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Avoiding Hospitalizations from Nursing Homes for Potentially Burdensome Care: What Helps Facilities Succeed?

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Introduction

Nursing home residents are often hospitalized for care that has the potential to be burdensome, in the sense that the risks outweigh the expected benefits.[1] These hospitalizations offer little hope of improving quality of life or changing the course of illness and usually involve residents close to death who are vulnerable to iatrogenic harms. Certain facilities are more successful than others at preventing potentially burdensome hospitalizations. The reasons for their success, however, are poorly understood. We sought to explore the causes of these transfers and identify practices that help facilities avoid them.

Methods

We conducted a qualitative study involving Connecticut nursing homes with hospitalization rates in the top or bottom 10% from 2008–2010. We identified facilities using publicly available data (www.ltcfocus.org) and conducted in-depth, semi-structured interviews with key staff members, using a standard interview guide, until theoretical saturation was reached; this occurred after the eighth facility visit and 31 interviews. Transcripts were analyzed according to the principles of grounded theory, using the constant comparative method.[2]

Results

Interviews occurred at four high-hospitalizing and four low-hospitalizing facilities and involved directors of nursing (8), facility administrators (7), social workers (6), physicians (2), advanced practice providers (5), and other staff (3).

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Participants at all facilities recognized that residents were hospitalized for potentially burdensome care and identified a common set of barriers that made it difficult to avoid such transfers (Table 1). There were key differences in how staff at low- and high-hospitalizing facilities approached decisions about hospitalization. Participants at high-hospitalizing facilities described an algorithmic process and tended to leave complex choices about hospitalization to families. Those at low-hospitalizing facilities emphasized their involvement in case-by-case decision-making and were willing to disagree with family members and attempt to change their minds (Table 2).

Discussion

Participants in this qualitative study of nursing homes with high and low hospitalization rates encountered similar barriers to avoiding potentially burdensome hospitalizations. Staff at low-hospitalizing facilities, however, described a conviction that certain patients should not be hospitalized and felt a responsibility to help patients and families reach the same conclusion. They avoided decision-making algorithms and followed the "enhanced autonomy" model recommended by experts, in which medical personnel do not remain neutral but explore disagreements with patients in "an intense exchange of medical information, values, and experiences."[3] They acknowledged how hard this was to do.

Our findings suggest that, to reduce potentially burdensome transfers, staff at less successful facilities will need to be encouraged to adopt similar attitudes and practices. How best to accomplish this kind of institutional culture change is unclear. The prevailing approach at the Centers for Medicare and Medicaid Services involves payment reform,[4] but there is only modest evidence to suggest that financial incentives will change provider behavior in the nursing home or improve facility quality.[5] Another strategy, taken by the Intervention to Reduce Acute Care Transfers (INTERACT) program, involves providing written materials to patients and providers, but facilities using INTERACT have had limited success in reducing hospitalizations for potentially burdensome care.[6] While our study adds key information about the behaviors that help nursing homes avoid such transfers, research is needed to understand how to promote these behaviors more broadly.

Our work has several limitations. We performed interviews in Connecticut, which has a high number of nursing home beds per capita. We interviewed an advanced practice provider at every facility but only a few physicians, who were on-site irregularly.

In summary, there were key differences in behavior towards potentially burdensome hospitalizations at nursing homes with high and low hospitalization rates. Work should focus on developing ways to encourage less successful facilities to adopt practices found at more successful ones.

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References

1. Ouslander JG, Lamb G, Perloe M, et al. Potentially avoidable hospitalizations of nursing home residents: frequency, causes, and costs. J Am Geriatr Soc. 2010; 58(4):627–635. [PubMed: 20398146]
2. Miles, MB., Huberman, AM. Qualitative data analysis : an expanded sourcebook. 2. Thousand Oaks: Sage Publications; 1994.
3. Quill TE, Brody H. Physician recommendations and patient autonomy: finding a balance between physician power and patient choice. Ann Intern Med. 1996; 125(9):763–769. [PubMed: 8929011]
4. Centers for Medicare and Medicaid Services. [8/1/2016] Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents. 2016. Accessed at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/InitiativetoReduceAvoidableHospitalizations/AvoidableHospitalizationsamongNursingFacilityResidents.html on
5. Briesacher BA, Field TS, Baril J, Gurwitz JH. Pay-for-performance in nursing homes. Health Care Financ Rev. 2009; 30(3):1–13.
6. Ouslander JG, Naharci I, Engstrom G, et al. Root cause analyses of transfers of skilled nursing facility patients to acute hospitals: lessons learned for reducing unnecessary hospitalizations. J Am Med Dir Assoc. 2016; 17(3):256–262. [PubMed: 26777066]

Table 1

Shared barriers to reducing potentially burdensome hospitalizations

1. Families' Beliefs about the Hospital and Nursing Home	
Theme	***Representative Quotation***
Guilt pushes families to "do everything," which includes hospitalization	When someone is dying, [families] want to them to have the last chance and that's what pushes them to send them. It's hard to decide, "I'm not sending mom to the hospital this last time." Because you're giving up. Essentially people will say that you're giving up. "You mean you didn't send her this time? You gave up." (#101, NP, high-hospitalizing facility)
The nursing home's dual custodial and medical identity leads to the belief that it provides inferior care	They view us as like a rest home. There's not really medical care here. They think: "look at that person, they're sick, better get them to the ER" . . . The family member will be right there: "Nope! I just want my mother to go to the hospital. You guys are just a nursing home. That's what you do there. She can live there. That's her home but if she's sick she needs to go to the hospital." (#402, director of nursing, high-hospitalizing facility)
2. Nursing Home Structure and Organization	
Theme	*Representative Quotation*
Clinicians are unavailable on nights and weekends	It's not a conversation that someone can have over the phone at 2 o'clock in the morning. Where a patient is decompensating during the day, that's when we're most successful at intervening and trying to prevent that hospitalization which isn't really going to benefit the patient. It's so frustrating when I come in on Monday morning and find out who got sent over the weekend. I just feel bad for the patient. Now they're getting poked and prodded and stuck, and nothing is going to change. (#703, NP, low-hospitalizing facility)
Staff face difficult decisions in relative isolation	The burden falls on me to say: "your mom and dad is not doing well, there's no chance of a meaningful recovery." I feel if I had some back up — it would be just so nice to have another really qualified internist to help with the tough calls. You might say, "what about Dr. X, what does he think?" I would feel much more comfortable if I had somebody with me. I find that even though I'm a nice guy, board certified internal medicine, [families think]: "you're not a cardiologist or an – ologist. You're just a physician in a community nursing home." I'm looking for support and there is none. (#503, physician, low-hospitalizing facility)

Table 2

Different approaches at low- and high-hospitalizing facilities

1. Case-by-Case Decision Making versus a Default Pathway	
LOW-HOSPITALIZING FACILITIES	**HIGH-HOSPITALIZING FACILITIES**
They see the hospitalization as, 'Well, if there's one last glimmer, if there's one last thing.' One of the things we talk to them about is, when you get to this end stage — because for many of our people it is the end stage — what's your goal? Is your goal treatment? Is your goal treatment with comfort? If your goal is comfort, then being treated in place is more likely to achieve that. (#201, social worker) I try to put whatever is going on with them in the context of the co-morbid conditions they have and get from the family what they would expect or what they would want to happen at the hospital . . . I try to say out loud: 'does this make sense?' (#703, NP)	The policy here is that if we can treat them here then we will, [but] every time somebody is changed clinically— like they're sick — most of the nurses just call the doctor and tell them they're sick. Of course, the doctor doesn't really see the patient. The doctor will just say: 'Okay, send them out.' (#103, nurse) When you have a patient who has a change of condition in a facility, if you ever really question if the patient should be in the hospital, you should do that — you should send the patient to the hospital if you question that. (#304, physician)
2. Trying to Change Families' Minds versus Deferring to Their Decisions	
LOW-HOSPITALIZING FACILITIES	**HIGH-HOSPITALIZING FACILITIES**
The nurses will talk to [families], the social worker will talk to them, we'll have meetings . . . If we can't convince them — and we're not trying to convince anybody to die, but we want to make them comfortable and really look realistically at the picture — we'll often ask the APRN or the doctor to talk with them . . .We're not trying to kill everybody. I don't want you to think we're trying to kill everybody. We just feel like it's the most comfortable for them. (#701, administrator) We've worked as hard as we can to educate [families] and I wouldn't say influence them, but if we do genuinely feel like it's not in their best interest, we'll work really hard to discourage someone who is making a bad decision. (#501, administrator)	It's a tricky dynamic as far as treating, sending, keeping, but overall I think the patient and the patient's family drives the decision-making. I give them all the options . . . I don't think I have a huge influence on changing [their minds]. I think that has to happen within the family. (#101, NP) Even if I think that the patient is at a point where there's not going to be much that they can do . . . I always end [the conversation] with: 'But in the end it's your decision what you want to do.' It's not my decision. Everyone has to make their own decision. (#303, PA) I don't try to jam my viewpoint down on anybody. I just say, "these are things you should consider now." (#301, administrator)