Published in final edited form as:

Brain Inj. 2017 ; 31(13-14): 1876–1881. doi:10.1080/02699052.2017.1346291.

Targeted Areas for Improving Health Literacy after Traumatic Brain Injury

Megan Moore, PhD^{1,2}, Taniga Kiatchai, MD^{2,3}, Rajiv C. Ayyagari^{2,4}, and Monica Vavilala, MD^{2,3}

¹School of Social Work, University of Washington, Seattle, WA

²Harborview Injury Prevention and Research Center, University of Washington, Seattle, WA

³Anesthesiology and Pain Medicine, University of Washington

⁴Johns Hopkins University

Abstract

Objective: To develop a framework to identify targeted areas for improving health literacy for caregivers after traumatic brain injury (TBI).

Method: Qualitative study using inductive and deductive qualitative content analysis was conducted in a large, urban, level I trauma center. Interviews were conducted with 23 caregivers of persons TBI. Participants perspectives on communication and preparation for discharge were explored and understanding of commonly used words and discharge instructions were assessed.

Results: Four types of communication patterns were identified: formal, informal, indirect, and caregiver-initiated. Informal and caregiver-initiated communication were most common. All caregivers reported confusion about family member's condition, care plan or discharge plan. Caregivers were not able to define commonly used terms in discharge instructions, and were confused by formatting and medical language. Caregivers were not aware of expected caregiving roles upon discharge. Conceptualizing findings within a Family-Centered Care model, we offer specific strategies to improve health communication and caregiver capacity building to enhance health literacy.

Conclusions: Health literacy and caregiver capacity to care for loved ones with TBI after hospital discharge is low. We offer specific targets for improvement in the areas of verbal and written communication and capacity building that take into account provider, patient, and family characteristics.

Keywords

health communication; health literacy; physician-patient communication; qualitative research; family centered care

Correspondance: Megan Moore, PhD, mm99@uw.edu.

Authors declare no conflicts of interest

Introduction

Low health literacy is costly and linked to poor health outcomes and disparities (1,2). In the United States, limited health literacy costs an estimated \$100 billion/year (1). Pooled analyses of published studies revealed nearly half of adults have low or marginal health literacy (2). Groups with higher rates of low health literacy include patients from racial and ethnic minority groups, non-native English speakers, and patients who have lower income or low education (3). Compared to those with adequate health literacy, persons with limited health literacy are less likely to receive preventative services, seek healthcare when they are more ill, and have less knowledge about disease and treatment plans (4). As a consequence, patients with low health literacy are more likely to report poor health, face increased rates of preventable hospitalizations and emergency care, and higher healthcare costs (4). Because low health literacy is linked to poor outcomes and differentially impacts low income and patients from racial/ethnic minority groups, improving health literacy is an urgently needed strategy for addressing health disparities (1,2).

Improving health literacy requires a focus on health communication. Although trauma is a leading cause of death and disability, there is a paucity of research on health literacy and health communication in trauma care. The few available studies have found large gaps in post-discharge health literacy (5), limited comprehension of injuries, care and postoperative instructions for trauma patients (6), and patient perceptions of receiving inadequate information (7,8). In one small study of children with traumatic brain injury (TBI), parents reported communication difficulty in the acute care setting and with transitions after trauma, especially when families had limited English proficiency (9). Utilizing data from interviews with racially and linguistically diverse parents of children hospitalized for TBI, a model of family-centered care after TBI was developed that highlights the importance of three core areas: communication, capacity building and coordination (9). Families reported they valued detailed and frequent communication that prepared them for their child's outcome and care needs. They also identified areas to improve provider, facility, and their own capacity to care for their child. This model provides a framework of key domains needed to provide family-centered care, which has been linked to improved patient outcomes (10–13). The present study aimed to understand in more detail how concepts of health literacy are related to domains identified in the model and to operationalize methods for achieving the communication and capacity building goals of the model. Specifically, this study aimed to explore with caregivers the specific communication patterns that lead to improved understanding of TBI and patient needs, patterns of caregiver understanding of health information, and strategies to improve preparation for caregiving (capacity building).

Methods

Setting

The study was conducted at a large, urban, level I trauma center. The payer mix for patients is diverse, including privately funded, publicly funded, and some unfunded patients. As is common, there are no standardized communication protocols at the facility with the exception of communication at time of discharge. At time of discharge, providers are

required to communicate instructions and patients or caregivers must sign that they have received those instructions.

Participants

After institutional human subjects approval, we conducted interviews with N=23 caregivers of 22 persons hospitalized with TBI. We were interested in interviewing patients' primary caregiver; two participants were caregivers for the same patient and both identified as primary.

Patients were identified via medical record review, and caregivers were then approached about interest in study participation. Participants were recruited from December 2015 to May 2016. Participants were mostly female (83%) caregivers with an average age of 44 years (SD 19.6). Participants were racially and ethnically diverse, including at least one participant who self-identified as White, Hispanic, Black, Native American, and Asian. Approximately 40% of participants reported their education level as high school or less; over half of participants reported some college, bachelor's degree or higher. All participants were identified caregivers of patients with moderate to severe injuries who had been in the hospital for an average of 12.3 days (SD 8.0) from admission to interview date.

Interviews

We conducted in-depth, semi-structured interviews. Participants were asked about experiences with in-hospital communication and discharge planning/preparation. Participants were also asked to define commonly used TBI care words and were asked to read and discuss their interpretation of standard discharge instructions. Standard discharge instructions were printed from the online system that the facility uses to provide patients with discharge instructions. Some examples of questions included are: Tell us about the kinds of instructions or information you have been given about your family members' discharge plan; Was the information helpful? How was information given to you? What challenges do you think you will face when your family member is discharged? Do you feel prepared for these challenges? What information would be helpful to get before leaving the hospital? How would you like to receive that information?

Data analysis

Interviews were recorded and transcribed verbatim. Consistent with recommendations for conducting qualitative analysis for health services research (14), we utilized qualitative content analysis to derive themes and identify recommendations for improving communication, caregiver understanding, and discharge instructions. Specifically, two study coders independently reviewed interviews and identified thematic codes using an inductive approach. Throughout the process, lead investigator read all interviews, met with coders, discussed coding process, consistency, and thematic code development. Discrepancies in coding were discussed and resolved. After coding was completed, investigators employed a consensus-based, deductive process to facilitate interpretation of findings within the Family-Centered Care model and to complete the model expansion (15,16). Analysis was completed using Dedoose qualitative software (17).

Results

Patterns of in-hospital communication were identified. Two major themes related to the caregiver experience of communication were also identified: 1) confusion and dissatisfaction and 2) lack of preparation for caregiving upon patient discharge. We expanded on the previously developed TBI Family-Centered Care Model (9) to provide specific intervention targets for improving health communication, including health information, caregiver capacity building, and health literacy after trauma.

Patterns of in-hospital communication

Four types of provider-caregiver communication were identified: formal, informal, indirect, and caregiver-initiated. Formal communication, identified by 10 participants, included direct, provider-initiated communication, including family meetings with physicians that were organized or part of rounds. Many caregivers wanted more formal, direct communication from providers believing this led to a better understanding of the patient's condition. The following quote illustrates desire for more formal communication and for the more thorough explanations that result. "I like more information versus less, but even just the [team's] willingness to provide that or have someone who would take the time to sit down and explain a little better...Because they do a really good job of dancing around the question, and I'm very good at coming back and saying, "No, you didn't answer this. I want this [information] precisely."

Informal communication, the most common type of communication reported (16 participants), included updates received from the bedside nurse or other healthcare team members that occurred in an unscheduled manner during the course of their work with patients. Caregivers reported frustration with lack of continuity of information when informal communication channels were used as well as barriers to formal communication. One caregiver said: "They [the physicians] come so early in the morning. It's like, I'm not really awake...and I can't get any sleep [because] it's really loud. And so I'm trying to wake up, trying to listen...And it was really hard. I'm being asked by all his [the patient's] family, all our friends, what's going on. And I'm...getting bits and pieces from different people. You know, nurse changes, and then [they say], "I don't know this, but I know this."

Indirect communication was reported by 2 participants and involved instances when family received information through avenues such as notes posted on boards in the patient room. Another caregiver reported getting information about discharge from the board in the patient's room, "They wrote on the board up there that in order for him to be discharged, he would have to have his restraints removed, and get the thing off his neck."

Caregiver-initiated communication, the other common type of communication reported (13 participants), was when caregivers sought specific or general information about the patient from healthcare providers. One caregiver quote illustrates how challenging this can be, "[Knowing who was the primary team] was really, really a muddled issue here. Got to where I understood it better finally because there was a surgical team that they always did the rounds and everything on ICU. But they said, we're contacting all these other people, your kidney people, your nephrology, your cranial/facial, the eye doctors, the whatever. But it

took me a while to realize, okay, if I got questions, I go to the general surgery people to get some answers and respond to me. It took me a while to learn that...I think what I've learned, it's okay for me to ask questions. I didn't used to. It's like, oh, I don't need to. But now it's like, you don't know the answer? You ask. You don't think they're doing something right, you push. You have a right to do that."

Caregivers reported that communication challenges arose because caregivers often bore the burden of initiating communication or interpreting communication from many different sources. Caregiver ability and empowerment to engage in this process varied.

Caregiver confusion

Caregivers universally reported confusion about some aspect of patient's condition, care, or discharge plan. One caregiver described confusion about the patient's condition, difficulty understanding providers, and the resulting frustration about lack of a clear recovery trajectory, "I don't know his name but he seemed to be a head doctor. He came in and gave us a big kind of talk and basically told us what we were looking at, that we were looking at months and weeks [of recovery] and you know, kind of like a reality check of the possibility of what we were looking at. And I think that was a little confusing, in the way he communicated. But that's because they keep on saying, "every individual's different"...it was pretty heavy information to take in, because it's reality. And of course we just wanna know what's gonna happen right now."

Another caregiver expressed confusion about the meaning of terms used to describe the patient's condition, "It was the issue of the brain bleed...I don't think I ever heard anything about concussion. I don't think I ever heard anything about traumatic brain injury. All I heard was brain bleed. He did have a second CAT scan...but never was there any discussion about any post-issues that there could be from concussion or traumatic brain injury."

Some caregivers reported that uncoordinated teams lead to uncoordinated and confusing communication. One caregiver said, "Well I guess one thing I would like more is better communication and understanding the day's protocol. Because they have...speech therapy, they have all these things but I never know when they are coming...And you know they X-rayed my husband's neck the other day, [and] I didn't know. I don't know who to ask, a nurse probably can't tell me...I don't get a lot of communication...I don't know if the nurses, they're making notes for the next nurse. And I guess every nurse is different."

In addition, caregivers had difficulty defining commonly used words in discharge instructions including terms such as "primary care" "arousable" and "well healed." They were confused by the formatting, lack of description or overly technical language used. After reading discharge instructions about symptoms to watch for and when to seek immediate medical attention one caregiver said, "I still don't know...in this one, in that case, if those things happen, if they would want you to call? Call the clinic or [someone else]? [They should] specify who they should call." Caregivers also reported confusion with medication management instructions. After reading the medication regimen, caregivers were confused about critical medication management issues such as indications for medication, dosage, timelines, and whether it was safe to combine medications.

Caregivers suggested providers might address confusion by providing explanations in several formats, providing more information about daily plans, and encouraging note taking. Providers might also consider assessing understanding and answering questions. For written health information, instructions should be patient-tailored and descriptive with summative high priority information clearly marked. See Table 1. Suggestions for providers who might lead the implementation of each strategy are also provided.

Lack of preparation for caregiving

Caregivers reported feeling ill-prepared for discharge with little understanding of the patient needs post-discharge. One caregiver described fear about discharge and the dilemma faced by providers who are balancing caregiver needs for information with unknown outcomes due to the nature of trauma: “We asked some things early on, because we wanted to, maybe, try to make some plans...Initially, the doctor says to me, “Well, I can’t give you any kind of a timetable. I’m setting you up for a real disappointment if things don’t go that way.” So that was fine. But, it’s just -- we didn’t know [about the consequences of a TBI]. And if we had known, I think I’d have been a little bit more prepared for it...And then they never really talked about it. And then, wham-o, right at the end we’re hearing it. And I have to be honest, it scares me.” Another caregiver reported wanting more information about next steps, “As we’re really entering into the discussion about serious outpatient treatment, I kind of wish sometimes they would sit down and explain with a little greater clarity what these steps look like.”

Caregivers reported not feeling empowered to take on the caregiving role during hospitalization. One caregiver described being actively discouraged from participating in patient’s care, “I had one incident that I got really upset...they had the fracture pan, which is even smaller than the bed pan. Well, we rang the buzzer and nobody came. Nobody came. Nobody came. And it was pretty uncomfortable. And he [the patient] says, “I got to get off this thing.” So I removed it. And the person who came in jumped all over me. And said I shouldn’t have done that. And I said, “You should have come when I called.” And her response to me was, “Now we have a bigger mess to clean up.” Strategies to address these issues in order to better prepare caregivers for discharge and caregiving are provided in Table 1.

Enhancing the Family-Centered Care Model: Recommendations for Improving Health Communication, Capacity Building and Health Literacy in Trauma Care

Caregivers provided valuable information on ways to improve communication, health information, and capacity building. Synthesizing the recommendations from participants with an integrated model of health literacy and concepts from work in family-centered care for injured children (9,18), we expanded the Family-Centered Care model in trauma care (See Figure 1). As has been previously posited (18), the pathway to health literacy and positive health outcomes is influenced by provider, patient and family characteristics and situational characteristics such as socio-economic status. The original Family-Centered Care model outlined three major domains: Communication, Capacity Building, and Coordination. Provider communication techniques encompass how information is given to patients and caregivers during interpersonal interactions. We expanded this domain to include specific

communication strategies, including frequent communication using structured tools, assessing understanding and answering questions and ensuring a coordinated message as well as strategies for improved health information, which can include content of written, audio or visual materials that caregivers receive such as discharge instructions. Coordination is also a key component identified in the previous model, including a focus on transitions of care and case management. Capacity building for caregivers includes methods to enhance connection and engagement in providing care in the hospital (e.g. feeding plans, skin care, therapy services) and providing concrete skills development in high priority caregiving tasks (e.g. medication management, follow up appointments). We have included additional capacity building strategies such as continuity of care communication, early discussion and training, and assessing understanding and observing competency in high priority tasks such as medication management. These domains are the focus in acute care setting and as the patient transitions to outpatient care. The model posits that these domains influence recovery, health literacy and health outcomes over the life course.

Discussion

In the present study, caregivers reported the most common communication patterns were informal and caregiver-initiated. Caregivers reported being confused about different aspects of patients' care and were not empowered or prepared for caregiving post-discharge. In addition, discharge instructions and commonly used medical words were difficult for caregivers to understand. These findings are consistent with the limited number of previous studies that have reported low trauma-related health literacy for patients after hospital discharge (5), difficulty with readability of orthopedic trauma-related standard patient education material (19), facial fractures (20) and trauma discharge summaries (21). Unique to this study is the identification of inpatient and discharge communication mechanisms that likely lead to low health literacy amongst caregivers. Strategies to improve in-hospital communication and health information were provided with the goal to improve health literacy.

Caregivers can play an important role in recovery after TBI but may also find they have many unmet needs related to caregiving and coping (22). Particularly for those with severe injuries, caregiving can become chronic and difficult (23). Caregiving after TBI has been associated with financial and marital strain, poor quality of life, and mental and physical health problems (24–28). Training on how to navigate the healthcare system and manage emotional symptoms after trauma may be associated with improved mental health for caregivers of those with polytrauma (29). Strategies to assist caregivers in understanding patients' condition, care plan, and discharge plan are warranted given the level of confusion that was expressed by participants in this study. In addition, given the limited preparation for caregiving experienced, future research can focus on enhancing caregiving training in core caregiving areas, strategies for coping with caregiver burden, and strategies to address the specific mental and physical burden of caregiving. Starting this training and capacity building as early as is appropriate in the hospital stay will likely benefit patients and caregivers.

In the enhanced Family-Centered Care model presented here, we linked the intervention domains of communication, capacity building and coordination to improved health outcomes and health literacy via the specific mechanisms identified in this study for improving care in each domain. We take a holistic view of the patient, caregiver, provider, and healthcare system as they relate to patient health outcomes. We expanded the model to include recognition that these domains are influenced by provider, family, and patient characteristics and environmental/situational characteristics acting in concert as the patient moves through the healthcare system and along their developmental life course. These characteristics must be taken into consideration when planning communication, capacity building efforts, and transition efforts. Successful intervention strategies that target these domains can improve health communication, caregiver capacity, transitions of care, and ultimately health literacy and patient outcomes. Future directions for this research include implementing and testing the model developed here. This study has identified key targets for intervention to enhance health literacy after trauma. Caregivers have shared their experiences and the limitations of their understanding of their loved one's injury and ongoing care needs. Well designed intervention studies that test the impact of the developed model on health literacy, satisfaction, and patient outcomes are needed.

Limitations

Data for the present study were collected at one urban, level 1 trauma center from caregivers of patients with TBI. Further research is needed to assess the applicability of the model in other healthcare settings and with other populations.

Conclusion

This study identified strategies for improving communication and caregiver capacity building. Building on models of health literacy and Family-Centered Care, an enhanced model was developed to guide intervention strategies to improve health literacy and health outcomes. Future research can test these trauma-specific health literacy tools to improve caregiver and patient understanding of care plans and discharge needs. Incorporating non-English speaking caregivers will also be important to assess differences in communication patterns and caregiver needs across cultures.

Acknowledgments

This work was supported by the National Center for Advancing Translational Sciences of the National Institutes of Health (KL2TR000421 to Dr. Moore).

References

1. Alper J. Health Literacy: Past, Present, and Future: Workshop Summary; Washington DC. National Academies Press; 2015.
2. Paasche-Orlow M, Wolf M. Promoting health literacy research to reduce health disparities. *J Health Commun.* 2010;15:34–41. [PubMed: 20845191]
3. Kutner M, Greenburg E, Jin Y, Paulsen C. The health literacy of america's adults: results from the 2003 national assessment of adult literacy. National Center for Education Statistics; 2006 p1–60.

4. U.S. Department of Health and Human Services. Health Literacy – Fact Sheet: Washington. 2010 Available at <http://health.gov/communication/literacy/quickguide/factsliteracy/htm> (accessed 4 February 2016).
5. Shahan CP, Weinberg JA, Magnotti LJ, Fabian TC, Croce MA. Trauma health literacy: in need of remediation. *J Trauma Acute Care Surg*. 2016;81:1167–70. [PubMed: 27244580]
6. Kadakia RJ, Tsahakis JM, Issar NM, Archer KR, Jahangir AA, Sethi MK, Obremskey WT, Mir HR. Health literacy in an orthopedic trauma patient population: a cross-sectional survey of patient comprehension. *J Orthop Trauma*. 2013;27:467–71. [PubMed: 23114414]
7. Hermans E, Winkens I, Winkel-Witlox ST, van Iperen A. Caregiver reported problems of children and families 2–4 years following rehabilitation for pediatric brain injury. *NeuroRehabilitation*. 2012;30:213–217. [PubMed: 22635126]
8. Hawley CA, Ward AB, Magnay AR, Long J. Parental stress and burden following traumatic brain injury amongst children and adolescents. *Brain Inj*. 2003;17:1–23.
9. Moore M, Robinson G, Mink R, Hudson K, Dotolo D, Gooding T, Ramirez A, Zatzick D, Giordano J, Crawley D, et al. Developing a family-centered care model for critical care after pediatric traumatic brain injury. *Pediatr Crit Care Med*. 2015;16:758–765. [PubMed: 26135064]
10. Lewin SA, Skea ZC, Entwistle V, Zwarenstein M, Dick J. Interventions for providers to promote a patient-centered approach in clinical consultations. *Cochrane Database Syst Rev*. 2001;4:CD003267.
11. Pollack MM, Koch MA, NIH-District of Columbia Neonatal Network. Association of outcomes with organizational characteristics of neonatal intensive care units. *Crit Care Med*. 2003;31:1620–1629. [PubMed: 12794396]
12. Roter DL, Hall JA, Kern DE, Barker LR, Cole KA, Roca RP. Improving physicians' interviewing skills and reducing patients' emotional distress. A randomized clinical trial. *Arch Intern Med*. 1995;155:1877–1884. [PubMed: 7677554]
13. Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW, Jordan J. The impact of patient-centered care on outcomes. *J Fam Pract*. 2000;49:796–804. [PubMed: 11032203]
14. Bradley EH, Currey LA, Devers KJ. Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health Serv Res*. 2007;42:1758–1772. [PubMed: 17286625]
15. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qual. Health Res*. 2005;15:1277–1288. [PubMed: 16204405]
16. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today*. 2004;24:105–112. [PubMed: 14769454]
17. Dedoose. 2015 Available at: www.dedoose.com.
18. Sørensen K, Van den Broucke S, Fullam J, Doyle G, Pelikan J, Slonska Z, Brand H. Health literacy and public health: A systematic review and integration of definitions and models. *BMC Public Health*. 2012;12:12–80. [PubMed: 2221851]
19. Eltorai AE, Thomas N, Yang H, Daniels AH, Born CT. Readability of trauma-related patient education materials from the american academy of orthopaedic surgeons. *Trauma Mon*. 2016;21:e20141. [PubMed: 27218045]
20. Sanghvi S, Cherla DV, Shukla PA, Eloy JA. Readability assessment of internet-based patient education materials related to facial fractures. *Laryngoscope*. 2012; 22:1943–1948.
21. Choudhry AJ, Baghdadi YM, Wagie AE, Habermann EB, Heller SF, Jenkins DH, Cullinane DC, Zielinski MD. Readability of discharge summaries: with what level of information are we dismissing our patients? *Am J Surg*. 2016;211:631–636. [PubMed: 26794665]
22. Adams D, Dahdah M. Coping and adaptive strategies of traumatic brain injury survivors and primary caregivers. *NeuroRehabilitation*. 2016;39:223–237. [PubMed: 27372358]
23. Doser K, Norup A. Caregiver burden in Danish family members of patients with severe brain injury: The chronic phase. *Brain Inj*. 2016;30:334–342. [PubMed: 26829640]
24. Peters LC, Stambrook M, Moore AD, Esses L. Psychosocial sequelae of closed head injury: effects on the marital relationship. *Brain Inj*. 1990;4:39–47. [PubMed: 2297599]

25. Marsh NV, Kersel DA, Havill JH, Sleight JW. Caregiver burden during the year following severe traumatic brain injury. *J Clin Exp Neuropsychol*. 2002;24:434–447. [PubMed: 12187457]
26. Verhaeghe S, Defloor T, Grypdonck M. Stress and coping among families of patients with traumatic brain injury: a review of the literature. *J Clin Nurs*. 2005;14:1004–1012. [PubMed: 16102152]
27. Chan J, Parmenter T, Stancliffe R. The impact of traumatic brain injury on the mental health outcomes of individuals and their family careers. *Advancement of Mental Health*. 2009;8:155–164.
28. Bayen E, Pradat-Diehl P, Jourdan C, Ghout I, Bosserelle V, Azerad S, Weiss JJ, Joel ME, Aegerter P, Azouvi P. Predictors of informal care burden 1 year after a severe traumatic brain injury: results from the Paris-TBI study. *J Head Trauma Rehabil*. 2013;28:408–418. [PubMed: 22691963]
29. Stevens LF, Pickett TC, Wilder-Schaaf KP, Taylor BC, Gravely A, Van Houtven CH, Friedemann-Sanchez G, Griffin JM. The Relationship between Training and Mental Health among Caregivers of Individuals with Polytrauma. *Behav Neurol*. 2015;2015:1–13.

Figure 1.
Framework for Improving Health Literacy, Health Communication and Caregiver Capacity after Trauma

Table 1.**Recommendations for improving communication, discharge instructions and caregiver capacity**

Communication Strategies	Team Members Leading Strategy
<ul style="list-style-type: none"> • Providers and teams should initiate formal, direct communication more frequently and utilize structured communication tools • Do not assume caregiver understands commonly used medical words (i.e. “primary care provider”, “well-healed”) • Assess understanding and answer questions • Provide verbal and written explanations ◦ Consider providing a daily schedule of procedures, main concerns and plan ◦ Consider providing meeting summary, drawings and explanations in writing after family meeting ◦ Encourage caregivers to take notes during meeting and review at end of meeting • Given the prevalence of informal communication, ensure all team members have updated and accurate patient information, coordinate messages 	<ul style="list-style-type: none"> • Attending physician, social worker, bedside nurse • All team members • All team members • Physicians, social worker, nurse, rehabilitation service providers • Attending physician, social worker or nurse
Written Health Information/Discharge Instructions	Team Members Leading Strategy
<ul style="list-style-type: none"> • Provide patient-tailored written instructions • Medication management instructions should include warnings, contraindications and purpose of each medication • Bold important information • Provide detailed descriptions as well as summative high priority information • Do not assume caregiver understands instructions or words on forms • Assess understanding and answer questions • Provide specific and detailed follow up information 	<ul style="list-style-type: none"> • Nurse • Pharmacist, Nurse • All team members • All team members • Nurse, social worker, rehabilitation service providers
Caregiver Capacity Building	Team Members Leading Strategy
<ul style="list-style-type: none"> • Continuity of care communication needed regarding next steps and preparation for caregiving and discharge needs • Start early with discussion and training of caregiving needs • Assess understanding and observe competency with high priority tasks 	<ul style="list-style-type: none"> • Nurse, social worker, rehabilitation service providers • Nurse, social worker • All team members