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)

Categories	Subcategories	Exemplars
Family or patient Indecisions		*"The one family member gets it, understand the diagnosis and understands that yeah mom can't go home but the other is like well no she can get back to where she was. They just don't decide on who they want to use for a caregiver so that's a problem because a decision hasn't been made. "*
Difficult Conversations	Disease Progression and decline	*It's a 'tightrope" conversation. As we try to meet customer satisfaction yet telling them what they don't want to hear like the need for hospice care"* *"Some family members are unrealistic as to what mom or dad can really do. They think they can more than what they're actually medically and physically able to do, they don't really want to admit that mom or dad is really going down"* *"It's a hard decision when the patient says 'Oh, it's time. I really can't be at home by myself and I've lived in this house for 50 years and I don't want to leave my home and my life'"*
	Home adaptation	*Some people have pets and so those can be obstacles, nobody wants to hear their pet is an obstacle so we have to handle that kind of gingerly… lot of people don't like change especially to their house even for safety issues "*
Coordinating Resources		*"Á lot of times although, against our advice and recommendations they will go home with very little support"* *"it's a process to get the doctor to sign the paperwork, then we write the order and fax it and it takes an undetermined time to get the equipment ordered and delivered so it's kind of a waiting game"*
Nonadherence to advice		*"I feel like we're the warning, we're screaming, warning, warning out there all the time and they don't heed that"* *"CHF patients are the frequent fliers. They never get better, A lot of times it's because they go home and eat a horrible diet of prepared meals that has all sodium. We had a patient on thanksgiving day that gained 14 pounds in one day. I asked what he was eating, He said, I had country ham and biscuits and gravy at my sister's house and five glasses of sweet tea: He was just a good old country boy . He doesn't know. We could educate him until we're blue in the face."* *"As far as hospital readmissions, they probably went home because they chose to and really just maybe didn't want to follow the recommendations. It's kind of the old saying you can lead a horse to water, but you can't make him drink."*
Care education issues	Devoting staff time	*"It takes a lot of education and we don't how much they comprehend. Patients need to teach it back, but with the multiple patients they take care of how much time do they really have to wait and listen. I think an educational person would be so helpful. That would be their focus to just sit her with you an hour and make sure that you got it"*
	Understanding of medications	*The medicine plays a huge role to help them [patient and family] understand the medications. We have initial meeting with families and they'll say 'well, they've changed all the meds'" especially the pain medicine with the new guidelines from the government*
Financial barriers		*·the biggest frustration is insurance companies not giving people enough time for therapy to gain strength. Many can't afford assisted living. Some assisted living are available through the Choices program but families tell me, "I'm not taking them there "* *"Biggest struggle is helping families understand their benefits" "You know a lot of times people think "I have insurance and it's going to cover everything. But we know it doesn't."* *"The family may not have money to pay for caregivers and they have a job and need to work so can't take care of their family member"*

IMPLICATIONS FOR APRN

- Staff training
  - Teach back techniques
  - Handling difficult conversations
- Palliative care consults
  - 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

VANDERBILT School of Nursing