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Original article

Are we “missing the big picture” in transitions of care? Perspectives of healthcare providers managing patients with unplanned hospitalization

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ABSTRACT

Background: Healthcare providers play a critical role in the care transitions. Therefore, efforts to improve this process should be informed by their perspectives.
Aim: The study objective was to explore the factors that negatively/positively influence care transitions following an unplanned hospitalization from the perspective of healthcare providers.
Methods: A qualitative study using semi-structured interviews conducted between February and September of 2016 at a single academic medical center. We enrolled fifteen healthcare providers from multiple disciplines involved in the management of patients experiencing an unplanned hospitalization. Respondents shared their experiences with care transitions and identified factors within and outside of the discharging health facility that impede or facilitate this process. Transcribed interviews were analyzed using emerging themes from the interviews.
Results: We identified six themes and associated subthemes from the interviews on factors that influence care transitions. Three themes focused on factors within the discharging healthcare facility: untailored and overloaded patient discharge information, timing of the post-discharge care conversation, provider-to-patient and provider-to-provider miscommunication. The other three themes were related to external factors including caregiver involvement, having a safe and stable housing environment, and access to healthcare and community resources. Providers discussed how these factors positively/negatively influence the hospital-to-home transition.
Conclusions: Our study identifies factors within and outside the discharging healthcare facility that influence care transitions, ultimately affect patient-centered outcomes and provider satisfaction with delivered care. Strategies aimed at improving the quality of care transitions should address these barriers and actively engage healthcare providers who are pivotal in care transitions.

1. Background

Care transitions refer to a set of coordinated actions aimed at ensuring the continuity of patient care as they transfer between hospital settings, different levels of care, health care providers and to and from home (Fitzpatrick & Kazer, 2012; Geary & Schumacher, 2012). There is broad consensus that an ineffective care transition poses a high risk for adverse medication related events, incomplete transfer of pertinent patient information, unscheduled hospital readmissions, and increased mortality (Forster, Murff, Peterson, Gandhi, & Bates, 2003; Jencks, Williams, & Coleman, 2009; Kripalani et al., 2007). Consequently, care transition redesign efforts aimed at improving the transition from inpatient to outpatient settings have been implemented with promising results such as improved patient outcomes, reduced hospital

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readmission rates, and cost effectiveness (Coleman, Parry, Chalmers, & Min, 2006; Jack, Chetty, Anthony, et al., 2009; Naylor et al., 2004). Healthcare providers play a prominent role in managing hospitalized patients and executing the discharge process. However, since the inception of these innovative programs little research has focused on understanding the factors that may present barriers to, or facilitate effective care transitions from the perspective of healthcare providers.

During the care transition, patients encounter multiple healthcare providers who ideally collaborate to improve quality of care, engender positive patient experience and reduce healthcare costs (Berwick, Nolan, & Whittington, 2008). However, available data from a limited number of studies highlight the frustration patients and their caregivers experience in dealing with multiple providers due to poor communication and insufficient care-coordination between providers in the inpatient and outpatient settings (Arora, Prochaska, Farnan, et al., 2010; Bell, Schnipper, Auerbach, et al., 2009). In addition, patient-level factors and their physical and social environment may influence the quality of care transitions (World Health Organization, 2016). Though all transitions of care are fraught with pitfalls, however those around an initial unplanned hospitalization are perhaps more disruptive for patients and their families as they may lack the benefit of optimizing comorbidities, harnessing economic resources, and mobilizing social support in advance of hospital admission as they might for a planned hospitalization (Fuji, Abbott, & Norris, 2012).

We conducted this qualitative study to explore the factors influencing care transitions from the perspective of healthcare providers involved in the management of patients experiencing an unplanned hospitalization and coordinating various aspects of their subsequent care transitions. We included providers from diverse specialties and varying years of experience to achieve a multidisciplinary perspective.

2. Methods

2.1. Study design

This study utilizes data from a Patient Centered Outcomes Research Institute (PCORI) funded research designed to improve the quality of care transition measures with input from three stakeholder groups: providers, patients and caregivers. Findings from the patient and caregiver interviews are detailed elsewhere (Erskine et al., 2018; Shirley et al., 2018). Here, we report methods and results from the provider interviews with relevant insights as to the barriers and facilitators of care transitions.

2.2. Participant selection and setting

The study was conducted at a tertiary care hospital in central Massachusetts. The research coordinator conducted informational sessions with nurse managers and nurse practitioners to introduce the study and invite participation. In addition, two physician investigators in our study (DM, cardiology; HS, trauma/emergency surgery) provided a list of potential study participants using purposive sampling; and snowball sampling was also utilized whereby recruited participants suggested colleagues to be contacted. To avoid sampling bias due to perceived pressure to participate in the study, the investigators did not notify any colleagues of pending contact from study team members for recruitment. The investigators were not involved in any initial contact of potential interviewees, nor in any further contact once consented. Furthermore, we maintained anonymity of the study investigators when listed participants were contacted and separate research personnel conducted the semi-structured interviews. The two investigators who provided the lists of potential participants were part of the multi-stakeholder advisory committee that designed the semi-structured interview guide. None of the study authors were interviewed as study participants. In addition, to recruit patient care staff from wards (e.g., bedside nurses, patient care associates) our lead research coordinator conducted brief information session and left flyers in documenting areas to aid in recruitment. Nine participants were identified by the study cardiologist and trauma surgeon, five were recruited through snowball referral, and one participant responded to study advertisements displayed in the hospital. Inclusion criteria were: (a) involvement in the care of patients with unplanned hospitalization, providing discharge/follow-up services, and (b) willingness to participate in a semi-structured interview, lasting no more than one hour. The research coordinator contacted 34 of 39 potentially eligible participants via electronic mail. Twenty enrolled in the study and 15 providers completed the interviews.

2.3. Data collection

A semi-structured interview guide was developed from the care transitions concepts discussed in prior literature (Geary & Schumacher, 2012) by an iterative process with two clinicians/co-authors (HS, DM) and input from a multi-stakeholder advisory committee comprising two patients, one caregiver and one hospital administrator. The interview guide asked respondents to describe the process of care transitions, factors influencing this process, and ways to improve transitions. The guide included open-ended questions, such as “Can you describe the information that is routinely provided to patients for the transition back to home? Do you feel that this is enough information for a successful transition or are there other things that you would want to provide?”, “What do you think are factors separate from the healthcare system that might affect the quality of transition?”. In addition, interviewers used probes to elicit detailed information regarding participants' experience with care transitions.

Between February and September of 2016, two research associates conducted 12 face-to-face interviews and 3 telephone interviews (to enable participants complete their interviews at the time most convenient for them). In-person interviews were conducted in private offices at participants' workplace with duration ranging from 18 to 48 min, and the telephone interviews lasted between 30 and 52 min. All interviews were audio-recorded, transcribed and imported into NVivo v.11.3.2 for subsequent coding and analysis (QSR International, Melbourne, Australia). Each study participant provided a written informed consent prior to the in-person or telephone interviews. The University of Massachusetts Medical School Institutional Review Board approved this study.

2.4. Data analysis

To ensure transparency of our research methods and trustworthiness of our findings, analyst triangulation was achieved by three authors from diverse academic backgrounds (HA, physician; NE, MD/PhD candidate; JL, acute care nurse practitioner) and with varying qualitative research experience analyze the transcripts independently and subsequently meet frequently to develop the coding structure. The team performed line-by-line review of the transcripts and conducted data analysis using the constant comparative method with codes developed iteratively and refined based on the emerging themes from the data (Braun & Clarke, 2006; Glaser, 1965). Disagreements on the codes and emerging themes were resolved by an independent adjudicator/co-author (HS) with substantial clinical and qualitative research experience. A final coding scheme was developed and applied to all transcripts and we observed thematic saturation with no emergence of new themes and repetition of information from the participants. Codes from data analysis are presented in Table 1.

3. Results

3.1. Participant characteristics

The study participants (n = 15) comprised physicians (n = 6), nurse

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