A qualitative evaluation of a patient-centered intervention to decrease re-hospitalization

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Conclusion

Our preliminary data demonstrate that elderly patients with multiple chronic illnesses struggle to take active part in self-care at home post discharge. Several barriers and opportunities were identified:

lack of trustful and continued relationship with the family doctor; and insufficient information about diagnosis and treatment was seen as barriers for most participants.

Possibilities to take active part in care was enhanced by a supportive social network and patient´s (intrinsic) motivation.

Background and aim

Hospital discharge is a hazardous period of patient care. Unwanted outcomes, such as errors in medication, therapy, and in follow-up of tests and procedures are common, and patient's active participation in self-care is highly important.

This qualitative study aims to evaluate barriers and possibilities for patients with multiple chronic illnesses to take active part in self-care at home post discharge.

Method

In this study we analyze data from 13 patients with multiple chronical illnesses participating in a post discharge motivational interviewing coaching intervention (Figure 1).

The intervention starts 2-3 days after the patients have been discharged from hospital to home. The patient and the coach meet in five sessions; one face-to-face and four telephone contacts over the course of 4 weeks. The sessions were tape recorded and analyzed using inductive qualitative content analysis.

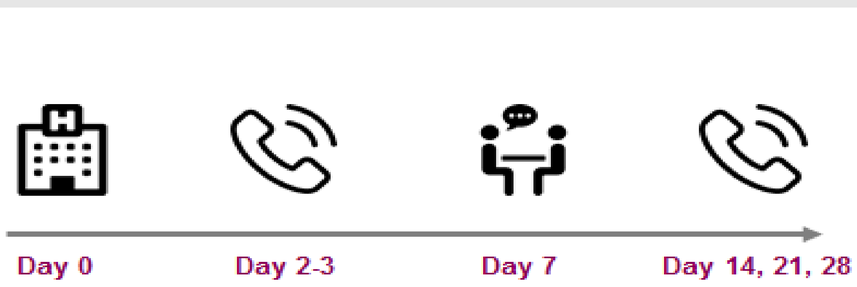

Figure 1. Timetable of the coaching sessions of the intervention.

Preliminary result

<u>Barriers for taking active part in care</u>

Some of the patients experience difficulties being involved in care due to limited information from health care staff and lack of knowledge about their situation.

A 79 year old man expressed after an ultra sound: "I don't know how many heart valve that is leaking, but I think it was more now than last time".

Several healthcare contacts, with no contact between each other, add a large responsibility on patients to coordinate their own health care.

A 71-year old woman with 7 different chronic illnesses expressed this as: "I have a heart doctor and I have a lung doctor and I have a family doctor but these three never meet"

Several patients also had to struggle with Swedish Social Insurance Agency to receive sick pay which reduces both energy and time from self-care.

<u>Possibilities for taking active part in care</u>

A social network makes it possible for patients to manage health goal and to fulfill changes in lifestyles.

Support from employer also reduces stress.

Motivation to improve health eg. by performing excercise is a possibility to affect health positively.

This study is a part of the sPATH intervention (Supporting Patient Activation in Transition to Home) . For more information on the RCT, the study protocol is available open access: <u>https://bmjopen.bmj.com/content/7/7/e014178</u>

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