Nurses’ Role in Managing “The Fit” of Older Adults in Skilled Nursing Facilities

Jacqueline Jones, PhD, RN, FAAN; Emily Lawrence, MPH; Amy Ladebue, BA; Chelsea Leonard, PhD; Roman Ayele, MPH; and Robert E. Burke, MD, MS

ABSTRACT
Post-acute care for older adults often involves transfer to a skilled nursing facility (SNF) following hospital discharge. This transition is often poorly coordinated and leaves older adults at risk for poor health outcomes, but new payment models offer opportunities to align improved care practices with payments. There is a dearth of evidence regarding the role of nursing and its potential to improve hospital to SNF care transitions. Ninety-nine semi-structured interviews were conducted with clinicians, patients, and caregivers from three hospitals and three SNFs. Results indicate a sharp contrast in the roles of hospital nurses—who are often silent partners in post-acute care decision making—and SNF nurses, who take a primary role as managing “the fit” for patients transitioning to a SNF. Nurses are uniquely positioned to make needed changes to culture to adapt to new payment models and improve patient outcomes. [Journal of Gerontological Nursing, 43(12), 11-20.]

ABOUT THE AUTHORS
Dr. Jones is Professor, Colorado University College of Nursing, Aurora, Ms. Lawrence is Qualitative Analyst, Ms. Ladebue is Qualitative Analyst, Dr. Leonard is Qualitative Analyst, Mr. Ayele is Qualitative Analyst, and Dr. Burke is Investigator, Denver-Seattle Center of Innovation, Denver, and Dr. Burke is also Hospitalist, Research and Hospital Medicine Sections, Department of Medicine, Denver VA Medical Center, Denver, Colorado.

The authors have disclosed no potential conflicts of interest, financial or otherwise. This work was supported by the National Institute on Aging (R03AG050885; R.E. Burke, principal investigator). Dr. Burke was also supported by a VA HSR&D Career Development Award (I1K2HX001796).

Address correspondence to Jacqueline Jones, PhD, RN, FAAN, Professor, Colorado University College of Nursing, 13120 E. 19th Avenue, Aurora, CO 80045; e-mail: Jacqueline.Jones@ucdenver.edu.
doi:10.3928/00989134-20171110-06
Contemporary post-acute care for older adults frequently involves transfer to a skilled nursing facility (SNF) after hospital discharge. However, such a move can often leave older adults at increased risk of poorly coordinated care and poor health outcomes (Neuman, Wirtalla, & Werner, 2014). For example, a significant negative outcome for one in four older adults is readmission to a hospital within 30 days of discharge (Burke et al., 2016; Mor, Intrator, Feng, & Grabowski, 2010). Hospital readmission puts older adults at risk of complications related to acute care, cognitive challenges, an increased likelihood of functional decline, and even increased mortality (Burke et al., 2016).

Hospital readmissions are often preventable and costly (Levinson, 2014), and thus have been the target of legislation to align payments to incentivize providers to improve the quality and safety of transitions (Burke, Cumber, Coleman, & Levy, 2017). These recent legislative reforms enforce greater levels of accountability for hospitals and SNFs for the costs and outcomes of care. Many hospitals and SNFs participate in bundled payments for acute and post-acute care, whether in Accountable Care Organizations (ACO) or Bundled Payments for Care Improvement (Sood, Huckfeld, Escarce, Grabowski, & Newhouse, 2011). In these models, the total costs of the inpatient and post-discharge care are bundled and lower-cost stays are financially rewarded, potentially driving patients away from SNFs and toward cheaper forms of post-discharge care or selection of healthier patients away from SNFs and toward more expensive forms of post-discharge care are bundled as the total costs of the inpatient and post-acute care (Huckfeld, Escarce, Grabowski, & Levy, 2017). These recent legislative reforms enforce greater levels of accountability for hospitals and SNFs for the costs and outcomes of care.

The role of nurses in this transition remains hidden and not yet amenable to interventions or optimization. There are several reasons why evaluating the roles of nurses in these transitions is of primary interest. First, the linchpin to success in many of the most widely implemented best practice models for reducing hospital readmissions in another context (hospital to home) is the use of nurses or nurse practitioners (NPs) as the effector arm of the intervention (Coleman, Parry, Chalmers, & Min, 2006; Dreyer, 2014; Kind et al., 2012; Naylor et al., 1999). Second, although the environment for post-acute care in SNFs is inherently multidisciplinary, it is primarily one of skilled nursing. Third, a concern is that an unintended consequence of new value-based payment models is that SNFs could become inclined to accept the healthiest patients, limit access to post-acute care for the sickest patients, and fail to transfer patients when medically necessary (Neuman et al., 2014). Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well trained in the care of complex acute and chronic illness and have current information about the patient’s goals, preferences, and clinical status (Coleman, 2003); few practitioners are better situated than nurses to address potential unintended consequences of new payment reforms because of their 24-hour surveillance and bedside presence.

Therefore, the current study asks: what is the role of nurses in the transition of older adults from the hospital to a SNF for post-acute care? This study considers nurses in SNFs to mainly consist of RNs and licensed practical nurses (LPNs) supported by certified nursing assistants (CNAs) at the bedside. NPs may also have a major role in this transition but are less consistently involved across all hospitals or SNFs.

**METHOD**

The current qualitative interpretive study is part of a program of research examining transitional care between the hospital and SNF. Qualitative interpretive inquiry (Thorne, 2016) is suitable when new knowledge construction is formulated through a health professional disciplinary lens and has a practice-related intention. This work draws on social constructionism where the experiences, interpretations, and perceived realities are multiple and contextually understood through the language of participants and research team composition. The research team included the disciplines of nursing, geriatrics, medicine, psychology, public health, social work, and anthropology, supported by specialist and academic credentials.

Iterative, semi-structured, in-depth interviews were conducted with key stakeholders from three hospitals and three SNFs in Colorado. Colorado hospitals and SNFs face the same reforms described above. Colorado is relatively unique in having an ACO-based model for Medicaid payment and a growing amount of waiver-based home and community-based services for older patients remaining in their home. However, these regional ACOs are still paid fee-for-service, and Medicaid does not cover rehabilitative care in a SNF, therefore, this
was not a factor in selection of sites or the analysis (McConnell et al., 2017). These locations were chosen to ensure maximum variability in the sample. SNFs included a Veterans Affairs (VA) Community Living Center co-located with the main VA hospital; a predominantly Medicaid-funded nursing home with a smaller Medicare-certified rehabilitation unit; and a community SNF that only provided short-term rehabilitation under Medicare. Hospitals included a VA hospital servicing a typical VA population (Nelson, Starkebaum, & Reiber, 2007; Randall, Kilpatrick, Pendergast, Jones, & Vogel, 1987), a quaternary-level university hospital serving a large referral base consisting of a predominantly urban population, and a safety-net public hospital serving a predominantly indigent and immigrant population. Clinical units included general medical wards, an Acute Care for the Elderly unit (Fox et al., 2013), and an orthopedic surgery unit. Health professionals, patients, and caregivers from across settings were invited to volunteer for a single in-person or telephone interview. In-person interviews were conducted at a convenient, private location for participants in the hospital or SNF. Participants received a $20 gift card reimbursement for participation.

An interview guide was developed based on the study team’s prior work and pilot tested. The guide was further iteratively refined simultaneously with ongoing data collection and data analysis. The guide was based on Burke, Kilpatrick, Vasilevskis, and Schnipper’s (2013) ideal transitional care bridge. Interviews were conducted by study-specific trained qualitative research analysts, digitally recorded, and professionally transcribed. The team used a well-established, team-based qualitative analytic toolkit for low-inference interpretive analysis of text data (Jones, Nowels, Sudore, Ahluwalia, & Bekelman, 2014).

In the study interview transcripts, researcher field notes and debrief summaries, reflexive team notes, and analytic memos formed the basis of the analysis. Line-by-line inductive coding techniques were used to identify in vivo statements in context. Similarities and differences within and across individual transcript data were discussed as a team. The team paid attention to any negative cases and resolved team differences through consensus. To achieve consensus, the team discussed, defined, and explained each code or theme label, drew on the diverse intradisciplinary perspectives afforded by the team’s composition, and agreed on the most complete interpretation. Deductive strategies were used to examine the a priori domains of the transition bridge as manifest in participants’ naturalistic expressions. In addition, a variety of data display techniques were used to conceptually map emerging themes and theme relationships. These elements formed the basis of ongoing individual, paired, and team discussions over a period of 12 months to describe the role of nurses in the transition of older adults from the hospital to an SNF for post-acute care. Institutional approval was gained from the Colorado Multiple Institutional Review Board.

RESULTS

Between February and September 2016, 99 participant interviews were conducted. Each interview lasted 40 to 70 minutes in duration and produced a total of 1,314 pages of text data. Participant characteristics are described in Table 1. Table 2 presents providers’ years of experience, and Table 3 reports nurses’ characteristics. The patient and
sub-themes, which characterize the dynamic process of how nurses continuously manage “the fit” of older adults and skilled nursing context of care. Illustrative examples of participant quotes are highlighted throughout the text by care setting to provide a snapshot of the rich detail provided by >40 health professionals.

**Theme 1: Nurses’ Role in Decision Making to Transfer Older Adults to SNFs**

This theme describes the role of nurses in the decision-making process to transfer older adults from the hospital to a SNF, which differs across care settings. Within the acute care hospital environment, nurses identified that they are not involved in the decision. The decision to discharge older adults is made by the physician and is based on the patient being “medically stable” and no longer needing acute care. Hospital nurses “just update the patient on what we’ve heard.” The culture of care is one of “get them to the place where they can leave the hospital even if not fully recovered.” One hospital nurse noted, “The doctor’s like, ‘Oh this person needs to be placed.’” The primary physician team is the principal driver of transfer decisions and seen by all participants from the hospital setting as the most important decision maker to move the patient. This decision making often occurs during team rounds where opinions from occupational therapy and physical therapy may be sought. Most nurses stated, “I don’t really challenge the decision,” or “It’s not something nursing is deciding on.” A social worker or discharge planner operationalizes the decision by engaging the family, sometimes the patient, in identifying a potential SNF based on insurance status. Nurse participants shared they were often “too busy” with the care of four or five complex patients and expressed they “don’t really know what skilled nursing looks like in a SNF,” as they have never worked in that setting. The RN role is perceived as reactionary to a medical decision: “We just care for them, if they’re medically stable, then we just go through the daily routine of giving them their meds.” One of many resources in a large team, nurses receive a discharge packet and try to call the facility prior to discharge.

However, in SNFs, RNs are advised when a consult has been requested and the physician will determine if the older adult is medically appropriate for that specific...
SNF based on any available clinical notes and medication lists. One physician said, “I know I can’t give [the patient] IV [intravenous] pain meds unless I sit there and push it.” In some SNFs, physicians will verbally communicate with referring physicians from the hospital but often rely on medical or surgical documentation related to diagnosis and treatment. The patient situation is immediately discussed with the Director of Nursing, charge nurse, or other bedside nurses in the SNF. The physician will “check in” and defer to nursing based on the availability of nursing skill mix and skill set in the setting of the complexity of other existing SNF patients, including cognitive status and physical, medical, and behavioral challenges. The ultimate decision to admit is based on the ability and capacity for nursing to manage “the fit” of the older adult with skilled nursing resources at any given time, as medical supervision occurs weekly or on an as needed basis.

Theme 2: Assessing the Fit Between Older Adult and SNF

For nurses in SNFs, their primary role is to consider “the fit” of individual older adults—their physical, psychological, and behavioral complexity within the context of other existing patients in the SNF. Nurses were perceived to be overwhelmed but optimistic about facilitating older adults’ goals, even when individuals have difficult discharge planning needs, such as homelessness. The culture of care in post-acute care settings such as SNFs is about rehabilitation, recuperation, and longer-term goal planning. Nurses “look at their needs to see if we can meet their needs…some of the consults we get, they have no set goals…sometimes a lot of people [at the hospital] that put in the referrals don’t understand exactly what goals they need.” Transfer to SNFs is premised on the ideal that the incoming older adult is medically stable.

Yet, many individuals, although stable, have multiple chronic conditions, complex medication regimes, undiagnosed dementia or cognitive challenges, and functional decline or weakness, and are assessed as not
independent enough with activities of daily living to go home, even with support. A senior SNF nurse said:

“Sometimes by the time they get to us the disease has gotten so bad...we're kind of battling up against a brick wall, their skin is so bad, their circulation's so bad...we get those patients.... It [diabetes] hasn’t been managed appropriate for so long it’s hard to figure out a baseline for them.”

Complex family dynamics also often accompany older adults due to these changes in independence and functional and physical capacity.

To effectively determine the fit, nurses in SNFs must be aligned with both care cultures, even if the rest of the acute care team is aligned with the former (i.e., acute care culture), and the rest of the SNF team the latter (i.e., SNF care culture). SNF nurses walk a line between stable and unstable and deterioration and improvement while working to meet the strong desires of older adults to “go home.” This is skilled nursing work and it starts with RNs “seeing every person as soon as they arrive,” and “observing them as they get oriented to the facility.” Nurses may have even gone “to the hospital to see them in person.” Nurses in hospital settings made the following concerned observations about nursing work in SNFs: “When she [older adult] was in one facility, she was in and out of a different hospital, went to another [SNF]... her skin is terrible...and now she is bedbound.”

Another nurse said, “It probably would be beneficial if I did visit a SNF...maybe I visit a bad one, who knows.” Conversely, a SNF nurse shared:

[Older adults] come to us and they look like, not good from the hospital...I’m thinking their assessment could have been better...he doesn’t look as stable...as to when to send to SNF, knowing what we are capable of doing. We have this much, they have more tools.

### Theme 3: Forwards and Backwards Handover of Nurses To, and For, Others

Handovers or handoffs are verbal exchanges that occur between nurses about a patient's medical status, interdisciplinary team interventions, and daily care needs. This theme describes the dynamic and bidirectional processes that occur as older adults transition from the hospital to a SNF and nurses strive to develop a comprehensive picture of their overall fit, medical stability, and long-term goals. When an individual arrives to the SNF, nurses will refer to the hospital nursing system to fill in details very often missing or not included in the paperwork, clinical notes, and reams of repetitive notes that can accompany the patient. One hospital charge nurse noted, “[SNF nurses] do usually ask some really good questions when we’re transferring...we try to make it efficient.” When a SNF and hospital are co-located or share electronic health record systems, this work is less of a challenge, as information transfers directly. Medication reconciliation is a primary, yet burdensome, task for SNF nurses as they struggle to ensure adequate pain management and ongoing therapy for conditions such as diabetes or heart failure.

SNF nurses will also act as a conduit between other health professionals in the SNF and missing information such as precautions and restrictions that guide therapy intervention safety. One nurse stated, “I will ask the nurses, they will get that information.” A hospital nurse stated, “Sometimes we will get a med check call back.” Other times, the orders are not yet in the system, which creates delays at the SNF level due to pharmacy service, no laboratory on site, and others. This incomplete information bundle from the sending hospital creates roadblocks for SNF nursing’s continuity of care and gaps in support they can provide for older adults.

### Theme 4: Keeping an Eye on Them and Keeping Them Here

Nurses are seen by others, and consider themselves, as the “eyes and ears” of the system to keep older adults safe in the SNF. A SNF nurse stated, “As a nurse, I’ve been taught that I am the last line of

---

**TABLE 3**

**NURSE CHARACTERISTICS (N = 10)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>n (%)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SNF (n = 4)</td>
<td>Hospital (n = 6)</td>
</tr>
<tr>
<td>Women</td>
<td>4 (100)</td>
<td>6 (100)</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>4 (100)</td>
<td>4 (66)</td>
</tr>
<tr>
<td>Latino/a</td>
<td>1 (17)</td>
<td></td>
</tr>
<tr>
<td>Other (biracial/mixed)</td>
<td>1 (17)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-graduate</td>
<td>2 (50)</td>
<td>1 (17)</td>
</tr>
<tr>
<td>College graduate</td>
<td>1 (25)</td>
<td>5 (83)</td>
</tr>
<tr>
<td>Some college</td>
<td>1 (25)</td>
<td></td>
</tr>
<tr>
<td>Years of experience&lt;sup&gt;a&lt;/sup&gt; (mean, range)</td>
<td>12 (3.5 to 11)</td>
<td>5.48 (0.75 to 12)</td>
</tr>
</tbody>
</table>

*Note. SNF = skilled nursing facility.*

<sup>a</sup> Two SNF nurses’ years of experience data were unavailable.

---

16

Copyright © SLACK Incorporated
defense for a lot of these patients.” This statement was supported by SNF geriatricians and senior medical providers, with one stating, “I am not here, we don’t do surveillance or check in here like in the hospital, we rely on the nurses,” and another saying, “Nurses are with the patient 24/7, they are the ones who notice.” Hospital nurses expressed concern about the lack of physician presence in SNFs, with one saying:

I know there is a physician on call, I know they get assessed right when they get in the building, but how long, when does the physician round, what’s their communication goal in the facility if something is not going right...they have LPNs and RNs...there’s a lot of stuff I don’t know.

Multidisciplinary teams, including NPs, in SNFs monitor older adults but as they may only see the patient twice per week, they communicate any concerns or clarify questions with nurses. However, SNF nurses participate in purposeful rounding, as one nurse stated, “See [older adult] if there’s wounds, they go in and check on them, it’s their [nurses] job to care for them and make sure they’re being checked on...three to 10, 20 times, it depends.” At the bedside, this may involve CNAs directly noticing, yet reporting, observations to nurses who then act to restabilize the patient, as one CNA explained:

Nurses try to do their best for the resident while they are here...could we have prevented that by maybe starting an IV, getting some labs, maybe we did get labs and they didn’t look good.... Being a nurse on the floor [of the SNF], it’s very overwhelming.

Safety monitoring poses a major surveillance challenge if RNs are less clinically experienced.

**Theme 5: There’s Something Not Right, Transferring Them Back to the Hospital**

The decision to rehospitalize an older adult “depends [on] what [is] going on.” According to one SNF nurse:

...Notice that there was something not right... [they] would’ve taken vitals...done a call for an EKG [electrocardiogram], contacted the physician immediately.... We take care of them the best we can but we are not going to risk a patient, we will send [them] to the ED [emergency department].

However, despite nurses’ monitoring and early detection of a change in patient condition, “most patients don’t want to go back to hospital, they would rather stay here and we do everything for them.” Early identification and assessment within the context of skillset, resources, and other patients initiates need to go back to the hospital as many SNF nurses and physicians noted, “We’ve become accustomed to them coming back to us so sick...we do our best to keep them as stable as we can.... Once you get to a certain point, there’s only so much you can do here at the facility.”

**DISCUSSION**

It is said that a system is perfectly designed to achieve the outcomes it delivers. The current system is designed to admit and discharge patients to discrete intensive environments. Episode-based payments lead to hospitals pushing patients out the door quicker and sicker, while SNFs react to business models with heavier ratios of patients to RNs supported by LPNs and CNAs (Clark et al., 2017; Fiset, Luciani, Hurtubise, & Grant, 2017; Vasilevskis et al., 2017). The current study identified that hospital nurses are often silent partners in transitional care decision making and continuity of care discussions with SNF care providers. Their input was often found in nursing notes or other aspects of disjointed, repetitive, or incomplete overall patient clinical records. Hospital nurses, when asked, verbally and retrospectively filled in missing information or provided context for past care of patients. However, nurses within SNFs seemed to take on a more direct role in assessment, monitoring, management, safety, and supporting of older adults’ needs, values, and goals of care. Five themes comprised the process nurses created in managing “the fit” between older patients and the SNF for post-acute care. This across-care culture process is important because to change hospital readmission outcomes in the current policy landscape, more attention should be placed on system-level redesign, including the culture of care. The role of NPs was limited in the current study, which raises the question of why when the evidence demonstrates their role in enhancing outcomes and cost reduction.

Under current payment models, the decisions to move older adults are often conceptualized by hospital clinicians as finding a place for them because they no longer have a medical need to remain within the acute care hospital. Yet, these older adults are not able to manage themselves at home with available support. Discharge from medical need to admission to skilled nursing care requires a change in how patient needs, values, and preferences are addressed and stewardship is provided across acute to post-acute transition. SNFs are often seen as “step downs” in care, which is often inaccurate, as the patient was hospitalized only a few days beforehand. Rather, it is a change in goals (and corresponding structure) that defines this transition, which is not a step down but rather a step toward older adults’ recovery, rehabilitation, and recuperation.

Opportunities exist to optimize transitional care between the hospital and a SNF that suggest a reframing or paradigm shift to understanding overall cultural models of acute and post-acute care and their priority in meeting the needs, values, preferences, and goals of care for older adults. In their current forms, acute care and post-acute care are
often seen as isolated, competitive silos. Now is the first time where payments are aligned with care models that “bridge” the transition, opening opportunities that have not existed before to think of this care as a continuum. The new policy imperative pushes for a continuity of care model that requires continuity of care culture and practices. Although all health professionals have a role to play in optimizing the system, nurses already existing within the system provide 24-hour surveillance and monitoring across these care settings.

Nurses, given their constant bedside presence and holistic person-centered perspective, are uniquely positioned to see both views and advocate for older adults through the care continuum. Nurses across the care continuum can give priority to what matters to patients, regardless of cognitive impairment or disability, thus enhancing the voice of older adults. Recent studies identify that along with appropriate in-hospital diagnosis by clinicians (Vasilevskis et al., 2017), the SNF setting and early identification of a patient’s deterioration are low hanging fruit for impacting unplanned hospital readmission (Davidson et al., 2017; Dizon, Zaltsmann, & Reinking, 2017; Jusela, Strube, Gallagher, Redman, & Ziemba, 2017; McHugh et al., 2017). Older adults have defined health to include social connectedness, independence, and being part of a community (Lane, Hirst, Hawranik, Reed, & Kokkman, 2017; O’Rourke & Sidani, 2017). To achieve the best outcomes, the system needs to modify, moderate, or attenuate elements within the processes of transitional care, including the perspectives offered by patients, caregivers, and their families. The ideal transitional care bridge (Burke, Guo, Prochaska, & Misky, 2014) provides some but not complete guidance as nurses themselves form a bridge across settings.

Another potential avenue to improving patient outcomes and performance in value-based payment models is the use of advanced practice nurses, particularly with geriatric training, in SNFs. Interest in these models has been growing since the publication of the Evercare model (Kane, Keckhafer, Flood, Bershadsky, & Siadaty, 2003) and reflects that the older model of an attending physician who rounds on their patients once per week may be outdated and unsafe given the increased intensity of patients being discharged to SNFs. In many ways, SNFs currently function as if they are hospital step-down units, but are not staffed to provide this level of care. The addition of a clinician with prescribing and decision-making authority on-site who can see patients as often as required adds a layer of safety and monitoring for high-acuity facilities (Burke et al., 2017; Ingber et al., 2017; Intrator, Zinn, & Mor, 2004; Unroe et al., 2015). This addition may be required if a recently proposed rule change by the Centers for Medicare & Medicaid Services requiring an in-person evaluation of a nursing home resident before transfer to the emergency department is put into action (Katz, Resnick, & Ouslander, 2015).

The goal of post-acute care in a SNF, when appropriate, is getting the patient home where activated older adults and their care partners can self-manage and self-monitor health conditions. Health care interactions are only a small fraction of older adults’ lives, and the rest of the time they are the ones taking charge of their health needs and day-to-day management. In some ways, this is the ultimate example of patient-centered care and reflects the aspiration of health systems. Optimization is not about changing the team composition or leadership but rather the primacy at any given point of the model or service being used to achieve older adults’ health goals. The current analysis identified that the nursing role is one of assessment, management, and monitoring of patient fit with this model of care, which occurs in multidisciplinary team collaboration. Once a patient’s needs no longer “fit” with the SNF environment, nurses manage the next phase of appropriate care in the care transition of older adults. The incongruent fit can occur through a change in the older adult’s medical condition in the context of available nursing skill mix (RN, LPN, CNA), nursing skill set (scope of practice), and needs of the existing group of SNF patients requiring a transfer to a higher level of surveillance or intervention. The incongruent fit can also be a result of having their goals for health outcomes met, thus needing discharge from the SNF.

If a change in culture toward a continuum existed, a novel nursing handoff would be required that resembles an ongoing continuity of care conversation that begins the nursing-led model in the SNF. Other direct communication systems would support these efforts (Dizon et al., 2017; Kim, Kuo, Hu, Gorodeski, & Rothberg, 2017; Petigara, Krishnamurthy, & Livert, 2017). Specific measures could be identified in relation to the overall transition of care process and nursing’s place in optimizing cost-effective, safe, and value concordant care. In line with this optimization, there is a need for an appropriate nursing skill set, nursing skill mix composition, and collaborative care communication that could be planned, educated, targeted, and measured in relation to transitional care outcomes. Given the important role nurses have in goals of care outcomes for older adults, more attention should be given to resource allocation of the SNF nursing work environment. The role and scope of RNs within SNFs is stretched in terms of ongoing acute and chronic medication management, surveillance of complex patient symptoms,
and, simultaneously, facilitating complex family dynamics, palliative care conversations, social connectedness, and safety. Further research on SNF workforce outcomes will facilitate a better grasp on nursing skill mix, including the cost benefit of having NPs on site.

**STRENGTHS AND LIMITATIONS**

SNFs vary by setting and payer system, skill mix, and appropriately prepared health professionals available to provide post-acute care for older adults at any given time. A strength of the current study was the execution of maximum variation sampling to study sites to vary the hospital and SNF partnerships. However, it was conducted in one state and may not transfer to other systems across the United States. The study was performed by a diverse research team of health professionals and academic disciplines to interpret the findings to strengthen the transferability of themes to other transition programs. A systems approach was used to include a wide variety of patients, caregivers, and health professionals to examine an aggregate of transitional care rather than an individual, day-to-day account of care practices.

**CONCLUSION**

When applying the ideal transitional care bridge domains, it is apparent that patient shared decision making, patient activation, and the role context of care settings play on the execution of maximum variation sampling to study sites to vary the hospital and SNF partnerships. However, it was conducted in one state and may not transfer to other systems across the United States. The study was performed by a diverse research team of health professionals and academic disciplines to interpret the findings to strengthen the transferability of themes to other transition programs. A systems approach was used to include a wide variety of patients, caregivers, and health professionals to examine an aggregate of transitional care rather than an individual, day-to-day account of care practices.

**REFERENCES**


Jusela, C., Struble, L., Gallagher, N.A., Red-