COMMENTARY

Reframing Hospital to Home Discharge from "Should We?" to "How Can We?": COVID-19 and Beyond

INTRODUCTION

The pressure to discharge patients from the hospital quickly has intensified with the ongoing coronavirus-2019 (COVID-19) pandemic as bed and staff availability are paramount.[1,2] In addition, patients and caregivers are eager to return home where the risk of viral transmission is less. This is especially important for older adults who are at the greatest risk for complications and mortality if they contract COVID-19.[3,4] Rehabilitation providers contribute uniquely to interdisciplinary discharge planning by providing critical evaluation of a patient's functional abilities and rehabilitation prognosis in the context of the individual's medical complexity, hospital course, psychosocial factors, and environmental features (i.e., home set-up).[5,6] The COVID-19 pandemic has retained these elements as critical to discharge planning.[7] However, there has been a major shift in perspective from which we view and make discharge decisions from "Should we discharge this person to home?" to "How can we make a discharge to home possible?" To be clear, safe and coordinated discharge planning has remained a priority during the pandemic. Some hospitalized older adults still require discharge to post-acute care facilities (e.g., inpatient rehabilitation facilities, skilled nursing facilities, transitional care units) to maximize their functional recovery before returning home. Yet, for hospitalized older adults who may be considered "on the fence" for discharge to home versus a post-acute rehabilitation facility, many rehabilitation and interdisciplinary providers have now reframed how they involve the patient and support network in the discharge planning. The purpose of this commentary is to outline a shift in the perspectives of rehabilitation providers on discharge decision-making during the COVID-19 pandemic by incorporating greater integration of caregivers in the discharge planning and increasing the use of shared-decision making approaches. If changes in the process of hospital discharge decision-making continue beyond the end of the COVID-19 pandemic, then further evaluation of their effects (intended and unintended consequences) on system, clinical, and patient-centered outcomes is warranted.

PRIORITIZING INTEGRATION OF CAREGIVERS INTO DISCHARGE PLANNING

Involving the caregiver support network has traditionally been a component of discharge planning.[5] However, the COVID-19 pandemic has led to heightened caregiver involvement due to fears associated with the hospitalized patient possibly contracting COVID-19 at a post-acute care facility. Thus, discharging home as soon as possible has become a greater priority. Many caregivers are now more willing to provide care at home following hospital discharge by means of rearranging work schedules (e.g., remote options, flexible hours), temporarily moving in with the patient, or having the patient reside with them. As a result, rehabilitation providers have increased communications with caregivers to provide a more comprehensive assessment of the patient's current functional status, detailed recommendations for ongoing rehabilitation, and intensified caregiver training on safe mobility.

UTILIZING SHARED DECISION-MAKING APPROACHES

Shared decision-making is a process by which patients and providers work together to make a decision that is aligned with what matters most to the patient.[8,9] Although patients have always wanted to return home following hospitalization, this desire has strengthened during the pandemic with the heightened fear of contracting COVID-19 outside of the home. As such, rehabilitation providers are adopting shared decision-making approaches that more deeply involve the patient at initial evaluation to better understand individual preferences, values, and circumstances in the context of a pandemic. One technique is to integrate motivational interviewing to help patients explore their goals (e.g., return home), why a goal may be reasonable or not (e.g., needs significant physical help, unable to navigate stairs), and how to achieve that goal (e.g., engagement in completing in-room exercise program and adhering to walking recommendations while hospitalized).[10,11] Linking these goals and patient capabilities at the initial rehabilitation evaluation helps the patient and providers to recognize earlier the need for caregiver involvement upon discharge to home.

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IMPLICATIONS FOR COVID-19 AND BEYOND

Caregiver involvement and shared decision-making are not new to the process of hospital discharge planning. Yet, these have each emerged as greater priorities during the COVID-19 pandemic as patients, caregivers, and providers are faced with complex discharge decisions that require timely action. Further research is needed to identify and evaluate effective, standardized approaches to hospital discharge planning in the context of the pandemic to ensure safe and cost-effective transitions of care. This may include implementing and evaluating models of care that integrate "at home" care,[12] environmental modifications,[13] paid caregivers,[14] and informal caregiver support.[15] This research can then provide the foundation for understanding and evaluating elements of pandemic discharge planning that are sustainable beyond the pandemic to improve patient-centered care and enhance patient and systems-level outcomes. The COVID-19 pandemic may provide an opportunity to re-evaluate how we view hospital discharge planning from "Should we discharge to home?" to "How can we make a discharge to home possible?"

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