Evaluating the Quality of Patient Decision-Making Regarding Post-Acute Care

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BACKGROUND: Despite a national focus on post-acute care brought about by recent payment reforms, relatively little is known about how hospitalized older adults and their caregivers decide whether to go to a skilled nursing facility (SNF) after hospitalization.

OBJECTIVE: We sought to understand to what extent hospitalized older adults and their caregivers are empowered to make a high-quality decision about utilizing an SNF for post-acute care and what contextual or process elements led to satisfaction with the outcome of their decision once in SNF.

DESIGN: Qualitative inquiry using the Ottawa Decision Support Framework (ODSF), a conceptual framework that describes key components of high-quality decision-making.

PARTICIPANTS: Thirty-two previously community-dwelling older adults (≥ 65 years old) and 22 caregivers interviewed at three different hospitals and three skilled nursing facilities.

MAIN MEASURES: We used key components of the ODSF to identify elements of context and process that affected decision-making and to what extent the outcome was characteristic of a high-quality decision: informed, values based, and not associated with regret or blame.

KEY RESULTS: The most important contextual themes were the presence of active medical conditions in the hospital that made decision-making difficult, prior experiences with hospital readmission or SNF, relative level of caregiver support, and pressure to make a decision quickly for which participants felt unprepared. Patients described playing a passive role in the decision-making process and largely relying on recommendations from the medical team. Patients commonly expressed resignation and a perceived lack of choice or autonomy, leading to dissatisfaction with the outcome.

CONCLUSIONS: Understanding and intervening to improve the quality of decision-making regarding post-acute care supports is essential for improving outcomes of hospitalized older adults. Our results suggest that simply providing information is not sufficient; rather, incorporating key contextual factors and improving the decision-making process for both patients and clinicians are also essential.

KEY WORDS: decision-making; post-acute care; hospital; skilled nursing facility.

J Gen Intern Med 33(5):678–84
DOI: 10.1007/s11606-017-4298-1
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Electronic supplementary material *The online version of this article (https://doi.org/10.1007/s11606-017-4298-1) contains supplementary material, which is available to authorized users.*

Received June 28, 2017
Revised November 6, 2017
Accepted December 14, 2017
Published online February 9, 2018

INTRODUCTION

The number of older adults transitioning to skilled nursing facilities (SNFs) is rapidly increasing,[1] and the aging of the U.S. population suggests this trend may only accelerate. Emerging payment reforms are sharpening focus on patient selection for SNF and on outcomes such as readmissions, rates of discharge back to the community, and costs.[2,3]

Despite the national focus on post-acute care brought about by legislation, relatively little is known about how hospitalized older adults and their caregivers decide whether to go to a SNF for post-acute care. Published studies have focused on the content of the information presented, rather than trying to assess the decision-making process[4,5] or on caregivers who recently placed a family member in a long-term care facility from home, rather than inpatients going to post-acute care.[6]

We sought to understand to what extent hospitalized older adults and their caregivers are enabled to make a high-quality decision about post-acute care in an SNF. We interviewed patients and caregivers in both the hospital and SNF setting about their experience with decision-making around SNF placement to elicit elements of context or process influencing their satisfaction with the outcome of this decision. This

information is crucial to inform future efforts to align patient needs and goals with resources following hospitalization.

METHODS

Study Design

This analysis is part of a larger qualitative study evaluating patient and provider decision-making regarding post-acute care in SNFs from both the hospital and SNF perspectives. We identified an evidence-based conceptual framework that describes key components of high-quality decision-making—the Ottawa Decision-Support Framework (ODSF)[7]—and used a framework design to guide our analysis.[8] The ODSF draws on concepts from psychology, decision analysis and conflict, social supports, and economic theory to assess patient needs for making a high-quality decision, what supports are available, and evaluation of the outcomes of the decision made.[9] It has been widely used to support development of patient decision aids in clinical situations where achieving a high-quality decision is challenging.[10–14]

Setting and Participants

We identified participants in three hospitals and three SNFs, including several different clinical units within the hospitals. The three participating hospitals included a VA hospital serving a predominantly male population often with significant medical comorbidity and weak social supports,[15,16] a quaternary-level university hospital serving a large referral base as well as a predominantly urban population, and a safety-net public hospital serving a predominantly indigent and immigrant population. We sampled participants from clinical units that primarily discharge older adults to SNFs, such as general medical wards, an Acute Care for the Elderly unit,[17] and an orthopedic surgery unit. SNFs sampled included: a VA Community Living Center (CLC) co-located with the main VA hospital that provided short-term rehabilitation only; a predominantly long-term, Medicaid-funded nursing home with a smaller Medicare-certified rehab unit; and a community SNF that only provided short-term rehabilitation under Medicare. The requirement for written informed consent was waived; the study was approved by the Colorado Multiple Institutional Review Board.

Hospitalized patients were eligible for inclusion if they had an unplanned hospitalization, were over age 65, and were being discharged to an SNF. We identified eligible patients through participation in interdisciplinary rounds on each unit or by hospital staff referral. Study staff relied on the expertise of the treating teams to determine if a patient was cognitively able to participate in an interview; patients deemed unable were excluded. SNF patients were eligible if they had recently been discharged from an acute care hospital for short-term rehabilitation, were over age 65, and did not have a level of cognitive impairment that would prevent them from meaningfully participating in the interview (determined by primary treating physician). We relied on referrals from Medical Directors, attending physicians, and Directors of Nursing at each SNF to identify eligible patients. We identified caregivers by asking patients, "Can you think of the one person besides a health care provider who helps you the most with your medical care?"[18]

Data Collection and Analysis

Between February and September 2016, qualitative analysts (EL, AL, RA) conducted a 20–60-min semi-structured in-depth interview with each participant. Interviews with patients were conducted in person, while interviews with caregivers were conducted in person or over the phone. Patients and caregivers were interviewed separately. We used an interview guide informed by prior research, theories and frameworks related to transitions of care and clinical experience (see Online Supplementary Material).[19–22] Topics included: evaluating the need for post-acute care; selecting post-acute care options; attitudes, knowledge, and beliefs about SNFs; influences on discharge decision-making; and post-discharge follow-up. Interviews were audio-recorded, professionally transcribed, validated, and analyzed in Atlas.Ti (v7.5.11; Scientific Software Development, Berlin, Germany). Participant demographics were collected using a brief questionnaire before each interview.

We employed a team-based approach to the framework analysis method. We initially used a deductive approach, looking for key components of the ODSF that are key components of high-quality decision-making. However, we discovered many key components of the ODSF were not discussed by participants, and the process did not fit this ideal decision-making model. We thus re-approached the data using an iterative inductive-deductive approach, identifying key themes and grouping them into broader concepts from the ODSF (context, process, and outcome). We used a framework matrix to identify patterns in the context and process characteristics for patients and caregivers (separately) where the outcome was optimal as described by the ODSF: informed, aligned with values, and not associated with regret or blame.[7] Finally, we identified suggestions of patients and caregivers for improving the decision-making process.

Initial codes were developed through group discussion; additional codes were developed in the process of thorough re-immersion in the transcripts by individual team members. As new codes emerged, they were discussed at team meetings to reach consensus on code labels and definitions until saturation was reached.[23] To ensure reliability of our findings we (EL, AL, RA, CL, RB) reread selected transcripts to confirm themes and patterns identified. We met weekly throughout data analysis to discuss the process and emergent themes, and key analytic decisions were documented as part of our audit trail.

RESULTS

We interviewed 32 patients and 22 caregivers ($n = 54$ total), across hospitals ($n = 32$) and SNFs ($n = 22$). Patients were generally elderly and white with Medicare as their payer. More

than 80% identified a caregiver, half of whom were children of the patient (Table 1). Overall, our results suggested most patients experience significant challenges to making a high-quality decision about post-acute care in a skilled nursing facility related to both contextual and process factors, resulting in suboptimal outcomes of their decisions.

Decision Context

The ODSF recognizes that high-quality decisions are affected by the personal and clinical characteristics of the person making the decision, as well as key elements of the external context in which the decision is being made.[7]

Patients and caregivers described barriers across these contextual domains (clinical, personal, and external) to high-quality decision-making. The presence of active medical problems that impaired full engagement in the decision being made was the main clinical barrier cited by patients and caregivers. Their prior experience failing at home and being readmitted, experience with SNF, sense of identity, and their social support were predominant personal drivers of decision-making. The pressure to quickly make a decision participants felt unprepared for was the main external contextual influence.

Patients described a variety of clinical reasons for difficulty attending to a decision about post-acute care, including receiving sedating medications, having their sleep/wake cycle disrupted, or having unresolved symptoms (such as weakness or pain; Table 2, quotes 1–3). Their prior personal experience with post-discharge care also strongly influenced their current decision-making process. For example, several patients had tried going home and been readmitted to the hospital or had been to SNF before, and these experiences were described as framing the decision to go to SNF after the current hospitalization (Table 2, quotes 4–6). The involvement of a caregiver (or lack thereof) was a key contextual determinant of SNF decision-making (Table 2, quotes 5–7). However, patients and caregivers experienced the decision as unexpected and rushed (Table 2, quote 8).

Table 1 Patient and Caregiver Participant Characteristics

Characteristic	Patient $N=32$ (%)	Caregiver $N=22$ (%)
Location of interview		
Hospital	18 (56)	13 (59)
Skilled nursing facility	14 (44)	9 (41)
Demographics		
Age, mean years (range)	75 (60–96)	54.09 (29–79)
Female	14 (43)	14 (63)
Veteran	18 (56)	2 (8)
Race/ethnicity		
White/Caucasian	23 (71)	11 (50)
Black/African American	4 (12)	2 (9)
Mixed/biracial	3 (9)	4 (18)
Asian	1 (3)	2 (9)
Latino/Hispanic	0 (0)	1 (4)
Native American	1 (3)	1 (4)
Educational level attained		
Grade school	5 (17)	1 (4)
High school/GED	6 (18)	2 (9)
Some college	7 (21)	8 (36)
College graduate	10 (31)	7 (31)
Post-graduate	4 (12)	3 (13)
Annual income ($)		
< 30,000	16 (50)	–
30,000–50,000	7 (21)	–
> 50,000	7 (21)	–
Household size of patient		
1	14 (43)	–
2–3	14 (43)	–
> 3	4 (12)	–
Insurance coverage of patient		
Medicare	28 (87)	–
VHA	10 (31)	–
Private insurance	11 (34)	–
Medicaid	4 (12)	–
Other/no coverage	7 (21)	–
Caregiver relationship to patient		
Child	–	12 (54)
Spouse	–	4 (18)
Sibling	–	3 (13)
Other	–	3 (13)

Household size was missing one patient response. Respondents could have more than one payer for insurance coverage. Rounding may result in values > 100%

Decision Process

A high-quality process as defined by the ODSF is one in which the patient's knowledge, values, and preferred role in decision-making are elicited and their needs identified.[7] Surprisingly, patients reported passive participation in the process and heavily relied on the recommendation of the hospital care team (Table 3, quotes 1–2). Very few described considering other post-discharge options and most described minimal discussion with the care team about the decision (Table 3, quote 3). In many cases, patients saw discharge to SNF as a way to leave the hospital, since they perceived their only other option was to remain in the hospital (Table 3, quote 4). Those who tried to understand how SNF placement might fit into their goals expressed frustration with how little information they were provided by the hospital care team (Table 3, quotes 5–6).

Decision Outcome

An ideal decision outcome is one that was informed, aligned with the patient's values, and not associated with regret or blame.[7] Since patients and caregivers described significant challenges to being informed and had difficulty connecting their values to SNF stays, patients most commonly expressed resignation and lack of choice and autonomy (Table 4, quotes 1–2). The relatively passive engagement with the process was striking given participants expressed a significant concern about loss of autonomy, and many had to undergo the transition to SNF before understanding how it might align with their goals (Table 4, quote 3). When SNF care was unable to realize those goals, participants were dissatisfied with the choice (Table 4, quote 4).

Key Ingredients for a Positive Decision Outcome

We identified few patients or caregivers who described their decision as informed, aligned with their values, and not associated with regret or blame. When this did occur, common themes that arose included their active engagement in the

Table 2 Key Quotes Regarding Decision Context

Themes, subthemes, and quotes	Role
Theme: contextual barriers and facilitators to high-quality decisions	
Subtheme: Clinical issues affect decision-making	
(1) [asked about decision regarding SNF]: You know, that is so foggy in my memory that I could not tell you an honest answer	Patient, CLC
(2) He was in a lot of pain in the hospital, so you know, who knows what went on	Caregiver, university
Subtheme: prior experience with post-discharge care	
(3) The one day that I went home, I was going home come hell or high water…It was the next day when I was bleeding I came back [to the hospital]…so that's when common sense kicked in	Patient, university
(4) She had been to multiple rehab facilities in the past, so she has kind of her favorite one set…and that's what she wanted to choose	Caregiver, university
Subtheme: presence of caregiver influences choices	
(5) I do not have any friends or a girlfriend…to come over and get me into the shower, get me out. Once you get old…nobody wants to be bothered with you	Patient, university
(6) We have already experienced care where they look right through him, they do not listen to him, and he is being ignored, and so I am afraid…I am sitting here right now because he needs an advocate for his care…I need to know that he's going to be at a rehab facility where he'll be taken care of	Caregiver, university
(7) He would rather be at home….I just told him point blank you have to go [to SNF]	Caregiver, public hospital
Subtheme: context requires unexpected and rushed decision	
(8) There were pages and pages of names, sort of confusing, and they were pushing me to pick a place, wanted me out of there right away, and all I could remember was I needed a place close to home…so within two hours, a person from [SNF] came in, interviewed me….and within another two hours, I was very nicely put in a van with a very nice driver and came to [SNF]	Patient, community SNF

CLC = VA community living center, SNF = skilled nursing facility

decision-making process (Table 4, quote 5), realization of how SNF is aligned with expressed care goals (Table 4, quote 6), and having both prior experience with SNF and control over which SNF they will go to (Table 4, quote 7).

Suggestions for Improvement

Patients expressed interest in being more active participants in decision-making, even though their ability to do so was often impaired because of sedation or acute medical illness. When discussing SNFs with patients, patients suggested two areas of improvement: first, they wanted to know what actually took place in an SNF and what it would be like on a day-to-day basis while they were there. Particularly for patients who saw this as a challenge to their identity as independent older adults, learning about and experiencing the therapeutic and recreational programs at the SNFs helped assuage their fears (Table 5). Second, they wanted unbiased reviews from multiple sources to assist in decision-making, from results of inspections, quality metrics, and being able to call a patient who had recently been there to hear about their experience. Caregivers strongly felt patients should have more time in the hospital prior to discharge to an SNF to be able to more fully recuperate and felt they should be much more involved in the decision-making, particularly given the frequent perceived inability of their loved ones to participate meaningfully in decision-making.

DISCUSSION

Post-acute care payment reforms are placing the decisions older adults make about post-discharge supports at the center

Table 3 Key Quotes Regarding Decision Process

Themes, subthemes, and quotes	Role
Theme: process barriers and facilitators to high-quality decisions	
Subtheme: patient perceives lack of active role in decision-making process	
(1) [I am going] because they said so I guess. She [the social worker] said I need to go to rehab, so I guess I do because it's the doctor's decision	Patient, university
(2) They gave me two or three sheets of paper….I do not know how much more they could tell me	Patient, university
Subtheme: unclear options, lack of interaction with care team	
(3) People need help….we need to be walked through this. I mean, seriously, this is not something we do every day. I cannot be expected to know the ins and outs of this stuff	Caregiver, university
Subtheme: SNF as only alternative to staying in the hospital	
(4) I sure did not want to be in the hospital…he [the doctor] did not talk about it much at all. All he wanted me to come here so I could do OT and PT. I had a choice….I could stay in the hospital or come here, so I wanted to come here, not be in the hospital	Patient, VA CLC
Subtheme: lack of information or communication	
(5) The communication…I think was piss poor the way they go about doing it. If they had even said look, it's a rehab facility and all of that….Gee whiz, we are not a bunch of idiots…tell us what's going on	Patient, university
(6) It's just that we have got no idea of what his immediate, medium, and long-term prospect is. Maybe something else will become clearer after his assessment today, but I really would like someone to tell us	Caregiver, university

CLC = VA community living center, SNF = skilled nursing facility

Table 4 Key Quotes Regarding Decision Outcome

Themes, subthemes, and quotes	Role
Subtheme: resigned to SNF, no autonomy or choice	
(1) I guess I do not have a whole lot of choice. I am pinned down, I cannot do anything for myself right now…I am just thankful I have a place to go I guess	Patient, university
(2) [Did you agree with the decision to come here from the hospital?] You never agree to something like this. You accept it because you know it's got to be…you are at the mercy of whatever comes down the pike	Patient, community SNF
Subtheme: SNF as challenge to pre-hospital identity	
(3) I was just convinced I was going to lose all control of my day…all my autonomy, I was going to lose it. If I would've known they had all these different therapists…I just think I would have felt so much better. I was just convinced that I was on a decline to being a senior citizen	Patient, community SNF
Subtheme: SNF acceptable as long as condition improves	
(4) [The conversations about SNF] were very positive, they, and we at that point thought you know, he'll get through this and get stronger, but he did not. It was really disappointing when he did not	Caregiver, community SNF
Subtheme: active participation and decision satisfaction	
(5) The doctor [from the CLC] asked me to explain to him in my own words what I felt was going on right now and asked me…if I agreed with them, and that going to the CLC would be advisable	Patient, VA CLC
Subtheme: identifying SNF is aligned with care goals and decision satisfaction	
(6) Oh, I said, my care that I have at home would not be adequate for the care I need and that's when he [the doctor] told me that…I would go to a rehab first and then we talked about it…	Patient, university hospital
Subtheme: control over which SNF is used	
(7) I just knew where it [the SNF] was. I knew that there were wonderful, caring people here. I watched them work with my husband	Patient, community SNF

CLC = VA community living center, SNF = skilled nursing facility

of a national debate about "who should go where."[24] Our results suggest hospitalized older adults and their caregivers are infrequently able to make a high-quality decision about post-acute care because of important contextual and process factors, leading to significant dissatisfaction with the ultimate outcome of the decision.

Perhaps the most significant result of our investigation is that supporting high-quality decision-making for patients regarding post-acute care requires far more than providing information. This has been the main paradigm in the limited literature evaluating how to improve patient decision-making regarding post-acute options, summarized as: *if*

Table 5 Patient and Caregiver Suggestions for Improvement

Suggestion	Quote	Role
Identify preferred role in decision-making	My opinion on that is I think it could've been a little bit better as far as talking to me and allowing me to be part of the decision-making of where I go to…	Patient, community SNF
Describe the experience of being in an SNF to patients and caregivers	Had I known what the recreational and therapeutic programs were like or what the place just in general was like…I would've been a whole lot better off than the way it happened because I did not know anything. From step one, I knew nothing about these places or what was going to happen to me	Patient, VA CLC
	It's a shock for someone to…suddenly be thrust into an environment of recovery in one of these places and it would just be helpful to have a strong orientation program for all parties	Caregiver, university hospital
Provide more consistent, standardized information about SNFs to patients	It would've been nice if they could've just given us an info card on each of these other places that would possibly be open. Particularly location, parking, reputation, results of any inspections by the VA, food, orthopedic programs, occupational therapy-type things	Patient, VA CLC
	They need to get someone there that is able to do an unbiased thing with all these things, the treatment and everything and the quality of care…that I can open up and read patient reviews and stuff in there, maybe a phone number I can call some patients up	Patient, VA CLC
Communicate with caregivers early and often	Let me reiterate…someone should have notified me that he was being moved [to an SNF]. He was not in a condition where he could tell me these things. He wasn't even able to hold a conversation, really…he was so doped up on Dilaudid and morphine that he could not carry on a conversation	Caregiver, VA CLC
	I did not have a say as far as the facility itself, you know, it was 'here's where she's going and good luck' so I thought that was very limited	Caregiver, university hospital
	I think as much family involvement as much as you can get, I think, that helps you make a lot of decisions well	Caregiver, community SNF
Allow more time for decision-making in the hospital	With [his] mobility that compromised, they really needed to make sure that he was going to be able to participate…and he wasn't…and the pneumonia should have been caught in the hospital, I firmly believe that	Caregiver, community SNF
	I do think that the transition should have gone a little bit slower. It was obvious to me that his cough was not doing so well, not to mention he was pretty much out of it…there was a good three days of him being very confused, at the facility, and really not able to tell doctors and the nurses what was really happening	Caregiver, community SNF

we could just provide better information, patient decisions and outcomes will improve.[4–6] We found patients and caregivers did desire objective information from a variety of sources when making a decision, but that gaining information was only one aspect of a much larger decision-making process.

How can we then support high-quality decisions in hospitalized patients about post-acute care, including SNF? Using the principles of the ODSF and our results, we posit that the decision to pursue post-acute care in an SNF should be approached similarly to a "goals of care" conversation used in palliative discussions. Patients for whom SNF is recommended usually have multiple significant comorbidities and impaired functional status; in addition, more than half are 80 years of age or older.[25] The stakes of such a decision are high, as costs of SNF care to patients can be significant, and failure to rehabilitate can lead to long-term nursing home placement.[26,27] Attending to important contextual factors and using a structured process to elicit patient (and caregiver) values, goals, and preferred role in decision-making—to tailor how information is provided and recommend post-discharge options—holds the best chance of supporting a high-quality decision.

This work should be interpreted in the context from which it was derived. For example, our hospital interviews only took place in predominantly academic and tertiary centers and all interviews took place in a single urban area; our findings may not be generalizable to community or rural settings. Strengths include a large, diverse sample of patients and caregivers and the ability to capture decision context, process, and outcomes by conducting interviews in the hospital and SNF setting. We used a validated, widely used framework for our qualitative framework analysis and robust methods to assure analytic quality.

These results, including common patterns leading to a high-quality decision and suggestions for improvement, suggest the utility of a structured, patient- and provider-"facing" intervention to improve the quality of post-acute care decisions. This is critically important as the number of older adults being discharged to post-acute care supports continues to increase[1,28] and incentives are rapidly changing as the result of post-acute care reforms.

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Funding *This work was supported by the National Institute of Aging, R03AG050885 (Dr. Burke, PI). Dr. Burke was also supported by a VA HSR&D Career Development Award (1IK2 HX001796).*

Compliance with Ethical Standards:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

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