Original Article

"They Need to Have an Understanding of Why They're Coming Here and What the Outcomes Might Be." Clinician Perspectives on Goals of Care for Patients Discharged From Hospitals to Skilled Nursing Facilities

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Abstract

Context. The number of patients discharged from acute care hospitals to skilled nursing facilities (SNFs) is rising. These patients have increasingly complex needs and many experience poor outcomes while under SNF care, including hospital readmissions. Patients' goals of care (GoC) are viewed as a factor contributing to unplanned hospital readmissions from SNFs. However, clinicians' perspectives of GoC for hospitalized patients discharged to SNFs are not well-described.

Objectives. To explore how clinicians view GoC for hospitalized patients discharged to SNFs.

Methods. Qualitative study using semi-structured interviews and thematic analysis.

Results. Forty-one clinicians from one acute care hospital and two SNFs completed interviews ranging in length from 14 to 52 minutes (mean = 32 minutes). Of the sample, 22% were nurses, 20% physicians, 15% were from care management, and 15% were from social services. Respondents viewed patients' GoC for continuing treatment at the SNF as important, but acknowledged that they were infrequently discussed during hospitalization. Many respondents felt that patients and families had unrealistic GoC for SNF care. Factors that contributed to unrealistic GoC included patients' limited knowledge of disease processes, prognosis, and treatment options; and inconsistent or insufficient communication of GoC among hospital and SNF clinicians, the patient, and family members. Respondents associated a lack of GoC or unrealistic GoC with patients' dissatisfaction with SNF care, unplanned transitions to hospice, and hospital readmissions.

Conclusions. Respondents reported that GoC conversations infrequently occurred during hospitalization, contributing to unrealistic patient and family expectations for SNF care and poor patient outcomes. Interventions are needed that facilitate timely, accurate, and consistent GoC discussions across care continuums. J Pain Symptom Manage 2018;55:930–937.

Key Words
Palliative care, skilled nursing facilities, qualitative research, hospitalization, goals of care

Introduction

Skilled nursing facilities (SNFs) provide care for an increasingly complex patient population. Patients discharged to SNFs after hospitalization are older, have a greater burden of comorbidities, and require longer hospital stays than those discharged home.[1–3] Of those patients discharged to

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SNFs, nearly 23% will be readmitted back to the hospital within 30 days, increasing their likelihood of further disruptions in care and diminished quality of life.[4,5]

As the number of patients discharged from hospitals to SNFs continues to increase,[1] interest in SNF care quality, including reducing unplanned hospital readmissions, has become a priority in health care and the focus of much research.[4,6–8] Patients' goals of care (GoC) include treatment preferences and expectations, discussions of prognosis, completion of advance directives, and end-of-life care planning. Problems associated with patients' GoC, including a lack of GoC discussions, or inconsistent or unrealistic care goals, are viewed to contribute to unplanned hospital readmissions from SNFs.[9–11] Hospital readmissions may occur because SNF clinicians question the appropriateness of placing high-risk or seriously ill patients with multiple comorbidities in SNFs, or may view ambiguous GoC as compelling rationale for returning the patient to the hospital in times of clinical crises.[9,12,13]

Although prior research suggests that unclear, poorly documented, or poorly communicated GoC play a role in unplanned hospital readmissions from SNFs,[9–13] less is known about how clinicians' view the role of GoC for hospitalized patients discharged to SNFs for post-acute care. Therefore, we sought to examine how clinicians view GoC for patients discharged to SNFs and how GoC are perceived to influence patient outcomes while under SNF care. Results from this study can inform the development of best practices for care transitions, improve patients' and caregivers' satisfaction with SNF care, and enhance the quality and continuity of patient care from hospital to SNF settings.

Methods

Study Design

The study was conducted through the Yale Center for Healthcare Innovation, Redesign and Learning (CHIRAL #P30HS023554-01). The objective of CHIRAL is to explore and improve care transitions occurring into, within, and out of the hospital setting. This study was a secondary analysis of qualitative data derived from a study of hospital to SNF care transitions. The primary study used a thematic analysis qualitative approach. Thematic analysis relies on the synthesis of qualitative data to identify patterns and develop themes across experiences.[14] Interviews, coding, and analysis of the primary study took place from June 2015 to February 2016, with analysis of the GoC care code occurring between May 2016 and October 2016. The primary study and secondary analysis were approved by the institutional review board of the participating institution.

Sampling

The sampling frame for the primary study involved two general medicine units from a large approximately 1550-bed northeastern urban academic medical center and two local SNFs: a 160-bed suburban for-profit facility and a 130-bed urban, non-profit facility. At the time of the study, the suburban SNF had a five-star quality rating from the Centers for Medicare and Medicaid Services, and the urban SNF had a three-star rating. Both facilities were among the top 10 volume recipients for SNF discharges from the hospital. From May 2014 to May 2015, the year immediately before study initiation, 16% of all hospital patients were discharged to SNFs, and 4.7% of patients were readmitted from SNFs to the hospital within 30 days.

The study researchers used purposive sampling to identify hospital and SNF clinicians with direct experience or in-depth knowledge of the patient transfer process. Inclusion criteria included self-reported experience with patient transfers between hospitals and SNFs. Researchers purposefully strove to sample a diverse representation of hospital and SNF clinicians, although sample size determination was based on data saturation.[15] Clinicians with a wide range of professional backgrounds were included in the sample, including physicians, nurses, nurse practitioners, physician assistants, social workers, care managers, specialty providers, and administrative professionals. Potential respondents were identified through contacts at the hospital and SNFs. Study researchers contacted potential respondents through direct e-mail contact or phone calls. Participation was voluntary and did not affect the respondent's relationship with the hospital, the SNF, or the university. Respondents were encouraged to refer others with experience in patient transfers to the study. Recruitment and data collection continued until data saturation was reached, that is the point at which there was sufficient information to inform study hypothesis and lead to replicable findings, no new codes were identified, and no new information obtained over several consecutive transcripts.[15] Interviewing stopped at the point of data saturation determining the final sample size.

Interview Procedures

Four qualitative researchers, including two authors (SF and MCB), served as interviewers for the primary study. Researchers collected demographic information and used a semi-structured interview guide that combined broad, open-ended questions with specific probes about the hospital-to-SNF transfer process.

Sample questions included "Can you walk me through the process of navigating the transition from the hospital to a skilled nursing facility" (Probe: What do you need to know to take care of your patients?); "What aspects of patient transitions to SNFs have been challenging?" (Probe: What makes the process challenging?); and "What has been your experience with patients who are readmitted from the SNF to the hospital?" (Probe: What are some of the reasons a patient may be readmitted?). Interviews took place at locations most convenient for respondents, most often their respective practice sites. Interviews were audio-recorded, with permission from the respondents, and professionally transcribed. The transcriptions were then imported into ATLAS.ti qualitative software, version 7.0 (Scientific Software Development GmbH, Berlin, Germany) for coding, retrieval, and analysis.

Data Analysis

Data analysis was inductive, using the constant comparative method as part of the thematic analytic strategy, in which codes and code content are compared with each other, across codes and interviews.[14,16,17] A multidisciplinary research team reviewed interview transcripts independently, then jointly performing a line-by-line review of transcripts. The team created a code key, comprised of codes representing segments of data within each transcript. Coding disagreements were resolved through group discussion and consensus. The team refined the code key as new codes arose from successive interviews. Interviews and coding occurred iteratively until data saturation was reached. At the point of data saturation, the code key was finalized, and the final code key applied to all transcripts. Memos were kept to track this process. Then, the team then created code reports that contained all the data segments across all transcripts for each code and analyzed the data collectively developing themes. Through this process, GoC emerged as a frequently occurring code and significant factor perceived to affect care transitions and care quality.

As part of the secondary analysis of the GoC code, two researchers independently then jointly reviewed the interview data coded with the GoC code as well as codes co-occurring with the GoC code, creating a code key using the constant comparative method de novo from the data. To facilitate the development of the code key, researchers used a query tool included in the ATLAS.ti software package to identify codes that co-occurred with the GoC code within respondents' interviews. Once coding of the transcript data from the GoC and co-occurring codes was complete, the team analyzed code reports and developed themes.

Data collection and analysis rigor were supported with written interview instructions, interview question guides, and coding procedures. Disagreements were resolved via group consensus. The trustworthiness of data collection and analysis was ascertained by triangulating findings through feedback sessions with study respondents and community stakeholders.

Results

Sample demographics are summarized in Table 1. Completed interviews ranged in length from 14 to 51 minutes with a mean of 32.4 minutes. Of the 41 respondents, 25 were employed by the hospital, and 16 were employed by SNFs. Respondents included a diverse representation of frontline staff and leadership from several departments involved in patient care within hospital and SNF settings. The sample had a mean of 15.5 years of clinical experience (range 2–41).

Three themes emerged from the data. These included: 1) the importance and perceived infrequency of GoC discussions during hospitalization before SNF transfer, 2) the need for accurate reflections and realistic perspectives of GoC on the parts of the patient, family, and clinician, and 3) the significance of GoC to patient care outcomes (Table 2).

"Sometimes patients don't have that talk in the hospital." The importance and perceived infrequency of GoC discussions during hospitalization

Respondents viewed GoC discussions as vital to patient care and hospital transfers to SNFs as valuable opportunities for hospital clinicians to discuss GoC with patients and family members. Many respondents

Table 1
Sample Characteristics of Study Respondents ($n = 41$)

Study Site, *n* (%)	
Hospital clinicians	25 (61)
Skilled nursing facility clinicians	16 (39)
Role, *n* (%)	
Frontline nurses	9 (22)
Physician (physicians, residents)	8 (19.5)
Care management	6 (14.6)
Social work or social services	6 (14.6)
Mid-level professionals (nurse practitioner, physician associate)	4 (9.8)
Nursing leadership	4 (9.8)
Admissions staff	3 (7.3)
Physical therapy	1 (2.4)
Highest degree earned, *n* (%)	
High school diploma	1 (2.4)
Nursing diploma	2 (4.9)
Associate's degree	2 (4.9)
Bachelors	10 (24.4)
Masters	18 (43.9)
MD/DO[a]	8 (19.5)
Years of experience, median (range)	15.5 (2–41)

[a]Doctor of Medicine/Doctor of Osteopathy.

Table 2
Themes and Illustrative Quotes

Theme 1: The importance and perceived infrequency of goals of care discussions during hospitalization	
Importance of goals of care discussions	P8 Hospital Transitional Coordinator: "I understand that things do happen. People get sicker. If the forecast could be a little clearer just from that physician's standpoint, or maybe not even a forecast, but when they tell us the patient is ready from that standpoint, it would help us to be a lot more efficient."
Infrequency of goals of care discussions	P29 Hospital Charge Nurse: "It becomes clear that they [hospital clinicians] haven't even spoken to the family about what their values are in the nursing home. I think people, especially at the end of life, or with the aging relatives want counseling, and they want wellness."
Theme 2: Realistic goals of care perspectives of the patient, family, and clinician	
Patient	P9 Skilled Nursing Facility Director of Social Services: "If you come here and you expect to be cured and you're not cured—it's an overall picture."
Family	P22 Skilled Nursing Facility Nurse Supervisor: "I mean, they're elderly when they're here, and I think sometimes the families expect so much more from them, when they're really so sick. They're in their late '80's or '90's and they expect them to be at the gym and working out, and its like, "Oh, my god."
Clinician	P23 Skilled Nursing Facility Nurse Practitioner: "They're [hospital clinicians] sending them here with the assumption, "You're gonna get rehab. In a couple weeks you're gonna get stronger and you're gonna go home. That is totally ridiculous."
Theme 3: The significance of goals of care to patient care outcomes	
Negative perceptions of the facility	P38 Skilled Nursing Facility Director of Social Services: "I think they came here on a Saturday. They were just so unhappy from the minute they walked in. I'm thinking, how did rehab get presented to them because all they wanted to do was go home. Then on Monday, they walked in and they just insisted—the son insisted that she go home that day."
Unplanned transitions	P37 Skilled Nursing Facility Director of Nursing: "Your mom's 95, she has dementia, she fell and broke her hip, look at her now. Well, she just needed rehab and the hospital said in two weeks you're gonna make a miracle, and make her back to where she was. The truth is she's not gonna recover. She may end up long term, and she also may die. You don't know how many patients we transition to that."
Hospital readmissions	P3 Skilled Nursing Facility Director of Nursing: "End-stage kidney disease, end-stage liver disease, she went back and forth in [heart failure] which is our numbers, your numbers. The family said she was full code. You don't know many times we sent this patient back and forth [to the hospital]."

felt that GoC should be initiated by hospital clinicians to "start that discussion before they leave the hospital because that would facilitate the transition a lot better than us having to deal with all of these issues …. they need to have an understanding of why they're coming here and what the outcomes might be (SNF medical director)." In addition to the topics frequently covered in GoC conversations such as treatment options and advance directives, respondents felt that for patients transferred from the hospital to the SNF conversations should include the purpose and expected outcomes of SNF care as well as care preferences if rehabilitative therapies no longer benefitted the patient.

Despite respondents' views that GoC conversations were important, many respondents felt that GoC were often not discussed during hospitalization. The perceived lack of GoC conversations during hospitalization was particularly frustrating for SNF respondents, who felt they frequently received patients from the hospital who were unaware of the severity of their illness, for example, "with metastatic disease who have no idea that that's the diagnosis (SNF medical director)," or who arrived at the SNF with unclear care goals. One SNF nurse practitioner talked about the difficulty of initiating GoC conversations in an SNF setting, saying "they don't know me. I'm not their community doctor. I'm not the person who is seeing them in the hospital." A SNF medical director argued, "It's ridiculous for a patient to get here and not know their diagnosis and think they're comin' here to do rehab for two days and then going home, cured of their disease."

Respondents cited several reasons for why they believed GoC conversations did not occur during hospitalization, including difficulties prognosticating, a lack of time and training necessary to conduct GoC conversations, and "misperceptions about what actually happens at facilities with the inpatient teams (hospital physician)." Others identified a desire by hospital clinicians to take a "wait and see" approach in the setting of a new diagnosis of a serious illness. A SNF nurse practitioner stated, "sometimes patients don't have that talk in the hospital, because maybe they're newly diagnosed with some type of cancer, it's almost like they're sent [to the SNF] as a waiting period to see how they do, to see if they can get strong."

Respondents viewed accurate, timely, and consistent communication and documentation about GoC among hospital clinicians, SNF clinicians, and patients and families, as pivotal in defining anticipations of SNF care and lessening the risk of poor patient outcomes. However, many respondents reported having difficulty identifying if and when GoC conversations took place. An SNF medical director said "we have a gap in discharge planning, getting the right information. There's not information about what discussions you've had with the families, what their understanding and expectation of their prognosis is and what they're gonna do for them here. They might have had [that discussion] but we don't know that."

"False hope, false anticipation or a too optimistic interpretation." Realistic GoC perspectives of the patient, family, and clinician

Respondents felt that discordant and unrealistic views of GoC were common among patients discharged to SNFs and their families, leading to confusion and disagreements over care plans and anticipated patient outcomes while under SNF care. Respondents believed that conflicting or unrealistic GoC were the result of limited GoC discussions during hospitalization or poor communication of GoC between patients, families, and hospital staff. One SNF social services director remarked "It wasn't that everybody did what they could do. It wasn't the fact that your body just couldn't do it. It's the fact that they were given maybe false hope or false anticipation or maybe too optimistic interpretation sometimes or maybe they didn't hear it at that point in their illness."

Respondents cited several additional key factors that they felt increased the risk of unrealistic GoC, including patients' and families' limited knowledge or misconceptions about the disease process, prognosis, and treatment options, including the inability to distinguish the purposes of curative treatment vs. a palliative approach. A hospital physician explained "we're talking about not returning to the hospital, going home with hospice or going to in-patient hospice that's a very different conversation … to really make sure that the patient and the family understand what that means. There's a lot of misconceptions out there though, you know, what is hospice and that kind of thing."

"It gets to be like a revolving thing between hospital and SNF." The significance of GoC to patient care outcomes

Respondents linked several poor patient outcomes to unclear or unrealistic GoC, including negative perceptions (among patients and families) of SNF care quality, unplanned transitions to hospice, financial burdens, and hospital readmissions. Respondents often believed that negative perceptions of SNF care quality as well as anger and resentment toward SNF staff were the result of unmet expectations of care goals. For example, an SNF director of social services said, "depending upon the individuals or families, what they anticipate and what they expect, the end result might be that the place wasn't good. It wasn't good because we didn't meet the expectation of what you thought was going to happen."

Respondents reported that unplanned transitions to hospice and unexpected financial costs for patients and family could occur when patients transferred to SNFs were unable to participate successfully in rehabilitation efforts. "The hospital's telling 'em, 'Oh, we're gonna discharge them for rehab," said one SNF nurse, "Then they get here, and there's no rehab potential. Then they wanna go on hospice, Medicare doesn't pay for the room and board here if they go on hospice. We can have hospice come here, but then they get stuck with the bills."

Respondents felt that undocumented, ambiguous, or unrealistic GoC could also lead to frequent hospital readmissions from SNFs, particularly for sick, elderly patients with complex care needs. A hospital care manager said "the elderly clientele, when you're 85, 88 it gets to be like a revolving thing between the hospital and SNF. Talking about goals of care and palliative care, a lot of people don't like to hear about that." Respondents felt that readmissions could also occur because of uncertainties in code status among patients, families, and clinicians. Without clear consensus on resuscitation efforts or documentation of code status from the hospital, SNF providers had to employ all resuscitation interventions. An SNF nursing director described patients "that come over from [the hospital] that basically they still wanna be a full code even though there's not much left for people to do to help them before the end of their life, but they're not ready to accept that, [so] we end up having people go back to the hospital."

Discussion

The purpose of this study was to describe how hospital and SNF clinicians view patient GoC for those hospitalized patients discharged to SNFs. We found that respondents in our study preferred GoC conversations be initiated during hospitalization, but reported that these discussions infrequently occurred before hospital discharge. Limited time spent discussing GoC was viewed as frequently leading to ambiguous or unrealistic care goals among patients and families while at the SNF. Other factors that contributed to unrealistic GoC included patients' knowledge deficits regarding the disease process, prognosis, and treatment options, as well as inconsistent communication of care goals among patients, family members, and clinicians. Unclear or unrealistic GoC were often perceived to lead to poor patient outcomes including patient and family dissatisfaction with care, family anger or resentment toward staff, unexpected financial burdens, and hospital readmissions.

Our findings align with others[18–21] who have stressed the importance of establishing GoC for patients cared for within SNF settings. Patients discharged to SNFs increasingly are older, multimorbid, with potentially life-threatening conditions such as advanced cancer,[22] are recovering from major

surgeries,[23] or are undergoing complex medical regimens including chemotherapy. Furthermore, for many of these patients, prognosis and rehabilitation potential are poor at the time of SNF admission,[24] a finding echoed in our clinician interviews. For example, a study of hospitalized nursing home patients with advanced dementia found that 61% were admitted to an SNF post-hospitalization for short-term skilled nursing care or rehabilitation services, likely for little benefit.[24] The increasing clinical acuity of the SNF patient population, coupled with SNF patients who may have poor prognoses or limited rehabilitation potential, likely drive the perceived need for early, clear, and consistent communication of GoC found in our study.

Respondents in our study reported that patients and families frequently had conflicting or unrealistic views of GoC for care continuation at the SNF. Discordance among patients, families, and clinicians about treatments and care goals has been noted elsewhere, in particular for estimated prognosis and curative vs. palliative care options.[25] Disagreements over GoC can have adverse consequences, including more aggressive treatments at the end of life and perceptions of poor care quality.[26] Discordant or unclear GoC have also been linked to dissatisfaction among SNF staff and perceptions of inappropriate post-acute placement.[27,28]

Prior work has underscored the role of GoC, specifically advance directives, in the prevention of hospital readmissions from SNFs.[19,28,29] Another option in the prevention of readmissions for SNF patients may be the use of portable orders for life sustaining treatments (POLSTs). POLSTs document patients' wishes for advanced care during a medical emergency and are transferrable across care settings. The use of POLST forms show promise, with recent evidence indicating that SNF residents with POLST forms in place receive goal-concordant care.[30,31]

The recent interest in identifying causes of hospital readmissions from SNFs is not surprising, given the financial penalties hospitals pay and the new penalties SNFs will soon pay because of excessive patient readmissions.[6] Beyond financial consequences, hospital readmissions from SNFs are costly for the patient, often leading to in-hospital complications and high rates of patient mortality.[28,32] Our findings build on previous reports by highlighting not only the perceived relevance of GoC in SNF-to-hospital readmissions, but also for an array of other outcomes including perceptions of care quality and financial burdens.

Early GoC discussions, that is, those that take place before hospital transfer, are potential opportunities for quality improvement in reducing hospital readmissions from SNFs.[9] However, as suggested by respondents in our study, many clinician-level barriers exist to starting GoC conversations before hospital discharge, including time constraints, inexperience in conducting GoC conversations, or perceptions of inadequate training.[33–35] Palliative care teams within SNF settings may be helpful in instances where care goals are not established during hospitalization or where unanticipated changes to a patient's status necessitate revisiting GoC. Use of palliative care services during SNF stays have been shown to facilitate communication of patient GoC, reduce hospital readmissions and delayed transitions to hospice, and improve symptoms and perceptions of care quality.[10,20,36] However, utilization of palliative care services in SNFs remains limited.[12,37]

Our findings highlight the importance of removing institutional barriers that hinder communication of care goals and preferences across disease trajectories and care settings. Often GoC are not documented in hospital discharge paperwork,[38] which can negatively impact care at SNFs.[11,27] Poor communication between hospital staff and SNFs can lead to poor care transitions, resulting in behavioral problems, patient harm, hospital readmissions, and other negative outcomes.[11,27] Those hospitals able to provide robust care coordination inclusive of care coordinators relaying GoC preferences to SNF staff, have noted reductions in hospital readmissions and increased care quality.[8,18,23]

A strength of the study is in the use of semi-structured interviews, which permit a more in-depth and nuanced understanding of participants' views. Much of the prior research on the value of GoC within SNF settings has relied on survey data.[9,21] However, there are also several limitations of the study that merit consideration. First, although a small sample size is appropriate for qualitative research when data saturation is reached,[15] our results are not representative of all clinicians, practice settings, or institutional cultures. For example, although we interviewed respondents from two SNFs and one hospital, given the sample size we were unable to compare responses by site or clinician, and these perceptions may differ. Our study purpose and target for data saturation were clinicians' perceptions of GoC. We did not intend to saturate on differences in perceptions of GoC among clinician types, and additional research is needed in this area.

The two SNF sampling sites did not have in-house palliative care teams, which may have influenced respondents' views on the importance of GoC to hospital-to-SNF transfers. Our sample also did not include all types of direct patient care staff, including licensed practical nurses and nursing assistants. These clinicians may have contributed unique insights into how GoC influence continuing care at the SNF. In addition, this study was an

analysis of existing qualitative data, using a sample recruited from a single hospital and two SNFs. Data analysis was limited to what was available within the existing transcripts, and study findings may not be generalizable to all hospital or SNF settings. However, although certain settings may communicate GoC across care transitions better than others, given the realities of most clinical practice settings, we suspect that these issues are common.

We found that most clinicians preferred hospital staff initiate GoC conversations before hospital discharge. Interventions are needed that train hospital and SNF staff to effectively conduct these conversations.[39,40] In addition, programs that develop and implement SNF-based palliative care teams may also help clarify GoC with patients and families.[19] Care transition interventions that facilitate clear documentation and communication of patient GoC between hospital and SNF settings are needed. Promising interventions already in use include hospital-SNF referral partnerships[23] and care coordination programs.[18] As the population of patients discharged from acute care hospitals to SNFs continues to grow in size and complexity, it will be critical to identify additional effective strategies to improve establishment of and communication about GoC.

Conclusion

This study examined clinicians' perceptions of GoC for patients discharged to SNFs. Respondents viewed GoC as pivotal to the transfer process, although infrequently discussed during hospitalization. GoC discordance among patients, families, or clinicians and ambiguous or unrealistic GoC were perceived to contribute to poor patient outcomes while at the SNF, including negative perceptions of SNF care quality and hospital readmissions. Interventions are needed that facilitate, establish, and communicate GoC discussions across care continuums from hospital to post-acute settings.

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