

Research Article

Clinical Interventions of Hospital at Home in Nursing Home in France: Barriers, Incentives and Guidelines

Louise Harlé

Assistance Publique - Hôpitaux de Paris (APHP), Hôpital Broca, 75013 Paris, France

Odile Marquestaut

Assistance Publique - Hôpitaux de Paris (APHP), Hospitalisation A Domicile (HAD), 75005 Paris, France

Elisabeth Balladur

Assistance Publique - Hôpitaux de Paris (APHP), Hospitalisation A Domicile (HAD), 75005 Paris, France

Sylvie Humbert

Assistance Publique - Hôpitaux de Paris (APHP), Hospitalisation A Domicile (HAD), 75005 Paris, France

Matthieu de Stampa

Assistance Publique - Hôpitaux de Paris (APHP), Hospitalisation A Domicile (HAD), 75005 Paris, France

ABSTRACT

Background: Hospital at Home (HAH) can intervene in Nursing Home (NH) in France for reinforcing the primary care quality of the very frail residents and reducing hospital admissions. But the development of this innovative care program is still limited and objectives of the study were to identify barriers and incentives of this collaborative intervention.

Methods: This is a qualitative study based on semi-structured interviews with clinicians and administrative professionals of the HAH of the Assistance Publique-Hôpitaux de Paris and two NH in Paris. Eighteen semi-structured interviews were conducted and data analysis used the Grounded Theory method.

Results: The willingness of collaborative practices expressed by the management level met resistances at clinical level;

clinicians from NH and HAH had an opposite vision of the nursing home; HAH clinicians felt isolated in their intervention in the NH and a lack of communication tools was compensated by the nurse managers.

Conclusions and recommendation: Barriers of collaborative interventions were numerous, more frequent at clinical level and mainly for the HAH clinicians whose practices in NH were isolated. Based on the study findings, recommendations are proposed for reinforcing the collaborative interventions: promoting a shared institutions project focused on resident benefits, fostering a common aging culture between clinicians and planning joint interventions with communication tools.

Key words: Hospital at Home, Nursing home, Collaborative intervention; Very frail older residents; Avoiding hospitalization.

How This Fits in with Quality in Primary Care

Based on the study, some recommendations are proposed:

- Promoting a shared institutions project focused on resident benefits,
- Fostering a common aging culture between clinicians from both institutions,
- Planning joint interventions with communication tools

Background

Most of the French nursing home (NH) ensure an all-inclusive solution for the very frail residents with accommodation, medical care and an adapted environment in public (43%) and private settings (31% in non-profit, 26% in profit) [1]. Frail residents present complex needs with a high risk of acute clinical exacerbations conducting to hospital admissions [2]. But hospitalizations for older adults increase their risk of falls, confusion and autonomy loss [3,4]. In the industrialized health

care systems, the development of the Hospital at Home (HAH) is expending for answering the growing will of patients to be treated at home [5]. HAH provides hospital level of care in the patient's home such as palliative care, supportive care, complex dressing or intravenous treatment [6]. HAH delivers intensive and continued primary care (24 hours and 7 days) provided by a large range of professionals, substituting hospital admission [7,8]. Providing acute primary care in NH by implementing HAH interventions could be effective in reducing hospital admissions for the very frail residents [9-12].

In France during the last decade, the HAH had been expanding (+130%) with more than 310 enrolled institutions, 110000 patients [13] and a growing number of older patients [14]. Since 2007, the French government had authorized HAH to intervene in nursing home for caring the very frail residents [15]. But the development of this innovative care program is still limited. In 2015, only 5360 residents had benefited from this program, which represented 4.8% of the HAH days and 1% of the hospital stays for the nursing home residents [16]. Given the importance of achieving effective collaboration, this study was undertaken to better understand the dynamics of these collaborative practices by identifying barriers and incentives from healthcare professionals. We realized a qualitative study recruiting both institutions' professionals working together. Our study should provide practical guidelines to more implement this innovative care program.

Methods

Given the lack of knowledge about the complexity of the collaboration, a qualitative method was considered as better appropriate gathering a lot of information on this scarcely-documented subject.

Study sample

The study has been carried in a public HAH at the greater Paris University Hospital's named Assistance Publique - Hôpitaux de Paris (APHP). This HAH is the first HAH implemented in France in 1957 and is the biggest public one with 820 patients a day. This HAH covers all the territory of Paris and closing departments with 20 based care units. Three care units have participated at the study. Two NH have been chosen because they worked with these 3 care units. The nursing home 1 (NH1) was private, located in Paris and had 100 residents. The nursing home 2 (NH2) was private, located in the department of Val de Marne and had 75 residents.

The study sample gathered 18 professionals from the HAH and NH including directors, physician coordinators, nurse managers, nurses and assisting nurses. All professionals have been shortlisted on the following criteria: working in the HAH or in NH for at least one year and having participated in the care program. All have been contacted through emails and phone calls by the main researcher, a public health doctor (LH) to obtain their consent and plan the interviews. Professionals received a written information file describing the design and modalities

of the study and then, after being given the opportunity to ask questions if they wished to, written consent was obtained from all of them. No-one contacted refused to collaborate.

However many healthcare opinions were collected from both HAH and NH are likely supportive and meaningful. The effort put in for merging of HAH and NH service is very appreciable.

A total of 3 directors, 5 physician coordinators, 5 nurse managers, 4 nurses and 1 assisting nurse took part in the study from the 3 care units of the HAH and from the 2 NH settings (Table 1).

Data collection

Qualitative data collection took place between Mai and August 2017 as one-to-one interviews at the working place. Meeting duration was approximately between 30 to 45 minutes. The questionnaire had been constructed on the literature review and was validated during a weekly staff meeting by a group of HAH professionals. All the interviews began by a general question before diving into more precise topics exploring 3 main themes:

1. The views of the professionals on providing care to elderly adults in an NH,
2. Collaborative practices of HAH and NH with an emphasis on coordination and communication processes,
3. Impacts of collaborative intervention on residents and professionals own practices. The interviewer was a graduating doctor, trained in qualitative research. All recordings have been anonymous prior to their analysis.

Data processing and analysis

All interviews were recorded and fully transcribed as verbatims. In order to classify recurring topics, the transcripts went through a three-pass coding process carried by three independent doctors: the main researcher (LH) and two other public health doctors (OM, MDS). An analysis grid was built beforehand and enhanced while analyzing the verbatims. The researchers looked at the following: topics frequency, divergence and convergence between participants and links between the topics. Each new idea was checked against the whole corpus for validation. The result gave us a list of illustrations which identifies relevant categories and relationships. Both coding and analysis processes were based on the Grounded Theory, whose main rule is to constantly go back to the analysis' results and the empirical data for comparison [17]. A preliminary categorization of findings

Table 1: HAH and NH interviewees.

	Director	Physician Coordinator	Nurse Manager	Nurse	Assisting Nurse
HAH					
Unit 1		✓	✓	✓	
Unit 2		✓	✓	✓	
Unit 3	✓	✓	✓	✓	
Nursing Home 1 (NH1)	✓	✓	✓	✓	
Nursing Home 2 (NH2)	✓	✓	✓		✓

took place following the first 10 interviews, saturation emerged after 14 persons interviewed and the remaining data were collected and used to validate the categories.

Results

Based on our results, we were able to identify barriers and incentives to collaborate between HAH and nursing home. They were grouped in four main topics.

Struggle between collaboration willingness at the management level and by clinicians

Directors of both institutions were willing to collaborate together. For the HAH director, the intervention of the HAH provided acute and intensive care for the NH and could better fit of the complex resident's needs.

"This is HAH mission to provide acute care within the nursing home (...). For us, this is a response to an important need" Director HAH.

For the management of the 2 nursing home, this care program aligned with public institutions policy and they were very favorable for these collaborative practices.

"To me, more than an interest, this is an obligation. Today, we're asked to work with HAH, which is part of the conventions" Director NH1.

"No concerns, I see only advantages" Director NH2.

Despite the willingness of the management level from both institutions, clinicians struggled to adhere to this care program, especially the ones from HAH. For some HAH nurses, there was a mismatch between the public mission of the HAH and its intervention in the private sector with high fees for living.

"This is really crazy [talking about the fees]. Those things happen that way! Really crazy!! Yeah, when you see how much residents pay! Multiplied by the number of residents... someone must be living pretty well" Nurse HAH2.

"With respect to how much they pay, the number of healthcare professionals isn't adapted" Nurse HAH1.

For some HAH nurses, their interventions in the nursing home could compensate a lack of staff.

"I feel that we're here to help the resident and the nurse of the NH. HAH nurses are the stopgap of the institution lacking staff to provide sufficient care" Nurse Manager HAH3.

For some other HAH clinicians, carrying operations at the NH was neither part of their initial project nor part of what made them join the HAH firsthand.

"Care professional's teams came to HAH to operate at people's homes, not in the nursing home which they consider as being a patient care setting." Nurse Manager HAH1.

Opposite vision between Nursing Home and HAH clinicians on what an NH was

Most HAH clinicians had a negative opinion of the Nursing Home. It meant anxiety and unhappiness.

"I hate it when I have to go to an NH (...) I shut my ears, because it's not possible" Nurse HAH2.

"Myself, I might have to go to an NH. I hope I will have severe cognitive impairments, so I won't realize what's going on" Nurse Manager HAH1.

"Those are very harsh places to live" Physician Coordinator HAH1.

HAH clinicians intervened mainly at the nursing home for complex dressing. They rated that these health care problems were, most of the time, due to a lack of quality of the care provided to residents.

"They have pressure ulcer problems, because, most of the time, the nursing isn't good enough" Nurse Manager HAH3.

"When the residents stay in bed, I have the feeling that they're abandoned, maybe it's harsh to say that, but it feels like they're left behind in their bed" Nurse Manager HAH1.

This bad feeling of the HAH clinicians was also related to the aging and what aging could be represented by the frailty and cognitive impairments and functional disabilities.

"In fact, it's not really the nursing home that I loathe, it is more this kind of aging form that society is reluctant to see to find solutions" Physician Coordinator HAH3.

From professionals of NH, points of view and discourses were radically different. The vision of the resident in the NH was more positive and less focused on the medical care. Social factors were considered as the first-class when medical care came in second line.

"Death here isn't felt as a big deal as social life is more important" Nurse NH1.

"If we focus only on medical care, the living place becomes inhuman" Nurse Manager NH2.

"To me, medical care should be seamless and invisible" Nurse NH3.

For the NH clinicians, residents were happier here in NH than at home, because they were surrounded and were not alone.

"I believe that we're doing good work with some residents as they are happier here than at home" Nurse Manager NH1.

"NH brings thing you cannot get at home, like socialization and living within a community. (...) Some people take part in activities they didn't do for 20 years, because here they find some pleasure again." Physician Coordinator NH1.

HAH clinicians felt lonely at the nursing home without a vision of joint care

For most HAH professionals, nursing home setting was seen more as an hospital than a private home.

"Nursing Home is not home, so we're all... we're all scared of some depersonalization" Physician Coordinator HAH2.

HAH clinicians also felt lonely in the NH compared to their interventions at home where the caregiver was usually present.

Most of the time, no-one was welcoming the HAH clinician when she/he arrived and their intervention were considered as impersonal.

"At the nursing home, we're alone; at home, there is usually the family and even if the person is alone, being at home means that they're fewer dependent. She's expecting us and welcomes us. It's very different" Nurse HAH1.

"At home, we can chat, laugh, it's ok (...), when we arrive, they give us something to drink; it's warmer. A breath of fresh air... at the nursing home, it's not the same thing" Nurse HAH2.

Furthermore, HAH clinicians felt like external care providers, like outsiders without a comprehensive vision of the resident situation.

"It is weird, we really feel like a service: 'Hello, we're HAH, we do our thing and off we go'. We have no clue about their personal life. No-one will give us information on how the people were before." Nurse HAH2.

Finally, there was a lack of medical reactivity in care adaptation for the HAH clinicians especially for prescription of pain killer treatments related to complex dressing.

"Preparatory meetings are not always followed by action, especially when it comes to pain killers." Physician Coordinator HAH3.

"Either we give up the care planning or we do without premedication, but this is only if the patient says: I'm OK, go for it" Nurse HAH2.

Communication failures between HAH and NH clinicians compensated by the nurse managers

On each side, care teams walked past each other without much exchange and communication.

"I have no problem with HAH professionals, but we hardly know when they come. They come, do their thing and go" Nurse Manager NH1.

"What we need is to talk to each other. We need to find them, but they also have to find us." Nurse Manager NH2.

For some NH clinicians, there was a care planning problem with HAH professionals. It changed regularly and did not take into account the nursing home's planning.

"They never come at the same time (...) they call, maybe one hour before and then there's some hick-ups. It happened that the HAH nurse arrives but the resident wasn't ready yet" Nurse Manager NH1.

Information about the patient care by HAH and NH did not flow seamlessly between all professionals. HAH professionals limited their action to the technical part without transmitting all tracking information to their nursing home colleagues. This difficulty really showed when the families asked for this information.

"There is never any transmissions, this is irritating, because nothing is written in their file (...) I try to catch them to ask, but

sometimes I'm too busy doing something else" Nurse NH1.

"Family comes to me, but I have no idea what to say: I don't know. What do you mean, I don't know. The plaster was done two days ago and you're the one who's responsible. Yes, but someone else is coming to do it. But still, it is your resident...I agree, I should have this information" Nurse NH1.

Medical information from the nursing home was also difficult to gain access to for the HAH staff. The tracking file was left in the room, but each team had its own lingo the other one could not decipher.

"Their file is so much locked by codes, that no-one can access it. Treatment room is also locked, so I have to find Tom, Dick and Harry to open it..." Nurse HAH2.

"It's really! I don't get it! This is what I thought the first time I looked at their file. I didn't dare touching anything, because I don't understand how it's organized" Care Assistant NH2.

Nurse Managers from both institutions helped to better communicate within their staff. Most of the clinicians identified them as key-roles to the inter-institutions relationships. Some regretted that the communication happened only at the management level and not between professionals.

"When there is a problem with the nursing home, I speak really quickly to my manager" Nurse HAH2.

"I think that a direct communication would save time and help when something goes wrong" Nurse Manager NH1.

Discussion

Our results showed that the willingness of collaboration expressed by the HAH and NH directors met a resistance at the clinicians level. Healthcare professionals from NH and HAH had an opposite vision of the NH, considered as a way to create social bond for the former and lived negatively for the latter. HAH clinicians felt isolated, producing impersonal care without a vision of joint intervention. Finally, communication difficulties between the two institutions were compensated by the nurse managers.

Both sides directors were very positive about these collaborative practices but clinicians were reluctant to intervene in NH. It means that integration does not come instantly by combining workgroups with one director [18]. We showed how this non adhesion from clinicians could be explained by a misunderstanding about how the NH was funded reinforced by the fragmentation between public and private sectors. Living in NH involved a tripartite funding in French system (hosting, care service and support service) and whatever the type of the NH, the care is paid by the public insurance and is not included in the fees paid by the resident. Otherwise, clinicians seemed to ignore the positive impact of this innovative care program for the residents. Those collaborative interventions strengthened first-line treatments and avoided untimely resorts to hospital facilities [19]. It was shown also that reinforcing the care in the NH could improve the quality of care and decrease the resource consumption for the palliative care [20]. In this context, it seemed a priority to promote a shared institutions project with

all stakeholders and explaining the potential benefits for the resident whatever the type of nursing home.

We showed an opposite vision of the NH by clinicians from both institutions. NH clinicians considered the NH as a living place and the HAH clinicians did not consider it as a home based care but as an institutional long term care. This could explain how the HAH clinicians remained critical about the quality of care which was reinforced by the complex needs of the very frail residents. But the question of the quality of care in NH stays entire. In 2011, a French government delegation showed a number of strong difficulties in the NH, such as, cultural divergences between social and healthcare services, primary care versus secondary care and a concern about insufficient medical resources [13,21]. Reducing the gap between the long term care services and the healthcare services by creating a common culture was an important objective for implementing this innovative care program.

Care in NH was seen as more impersonal compared to the warmer relation at home and the HAH clinician's interventions were perceived like a care transfer. This result traduced a misunderstanding about the roles of clinicians and their links in this collaborative model. Our results insisted also on the lack of communication tool between HAH and NH clinicians during the follow-up of the resident care. Many studies had identified communication deficiencies of the NH, especially with emergency services [22,23]. Setting up a proper communication protocol seemed to be a main priority. This work could be inspired by the implementation of a standardized comprehensive assessment tool in France [24] and the systematic Pearson review [25]. Furthermore, nurse managers played an important role in the transmission of the information. In the USA nursing homes, it has been shown that such leaders coming from a nursing background had a natural authority in their teams and helped reduce hospitalizations [26]. Their role was to encourage healthcare professionals to use communication tools, set up continuous quality improvements and tracked the results.

Limitation of the study

- Bias in the selection of the sample of HAH clinicians from the AP-HP
- Lack of assisting nurses and general practitioners in the sample
- Creation of the questionnaire done by professionals from HAH and not from the NH

This first qualitative study on the relationship between HAH and NH healthcare professionals had included a large and multidisciplinary sample of participants from both structures reinforcing the impacts of the results.

Conclusion

Barriers of collaborative interventions were numerous, more frequent at clinical level and mainly for the HAH clinicians whose practices were more impersonal. A better understanding of the relationships between HAH and NH clinicians was a major issue for improving the quality of care in NH and avoiding hospitalizations for very frail older resident.

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Consent for Publication

Participants gave consent for direct quotes from their interviews to be used in this manuscript.

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ADDRESS FOR CORRESPONDENCE:

Dr. Matthieu de Stampa, Assistance Publique - Hôpitaux de Paris (APHP), Hospitalisation A Domicile (HAD), Unité Mixte de Recherche (UMR) 1168 INSERM, UVSQ, VIMA: Vieillesse et Maladies Chroniques, InterRAI France, 14 rue Vésale, 75005 Paris, France, E-mail: matthieu.de-stampa@aphp.fr

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