BARRIERS TO TRANSITION FROM SNF TO HOME: DISCHARGE TEAM’S PERSPECTIVE

Linda Beuscher, PhD, RN, FNAP

PURPOSE
- Gain understanding of SNF to home transition challenges from the interprofessional discharge team's perspective
- Identify opportunities for improvement in transitioning care

BACKGROUND
- 1.8 million older adults transfer from hospital to SNF
  (Centers for Medicare and Medicaid Services [CMS], 2017)
- 14% hospital 30-day readmissions
  (CMS, 2017)
- Average SNF stay 20 days
  (CMS, 2017)
- Transitional Care Frameworks
- E Coleman- Four Pillars
- M Naylor- TCM

METHOD
- Individual interviews
- Semi-structured questions from frameworks
- Audiotaped and transcribed verbatim
- Content analysis

SAMPLE
SNF staff members (N=11) four SNFs | Social worker (n=6), therapists (n=3), nurses (n=2)

IMPLICATIONS FOR APRN
- Staff training
  - Teach back techniques
  - Handling difficult conversations
- Palliative care consultations
- Disease progression
- Follow-up communication with patient and family
- Ensure comprehension of information/instructions
- Medication review

ACKNOWLEDGEMENTS
Vanderbilt Institute for Clinical and Translational Research grant, VU School of Nursing Scholarly Project VU Qualitative Research Core Team. VUMC Center for Quality Aging