



# Beyond Discharge: The Role of Pediatric Skilled Nursing Facilities in the Children's Hospital Continuum of Care



Strengthening post-acute transitions for medically complex and technology-dependent children

Heather Spaulding, MSN-Ed, APRN-CNS, RN-BC, CPN, ACCNS-P • Silver State Pediatric Skilled Nursing Facility • Las Vegas, Nevada

## BACKGROUND

Children with medical complexity often have chronic conditions, functional limitations, technology dependence, frequent hospitalizations, and significant care coordination needs. Discharge planning for this population requires more than medical stability; it requires a realistic next care setting, reliable equipment, caregiver readiness, and coordinated handoff.

For this population, **medical stability does not always mean home readiness**. Pediatric home health access gaps, equipment delays, caregiver training needs, and fragmented communication can prolong hospitalization and increase transition risk.

Pediatric skilled nursing facilities provide a critical post-acute bridge for medically complex children who no longer require acute hospitalization but continue to need skilled nursing, respiratory support, nutrition management, therapy carryover, developmental care, and family-centered transition planning before discharge home.

## PURPOSE

To demonstrate how pediatric skilled nursing facilities strengthen children's hospital discharge planning for medically complex, technology-dependent children through post-acute stabilization, caregiver preparation, interdisciplinary coordination, and transition-to-home support.

This poster combines current pediatric literature with local Silver State Pediatric Skilled Nursing Facility data to demonstrate why pediatric SNFs should be included earlier in discharge planning.

## METHODS

A knowledge enhancement approach was used to synthesize current pediatric literature on children with medical complexity, pediatric home health access gaps, discharge readiness, and pediatric post-acute care.

Local practice data from Silver State Pediatric (SSP) Skilled Nursing Facility (SNF) were reviewed, including admission source, technology-dependent resident characteristics, average length of stay before home discharge, resident days, hospital admissions/transfers, hospital admission rates, and available 30-day readmission trends.

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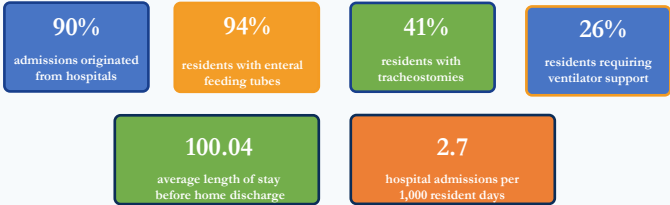
## PEDIATRIC SNF AS THE BRIDGE



Stabilize. Teach. Coordinate. Develop. Transition.

Pediatric SNFs provide skilled nursing, respiratory support, nutrition management, rehabilitation carryover, developmental care, caregiver education, and interdisciplinary coordination in a child-centered environment.

## RESULTS: SSP LOCAL DATA



From first quarter 2025 through first quarter 2026, 43 of 48 admissions originated from hospitals. In May 2026, 32 of 34 residents had enteral feeding tubes, 14 had tracheostomies, and 9 required ventilator support. Since opening in September 2021, the average length of stay before home discharge was 100.04 days. Hospital tracking from January 2025 through March 2026 showed 37 hospital admissions/transfers across 13,633 resident days.

**Local data support SSP's role in hospital throughput, technology-dependent care, and transition planning before home discharge.**

**Note:** 30-day readmission trends were available in reviewed reports; 90-day readmission data were not available.

## CONCLUSIONS

Pediatric skilled nursing facilities should be recognized as essential partners in children's hospital discharge planning. SSP local data demonstrate that pediatric SNFs support hospital throughput, care for a highly technology-dependent population, and provide a structured transition period before home discharge.

**A safe discharge is not defined only by leaving the hospital; it is defined by whether the next care setting is prepared, the family is supported, and the care team is aligned.**

## IMPLICATIONS FOR PRACTICE

Early pediatric SNF involvement should be considered for children with tracheostomies, ventilator dependence, enteral feeding needs, complex medication regimens, developmental or rehabilitation needs, limited home nursing availability, or unclear home readiness.

**CALL TO ACTION: Include pediatric SNFs earlier in hospital discharge planning conversations for medically complex and technology-dependent children.**

## KEY TAKEAWAY

Medical stability does not always equal home readiness. Pediatric skilled nursing facilities help close the gap between hospital discharge and safe transition home for medically complex, technology-dependent children.



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