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Behavioral Health Services with Short-Stay Residents in Skilled Nursing Facilities: A Qualitative Study of Clinicians and Administrators

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Abstract

Objectives: The perspectives of professionals involved in behavioral health (BH) services with short-stay residents in skilled nursing facilities (SNFs) are rarely captured in the literature. This study examines the real-world experiences of BH clinicians and administrators in post-acute/subacute care units in SNFs.

Methods: This qualitative study used semi-structured interviews with 18 clinicians (e.g., psychologists and social workers) and five administrators (e.g., directors of social services or BH company executives) involved in BH services with short-stay SNF residents. Interviews were recorded, transcribed, and analyzed by two independent coders using conventional thematic content analysis.

Results: Three themes emerged from the data: (1) BH needs are high among short-stay residents and families during post-acute care transitions; (2) BH services offer multiple unique opportunities to enhance post-acute/subacute care in SNFs; and (3) barriers to providing optimal BH care exist at multiple levels and require action from BH clinicians and stakeholders.

Conclusions: Variability in clinician roles and barriers to optimized care suggest the need for future research targeting best practices and implementation strategies for BH services with short-stay SNF residents.

Clinical Implications: Results identified multiple ways in which BH services may enhance resident, family, and staff outcomes, as well as the milieu in SNFs.

Keywords

skilled nursing facility; post-acute care; mental health; behavioral health; qualitative

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Each year, over 1.5 million Medicare beneficiaries receive post-acute/subacute care services in skilled nursing facilities (SNFs; MedPac, 2020). SNFs typically offer both residential long-term care (i.e., long-stay residents) and short-term (i.e., up to 100 days) post-acute rehabilitation and subacute care for patients who require additional care after hospital discharge (i.e., short-stay residents) in the same facility (Murad, 2012). National data found that 43% of residents are in the SNF setting to receive short-term services (Harris-Kojetin et al., 2019). Short-stay and long-stay residents are comparable in rates of chronic conditions, like heart disease and arthritis. However, short-stay residents tend to be younger (e.g., 44% of long-stay versus 32% of short-stay residents are age 85+), are more likely to be male (e.g., 32% of long-stay versus 40% of short-stay residents are male), and evidence lower rates of Alzheimer's disease and related dementia (e.g., 59% of long-stay versus 37% of short-stay residents have this diagnosis). In addition, 43% of short-stay, compared to 53% of long-stay residents are diagnosed with depression (Harris-Kojetin et al, 2019). The current study targets post-acute/subacute care in SNFs; therefore, for the remainder of the manuscript, the term "SNF resident" will refer to short-stay residents unless otherwise noted. Further, although the authors use the term SNF, consistent with the American healthcare system, similar models of short-term post-acute/subacute care embedded within long-term care settings exist across multiple healthcare systems (e.g., "residential rehabilitation" in the United Kingdom; Wang et al., 2019).

Compared with individuals receiving post-acute care in other settings, SNF residents are typically older and report higher rates of medical and psychological co-morbidities (Conca et al., 2018; Lewin Group, 2009; Tian, 2016). About 25% to 60% of short-stay SNF residents report behavioral health (BH) issues, such as anxiety, depression, insomnia, or chronic pain (Martin et al., 2011; Simmons et al., 2016; Simning et al., 2019). Indeed, a bidirectional relationship exists between physical health or physical recovery and mental health in older adulthood, particularly in the context of functional changes following an acute medical event (Barry et al., 2011; Luo et al., 2020). Thus, it is not surprising that when untreated, BH issues relate to lower physiotherapy participation, poorer rehabilitation efficacy, and longer time to discharge for short-stay SNF residents (Gustavson et al., 2019; Lequerica et al., 2009; Yohannes et al., 2008). After discharge, untreated BH issues increase the risk for re-hospitalization, long-term care placement, and poor health-related quality of life (Galloway et al., 2016; Kringle et al., 2018; Martin et al., 2012; Webber et al., 2005). Thus, BH services may enhance short-term and long-term outcomes for SNF residents receiving post-acute/subacute care.

In the United States, post-acute/subacute care teams in SNFs typically consist of nursing, physical therapy, occupational therapy, speech and language pathology, and non-therapy ancillary services, which sometimes includes BH (MedPac, 2020). Current estimates of BH service utilization in SNFs are missing from the literature. Although, a prior study reported that only 3% to 5% of short-stay residents with anxiety or depression met with a licensed BH professional during a SNF stay (Fullerton et al., 2009). This study also reported that psychopharmacology was the preferred method to address BH issues in SNFs (Fullerton et al., 2009). Yet, short-stay SNF residents are often at high risk for side effects due to polypharmacy (Bachmann et al., 2018). Further, previous research supports the efficacy of non-pharmacological psychological interventions for reducing depression and improving

health-related quality of life among older adults in other post-acute care settings (Hummel et al., 2017). Together, these findings suggest there is an unmet need for non-pharmacological BH services in post-acute/subacute care units in SNFs.

The multidisciplinary and transitional context of short-term SNF units pose unique challenges to providing and evaluating BH services (Quinn et al., 2008; Strong et al., 2020). Capturing the voice of professionals that are directly involved in the delivery of BH services with short-stay SNF residents can provide valuable insight into this important service within this complex setting of care (Morse, 2007). The current study used semi-structured qualitative interviews with clinicians and administrators involved in BH services in post-acute/subacute SNF units. The aims were to: (1) understand the day-to-day clinical experiences of delivering BH services, (2) identify perceptions of effective BH care practices, and (3) classify challenges to BH services with short-stay SNF residents.

Materials and Methods

Research Design

The current study used a descriptive qualitative design. Thematic content analysis guided methodological and analytic approaches (Braun & Clarke, 2006). The authors followed the Consolidated Criteria for Reporting Qualitative Research guidelines to ensure comprehensive reporting (see Supplemental Material; Tong et al., 2007). All study procedures were approved by the affiliated institutional review board (COMIRB #19–1058).

Participants & Sampling Procedures

Participants were recruited using convenience sampling strategies, including: emails to professionals known to the investigators; emails to professional organizations and listservs; and snowball sampling. Sampling strategies targeted individuals and organizations that would provide heterogeneity of professional background (e.g., psychologist listservs and SNF operators). An estimated 1,400 professionals were reached, 41 (3%) responded to recruitment strategies. Eligibility criteria were: (a) licensed mental health clinician (i.e., licensed professional counselor, licensed clinical social worker, or licensed psychologist), or clinical manager, director of BH services, or other administrative leadership position for a SNF or BH company; and (b) at least six months experience with short-stay residents in the SNF setting. It is important to note that this study defines a BH company as an employer of multiple clinicians and contracts with SNFs to offer BH services (i.e., not private practice or employment by the SNF). The current study excluded professionals that only provided services with long-stay residents. Participants involved in care with both short- and long-stay residents were included in the current study and prompted to respond to interview questions only regarding their work with short-stay residents. Of the 41 initial volunteers, 16 declined or could not be reached for follow-up and two were excluded for providing services exclusively with long-stay residents. Overall, 23 professionals were included in the current study, see Table 1. No participant withdrew from the study. Each participant was only interviewed once.

Data Collection Procedures & Instrument

Data collection occurred between August 2019 and October 2019. Prior to interviews, participants received a description of the procedures and purpose of the current study (i.e., understand the roles and barriers to care for BH services in short-term SNF units to, ultimately, inform future patient-oriented research). Each participant reviewed informed consent and provided verbal consent prior to the interview.

The primary author [EP], a clinical psychology fellow trained in qualitative research methods, facilitated all interviews. Most interviews (n = 22) were conducted via telephone; one interview was conducted in-person at the participant's workplace. For each interview, the participant and interviewer were the only individuals present. Interviews lasted between 28 and 51 minutes (M = 38.22, SD = 7.85 minutes). Participants also completed a brief online demographics survey and were compensated $40 for their time.

The current study used a semi-structured interview guide with prompts. The interview guide was developed by the primary author [EP]. During development, questions were revised with input from the research team and qualitative research experts. The final interview guide was reviewed by an interdisciplinary group of experts in aging and health services prior to use. Interview questions addressed common practices and roles for BH clinicians, as well as barriers and facilitators to BH care with short-stay SNF residents, see Table 2.

After each interview, the interviewer completed reflective memos. At the conclusion of data collection, the interviewer [EP] reviewed memos for the emergence of new themes and discussed saturation with the research team [RB, RSB, JDP].

All interviews were audio recorded and transcribed verbatim using a HIPAA-compliant professional transcription service. Identifiable information was removed during transcription. Transcribed interviews were not returned to participants.

Data Analysis

The current study analyzed data using conventional thematic content analysis (i.e., codes were defined during data analysis and derived from the data; Hsieh & Shannon, 2005). This inductive analytic strategy was suitable for the current study because our aim was to identify latent themes emerging from the experiences of professionals involved in BH services with short-stay SNF residents (Braun & Clarke, 2006). Two authors, trained in qualitative research methods, completed all data analysis [EP, RB]. Transcribed interviews were uploaded to Atlas.ti 8 for analysis.

Each coder independently read transcripts numerous times to generate an initial codebook. A final coding structure was developed by joint coding five interviews. During the development of the codebook, the coders met three times to achieve consensus. Next, coders independently coded and cross-coded interviews. For example, Coder A analyzed nine interviews and Coder B analyzed nine different interviews; then, each coder re-analyzed the other set of interviews. This procedure ensured that each interview was coded twice. Coders met bi-weekly throughout data analysis. The purpose of these meetings was to reach consensus on unclear codes and discuss potential biases. Different backgrounds among the

coders (e.g., gender and academic discipline) allowed for challenging of biases. Audit trails were kept for each iteration of the codebook and both coders generated memos after each meeting.

After interviews were coded, both coders engaged in cognitive mapping exercises and condensed similar codes to generate a list of themes. The coders discussed and agreed upon themes and subthemes during two meetings. A coding tree is available in the Supplemental Materials. The final code structure and representative quotes were synthesized and reviewed by a psychologist with clinical and research experience in post-acute/subacute care units in SNFs, who was not a member of the research team or a study participant. The third party reviewer and the first author engaged in peer debriefing to increase credibility of findings (Creswell & Miller, 2000).

Results

Three themes emerged from the data: (1) BH needs are high among short-stay residents and families during post-acute care transitions; (2) BH services offer multiple unique opportunities to enhance post-acute/subacute care; and (3) barriers to providing optimal BH care exist at multiple levels and require action from BH professionals. See Figure 1 for an overview of themes and subthemes.

High BH Needs

Participants reported that the transition to post-acute/subacute care in a SNF is a particularly stressful point in residents' and families' illness and rehabilitation trajectories. Many participants described SNF admission as a *triggering event* for BH issues. Participants suggested that psychological stress associated with acute medical events, as well as transitioning to the SNF setting for post-acute/subacute care (e.g., perceived lack of autonomy and being away from home), exacerbated existing BH concerns or contributed to the onset of new BH issues for both residents and family members. For example, the clinical director of a BH company stated:

> "[residents] have already undergone a major medical trauma that required at least a minimum of hospitalization and that's traumatic enough in of itself. But then they're unable to go back home and so they need to be in a SNF setting for God knows how long… possibly even being unable to ever recover and to go back home at all… And so, we do see a lot of adjustments disorders, we see a lot of depression, and we see a lot of anxiety about the future and about their future level of functioning. And just being in a SNF even that requires a lot of adjustment (FMD13; M, Administrator)."

Participants also noted the importance of gaining *access to BH* services during the period of heightened stress associated with a short-term SNF stay. Participants reported that contact with BH was important for residents and families who may be experiencing undetected or untreated BH issues that either started before or around the time of SNF admission. For example, a psychologist stated:

> "We get [the resident] into short-stay and everything kind of slows down and I'm able to sit down with them, really get a lot of information, feed it back to them, feed it back to their outside providers, feed it back to the family member, give them all some good understanding. And the feedback to the family member is therapeutic in of itself.… I feel like I'm righting the ship before they leave (MHP23; M, Clinician)."

Although participants reported SNF stays were a time of high BH need, many described challenges to engaging residents in BH interventions related to the short length of stay and residents' *medical priorities*. These challenges included demanding rehabilitation schedules that contributed to resident fatigue or limited availability for appointments, as well as residents attitudes toward BH as not a necessary part of their rehabilitation care plan.

Unique Opportunities for BH to Enhance Post-Acute/Subacute Care

Participants described multiple unique opportunities for BH services to improve post-acute/subacute care in SNFs. Participants reported that there were *multiple targets of BH interventions with short-stay residents*. First, interventions often targeted residents' psychological health, including providing psychoeducation and building coping skills, especially in the context of adjustment to changes in health and function. Second, BH services complemented rehabilitation goals by addressing motivation, adherence, and other BH-related barriers to medical rehabilitation (e.g., pain management and health behavior change). For example, a psychologist stated:

> "The biggest factor and the reason that we're employed by skilled rehab settings is because they want to see an increase in engagement in physical therapy and decreased return to the hospital… we're helping [resident] with the emotional aspects, so that they can focus on the physical (MHP13; F, Clinician)."

Third, participants noted that BH services targeted challenging resident behaviors. Participants added that this role sometimes felt like BH was called upon to maintain social order. For example, a psychologist stated:

> "If [the resident] can function more effectively in the nursing home even for the short time they're there, if they are compliant with taking medication, taking baths, participating in group activities, eating… those are the outcomes that the SNF is looking for. They just really want nice, happy, compliant patients (MHP42; M, Clinician)."

Participants described engaging in numerous *collaborative care* practices, including consultation and discharge planning. Participants also described *advocacy* as a key opportunity for BH to improve post-acute/subacute care in SNFs. Advocacy involved providing psychosocial support for residents, as well as promoting person-centered and compassionate care practices. Both collaborative care and advocacy often centered around residents that staff perceived as difficult to provide care for because of behavioral or communication struggles associated with cognitive impairment, delirium, or serious mental illness. For example, a psychologist stated:

> "I've joked with my peers about [BH] being the givers of empathy. I think sometimes staff that are dealing with somebody that's struggling with a mental health issue can see the resident just being difficult or frustrating and really struggle in interacting with the resident and remaining empathetic to the resident, I can help them take a different stance and a different viewpoint (MHP13; F, Clinician)."

Another opportunity for BH was *intervening with organizations and stakeholders* that impacted care. This involved identifying sources of stress from various stakeholders (e.g., staff stress and burnout; inter-personal conflict; facility policies and practices; and family stress) and engaging in practices to minimize the impact of identified stressors on resident care and/or to improve the milieu of the unit. The CEO of a BH company described the need for this role in the SNF setting by stating:

> "You've got the staff who is really overworked, who are stressed out. You've got, of course, the residents, and then you have the families. So, if there's a dysfunction in any of those different domains, then we've got a problem (FMD18; M, Administrator)."

To address staff stress and burnout, participants discussed providing psychosocial support and psychoeducation. For example, a psychologist stated:

> "This can be a really stressful and tough environment to work in and so being a person who sometimes checks in with nurses or other colleagues after a rough resident interaction or a hard week and being able to offer not just education but also genuine empathy and support for colleagues is really part of the role [BH] adopts in these settings (MHP22; F, Clinician)."

To address inter-personal conflict, BH clinicians reportedly facilitated conflict resolution and provided psychoeducation on communication and de-escalating skills with the parties involved (e.g., residents, staff, or family members). To address administrative policies or practices that negatively impacted care, participants reported joining committees or conducting quality improvement projects. To address stress within the family, participants described engaging family members in BH interventions. Often, family interventions involved support and education around discharge planning and decision-making, as well as promoting coping skills among specific family members or other informal care partners.

Participants also described *variability in the clinical duties* that BH adopted in SNFs. While some clinician participants reported engaging in all of the aforementioned roles, others described only adopting one or two specific roles in their practice. For example, a psychologist noted:

> "My contribution is very narrow… I do not involve myself in the operation of the building, so my advocacy function is turned off… my job is more to teach [the resident] how to be resilient. If there are concerns, we pass those on to the social worker or the director of nursing. I mean if I were to frame it: we walk in, we do our therapy and walk out (MHP42; M, Clinician)."

Barriers to Providing Optimal BH Care and Actions to Address Barriers

Participants reported multiple barriers that impacted the delivery of optimal BH care, which we define as providing services that meet the BH needs of residents, families, or staff. Barriers were noted across multiple levels of care, including the healthcare system, facility, clinician and employer, and resident and family. Participants also described engaging in various actions to address identified barriers in practice, see Table 3.

Healthcare system barriers included unfavorable insurance reimbursement and facility structures that were not inclusive of BH. For example, a psychologist stated:

> "For financial reasons I have to be wary of my time…I have to explain to [the facility] that Medicare is not going to pay me for staff time, which inevitably I do a lot of anyway (MHP12; F, Clinician)."

In response to these system-level barriers, clinician participants described providing unpaid services, negotiating with their employer or facility administration to be compensated for non-billable services, and lobbying for BH services in post-acute/subacute care in SNFs either locally or nationally. For example, a psychologist described practices to balance workload and compensation:

> "I have to make a certain amount of money every day. And I know what my rates are, and I know who I might see for a referral that day… I don't have to bill for nine hours to make my day officially profitable for me. So that leaves me a couple hours that I'm willing to just put into the system to try to make things work better (MHP14; M, Clinician)."

Participants identified various *facility barriers* to optimal BH care, including: staff turnover, difficult personalities, poor inter-professional relationships, and ineffective collaborative care practices. Participants also reported that the unit or facility culture can contribute to a perceived de-valuing of BH, as evidenced by inconsistent referrals, lack of knowledge of the roles of BH, and negative attitudes toward BH as a discipline. Facility resources and physical spaces were also a barrier to optimal care. Specifically, limited office space posed challenges to privacy during BH sessions and reduced efficiency with administrative tasks like charting.

In response to facility-level barriers, participants reported engaging in the following practices: quality improvement initiatives; providing informal education and formal trainings about roles and benefits of BH; gaining trust through successful cases, especially residents that initially posed a challenge for staff; building strong relationships with staff and administrators; focusing on relationships with "gatekeeper" for referrals; and attending care plan meetings. For example, the clinical director of a BH company described steps for gaining "buy-in" for BH services:

> "We can provide psychoeducation just about what we do, and how we do it, and why we do it, and the benefits of that. Another thing is just doing our job and doing it well. And so, just showing up, being consistent, being friendly, knowing our residents, consulting with staff, communicating. That's probably the more

> significant and primary way in which we win over a staff member who might be more aloof (FMD13; M, Administrator)."

Clinician barriers included time constraints, often due to only providing care in a SNF once a week (i.e., multiple facilities on the clinician's caseload), and insufficient training relevant to post-acute/subacute care in the SNF setting. In response to time constraints, clinician participants described keeping flexible schedules to accommodate various needs or, alternatively, being selective about activities while in certain facilities (e.g., not attending care plan meetings when individual case load is high). In response to limited training, clinician participants noted that joining a large BH company provided support through orientation materials, supervision, and continuing education.

Participants discussed additional *employer* factors, such as the benefits of working for a large BH company or the Veteran Affairs (VA), including administrative support and salary pay. Thus, joining a BH company or the VA was a response to the various challenges associated with navigating the high administrative burden in private practice. For example, a psychologist noted:

> "[The company] goes to the nursing homes, they have these relationships, they establish these accounts. They do all that hard work (MHP19; F, Clinician)."

Participants identified multiple *resident and family barriers* to optimal BH care. Resident barriers included limited cognitive ability and lack of time for BH services due to short length of stay. In addition, attitudes and knowledge of BH among both residents and families were identified as barriers to optimal care. Poor family support for rehabilitation and BH goals was also identified a barrier to optimized care. For example, a psychologist stated:

> "Did the family create an environment that was healthy or do they all have unhealthy lifestyles and they're not going to support if this person tries to come home and start exercising and eating healthy and things like that?... sometimes I get called in just because the family is making [rehabilitation success] difficult (MHP11; F, Clinician)."

Clinician participants reported multiple strategies to respond to resident and family barriers, including: discussing BH services using non-threatening language; providing psychoeducation on the process and benefits of BH services; building rapport and trust; including families in BH services; and prioritizing assessment and treatment planning over longer BH interventions. For example, a psychologist described adjusting treatment strategies because of the short length of stay by stating:

> "A lot of times I'm just getting the ball rolling and a lot of times it's going to have to be continued. I'm more just letting people know what I think the issues are and it's going to have to be followed up on [in the community] because there's just not enough time (MHP15; F, Clinician)."

Discussion

The goal of this study was to examine the real-world experiences of professionals involved in the delivery of BH services with short-stay SNF residents. The current sample of

clinicians and administrators offered insight into the high need for BH services, various opportunities for BH to enhance care, and the challenges to providing optimal care in short-term SNF units. These findings highlight the everyday experiences of BH professionals working with short-stay SNF residents, which may help guide future translational research efforts related to this potentially valuable, yet understudied service.

The current sample described the clinical relevance of post-acute care transitions for residents and families. Specifically, many participants conceptualized precipitating medical events as traumatic, which reportedly impacted the psychological health and rehabilitation capacity of residents, as well as family members, during a SNF stay. This trauma-focused framework is consistent with a growing body of literature that suggests, following an acute medical event, patients and families may experience psychological symptoms consistent with post-traumatic stress (Edmondson, 2014; Johnson et al., 2019; Meli et al., 2019). However, few studies target the prevalence, course, consequences, or treatment of post-traumatic stress symptoms among short-stay residents and their family members in SNFs. These areas of research may be important for guiding the role of BH in addressing trauma-related symptoms in post-acute/subacute units in SNFs.

Participants in the current study consistently reported that BH services and clinician roles were shaped by the physical rehabilitation focus of short-term SNF units. For example, participants noted that BH assessments and interventions often targeted treatment adherence (e.g., motivation) or health-related issues (e.g., pain management and lifestyle changes) to support rehabilitation care plans. These findings suggest that integrating BH into post-acute care teams in SNFs may positively contribute to rehabilitation outcomes. Participants also reported engaging in practices consistent with the types of BH services often provided in long-term care units, like managing challenging behaviors and providing staff education related to dementia (Molinari et al., 2020). Therefore, BH practice in post-acute/subacute SNF units incorporates aspects of both rehabilitation psychology and psychological practice in long-term care.

Overlapping competencies in rehabilitation psychology and geropsychological practice in long-term care include understanding healthcare systems and interdisciplinary teams, as well as promoting psychological adjustment, providing staff consultation, and facilitating family support (Cox et al., 2010; Molinari et al., 2020). In SNFs, the obvious difference between BH practice with short- and long-stay residents is the length of stay, which impacts the delivery of interventions. For example, some participants in the current study preferred using assessment, feedback, and psychoeducation with short-stay residents to accommodate the brief window for engagement with BH during a SNF stay. In addition, participants described working with short-stay residents to adapt to physical and functional changes, whereas long-stay residents are often coping with residential and social changes (Molinari et al., 2020). Further, some participants reported continuing treatment with certain short-stay residents after discharge from the SNF to a previous residence. The ability for stepped-care during post-acute care transitions is unique to short-stay residents and is an important area of future investigation (Meuldijk & Wuthrich, 2019; Quinn et al., 2008). Current guidelines for BH practice in long-term care settings incorporate language accommodating of short-stay residents (Molinari et al., 2020). However, differences in service delivery and

clinical needs noted in this study (e.g., discharge planning and coordinating treatment goals with rehabilitation care plans) may require further development of practice guidelines and training protocols specific to post-acute/subacute units in SNFs.

Participants reported that staff- and facility-level interventions can promote compassionate and person-centered care for residents labeled as challenging, often due to cognitive limitations, delirium, or serious mental illness. More psychiatrically complex patients are transferring to SNFs for post-acute/subacute care, suggesting these roles for BH may help improve overall quality of care in the SNF setting (Fullerton et al., 2009; White, 2019). However, interventions targeting staff and the milieu are rarely manualized and, thus, few studies provide empirical support for these types of intervention (O'Shea Carney & Norris, 2017). Further, staff, facility, and system barriers (e.g., reimbursement models) limited the ability for some participants in the current study to incorporate staff- and facility-level interventions into everyday practice in the SNF setting. Investigating the feasibility and effectiveness of consultative, psychoeducational, and supportive services targeting staff and the milieu may comment on the value of BH services in post-acute/subacute SNF units.

Family, or informal care partners, emerged as an important topic across all three major themes. As one psychologist stated, "medical illnesses take place within the context of the family (MHP11; F, Clinician)." Participants in the current study believed that BH clinicians were particularly well-suited to manage family issues in the SNF setting, which reportedly included inter-personal conflict, psychological distress, lack of care-related information, emotional and practical barriers to discharge planning, and poor support for rehabiliation goals. Previous research on informal care partners in post-acute care often target home-based or outpatient settings (Ariza-Vega et al., 2019; Liu et al., 2015). However, SNFs may impact the psychological experience of care partners differently than outpatient or in-home settings; for example, navigating staff relationships and physical distance (Nahm et al., 2013). Future research is needed to investigate the BH needs, as well as the feasibility and benefit of interventions that can promote psychological health and sucessful care transitions among family or informal care partners during a short-term SNF stay.

The current study has a few limitations to consider. First, convenience sampling may have contributed to bias. For example, the majority of participants were employed by BH companies (n = 17, 74% of clinicians), which may reflect sampling strategies (e.g., snowball sampling among co-workers within the same company). Given that the role of BH companies was an emergent subtheme, it is unclear whether sampling bias influenced this finding. Second, we did not return professionally transcribed interviews to participants for comment or correction. Rather, we had a third party content expert comment on the credibility of findings. Lastly, data saturation cannot be assumed. At the conclusion of data collection, the study team determined themes were sufficent for intepretation (Saunders et al., 2018). However, it is possible that results did not capture the full spectrum of experiences of professionals involved in BH services with short-stay SNF residents.

Findings from the current study suggest that resident heterogeneity and the medical rehabilitation setting both afforded unique opportunities for BH and contributed to barriers in post-acute/subacute care units in SNFs. Despite barriers, participants described multiple

ways that BH services can enhance positive outcomes for residents, families, and staff in short-term SNF units. The delivery of BH services in post-acute/subacute care units in SNFs is rarely discussed in the literature, leaving limited research that can inform best practices in this setting. Findings from the current study may help inform future areas of research related to BH services with short-stay SNF residents, including, but not limited to, trauma-related focused and staff-level interventions, stepped-care models, and evidence-based practices for informal care partners.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Clinical Implications:

- In addition to contributing to rehabilitation care plans, BH may enhance post-acute/subacute SNF care through advocacy and staff education and support.
- Post-acute/subacute units in SNFs may be an important point of contact for assessment, psychoeducation, and treatment planning for BH concerns among older adults and their family.
- Family care partners may benefit from BH services during short-term SNF stays; yet, future research is needed to address clinician, facility, and system barriers with this patient population.

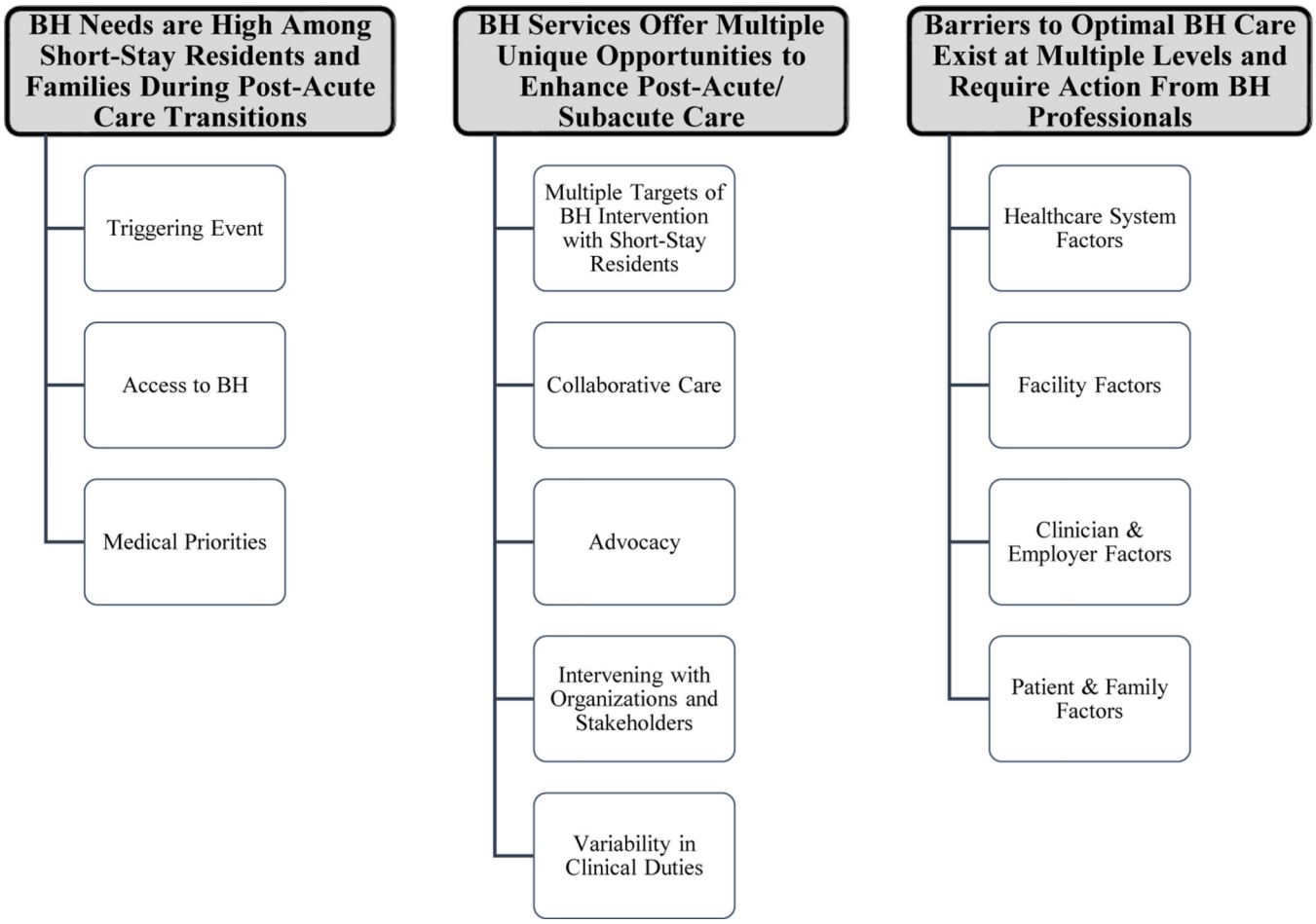

Figure 1.
Overview of themes and subthemes

Table 1

Participant characteristics

	N or *M*(SD)
Age	
30–39	6
40–49	7
50–59	6
60+	4
Gender: Women	16
Educational Background	
PhD Psychologist	9
PsyD Psychologist	5
Licensed Clinical Social Worker	6
Mental Health Counselor	1
Healthcare Administration	2[a]
SNF experience (in years)	8.3(9.4)
Employer	
Veteran Affairs	2
Private-Practice	2
BH Company	17
SNF Operator	2[a]

Note.

[a]Administrators only.

Table 2

Sample Interview Questions

Tell me about your experiences in the SNF setting.
What are the common presenting problems for BH in SNFs?
What are some barriers to providing BH services in the SNF setting?
How does BH work with the other disciplines in SNFs?
What differentiates BH from other disciplines in the SNF setting?
What outcomes are most important for patients while in a SNF?

Note. All questions refer to short-term post-acute/subacute SNF units.

Table 3

Overview of Barriers to Optimal BH in SNFs and Participant Responses

Level	Barriers	Responses to Barriers
Healthcare System	• Insurance does not reimburse service • SNF guidelines do not include BH services	• Provide service without compensation • Negotiate with employer or facility to be compensated for unbillable service • Advocate for BH services in SNFs locally and nationally
Facility	• Poor facility culture & high staff turnover • Interpersonal difficulties with facility staff • Poor team collaboration • Knowledge & attitudes toward BH • Ineffective referral processes • Facility resources, office space, & privacy	• Lead quality improvement initiatives to improve the milieu • Build strong relationships with staff and administration • Attend care plan meetings • Provide education and trainings about the roles and benefits of BH • Get buy-in for BH through successful cases • Focus on building relationships with “gatekeeper” for BH referrals (e.g., social services staff)
BH Clinician & Employer	• Limited training experience • High administrative burden in private practice	• Seek supervision and continuing education through employer • Join BH company that has administrative support
Patient & Family	• Knowledge & attitudes toward BH • Poor family support for patient’s goals • Patient length of stay & lack of time for BH • Patient cognitive impairment	• Introduce BH services using non-threatening language to build rapport and trust • Provide education on process and benefits of BH services • Engage family in BH services • Prioritize assessment and treatment planning over interventions in SNFs