Perceptions on Discharge Instructions

by Guatemalan and UVA Community Members and Clinicians

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ABSTRACT

Discharge instructions are a crucial piece to the continuum of care that patients should receive at the end of their time in the hospital and clinics. Unfortunately, many patients leave the hospital and health clinics with a limited understanding of their time in the medical center and an even worse understanding of what to expect after leaving the hospital or clinic. This paper looks at the perceptions on the discharge instructions and post-visitation summaries received from the perspective of patients and clinicians in Guatemala and at the UVA Health System. Ultimately, it was found that for patients who do not speak the native language, patients and physicians believe discharge instructions can be improved. Patients and clinicians were interviewed using qualitative surveys to learn about the current process of delivering post-visit instructions and their effectiveness.

BACKGROUND

Discharge instructions and after-visit summaries provide valuable information to patients regarding their health and the management of their health after leaving the clinic or hospital. Discharge instructions and after-visit summaries are written by clinicians and include information about the care the patient received, the medicine to be taken after the visit, follow up care instructions, and education for the patient and their family. When patients do not understand their discharge instructions, they often return to the hospital or clinic with the same problem or with a worsened condition. This usually leads to higher costs for the patient and the medical facility. While many readmissions are due to complications that cannot be prevented, proper discharge instructions could help some patients seek appropriate services instead of having to return to the hospital. It has been found that intervention by patient navigators in helping the patient navigate the healthcare system did lead to reduced readmission rates.

The UVA Health System serves not only a large and diverse Hispanic population from Charlottesville but also the surrounding counties and cities. When Hispanic community members receive medical care they often face difficulties with linguistic barriers, medical insurance, patients face when interacting with the healthcare system. Limited communication can breakdown the patient-provider relationship, which can affect the quality of patient care. Health care facilities are being increasingly challenged to care for patients with LEP. Of the 25.1 million people reporting to have LEP in the US, Spanish speakers account for 62% of the foreign language speakers. An effort to address this growth has resulted in the UVA Health System implementing ways to address language deficits by using CyraCom phones and in-person interpreters.

It is during these discharge instructions when patients...
and families have a chance to clarify hospital visits and ask about information regarding follow-up care and discharge medication concerns. Hispanic patients often times do not get this opportunity to discuss their questions and doubts. Of particular importance is how well this population can understand their prescription regimen. Instructions delivered in the English language during hospital discharge for Hispanic patients result in significantly diminished understanding of follow-up appointments and medication use [6]. In one study, Hispanic patients were found to receive less effective discharge summaries which lacked appropriate referral care [7]. Additionally, LEP patients who were given discharge instructions in English had a considerably decreased time between readmissions [8]. Thus, there appears to be a disparity among English-speaking and Spanish-speaking patients during discharge.

One method of addressing the disparity in discharge summaries has been the use of patient navigators. Patient navigators (PNs) work by bridging the gap between patients and the health care system. They function as care coordinators who facilitate communication between providers and patients and they act as caring and knowledgeable allies [9]. Research by Enard & Ganelin (2013) has shown that patient navigation can be beneficial in linking vulnerable patient populations to proper support and medical resources, decreasing care disruptions and producing a higher level of patient satisfaction. However, there have not been any studies looking at the use of a discharge-oriented patient navigator for Hispanic patients. Using a patient navigator system during the discharge process of Hispanics has the opportunity to improve Spanish speaking patients’ trust in the health system by providing knowledge, resources and respect for their linguistic and cultural differences. A discharge patient navigation system has the potential to reduce the disparities that exist in the medically underserved Hispanic community in the United States and the Charlottesville area by removing the barriers that prevent proper health care compliance and access to care [10].

In respect to the discharge process in Guatemala, the healthcare system has yet to accommodate the needs, culturally and linguistically, into the care medical staff provide to indigenous Mayan patients. During a medical visit they might receive the same information as a Spanish-speaking patient. However, the level of comprehension and information retention is not the same. There are no resources or information available in their language.
after discharge in most health posts even though the patient population is primarily the indigenous Maya. The literature says that “about 10% of discharged patients have new or worsening symptoms within days to weeks and the readmission rate is high” [11]. Because of the lack of resources and information available to them, they are more likely to come back or be readmitted to the hospital or clinic due to lack of understanding of the disease, treatment, and medication administration.

Most healthcare providers in Guatemala are Ladino (Spanish-speaking people of mixed Spanish and indigenous heritage) and rarely make an attempt to communicate in indigenous languages. On the other hand, “many Mayans are not able to communicate effectively in the country’s official language-Spanish” [12]. Since the providers do not speak their native language, many indigenous Mayans would rather choose to seek care from the folk-traditional sector. Because they do not like the way they are treated and because care is not personalized to meet their needs, they are likely to only go to a doctor if the problem is far too advanced for a folk-practitioner to treat. If the information given to them after discharge was clear and in their language, then there might be a lower readmission rate to hospitals and clinics. Also, patients might feel comfortable enough to come back for preventive care rather than acute care. In general, after-visit summaries and discharge instructions vary between clinics and between providers. This paper specifically looks at the quality of discharge instructions to patients in Guatemala and in the UVA Health System.

Photo taken in Guatemala. By Logan Haley.
involved asking the patients about their experiences during their last medical visit. In Charlottesville, participants were interviewed in the UVA waiting areas and at Charlottesville community events. Medical staff in Guatemala were interviewed when available in the aforementioned clinics and hospitals. Medical staff at UVA were identified by mentors and were contacted for availability according to IRB protocol. Interviews with medical staff were performed at the UVA Health System.

The interview instrument was developed with the help of UVA clinicians and Guatemalan mentors. It was piloted among Guatemalan community members and staff members. Through feedback, we revised questions to give participants a chance to provide open ended opinions of the discharge instructions. Interviews were jointly performed by a UVA medical student, UVA nursing student, and a Guatemalan research advisor in Guatemala. At UVA, interviews were performed by a UVA medical or nursing student. Interview responses were recorded by one research member and discussed after the interview to review any unclear information.

Questions for the interview explored a number of themes. A few questions were involved in exploring the level of trust in the healthcare system and the patient’s ideal medical team. The majority of the interview questions involved looking at the information and quality of discharge instructions or after visit summaries. The last major theme involved looking at the language services available to patients during their visit and during their discharge. Lastly, the patients were asked to give their opinions on what could be done to improve the information they receive during and after a medical visit. Data analysis was performed through both a qualitative and quantitative perspective. Questions that had binary answers such as yes, no, sometimes were quantified. Questions that involved patient’s experiences or clinician’s discussion of the medical visit were analyzed by categorizing responses and looking for similarities among different responses and for unique responses.

## RESULTS

The data analysis for this report is based on the data gathered from surveys at various Guatemalan health posts and hospitals. In the Charlottesville area, the data from the surveys were obtained from the UVA Health System Emergency Department, Pediatrics, Internal Medicine, and the University Medical Associates. We obtained a total of 20 surveys from the Guatemalan medical staff, and 40 surveys from the patients who were waiting to be seen and others who had already seen the provider. In the U.S. we obtained a total of 11 clinician surveys and 20 surveys from Hispanic community members. The surveys and interviews to the patients consisted of 17 questions regarding their opinions about the information they received during and after a medical visit. The surveys for the medical staff had eight questions about their discharge process as well as what types of resources were available for non-Spanish speaking patients in Guatemala and non-English speaking patients at UVA.

### UVA Health System Data

#### Clinician Surveys

We interviewed 11 clinicians at the UVA Health System whom all have had previous interactions with Spanish-speaking patients. Gender, age, ethnicity, and preferred spoken language were not assessed in these surveys.
We were interested in their opinions and their role in the clinic or hospital. Out of the 11 participants, we interviewed 6 nurses, 2 doctors, and 3 social workers (Table 1). The first question asked was about the current discharge process. In general, discharge at the UVA Health System starts when the patient is ready to leave the clinic or hospital. Then the doctor types up a summary and delivers it along with prescription information. Ideally, the doctor will explain follow-up care, medicine, dosage, lifestyle changes, and education. The nurse will print out the after visit summary (AVS), review the information with the patient, and then get the patient ready to leave the hospital with any additional instructions. For Spanish-speaking patients, clinicians reported that a number of doctors translate these instructions using Google Translate, then they might use the CyraCom telephones to explain the summary in Spanish. For health care providers at the University of Virginia, many indicated that there was information available in Spanish for non-English speaking patients (Figure 1). UVA providers also indicated that language was a barrier to trust.

When medical staff were asked why patients need to come back to the hospital, many indicated that there was no access to a patient care provider (PCP) in the patient's hometown. One nurse mentioned that their service does a “lousy job of teaching people and not just Hispanic patients. Lack of education and good discharge instructions.” When clinicians were asked about the difference in the discharge summary process for non-English speakers, most providers indicated there was no difference. Some described the only difference was the Spanish instructions. There were several providers who said that the discharge summary process should be different for Spanish-speakers and that it is difficult to provide the same level of education to Spanish-speakers than it is to English-speakers. Medical staff indicated that the quality was different between Spanish and English-speaking patients. One provider mentioned that they are “not required to give instructions in Spanish.” It was also noted that delivering discharge instructions is more time intensive and laborious and that some patients might not be able to understand any of it.

Clinicians also indicated that more interpreters would benefit around the UVA Health System. Some staff wanted to make using phones and interpreters an absolute requirement. Another
provider mentioned that the information from the inpatient care is not very well prepared. One doctor mentioned that the inpatient team should send information directly to the PCP where the patient will be going for follow-up care. This same doctor mentioned that there needs to be a better “hand-off to the outpatient side” of care. Lastly, almost all of the providers indicated that having students who facilitated the discharge process would be a useful addition to the medical team (Figure 1).

**Patient Surveys**

The sample consisted of 20 participants, 11 females and 9 males. Out of these 20 participants, 17 prefer to speak Spanish during their medical visit, 2 prefer English, and one participant prefers either language when talking to their provider (Table 2). It was noted that Hispanic patients at UVA would like their providers to explain everything pertaining to their case in details; to be able to engage in a meaningful conversation, to show a caring interest in the patient, and most importantly to treat them with kindness, trust, and patience due to the language barrier. Spanish-speaking patients who have received medical care at UVA reported that there are certain qualities that UVA providers can work to improve. For example, they believe that their providers are always in a rush, do not provide complete explanations, take a long time to see the patient, show indifference, have a cold attitude, and are disengaged in the patient’s care. However, when asked if they trusted their UVA providers, most responded that they trust their providers’ intentions and that doctors are approachable for the most part.

When the participants were asked what type of information they received during their visit and before they are discharged, most responded the pathophysiology of the disease and diagnosis, procedures, lifestyle, treatment, test and lab results, and medication information. Overall they believe the information they received was appropriate, however they indicated that there is slight doubt and desire for more visuals. In regards to language services provided at UVA, a majority of the participants stated these services are sufficient. Nevertheless, not all providers know how to use CyraCom phones and patients believe that in-person interpreters would be more “efficient and better.”

When patients were asked about the information they receive about their medications, they reported that they are usually given the name of the medication, how often to take them, and the reason why they should be taken. However, information regarding side-effects and contraindications are often not included in the patients’ discharge instructions. Patients stated that the prescription information they received was difficult to understand (Figure 2). Participants also thought that having a student discharge navigator would be useful for them. Lastly, participants were asked how the UVA Health System can improve the information Hispanic patients receive after they are discharged. The responses ranged from hiring more
bilingual staff and providing more written resources in Spanish, to having a person who can speak the language so they can contact them for follow-up questions and emergencies.

Quetzaltenango, Guatemala Data

Clinician Surveys

The sample size for this part of the study consisted of 20 participants. Out of these 20 participants, we interviewed 2 doctors, 11 medical students, 1 nursing student, and 6 nurses (Table 1). The surveys for Guatemalan and U.S. clinicians were the same, with the exception of language. The discharge process in Guatemala is similar to UVA’s, however there are a few differences. First, a clinical diagnosis is developed based on the treatment completion knowing that the pathology can be treated at an ambulatory level of care. Then clinicians provide instructions based on the patient’s educational level, and if they cannot be treated at the clinic or medical facility, the patients are referred to a higher level of care. Patients are also provided with an educational plan, appointments for external consults if needed, and medication prescriptions with a verbal explanation on how to administer the medications. There are also no written instructions provided to the patients. Finally, after the patients have left the clinic or hospital, their names are written down in a records book.

Some of the reasons why patients in Guatemala are readmitted to the hospitals and clinics after discharge are: failure to follow or complete treatment, follow-up visitations, patients wanting to learn more about their test results, antibiotic resistant infections, not understanding discharge instructions, patients cannot afford to continue or start pharmacological treatment at home due to expensive medications, and failure to follow education plan. Most Guatemalan clinicians believe that the level and quality of care they provide to their patients is equal. However, some argue that the care provided to their Spanish speaking patients differs from that of non-Spanish speakers in terms of language. For example, they believe that there is a lack of communication and understanding “because when they do not understand adequately what we tell them, they don’t follow the treatment correctly.”

The opinions of Guatemalan clinicians in regards to reducing this language disparity are to hire interpreters and translators at every health post and hospital, having bilingual providers, providing patients with more resources in their language, and train more doctors and nurses to learn a second language. Clinicians indicated they did not have information available for non-Spanish speaking patients. They also reported that language was indeed a barrier to trust. Finally, almost all of the providers stated that having students who facilitated the discharge process would be beneficial (Figure 1).

Patient Surveys

The sample consisted of 40 participants, 30 females and 10 males. Twenty six participants were indigenous and 14 were Ladino (Table 2). Almost all participants spoke Spanish and prefer to speak Spanish during their medical visit. Sixteen participants speak both Spanish and Quiche, 22 speak only Spanish, and one participant speaks only Quiche. In general, Guatemalan community members indicated several themes in what they wanted from a medical professional when being discharged. There were 37 indications that doctors treat the patient well and talk to them in a polite and friendly manner. Community members also wanted doctors to explain the medicine and illness well to them so they could better understand their health. Some of the aspects of a doctor visit that community members did not like include impatient doctors, doctors who do not explain or give information, and a fast examination. There were two patients who indicated that doctors would not listen to them because they speak Quiche.

Most patients indicated they trust their doctor for medical advice because they are visiting
them for this purpose. In regards to medication, a large number of patients found prescription information to be difficult to understand (Figure 2). Patients described difficulty in not fully understanding the medication and that the doctor would sometimes use “big words” about medications. One patient in particular reported how since he could not read, he was not able to understand the written instructions he received about his medicine.

One patient in particular reported how since he could not read, he was not able to understand the written instructions he received about his medicine. Most patients also reported the doctor gave some recommendation on preventable medicine during the patient visit. When asked about what would make the discharge process better, patients indicated they would like more doctors, doctors who carry on with continuity of care when starting their shift, and doctors who talk about what is difficult to understand and try to explain it in an easy way. Participants also indicated that having student discharge navigators would be beneficial to them (Figure 2).

**DISCUSSION**

This study helped us to gain insight into the patients’ opinions about the information they receive from their doctors and nurses and how this information can be improved. It is apparent that they are satisfied with the services provided and that having a program where information after discharge was explained to them in their language would be helpful. Both patients and clinicians believe that this will help improve understanding information after discharge, and building a trust relationship with each other. Overall, a discharge patient navigation system has the potential to remove the barriers that prevent proper health care compliance and accessibility to care. Future studies could involve programs where nursing and medical students who can speak the language can be trained to help assist during discharge and education plans. Other future studies could involve programs where students can work with high risk patients to help monitor their progress by telephone and assist in getting patients follow-up care when they need it.

Moving forward with this project, the authors believe students could begin a pilot program in a department in the UVA Medical Center. The pilot would involve having UVA medical and nursing students talk to Spanish-speaking patients after their visits about the available resources and questions patients have about their follow-up care. Ideas that were given during the study involve looking at the various free clinics around Virginia that could accept patients once they go back home for follow-up purposes. In the end, this study helped us understand what patients and physicians think about follow-up care and how it can be improved both in Guatemala and in the UVA Health System.

**REFERENCES**


Psycho-Oncology, 21(12), 1309-1315. doi:10.1002/pon.2018


Photo taken in Guatemala. By Logan Haley.
## APPENDIX

### Table 1.
Demographic Information for Health Care Professionals.
Information on the medical staff interviewed in Guatemala and at the UVA Health System.

**Demographic Information for Health Care Professionals**

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### Table 2.
Demographic Information for Community Members.
Information on the community members interviewed in Guatemala and at the UVA Health System and surrounding areas.

**Demographic Information for Community Members**

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<tr>
<td>Speak Indigenous Language</td>
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</table>
Figure 1. Quantitative responses from Health Care Professionals. Analyzed whether health care professionals had information for non-native speakers, whether language was a barrier to trust, and if having student discharge navigators would be helpful.

Figure 2. Quantitative responses from Community members. Analyzed whether prescription information was difficult to understand and if community members found student discharge navigators to be useful.