Patients and caregivers value caring, continuity, and accountability in care transitions

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In the transition from hospital to home, patients and caregivers seek clear accountability, continuity, and caring attitudes across the care

continuum.

One-hundred and thirty-eight patients and 110 family caregivers participating in focus groups and interviews identified three desired outcomes of care transition services: feeling prepared and able to implement care plans, unambiguous accountability from the healthcare system, and feeling cared for and cared about by clinicians.

Five services or clinician behaviors were linked to these outcomes: providing actionable information; collaborative discharge planning involving patient and caregiver; using empathic language and gestures; anticipating the patient's need to support self-care at home; and providing uninterrupted care with minimal handoffs.

When participants' desired outcomes were realized, they characterized care as excellent and trustworthy.

In addition, caregivers experienced less distress and reported adherence to discharge plans increased.

When desired outcomes were not met, patients and caregivers felt deserted by the health care system and perceived medical care as transactional and unsafe.

Poor and fragmented care transition experiences, the authors suggest, can have substantial consequences, including creating patient and caregiver mistrust, anxiety, and confusion; precipitating family conflict; and contributing to inefficient care delivery, avoidable health system use, and delayed recovery.

To ensure that care transitions are safe and supportive of patients' recovery, the authors state that health systems must better prepare patients and caregivers for self-care at home and design accessible

means of ongoing care support when and where it is needed.

More information: Suzanne E. Mitchell et al. Care Transitions From Patient and Caregiver Perspectives, *The Annals of Family Medicine* (2018). DOI: 10.1370/afm.2222

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