

THE PATIENT WHO SAID YES

*Why discharge plans are agreed to and not followed—and what
communication skill can realistically change*

44%

Of patients did not follow at least one medication change made at hospital discharge

A decision-maker's white paper

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Executive summary

Canadian hospitals discharged patients from roughly 3.14 million acute inpatient stays in 2024–25. Approximately one in eleven of those patients returned within thirty days. Readmissions are estimated to cost the Canadian system in the order of \$2.9 billion annually, although the figure varies by source and no published methodology accompanies it.

Most readmissions are not preventable, and no communication method will change that. A systematic review of 34 studies found a median of 27.1% of readmissions judged avoidable, with estimates ranging from 5.0% to 78.9%—a spread that reflects genuine disagreement about what “avoidable” means. The dominant predictors of readmission are length of stay, comorbidity burden, heart failure, COPD, renal insufficiency, cancer, polypharmacy and prior utilization. Those are illness and system variables, not conversation variables.

Inside the portion that is influenceable sits a specific and well-documented failure: the patient agreed to the plan, and then did not follow it—because the agreement was never tested.

Canadian evidence puts a number on it. In a McGill University Health Centre study of 2,655 patients, 44% were non-adherent to at least one medication change made at discharge. Those non-adherent to all changes had 1.35 times the adjusted hazard of a 30-day adverse event compared with those adherent to all; 32% of the cohort experienced readmission, an emergency visit or death within thirty days. An earlier Ottawa study found 23% of medical patients experienced an adverse event after discharge, 72% of them drug-related, and roughly half preventable or ameliorable.

Motivational interviewing and structured communication techniques such as teach-back address one part of this: whether the person leaves with a plan they understand, believe is workable, and have actually committed to. The evidence supports that claim about preparedness and adherence. It does not support a promise about readmission rates, and this paper says so plainly.

The practical conclusion

- Treat the discharge conversation as a decision to be tested, not information to be delivered.
- Expect improvement in preparedness, comprehension and adherence—not in 30-day readmission.
- Simpler interventions outperform complex bundles at 30 days; resist the urge to build a program.
- Cost-related non-adherence is not a communication problem. Identify it and route it differently.
- Fund coaching after the workshop, or expect the skill to decay within six months.

The numbers at a glance

Indicator	Latest defensible figure	Meaning for leaders
~1 in 11	Patients readmitted within 30 days	National rate reported at 9.4% for 2020–21.
\$2.9B	Estimated annual cost of readmissions, 2023	Older sources cite \$1.8–2.3B; no published method.
27.1%	Median share of readmissions judged avoidable	Range across studies: 5.0% to 78.9%.
44%	Patients non-adherent to a discharge medication change	Canadian cohort, n = 2,655.
23%	Medical patients with an adverse event after discharge	72% drug-related; about half preventable.
70%	MHSU patients seen by a physician within 30 days	Ranges from 53% in SK to 73% in BC and AB.

1. What actually happens between the plan and the follow-through

The discharge encounter has a recognizable shape. A clinician, usually short of time, explains the diagnosis, the medication changes, the warning signs and the follow-up appointment. The patient—tired, unwell, often medicated, sometimes accompanied by a family member who will do the actual work—nods. The plan is documented. Everyone proceeds.

What the record shows is that advice was given. What it does not show is whether the person understood it, believed it was possible, or intended to do it.

Comprehension is worse than clinicians assume

The most-cited study of discharge comprehension found that 58.1% of patients could not state their diagnosis, 72.1% could not list all their medications, 62.8% could not state the purpose of their medications, and 86.0% could not name major side effects. That study is American, from 2005, and involved only 43 patients—it should be cited with those caveats. It is nonetheless consistent with what Canadian health-literacy data suggest: the Canadian Council on Learning estimated that 60% of Canadian adults lack the capacity to obtain, understand and act on health information, based on survey data now two decades old.

The practical point does not depend on the precision of those figures. A plan the patient cannot restate is not a plan the patient can follow.

Agreement is not commitment

What the encounter produces	What the outcome requires
The patient hears the plan	The patient can restate it in their own words
The patient agrees to the plan	The patient believes it is achievable in their circumstances
The patient is told the follow-up date	The patient has a way to get there
The medication list is reconciled on paper	The patient knows what changed and why
No objection is raised	Objections were actively invited and addressed

2. Where the cost shows up

A failed discharge conversation does not produce a single identifiable cost. It produces a distributed one, spread across readmission, emergency use, medication harm and rework.

Pathway	How cost appears	Canadian evidence
Medication non-adherence	Adverse events, treatment failure, avoidable harm	44% non-adherent to at least one discharge change; aHR 1.35 for 30-day adverse events
Post-discharge adverse events	Emergency visits, readmission, investigation	23% of medical patients; 72% drug-related
Missed follow-up	Deterioration discovered later and more expensively	30% of MHSU patients see no physician within 30 days
Readmission	Second stay, typically more expensive than the first	Second medical hospitalization averaged \$10,404 vs \$7,287
Medication incidents	Omitted doses and reconciliation failures	Omission was the most commonly reported incident type in returns to hospital

The cost of a standard hospital stay in Canada was \$7,619 in 2020–21, with teaching hospitals ranging from roughly \$6,000 to \$16,000. These are averages, not marginal costs, and should not be treated as money released by avoiding a stay.

3. What the evidence supports—and what it does not

This is the section where transitional-care proposals usually overreach. The literature is unusually clear about which claims survive scrutiny.

Supported conclusions

- Structured discharge planning produces a small reduction in readmission: relative risk 0.89 and a length-of-stay reduction of 0.73 days, both at moderate certainty, across 33 trials and 12,242 participants.
- Simpler interventions outperform complex ones. In a network meta-analysis of 126 trials and 97,408 participants, low-complexity interventions reduced 30-day readmission (OR 0.78) while high-complexity bundles did not (OR 0.96, not significant).
- A coach-supported, patient-owned transition model reduced 30-day readmission from 11.9% to 8.3% and 90-day readmission from 22.5% to 16.7% in a 750-patient trial.
- MI improves medication adherence across chronic conditions: relative risk 1.17 in one meta-analysis of 17 trials; a small but precise pooled effect of 0.12 in another of 16 trials.
- Teach-back discharge education in heart failure was associated with reduced overall readmission (OR 0.40), although the one-month result specifically was not significant.

Claims the evidence does not justify

- That communication training reduces 30-day readmission. Canada’s own flagship trial, PACT-HF, randomized 2,494 heart-failure patients across ten Ontario hospitals and found no difference in the three-month composite (HR 0.99) or at three years—while improving discharge preparedness and quality of life.
- That a communication tool rollout moves utilization. The Patient Oriented Discharge Summary reached 78% of discharges across 21 Ontario hospitals and raised teach-back use by 11 percentage points, with no significant change in readmissions or emergency visits.
- That any single lever fixes follow-up. Ontario introduced a financial incentive for timely post-discharge follow-up; across more than eight million discharges, it did not change early follow-up rates.
- That MI works uniformly. Across 54 randomized trials of MI for medication adherence, adherence improved significantly in only 23. A 2025 trial of five post-discharge MI sessions in 207 heart-failure and COPD patients found no effect on rehospitalization or patient activation.
- That readmission is a clean quality signal. Pooled discrimination of 16 readmission risk models was only 0.71, and the strongest predictors are illness severity and prior utilization.

The honest summary: communication interventions reliably improve what patients understand, believe and do. They do not reliably move thirty-day readmission. A proposal that promises the second will be judged by it.

4. What a better discharge conversation actually looks like

The shift is not from a short conversation to a long one. It is from delivering a plan to testing one.

Common pattern	MI-informed alternative
Explain the plan and ask “Any questions?”	Ask the person to describe the plan back in their own words
Confirm the patient agrees	Ask how confident they are, on a scale, and why not lower

Common pattern	MI-informed alternative
List the medication changes	Ask what they think each change is for, and what concerns them
Provide the follow-up appointment date	Ask what might get in the way of attending, and plan around it
Repeat the instructions when the patient seems unsure	Ask what would make this plan workable at home
Document that education was provided	Document what the patient committed to and what they identified as the risk

Five behaviours worth training

- Teach-back, used as a check on the clinician's explanation rather than a test of the patient.
- Confidence and importance rulers, which surface doubt that a yes conceals.
- Asking permission before advising, which measurably reduces defensiveness.
- Eliciting the patient's own reasons for the plan rather than supplying more of the clinician's.
- Explicit naming of the first obstacle, and a plan for it, before the person leaves.

5. Designing the intervention so it holds

Two findings should govern the design of any discharge-communication program, and both cut against how these programs are usually funded.

Complexity is not a virtue

The network meta-analysis of 126 trials found low-complexity interventions reduced 30-day readmission while high-complexity bundles did not. This is counter-intuitive and worth taking seriously: a large program with many components is harder to deliver consistently, harder to sustain, and easier to abandon. A smaller, better-executed change is more likely to hold.

Coaching is the active ingredient

Across 21 training studies covering 987 practitioners, workshop training produced a substantial immediate skill gain of 0.76. Without follow-up feedback, skills eroded over six months at an effect size of -0.30 . With coaching, decay was prevented. Independently, a meta-analysis of MI for medication adherence found coaching during implementation to be the strongest moderator of effectiveness.

A discharge-communication program funded as a single in-service is, on this evidence, a program with a negative six-month trajectory.

Suggested 90-day pilot

Period	Actions	Evidence produced
Weeks 1–2	Select one unit and one patient population; baseline comprehension, adherence and follow-up attendance	Baseline dashboard and real discharge scenarios
Weeks 3–4	Workshop on teach-back, confidence testing and obstacle planning, with observed practice	Initial skill assessment
Weeks 5–8	Apply at the bedside; coaching sessions and peer observation	Fidelity samples and workflow barriers
Weeks 9–12	Reinforce; analyze early indicators	Pilot report and scale recommendation

6. Choosing and measuring the right pilot

Select the transition where the decision matters, the data already exist and one leader owns the workflow.

Candidate	Why it works	Possible measures
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Heart failure or COPD discharge	High readmission volume, defined medication changes	Teach-back completion, 7-day follow-up, medication pickup
Medical ward discharge with 3+ medication changes	Non-adherence risk concentrates here	Patient can name changes; pharmacy fill within 7 days
Mental health or substance use discharge	30% receive no physician follow-up	Follow-up attended within 30 days
Surgical discharge with home care handoff	Clear handoff, administrative data available	Home care first visit completed, ED return within 14 days

Measurement hierarchy

Stage	Measure	Timing
Reach	Eligible staff trained and participating	Immediately
Learning	Observed use of teach-back and confidence testing	Pre/post and 30 days
Comprehension	Patient can restate diagnosis, changes and follow-up	At discharge
Adherence	Medication pickup and continuation at 7 and 30 days	7–30 days
Follow-up	Attendance at the first post-discharge appointment	7–30 days
Utilization	Emergency return and readmission	30–90 days, reported without attribution claims

A simple economic model

Estimated annual value = additional completed follow-ups × avoided cost per failure + staff time released – program and implementation cost

Suppose a medical unit discharges 1,500 eligible patients a year and currently achieves 66% follow-up within fourteen days. A sustained improvement to 74% represents 120 additional completed follow-ups. The organization must then determine what proportion of those prevent a return and what a return costs locally. Given the evidence above, the responsible first report describes improved preparedness and follow-up—not booked savings.

7. Risks and safeguards

Risk	What goes wrong	Safeguard
Readmission promised as the outcome	Program judged a failure despite real gains in preparedness	Commit to comprehension, adherence and follow-up measures
Teach-back used as a compliance check	Patients feel tested; discord rises	Frame it as checking the clinician's explanation
Cost-related non-adherence misread as motivation	Conversation applied to a financial barrier	Screen for cost; route to coverage and pharmacy support
Bundle creep	Complexity reduces delivery and sustainability	Keep the intervention low-complexity by design
Workshop-only funding	Skill decays within six months	Fund three to four coaching contacts over six months
Documentation substituting for practice	A new field is completed; nothing changes at the bedside	Observe practice; audit behaviour, not charting

8. Recommendations for executives

1. Name the decision, not the training. Begin with “leave with an owned plan” or “attend the first follow-up,” not “teach communication skills.”
2. Pick one unit and one population. The evidence favours smaller and simpler over comprehensive.

3. Baseline comprehension before you train anyone. Ask discharged patients to state their diagnosis, changes and follow-up.
4. Set expectations with your board in advance: this program targets preparedness, adherence and follow-up. Readmission is reported, not promised.
5. Screen for cost-related non-adherence separately; 4.9% of Canadians report it and no conversation resolves it.
6. Fund the coaching tail before approving the workshop.
7. Include family and caregivers in the conversation, because they frequently do the work the plan requires.

Conclusion

The discharge conversation is one of the most repeated encounters in the health system and one of the least examined. It happens thousands of times a day, it is documented as education provided, and its success is almost never measured at the point where it fails.

Canada has already tested the large version of this idea. PACT-HF randomized nearly 2,500 patients and did not move readmission—but did improve discharge preparedness and quality of life. The Patient Oriented Discharge Summary reached most discharges in 21 hospitals and raised teach-back use without shifting utilization. These are not arguments against better discharge conversations. They are arguments against selling them as a readmission strategy.

The defensible claim is narrower and more durable: patients who leave understanding their plan, believing it is workable and knowing what will get in the way are in a better position than patients who simply agreed.

For a hospital, that is worth doing on its own terms, and worth measuring honestly. One unit, one population, one baseline, and one test of whether the patient who said yes can tell you what they said yes to.

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About the author

Brittany Godin works with health and social-service organizations on the communication skills that determine whether good intentions become completed care. Through Compassion Campus she teaches and coaches motivational interviewing as an operational capability—built through practice, observation and feedback rather than delivered as a one-time workshop—and helps leaders design pilots that test whether better conversations actually change what happens next.