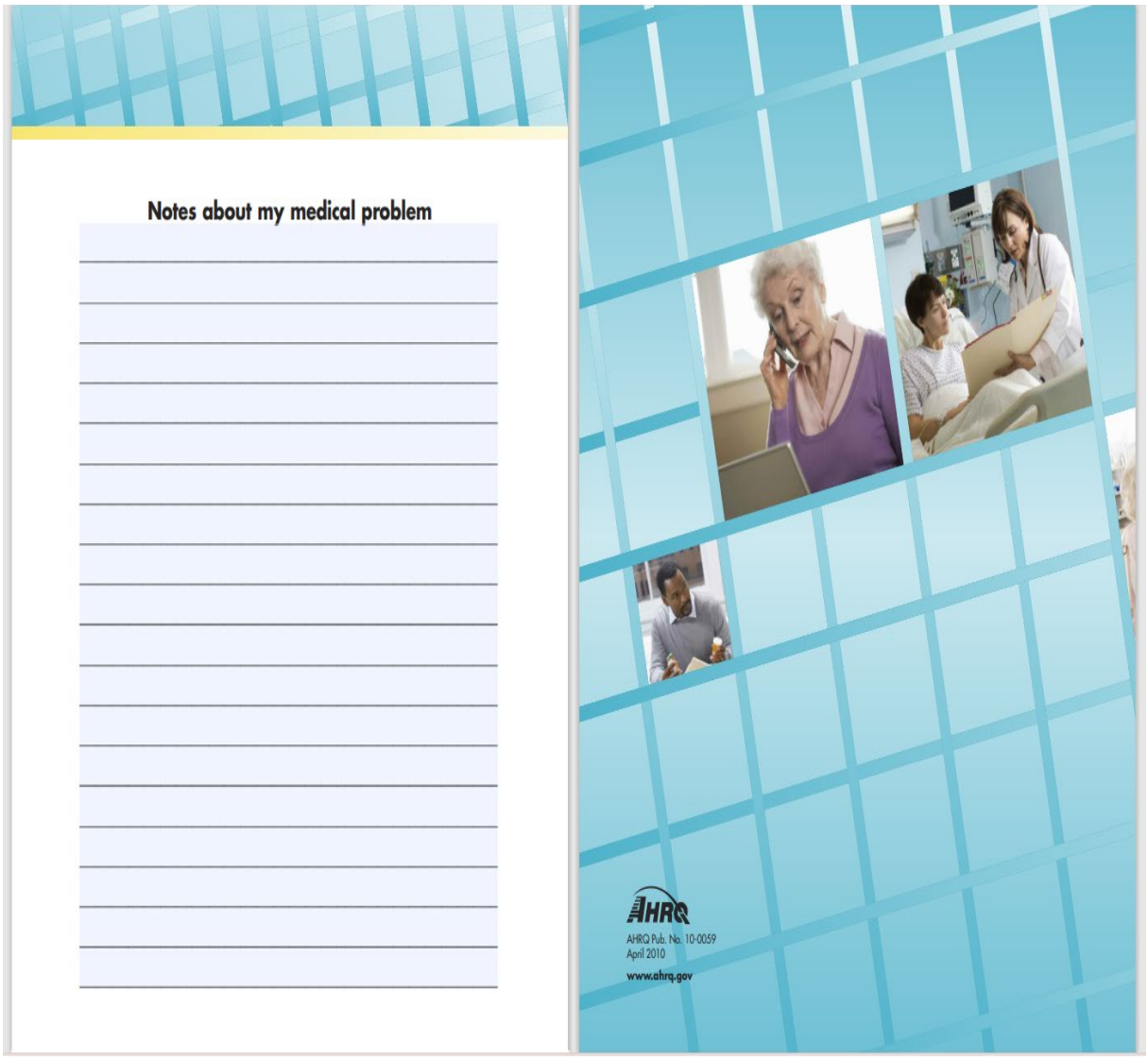
- ☐ My medicines _____
- ☐ My test results _____
- ☐ My pain _____
- ☐ Feeling stressed _____

Other questions or concerns _____

8

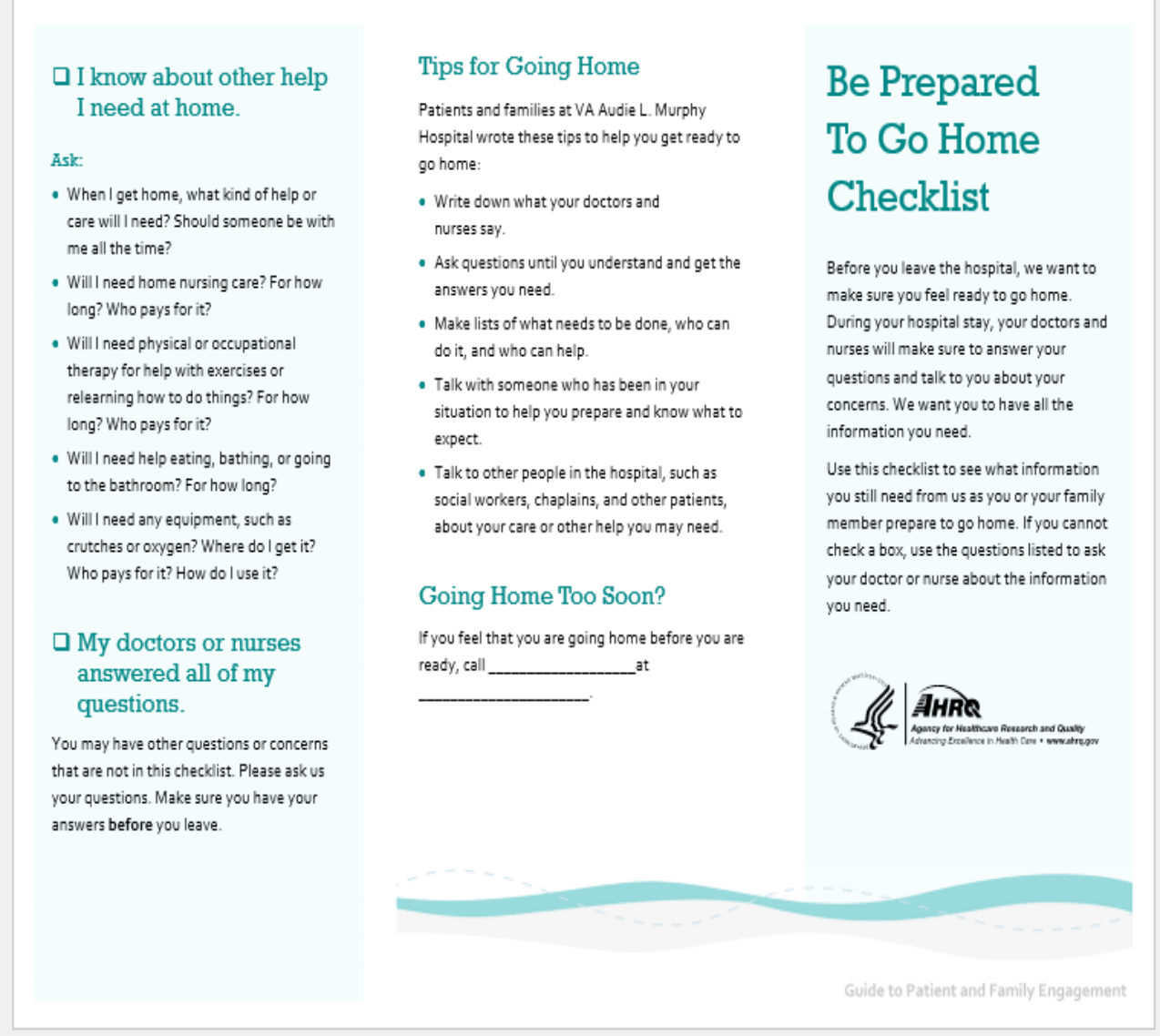
Appendix G

AHRQ Taking Care of myself at Home guide pgs. 11-12.



Appendix H

AHRQ Discharge Checklist pg. 1



❑ I know about other help I need at home.

Ask:

- When I get home, what kind of help or care will I need? Should someone be with me all the time?
- Will I need home nursing care? For how long? Who pays for it?
- Will I need physical or occupational therapy for help with exercises or relearning how to do things? For how long? Who pays for it?
- Will I need help eating, bathing, or going to the bathroom? For how long?
- Will I need any equipment, such as crutches or oxygen? Where do I get it? Who pays for it? How do I use it?

❑ My doctors or nurses answered all of my questions.

You may have other questions or concerns that are not in this checklist. Please ask us your questions. Make sure you have your answers **before** you leave.

Tips for Going Home

Patients and families at VA Audie L. Murphy Hospital wrote these tips to help you get ready to go home:

- Write down what your doctors and nurses say.
- Ask questions until you understand and get the answers you need.
- Make lists of what needs to be done, who can do it, and who can help.
- Talk with someone who has been in your situation to help you prepare and know what to expect.
- Talk to other people in the hospital, such as social workers, chaplains, and other patients, about your care or other help you may need.

Going Home Too Soon?

If you feel that you are going home before you are ready, call _____at _____.

Be Prepared To Go Home Checklist

Before you leave the hospital, we want to make sure you feel ready to go home. During your hospital stay, your doctors and nurses will make sure to answer your questions and talk to you about your concerns. We want you to have all the information you need.

Use this checklist to see what information you still need from us as you or your family member prepare to go home. If you cannot check a box, use the questions listed to ask your doctor or nurse about the information you need.

AHRQ Agency for Healthcare Research and Quality Advancing Excellence in Health Care • www.ahrq.gov

Guide to Patient and Family Engagement

Appendix I

AHRQ Discharge Checklist pg. 2

❑ I feel confident that I or someone close to me can take care of me at home.

Ask:

- How do I take care of any wounds, cuts, or incisions? Can you show me how to do this?
- What foods or drinks should I avoid? For how long?
- Are there any activities I should not do like driving, sex, heavy lifting, or climbing stairs? For how long?
- What exercises are good for me? When and how often should I do them?
- What do I need to do to make my home safer?

❑ My family or someone close to me knows I am coming home and knows the next steps in my care.

Ask:

- Will I need help when I get home? If so, who will help me? What do they need to do to get ready?
- What should I do if there is no one at home who can help me?

❑ I know what my medicines are and how to take them.

Ask:

- What medicine(s) do I need to take when I leave the hospital? Do I take the same medicines that I took before I went into the hospital?
- What is the name of this medicine? Is this the generic or brand name?
- Why do I take this medicine?
- When and how do I take this medicine?
- How much do I take?
- What does this medicine look like?
- What are potential side effects of this medicine? What problems do I need to look out for?
- Will this medicine interfere with other medicines, foods, vitamins, or other herbal supplements I take?
- Where and how do I get this medicine?
- What medicines can I take for pain? Upset stomach? Headaches? Allergies?

❑ I know what problems to look for and who to call if I have problems at home.

Ask:

- What problems do I need to watch for when I get home? If I have problems, how do I know when I should call?
- Who do I call if I have questions or problems when I get home?
- If I have questions about my care after I leave the hospital, should

  call_____

  at _____

❑ I know when my followup appointments are and how to get there.

Ask:

- What appointments do I need after I leave the hospital? Can the hospital help me make these appointments?
- Am I waiting on results of any tests? When should I get the results?
- Are there tests I need after I leave the hospital?