Improving care transitions for patients

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Disruptions in care and poor communication can affect the one in four Medicare patients who move from a hospital to a skilled nursing facility (SNF) after a hospitalization for an acute illness. But there are several untapped strategies to improve those care transitions, say Yale researchers in a newly published study.

In "Care Transitions Between Hospitals and Skilled Nursing Facilities: Perspectives of Sending and Receiving Providers," Yale co-authors Meredith Campbell Britton and Dr. Sarwat Chaudhry report results of interviews conducted with 25 hospital providers and 16 SNF providers at three facilities. The participants cited challenges with managing increased patient care complexity, identifying an optimal care setting, managing rising financial pressures, and overcoming barriers to effective communication.

To enhance care, future interventions "should focus on enhancing communication between clinicians, promoting provider understanding of post-acute care and developing strategic opportunities to align facilities," the authors noted.

More information: Meredith Campbell Britton et al. Care Transitions Between Hospitals and Skilled Nursing Facilities: Perspectives of Sending and Receiving Providers, *The Joint Commission Journal on Quality and Patient Safety* (2017). DOI: 10.1016/j.jcjq.2017.06.004