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“They’re on the Fast Track”: Older Blacks Describe Experiences of Nursing Care Quality During Hospitalization

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Abstract

Older Black patients are at increased risk for experiencing a hospital readmission. This disparity may be related to a variety of factors, including care received during hospitalization. The purpose of this study was to elicit the perceptions of older Black patients at high risk for readmission, and explore their nursing care needs and preferences during and following hospitalization. A qualitative descriptive design was used, including individual interviews with 19 Black members of a Program of All-Inclusive Care for the Elderly facility located in a northeastern urban setting. Four themes were captured encompassing characteristics of nursing care quality, unmet care needs, nurse–patient communication, and observations of competing nursing demands. Efforts to improve care transitions and prevent readmissions must address the needs and preferences of high-risk older Black patients while also attending to system-level inefficiencies that decrease the ability for nurses to complete all aspects of care.

Keywords

acute care setting; health care settings; clinical research areas; community-based care; disparities; minority perception of care; unmet care; qualitative; methods; staffing; nursing interventions

Introduction and Background

As many as a quarter of all older adults discharged from an acute hospitalization will return within 30 days (Jencks, Williams, & Coleman, 2009). Older Black patients bear a disproportionate risk of readmissions (Centers for Disease Control and Prevention, 2011; Joynt, Orav, & Jha, 2011), resulting in increased health care costs, functional decline, and greater need for skilled nursing when transitioning back to community settings. In October 2012, the Centers for Medicare and Medicaid Services (CMS, 2016a) began levying penalties on hospitals for higher-than-expected readmission rates. Threats to reimbursement have spurred a range of interventions to avert readmissions and include the use of advanced practice nurses (APNs) and community health workers (Kripalani, Theobold, Antcil, &

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Vasilevskis, 2014). Although a subset of readmission reduction strategies have led to positive results, no single approach has been repeatedly effective in reducing readmissions for older Black patients (Hansen, Young, Hinami, Leung, & Williams, 2011). This may be due to the complex nature of disparities that are often linked to multifactorial mechanisms operating at the patient, provider, and system levels (Adler & Stewart, 2010). Older Black patients are more likely to experience excess medical comorbidities and lower socioeconomic status (SES; Centers for Disease Control and Prevention [CDC], National Center for Chronic Disease Prevention, and Health Promotion, 2015). In addition, they are more apt to utilize emergent care services (Levine et al., 2011; Tang, Stein, Hsia, Maselli, & Gonzales, 2010). However, even after accounting for the influence of SES status and prior health conditions, studies note that older Black patients remain at higher risk for readmissions, which suggest increased vulnerability among this minority population (Brooks-Carthon, Lasater, Rearden, Holland, & Sloane, 2016; Joynt et al., 2011).

A growing body of research suggests that there may be opportunities to prevent readmissions through improvements in nursing care services during the acute admission. McHugh and colleagues found that patients cared for in settings characterized by a less-than-favorable nurse practice environment were more likely to experience a hospital readmission (McHugh & Ma, 2013). Others note that patients hospitalized in settings with lower nurse staffing were at greater risk for readmissions (Weiss, Yakusheva, & Bobay, 2011). These findings suggest that when nurses are understaffed or underresourced, they may be unable to complete the wide range of care activities assigned to them, including patient education, care coordination, or explaining complex medication. Some studies note that nurses spend only 20% to 30% of their time in direct patient care, attending instead to nonclinical administrative demands or “miss” care altogether due to a lack of time (Kalisch, Landstrom, & Hinshaw, 2009; Robert Wood Johnson Foundation, 2011).

Nursing care omissions have gained widened attention in recent years in light of studies linking them to adverse patient outcomes, including patient dissatisfaction, medication errors, hospital-acquired infections, and pressure ulcers (Schubert et al., 2008). In their examination of 168 U.S. hospitals, Lucero, Lake, and Aiken (2010) found wide variation in the proportion of registered nurses (RNs) who reported leaving nursing care incomplete. Twenty six percent of nurses reported having insufficient time to complete discharge planning, and 74% reported failing to update or develop a nursing care plan. Unmet nursing care was associated with numerous patient safety errors, including wrong medication, infections, injuries, and falls (Lucero, Lake, & Aiken, 2010). Our research examining the relationship between unmet nursing care and readmissions found that older Black patients are more likely to receive care in hospital settings where nursing care is more frequently missed (Brooks-Carthon et al., 2016). Older Black patients face greater risks of readmissions when nurses report that they are unable to perform critical nursing care functions such as patient communication, care documentation, or timely medication administration (Brooks-Carthon et al., 2016).

Despite the documented relationship between inpatient nursing care and readmission outcomes, these findings are based on administrative data and nurses' reports of care quality. We currently lack minority patient perspectives about the nursing care received during

hospitalization. The paucity of elicited data regarding perceptions of nursing care leaves lingering questions regarding patient experience with nurses and how care might be optimized to address the particular concerns of older Black patients. It is well documented, for instance, that minorities are more likely to report barriers to communication, perceived discrimination, lower trust, and a limited number of quality interactions with health care providers (Martin, Roter, Beach, Carson, & Cooper, 2013; Meghani et al., 2009; Tajeu et al., 2015). Many of these studies, however, examine clinical interactions between minorities and physicians (Beach et al., 2011; Cuffee et al., 2013). The development of successful interventions to reduce readmission disparities hinges on understanding the experiences of older Black patients and exploring if nursing care addresses their needs and prepares them for successful transition back into community settings. The purpose of this study was to elicit the perceptions of older Black patients at high risk for readmission and determine what elements of nursing care they were able to report on following a hospitalization.

Prior literature suggests that race, SES, and chronic medical illness all serve as predictors for readmission; hence, our study was conducted at a Program for All-Inclusive Care for the Elderly (PACE) facility in a West Philadelphia “Promise Zone.” Promise Zones are federally designated communities that have been nationally targeted to promote financial investment to reduce impoverishment, and promote job and educational training programs (The White House Office of the Press Secretary, 2014).

Method

Design

In this qualitative descriptive study, we used semi-structured interviews to gain preliminary understanding of older Black patients’ perceptions of the care provided by bedside nurses during a hospitalization (Sandelowski, 2000). Our study design allowed us to (a) explore global satisfaction with nursing care, (b) define specific attributes of high and low nursing care quality, (c) uncover aspects of nursing care that were left incomplete, and (d) learn whether nursing care was aligned with needs and preferences.

Participants

Our study participants included a purposive sample of 19 members of a PACE facility between May 2014 and April 2015. PACE is a Medicare program that integrates the delivery and financing of services for frail, disabled adults who require nursing home-level care but are able to safely reside in community settings. PACE organizations provide and coordinate a continuum of medical and social services, including primary care, occupational and recreation therapy, home health care, and nursing home care. PACE enrollees attend an adult day health center where they receive most services from a multidisciplinary care team (CMS, 2016b).

The PACE members included in the study self-identified as Black or African American, were aged 60 and above, and had experienced a hospital discharge within the past 60 days. All participants had the capacity to be interviewed, as indicated by a recently documented mini mental state exam (MMSE) score >26. Potentially eligible patients who met all

inclusion criteria were identified by a discharge nurse practitioner employed by the PACE program. After identification, a trained research assistant reviewed eligibility criteria and approached eligible persons at their next visit to the PACE facility. Written informed consent was obtained from each participant prior to beginning the interview. Those who completed the study were offered a \$15.00 gift card for their participation. Institutional Review Board approval was obtained from the Office of Research Protections (Figure 1; recruitment protocol).

Data Collection

Study participants were initially asked to complete a demographic questionnaire that captured sociodemographic information (i.e., age, race/ethnicity, gender, marital status, number of children/grandchildren, educational level, functional status, social support status) as well as medical information (i.e., medical history, medications, number of years in PACE program, information related to prior hospital admissions). Following completion of the demographic questionnaire, semi-structured interviews were performed in a private location within the PACE facility. The interview guide was developed based on a review of the literature and our prior research (Brooks-Carthon et al., 2016).

We began each interview by asking participants about their recent hospitalization, associated medical condition(s), self-management, and availability of social support (i.e., “How long have you had your illness?” “What is it like to manage your illness at home?” “Is there anyone who helps to take care of you?”). Next, participants were asked to describe positive and negative aspects of their overall hospital care (i.e., “What aspects of your overall hospital care were you pleased with?” “What things would you change if you could?”). Finally, participants were asked to discuss their views and preferences specific to nursing care. This included a description of qualities/attributes of a nurse they considered the “best” and “worst” during their hospital stay, their level of satisfaction with the nursing care they received, and the different types of nursing activities witnessed by the participant. Interviews lasted approximately 40 min, and were audio recorded and professionally transcribed. Field notes were taken before, during, and after participant interviews to provide observations that would assist in data analysis. We conducted interviews until we reached the point of data saturation. Representative questions from our interview guide are located in Table 1.

Analysis

Demographic information was summarized using descriptive statistics. Semi-structured interview transcripts were then analyzed using qualitative content analysis (Hsieh & Shannon, 2005). First, we evaluated a subset of three interview transcripts. The content of these transcripts was independently read and coded by two individual researchers (M.B.C. and D.P.). During this initial step, researchers took note of quotes that were reflective of key thoughts and grouped key concepts that emerged from the data. Our initial analysis revealed 14 broad concepts (“nodes”). From this set of concepts, we looked for ways in which they were related or linked. This led us to reduce our broad concepts down to four as concepts with overlapping characteristics were collapsed under a single theme (Table 2). During this period, the team met regularly, and once agreement was reached on final thematic categories, the remaining transcripts were independently coded. Analysis of the remaining transcripts

did not reveal further concepts. Discrepancies that emerged between the two coders were presented to the entire study team, and the group decided the code assignment. NVivo, a qualitative data management system, was used to conduct a thematic content analysis. A subset of transcripts and field notes was presented to a group of qualitative researchers to confirm the accuracy of the interpretations of the data.

Results

We conducted 19 interviews of self-identified Black/African American members of a PACE facility. Characteristics of the study participants are given in Table 3. Participant's mean age was 74.6 years ($SD = 8.21$ years), and 78.9% of our sample were female. The mean MMSE was 28 ($SD = 1.7$). The majority of our participants reported being either widowed (38.9%) or divorced (33.3%), and reported either high school graduation (47.4%) or less (42.1%). The three most commonly reported comorbidities included hypertension (78.9%), diabetes (68.4%), and heart failure (31.6%). On average, each participant was prescribed 7.79 ($SD = 5.9$) medications. The average length of stay for was 4.6 ($SD = 4.76$) days, and a total of six (32%) participants reported experiencing a readmission within the 120 days prior to our interview. More than a third of participants returned to living arrangements that included family members (26.3%) or assisted living environments (15.8%), and most reported support from certified nursing assistant (CNA) or home health aides (73.7%) alone or in conjunction with family members (47.4%). Participants were discharged from five different hospitals in the local Philadelphia community, four of which held Magnet status. Sixteen (85%) of our participants were discharged from hospitals with Magnet designation.

Findings from the semi-structured interviews are presented in four themes related to nursing care needs and preferences for older Blacks during and after hospitalization.

“They Go to the Wall”: Perceptions of Quality Nursing Care

Participants were asked about the general quality of nursing care experienced during their recent hospitalization. Participants were encouraged to relate qualities of nurses and nursing care that they regarded as “best” or “worse,” and were then asked to provide examples of care experiences. A number of respondents described qualities of a “good nurse” as an individual who spent adequate time providing instructions related to medications or procedures:

She took the time to go over the instruction with me to make sure I understand.

They explained, each time they come in my room they let me know what procedures they're going to do and explain it to me.

They set up everything for me. Gave me my prescription. They came and explained to me the discharge paper, stuff like that. She was very helpful.

When asked to provide an example of nurses meeting expressed needs, others reported favorably when nurses addressed pain in a timely fashion or took the time to get to know them:

She came and gave me my medication. When I asked for medication for pain, about ten minutes she came right back to the room with it. And she talked to me and joked around with me, stuff like that, you know, tried to make me feel better.

Well she was very pleasant and she was in and out the room making sure I was okay, made sure I was comfortable.

They are people who see interest of the patient. They always with you every two or three hours' time. They go to the wall and ask you how you feeling.

Other participants expressed positive experiences when nurses simply went out of their way to show that they cared.

She was an older woman and they know how to exude that motherly care.

She was nice. She was kind. She was sympathetic. I mean she could feel for you and she saw the distress I was in.

She always made me smile even when I was in pain.

I don't care what I asked them to do, I mean I realize that they had other people they had to service, but within a good amount of time they actually got back to me, as far as I'm concerned, quickly and they helped me out.

"I Was Hungry All the Time": Perceptions of Unmet Care Needs

Although many participants were initially hesitant about expressing any negative aspect of their nursing care, with careful probing, they did express several perceptions of unmet care needs. Participants felt that many basic care needs, such as food, bathing, and toileting, were either delayed or left unmet. One participant reported, "... I was having a problem with constipation and they give me something like to help me go to the bathroom, and I had asked for a commode. And they took their time about giving me that ...". Other reported, "I was hungry all the time" and "... Nobody washed me." In addition to these neglected basic care needs, participants also expressed that nursing staff could be inattentive and, in some cases, completely absent:

... I would scream, "I need help." Nobody came. So I would just pray because God knows your needs. And eventually somebody would come.

Participants also expressed that pain was not adequately addressed. They described a lack of timely pain medication, receiving ineffective pain treatment, or disregard for their pain from nursing staff. A participant with a pressure ulcer described her experience:

... it was hard because they had to turn me over to clean me up when I moved my bowels. And because my back hurt so bad, it was so, so painful. And I thought they were so rough, you know, but I know they had to do what they had to do. But they were rough and they hurt my behind.

One participant recalled difficulties receiving adequate pain management, specifically making the nurse understand that her pain was not adequately addressed with the new pain medication prescribed following orthopedic surgery:

... So I'm crying most of the time, until I got across to that RN that that medication wasn't working and can we try what I came in with?

Discharge preparation was another nursing care activity that was described by participants as rushed, inadequate, and/or incomplete. Nurses would reportedly just "fly through" discharge instructions. One participant stated, "They just gave me the forms." Others reported a lack of education and preparation for the transition from hospital to home, leaving them to figure things out once they left the hospital. Expressing frustration with this process, a participant said

... sometimes they give you instructions and you don't understand your instruction. They just run through it real fast and hand it to you for you to take home and deal with it.

"When You Don't Speak Up You Get Overlooked": Perceptions of Communication

Participants were asked to describe the quality of communication between themselves and nursing care providers. Some participants reported very positive interactions, describing how their nurses made it a point to engage in conversation with them and build rapport:

Oh, the nurses come in, she'd speak, "How are you feeling today Miss M? How are you feeling today?" You know she made me feel—It made me feel good.

Others expressed feeling as though their opinions were not valued or that they were being "disrespected" and their needs disregarded. One participant who had been managing her diabetes for some time at home described an example where her care management routine was not validated and she experienced an episode of hypoglycemia:

I don't think she listened because she said, "Well I have to give you your insulin anyway." Because I take two insulins, a long acting and a short acting. I said, "Well maybe you shouldn't give me the short acting one because that's the one that usually makes my sugar drop down." And she gave it to me anyway and that's what happened.

Another participant described an instance where she felt powerless and that her verbal expressions of pain were ignored:

And I screamed, "You're hurting me." She responded, "But we have to clean you up. You can't stay like this." So I'm a patient; what can I do? I had to let them do what they said they had to do.

When patients did try to speak up and communicate with their nurses, some felt belittled or they were met with frustration or anger:

Because it's the way they talk to you, like you're two years old.

Sometimes people talk to you; and some just don't, they'll go ahead and do what they're supposed to do and go on back to business. Sometimes I have to call too often, and then they get mad.

Despite many examples of suboptimal communication, some participants expressed a feeling of personal responsibility in establishing good communication. Several participants

emphasized the importance of using communication as a form of self-advocacy, citing that “the other person is not a mind reader” and “if you don’t speak up, you’ll get overlooked.”

“They’re on the Fast Track”: Nurse Workload and Competing Demands

When describing how they handled instances when care was not met as desired, many participants felt as though nurses were overburdened with the care of others. Participants feared that requests for more personal care might mean that care would be averted from others,

For her to be able to devote more time for my care would be very selfish.

I can’t wish she had more time. She wouldn’t have time to do nothing for nobody else if she spent all the time with me.

Well, I’m not the only patient, you know. If you’ve got a few minutes, that would be nice. But if not, I understand.

After taking note of nursing workloads, participants were hesitant to request additional time from nurses:

I noticed sometimes they be short of help. And sometimes, like, it would take a little time for them to come because they’ll be on another floor.

It would be nice if they had more time to devote for each of their patients but they don’t. They’re on the fast track. They’ve got to try and get this done. They maybe have 25, 30 people they have to wait on that ward.

Other participants understood that nurses were busy, “I know there’s a lot of us and everything and they’re very busy,” but they also expressed a desire for increased compassion and indicated that it would be nice if they could “really listen and try to be a little patient.”

Discussion

We carried out this study to understand the nursing care experiences of older Blacks following a recent hospital discharge as voiced by individuals at high risk for readmission. Although each of our participants were actively living in community settings with support from a PACE program, they were all burdened with high rates of chronic disease and had experienced a recent hospitalization. Moreover, a third of our participants had been rehospitalized more than once within four months of our interviews. Our participants’ frequent interactions with the health care system provided them with a frame of reference to gauge the quality of nursing care delivered during their most recent hospitalizations.

Our results revealed that older Black patients are able to extensively describe the quality of nursing care they received during hospitalization and report when care was omitted or missed. Although much of the prior research on nursing care quality has evaluated the perspectives of nurses, our study viewed older minorities as “experts”—fully capable of providing accurate assessments of their care experiences. Participants primarily expressed global satisfaction with care, but when questioned about specific aspects of care delivery, all respondents provided examples of nursing care that was missed. This included unmet basic

care needs, communication failures, limited information sharing, and inadequate pain management. Similar observations were noted by patients in a qualitative study by Kalisch, McLaughlin, & Dabney (2012) where patients reported that activities such as patient education, communication, and discharge planning were missed frequently. Although the Kalisch study did not specifically focus on older minority populations, it further supports that patients notice deficits in nursing care quality (Kalisch et al., 2012).

Our results are also consistent with growing reports from nurses who themselves report an inability to provide all aspects of necessary care due to time constraints, limited resources, or interprofessional communication failures (Kalisch, Tschannen, Lee, & Fries, 2011; Rochefort & Clarke, 2010; Schubert et al., 2008). The consequences of unmet nursing care for older Black patient outcomes have been relatively unexplored. Although four themes related to care quality emerged from our interviews, missed opportunities for meaningful communication and information sharing was one of the most consistent themes expressed from participants. Nurses by virtue of their frequent and close contact with patients during the acute care episode are assumed to have ample opportunities to affect the trajectory of care through patient education, counseling, or time spent building rapport and establishing relationships. This may not, however, be the case. Although it is well understood that adequate communication and psychosocial support serve as prerequisites for effectively introducing new therapies, or discharge instruction, recent studies suggest that nurses commonly have little time to engage in effective communication strategies (Brooks Carthon, Lasater, Sloane, & Kutney-Lee, 2015). Limited opportunities for communication during hospitalization raise a number of concerns for successful transitions from hospital to home, particularly for populations facing cumulative socioeconomic challenges coupled with chronic illness. Our sample of older adults were all dually eligible for Medicaid services and had earned less than a high school degree. The co-occurrence of poverty, age, race, and low health literacy intersect and compound the importance of establishing effective communication as a pathway to shared goal creation and patient empowerment (Chen, Mullins, Novak, & Thomas, 2016).

Our interest in eliciting perceptions of unmet nursing care among Black populations was conducted as part of a larger goal to help facilitate efforts to integrate patient preferences into treatment plans through a focus on nurses as frontline care providers. Our results confirm that nurses, who play an important role in perceptions of satisfaction during hospitalization, are, however, often hard-pressed to provide all aspects of care. Nurses were viewed as busy, or “on the fast track,” which in some cases placed older Blacks in the role of passive recipients of care—having treatments “done to them”—as opposed to engaged participants in recovery.

In many instances, participants attributed care omissions to their observations of nurse workloads and were subsequently less likely to advocate for their individual needs. These patient observations are analogous to similar reports in the literature, which suggest that unmet nursing care is largely the symptom of much larger systemic deficits, such as poor staffing and suboptimal work environments (Brooks Carthon et al., 2015; Jones, Hamilton, & Murry, 2015; Papastavrou, Andreou, & Efstathiou, 2014). Although it is well established that patient-centered care necessitates attention to a person’s individual needs and

preferences, care activities associated with establishing rapport— such as meaningful communication—may be implicitly rationed or deprioritized in the face of decreased time and resources. Our study participants appeared to be caught in the midst of the rising tension between their needs for comprehensive (time-intensive care) and the demands of health care systems, which fail to allocate sufficient time or resources for nurses to deliver such services.

Time scarcity and unsupportive work nurse environments may have deleterious consequence for older Black patients and have been linked to repeat hospitalizations. Efforts to reduce readmissions to date have focused on improving the discharge process, and included the use of chronic disease case managers and transitional care teams (Coleman, Parry, Chalmers, & Min, 2007; Kangovi et al., 2014; Naylor et al., 2004). Our results suggest that efforts to improve care transitions and reduce readmission must focus directly on care provided by frontline providers as opportunities to facilitate transitions into community settings may be hampered when nurses are unable to attend to all predischarge care needs.

Limitations

There are several limitations to this study that should be considered when evaluating our findings. Although our population was representative of a group at high risk for readmissions, our results might have differed had we included members of other racial/ethnic groups or had we narrowed our sample to a particular chronic illness (e.g., heart failure). Furthermore, because our participants were drawn from a single PACE facility, in an urban region, our results might have changed had we interviewed community-residing elders who were not enrolled in a PACE program or those from other geographical settings.

Conclusion

Nursing's obligation to reduce human suffering hinges on the ability for them to provide the right care at the right time. One might argue that this obligation is heightened when providing care for vulnerable populations. Our findings suggest that nurses are not consistently able to provide necessary care and when care is omitted, older Black patients notice. These narratives offer important perspectives about the relationship between nursing care quality and outcomes, and have significant implications for future initiatives to address the needs of Black patients at risk for gaps in transitions and avoidable readmissions.

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References

- Adler NE, Stewart J. Health disparities across the lifespan: Meaning, methods, and mechanisms. *Annals of the New York Academy of Sciences*. 2010; 1186:5–23. [PubMed: 20201865]

- Beach MC, Saha S, Korthuis PT, Sharp V, Cohn J, Wilson IB, Moore R. Patient–provider communication differs for Black compared to White HIV-infected patients. *AIDS and Behavior*. 2011; 15:805–811. [PubMed: 20066486]
- Brooks-Carthon JM, Lasater KB, Rearden J, Holland S, Sloane DM. Unmet nursing care linked to rehospitalizations among older Black AMI patients: A cross sectional study of U.S. hospitals. *Medical Care*. 2016; 54:457–465. [PubMed: 27075902]
- Brooks Carthon JM, Lasater KB, Sloane DM, Kutney-Lee A. The quality of hospital work environments and missed nursing care is linked to heart failure readmissions: A cross-sectional study of US hospitals. *BMJ Quality & Safety*. 2015; 24:255–263.
- Centers for Disease Control and Prevention. Health disparities and inequalities report—United States, 2011. Atlanta, GA: U.S. Department of health and human services; 2011. (Morbidity and mortality weekly report surveillance summary). Publisher: Epidemiology and analysis program office; surveillance, epidemiology and laboratory services senterf for disease control and prevention (CDC)
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention, and Health Promotion. At a glance 2015: Racial and Ethnic Approaches to Community Health (REACH), finding solutions to health disparities. 2015. Retrieved from <http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2015/reach-aag-508.pdf>
- Centers for Medicare & Medicaid Services. Readmissions eduction Program (HRRP). Baltimore: MD: 2016a. <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html> [Retrieved on 19 September 2016]
- Centers for Medicare & Medicaid Services. PACE. 2016b. Retrieved from <https://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html>
- Chen J, Mullins CD, Novak P, Thomas SB. Personalized strategies to activate and empower patients in health care and reduce health disparities. *Health Education & Behavior*. 2016; 43(1):25–34. [PubMed: 25845376]
- Coleman EA, Chalmers PC, Min SJ. The care trnasitions intervention: Results of a randomized controlled trial. *Arch. Intern Med*. 2006; 166(17):1822–1828. [PubMed: 17000937]
- Cuffee YL, Hargraves JL, Rosal M, Briesacher BA, Schoenthaler A, Person S, Allison J. Reported racial discrimination, trust in physicians, and medication adherence among inner-city African Americans with hypertension. *American Journal of Public Health*. 2013; 103(11):e55–e62. [PubMed: 24028222]
- Hansen LO, Young RS, Hinami K, Leung A, Williams MV. Interventions to reduce 30-day rehospitalization: A systematic review. *Annals of Internal Medicine*. 2011; 155:520–528. [PubMed: 22007045]
- Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qualitative Health Research*. 2005; 15:1277–1288. [PubMed: 16204405]
- Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine*. 2009; 360:1418–1428. [PubMed: 19339721]
- Jones TL, Hamilton P, Murry N. Unfinished nursing care, missed care, and implicitly rationed care: State of the science review. *International Journal of Nursing Studies*. 2015; 52:1121–1137. [PubMed: 25794946]
- Joynt KE, Orav EJ, Jha AK. Thirty-day readmission rates for Medicare beneficiaries by race and site of care. *Journal of the American Medical Association*. 2011; 305:675–681. [PubMed: 21325183]
- Kalisch BJ, Landstrom GL, Hinshaw AS. Missed nursing care: A concept analysis. *Journal of Advanced Nursing*. 2009; 65:1509–1517. [PubMed: 19456994]
- Kalisch BJ, McLaughlin M, Dabney BW. Patient perceptions of missed nursing care. *The Joint Commission Journal on Quality and Patient Safety*. 2012; 38(4):161–167. [PubMed: 22533128]
- Kalisch BJ, Tschannen D, Lee H, Friese CR. Hospital variation in missed nursing care. *American Journal of Medical Quality*. 2011; 26:291–299. [PubMed: 21642601]
- Kangovi S, Mitra N, Grande D, White ML, McCollum S, Sellman J, Long JA. Patient-centered community health worker intervention to improve posthospital outcomes: A randomized clinical trial. *JAMA Internal Medicine*. 2014; 174:535–543. [PubMed: 24515422]
- Kripalani S, Theobald CN, Anctil B, Vasilevskis EE. Reducing hospital readmission: Current strategies and future directions. *Annual Review of Medicine*. 2014; 65:471–485.

- Levine DA, Neidecker MV, Kiefe CI, Karve S, Williams LS, Allison JJ. Racial/ethnic disparities in access to physician care and medications among US stroke survivors. *Neurology*. 2011; 76(1):53–61. [PubMed: 21084692]
- Lucero RJ, Lake ET, Aiken LH. Nursing care quality and adverse events in US hospitals. *J Clin Nurs*. 2010; 19(15–16):2185–2195. [PubMed: 20659198]
- Martin KD, Roter DL, Beach MC, Carson KA, Cooper LA. Physician communication behaviors and trust among Black and White patients with hypertension. *Medical Care*. 2013; 51(2):151–157. [PubMed: 23132201]
- McHugh MD, Ma C. Hospital nursing and 30-day readmissions among Medicare patients with heart failure, acute myocardial infarction, and pneumonia. *Medical Care*. 2013; 51(1):52–59. [PubMed: 23151591]
- Meghani SH, Brooks JM, Gipson-Jones T, Waite R, Whitfield-Harris L, Deatrick JA. Patient-provider race-concordance: Does it matter in improving minority patients' health outcomes? *Ethnicity & Health*. 2009; 14:107–130. [PubMed: 19012091]
- Naylor MD, Brooten DA, Campbell RL, et al. Transitional care of older adults hospitalized with heart failure: A randomized, controlled trial. *J Am Geriatr Soc*. 2004; 52:675–684. [PubMed: 15086645]
- Papastavrou E, Andreou P, Efstathiou G. Rationing of nursing care and nurse–patient outcomes: A systematic review of quantitative studies. *The International Journal of Health Planning and Management*. 2014; 29:3–25. [PubMed: 23296644]
- Robert Wood Johnson Foundation. Transforming care at the bedside: An RWJF national program. 2011 Retrieved from http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2011/rwjf70624.
- Rocheffort CM, Clarke SP. Nurses' work environments, care rationing, job outcomes, and quality of care on neonatal units. *Journal of Advanced Nursing*. 2010; 66:2213–2224. [PubMed: 20626479]
- Sandelowski M. Focus on research methods—whatever happened to qualitative description? *Research in Nursing and Health*. 2000; 23:334–340. [PubMed: 10940958]
- Schubert M, Glass TR, Clarke SP, Aiken LH, Schaffert-Witvliet B, Sloane DM, De Geest S. Rationing of nursing care and its relationship to patient outcomes: The Swiss extension of the International Hospital Outcomes Study. *International Journal for Quality in Health Care*. 2008; 20:227–237. [PubMed: 18436556]
- Tajeu GS, Cherrington AL, Andreae L, Prince C, Holt CL, Halanych JH. “We'll get to you when we get to you”: Exploring potential contributions of health care staff behaviors to patient perceptions of discrimination and satisfaction. *American Journal of Public Health*. 2015; 105:2076–2082. [PubMed: 26270291]
- Tang N, Stein J, Hsia RY, Maselli JH, Gonzales R. Trends and characteristics of US emergency department visits, 1997–2007. *Journal of the American Medical Association*. 2010; 304:664–670. [PubMed: 20699458]
- Weiss ME, Yakusheva O, Bobay KL. Quality and cost analysis of nurse staffing, discharge preparation, and post discharge utilization. *Health Services Research*. 2011; 46:1473–1494. [PubMed: 21517836]
- The White House Office of the Press Secretary. Fact sheet: President Obama's promise zones initiative. 2014. Retrieved from <https://www.whitehouse.gov/the-press-office/2014/01/08/fact-sheet-president-obama-s-promise-zones-initiative>

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Figure 1.

Qualitative research protocol.

Note. MMSE = mini mental state exam; PACE = Program of All-Inclusive Care for the Elderly; PI =Principal Investigator.

Table 1

Representative Semi-Structured Interview Questions.

1	How long have you had your illness (e.g., diabetes, problems with your heart)?
2	Is there anyone who helps to take care of you? <ol style="list-style-type: none">a. What kinds of things do they help you with?b. Tell me about when and how they started helping you
3	Can you recall the nurse who you would describe as “the best?” <ol style="list-style-type: none">a. Can you tell me more about him or her?b. What was it about him or her that made you feel this way?
4	Can you recall the nurse that you would describe as “the worst?” <ol style="list-style-type: none">a. Can you tell me about that person?b. What were the qualities they displayed?
5	Can you tell me about how nurses responded to you when you had questions or concerns?
6	How satisfied were you with the attention given to your needs?
7	What things do you wish your nurse had more time to do for you?
8	How important would you rate the following tasks provided to you by your nurse? <ol style="list-style-type: none">a. Educate you about your medical condition or medications?b. Provide pain medications in a timely fashion?c. Prepare you for discharge?d. Spend time talking to you and getting to know you?e. Did your nurse communicate with you about your medical condition in a way that you could understand?

Table 2

Qualitative Themes.

Theme	Definition
Perceptions of quality nursing care	Attention to patient needs, nurse availability, spending adequate time on care tasks, timeliness, personal qualities, and demeanor of nurses.
Perceptions of unmet care needs	Patient experiences or statements that reflect care needs not being met, nursing care not completed
Perceptions of communication	Describes ease of information exchange, provisions of patient education, adequate responses to questions, instructions free of medical jargon, and ability to build rapport.
Nurse workload and competing demands	Includes observations of nurses' duties, functions, and workloads; how nurses balance their workload; and how patients perceive their own care needs within the context of a nurse's workload

Table 3

Sample Demographics.

Patient characteristics	<i>n</i> (<i>N</i> = 19)	%
Age (y), <i>M</i> (<i>SD</i>)	74.68 (8.21)	
Race		
Black/African American	19	100
Ethnicity		
Not Hispanic or Latino	18	94.7
Unknown/not reported	1	5.3
Gender		
Female	15	78.9
Male	4	21.1
Marital status		
Single	2	11.1
Married	0	0
Separated	3	16.7
Divorced	6	33.3
Widowed	7	38.9
Children, <i>M</i> (<i>SD</i>)	3.74 (2.18)	
Grand children, <i>M</i> (<i>SD</i>)	8.05 (6.87)	
Educational level		
Did not graduate	8	42.1
High school	9	47.4
Some college/technical	1	5.3
College	1	5.3
Top three most common comorbidities		
Hypertension	15	78.9
Diabetes	13	68.4
Heart failure	6	31.6
Medication, <i>M</i> (<i>SD</i>)	7.79 (5.96)	
Length of hospital stay, <i>M</i> (<i>SD</i>)	4.63 (4.76)	
MMSE	28.21 (1.72)	
Living arrangements		
Alone	11	57.9
With family	5	26.3
Assistive living	3	15.8
Types of social support		
Family member	9	47.4
Home health aide/CNA	14	73.7
Other	2	10.5
None	1	5.3
Frequency of assistance at home, visits per week, <i>M</i> (<i>SD</i>)	6.17 (4.36)	

Patient characteristics	<i>n</i> (<i>N</i> = 19)	%
Readmission <120 days	6	34

Note. MMSE = mini mental state exam; CNA = certified nurse assistant.

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