2023

# Community-Dwelling Older Adults' Perceived Self-Efficacy and Readiness for Discharge After Receiving Occupational Therapy Services at a Skilled Nursing Facility (SNF).

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Presented in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Occupational Therapy

Eastern Kentucky University
College of Health Sciences
Department of Occupational Science and Occupational Therapy

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2023

## Acknowledgments

First of all, I would like to thank God for his wisdom, guidance, and grace to me in pursuing my doctorate degree in occupational therapy. I thank my lovely parents, friends, and church family for their endless prayers for me during these years. Thank you for their understanding and motivation to allow me to pursue this degree and for their unconditional love and support.

I want to thank my dear God-sister, Yuti Huang, who listened to my concerns and worries throughout my academic year. She was always there to encourage me and give me advice, especially with her expertise in research. Most importantly, thank you for endless prayers to keep me going.

To the Eastern Kentucky University OTD faculty for sharing their knowledge, guidance, encouragement, patience, and time to guide me through my academic journey. A special thank you to my capstone mentors, Dr. Simpkins and Dr. Causey-Upton, for their generous support, expert guidance, patience, knowledge, and encouragement in helping me to complete my capstone. Their expertise in gerontology and research methodology fosters my skills and confidence in conducting evidence-based research. Thank you for your valuable feedback and advice along the way.

Special thanks to the Smith Ranch Generation Health Care team for allowing me to conduct my research and further explore the community-dwelling older adults' perceptions of discharge preparedness in a SNF. To the research participants of my capstone study, I acknowledge and extend my gratitude for the participants' patience and time in completing each research questionnaire and for trusting me with their words.

## Executive Summary

**Background:** Older adults who plan to go home from a SNF after having injuries have increased concerns about their transition and feel they have limited knowledge and information on community resources. There is research on the critical roles of occupational therapy in preparing community-dwelling older adults to transition home from SNF. However, limited research on community-dwelling older adults' perception of their self-efficacy and discharge preparedness after receiving occupational therapy services at SNF.

**Purpose:** This project examines the perceptions of community-dwelling older adults' preparedness and self-efficacy after receiving occupational therapy services in a SNF to increase their quality of life and decrease hospital readmissions after they return home.

**Theoretical Framework:** The Value and Meaning in Occupations Model (ValMO) and Model of Occupational Wholeness theoretical framework were used to frame and provide context for this study to assess community-dwelling older adults' self-perceived occupational performance and satisfaction and the effectiveness of the intervention.

**Methods:** A convergent mixed-method, pretest, and posttest design. This design selected participants admitted to a skilled nursing facility to address community-dwelling older adults' perception and self-efficacy during SNF discharge preparation.

**Results:** The quantitative pretest, posttest, and two-week phone call follow-up results reveal a statistical significance ($p<0.05$) in community-dwelling older adults' self-efficacy. A qualitative data analysis revealed five themes: *happy about education, discussion with the interdisciplinary team, occupation-based intervention, client-centered intervention,* and t*reatment frequency.*

**EASTERN KENTUCKY UNIVERSITY**

**COLLEGE OF HEALTH SCIENCES**

**DEPARTMENT OF OCCUPATIONAL SCIENCE AND OCCUPATIONAL THERAPY**

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Date of Submission: __11/21/2023_____

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## Section I: Nature of the Problem/Problem Identification

Older adults who plan to go home from a SNF after having injuries have increased concerns about their transition and feel they have limited knowledge and information on community resources. Discharge readiness is typically based on a clinical team's decision on a client's functional and medical status (Knier et al., 2015; Weiss et al., 2007). Additionally, the medical team's decision on how clients can return home differs from what clients perceive to be safely returning home (Weiss et al., 2007). According to Knier et al. (2015), a patient's inability to comprehend and recall discharge instructions, family caregivers' lack of confidence in caring for patients, and limited resource access are pivotal factors alongside for patients and caregivers to transition home. As a result, some older adults have an increased fear of returning home, resulting in remaining in a long-term care facility or, if they return home, they may go back to the hospital within 30 days (Weerahandi et al., 2019). Approximately 1.7 to 1.8 million fee-for-service Medicare beneficiaries received rehabilitation services in 15,000 SNFs annually (Simning et al., 2019; Toles et al., 2017). In addition to that, Simning et al. (2019) indicated that the goal for most community-dwelling older adults with disabilities who transitioned to SNF from the hospital is to return home; however, only 49.9% of older adults in the SNF were discharged to home, group home, assisted living facilities, or board-and-care within a year. Additionally, 49.9% of older adults and 24.2% of individuals were readmitted to the hospital within 30 days of returning from a SNF (Cheney, 2019). This indicated that nearly half of older adults remained in the SNF after hospitalization; if they did go home, almost half of all older adults were readmitted to the hospitals.

There is research on the critical roles of occupational therapy in preparing community-dwelling older adults to transition home from SNF (Provencher et al., 2020; Simning et al., 2019,

& Toles et al., 2017). However, there is limited research on community-dwelling older adults' perception of their self-efficacy and discharge preparedness after receiving occupational therapy services at SNF. A literature review was conducted to better understand the discharge preparedness and self-efficacy of community-dwelling older adults' perception in transitioning from SNF to the community and identify occupational therapy services' roles in discharge preparedness.

**Abbreviated Review of Literature**

According to Toles et al. (2016), 1.7 million Medicare beneficiaries are transferred to SNFs after hospitalization with an average length of stay of 24 days, and the total cost to Medicare was $28.8 billion. A SNF provides continuity and coordination of transitional care for older adults after hospitalization to decrease complications and hospital readmission before they return home (Toles et al., 2016). However, 31% of patients who stay in a SNF did not meet the requirements for discharge planning, such as detailed discharge instructions for individuals to safely return home, resulting in Medicare paying approximately $5.1 billion for patients' stay in the SNFs (Levinson, 2013).

Many studies provided a positive correlation between discharge planning interventions and identified the factors that enhance community-dwelling older adults' discharge experiences. Several descriptive studies on transitional care intervention in SNFs focus on the environmental barriers and physical and psychosocial need for intervention to increase individuals with disabilities' success in returning to the community and their quality of life (Gretschel et al., 2017; Simning et al., 2021). In addition, Provencher et al. (2020), Toles et al. (2017), and Wales et al. (2018) studied the effectiveness of discharge planning interventions such as HOME and Connect-Home, occupational therapist-led transitional care intervention programs to identify the

feasibility of incorporating discharge planning intervention in a SNF setting. Although numerous studies identified the benefits of discharge planning for community-dwelling older adults in a SNF and addressed healthcare professionals' perception of quality of care in patients receiving discharge planning services (Knier et al., 2015; Simning et al., 2019), patients' perceptions of discharge quality and preparedness for discharge were not fully understood. Knier et al. (2015) addressed that the discharge planning content may be delivered hurriedly or without thoroughly considering individuals' learning needs. Additionally, limited studies were identified on how community-dwelling older adults perceive occupational therapy education in discharge planning and their self-efficacy in occupational performance.

**Problem Statement**

While there was research regarding the effectiveness of discharge planning and intervention, more research is needed in discharge planning for community-dwelling older adults. Hospital readmission occurs when a patient cannot comprehend and recall discharge instructions, family caregivers lack confidence in caring for patients, and there is limited resource access after returning home (Knier et al., 2015). Additionally, there are significant hospital readmissions after community-dwelling older adults return home. Weerahandi et al. (2019) identified that 24.2% of community-dwelling older adults hospitalized with heart failure were discharged home from SNF and readmitted to the hospital within 30 days. Therefore, further studies on community-dwelling older adults' perception of discharge quality and preparedness, perceived occupational therapy education in discharge preparedness, and perceived self-efficacy in occupational performance may address the gap during transitional care from SNF to home.

**Purpose**

This project examined the perceptions of community-dwelling older adults' preparedness and self-efficacy after receiving occupational therapy services in a SNF to increase their quality of life and decrease hospital readmissions after they return home.

**Proposed Capstone Project Methods**

The Proposed Capstone Project was a convergent mixed-methods, pretest, and posttest design. This design selected participants admitted to a skilled nursing facility. This project used the Readiness for Hospital Discharge Scale (RHDS) instruments (Knier et al., 2014; Nurhayati, 2019) and the General Self-Efficacy Scale (GSES) (Schwarzer, 2012) to measure the patients' perceptions of readiness for discharge. Participants received a pre-test and post-test with GSES to identify their occupational performance. RHDS tools determined how participants felt about their preparedness to be discharged home (Knier et al., 2014; Creswell & Creswell, 2018). In addition, the researcher collected the number of days the participants received occupational therapy services and how many days they were in the facility.

**Settings/population:**

This study consists of 92 community-dwelling older adults with disabilities aged 65 or older receiving rehabilitation in SNF and planning to return to the community. Participants were eligible to participate with their cognitive scores from the Montreal Cognitive Assessment (MOCA) indicating cognitively intact or mild cognitive impairment with various diagnoses as long as their cognitive scores indicated mild or intact cognitive state.

**Timeline:**

The timeline for completing the interviews were from January to August, 2023.

Quantitative data were collected on the patient's initial admission, before discharge to home, and two weeks after all participants returned home. In addition, participants received the GSES on the initial admission, before discharge, and two weeks after returning home and received RHDS questionnaires before discharge to the community.

**Project Objectives**

The objectives of the research study were to:

1. Identify perceptions of discharge preparedness of community-dwelling older adults' experiences during SNF stay through the RHDS tools.
2. Understand community-dwelling older adults' self-efficacy in occupational participation after receiving services in SNF.
3. Describe implications for occupational therapy practice for community-dwelling older adults' preparedness to return to the community after suffering illness.
4. Identify the difference between the length of stay and discharge preparedness in community-dwelling older adults.

**Theoretical Framework**

The Value and Meaning in Occupations Model (ValMO) and Model of Occupational Wholeness theoretical framework supported the construct to assess community-dwelling older adults' self-perceived occupational performance and satisfaction and the effectiveness of intervention (Persson et al., 2001; Yazdani & Bonsaksen, 2017). Semi-structured interview questions mirrored the structure of ValMO model and the Model of Occupational Wholeness theoretical framework. Without occupation-based intervention, older adults may experience a decline in their occupational engagement, performance, and self-efficacy, which impacts their health and quality of life and fear of returning home.

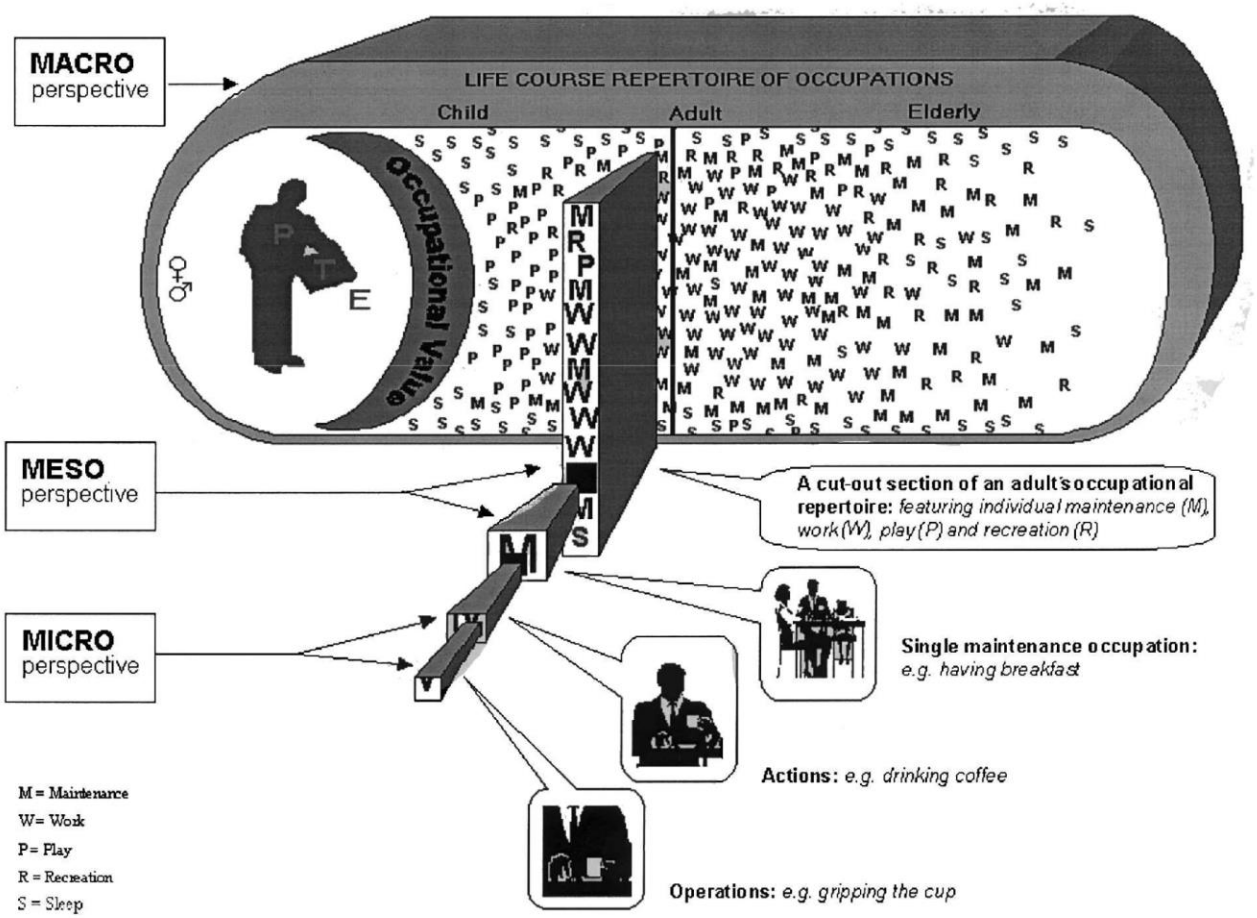
ValMO model adopts a person-task-environment triad emphasizing client-centered intervention through how individuals perceive meaning and value in their daily occupation (Persson et al., 2001; Cho, 2022). Individuals' engagement in their meaningful occupation can evolve from how they perceive the purpose of a situation (Persson et al., 2001). This model addresses the concept of meaning in which individuals' occupations cannot be fulfilled without concordance with their purpose and meanings in their occupation. Meaningful occupation can foster an individual's sense of meaning in life, impacting their health and well-being (Persson et al., 2001). Occupational value refers to individual experiences through occupational participation in everyday life. Individuals need to possess occupational value before they can experience meaning in their occupation (Persson et al., 2001). This model links to three interacting perspectives on an individual's occupation: the macro, meso, and micro perspectives (see Figure 1). The macro level is occupations related to an individual's lifelong story, linked to their self-concept and personal identity, that generate their sense of meaningful occupation (Persson et al., 2001; Cho, 2022). The meso perspective is occupations that an individual performs occasionally or regularly to form a basis of daily tasks within a single day; for example, having breakfast is the everyday occupation that an individual needs to maintain that becomes their daily routine (Persson et al., 2001; Cho, 2022). The micro level of occupation consists of two sections- the actions within a single occupation, such as drinking a coffee while having breakfast, and the operations of an action, such as gripping the cup while drinking coffee (Persson et al., 2001). ValMO model emphasizes that all occupations are meaningful considering the interactions among the macro, meso, and micro occupation levels (Persson et al., 2001).

The ValMO model served as a foundation for understanding how community-dwelling older adults perceived the value and meaning of SNF discharge preparedness in their daily

occupational participation. Considering the interactions of the macro, meso, and micro levels in a person's SNF discharge preparedness gave this researcher a complete understanding of how community-dwelling older adults perceived discharge readiness based on their value and meaning in their occupational engagement.

**Figure 1**

*Macro, Meso, and Micro Perspectives on Occupation.*

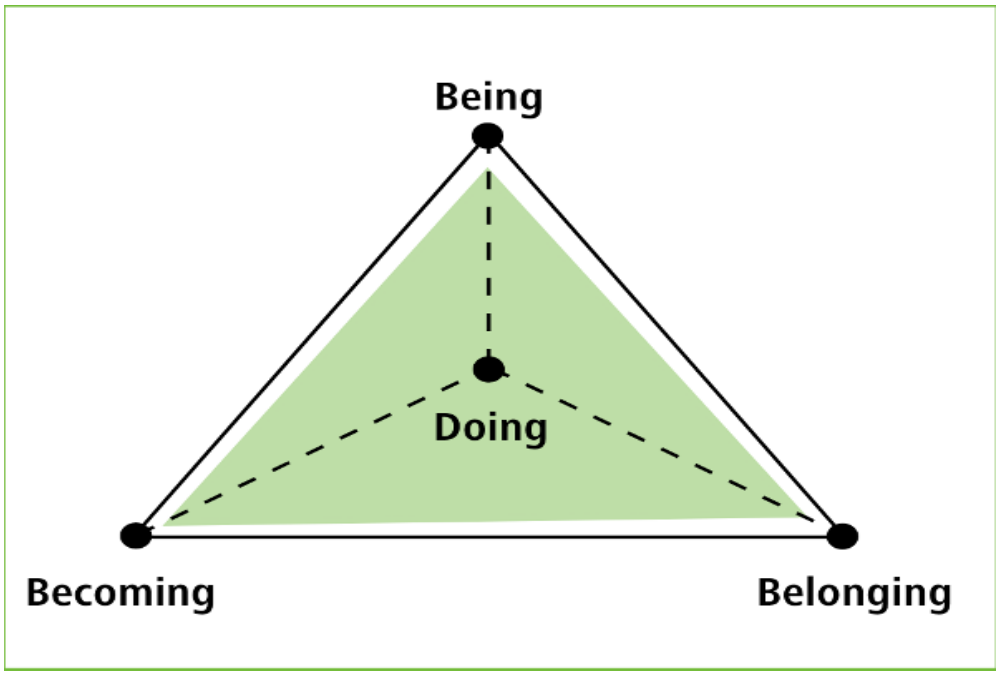



The Model of Occupational Wholeness emphasizes the combination of four dimensions in occupation: being, becoming, belonging, and doing. This model stresses that individuals' sense of occupational wholeness, health, and well-being is when their basic needs of being,

becoming, and belonging are met through what they do (Cho, 2022; Yazdani et al., 2017). This model is illustrated by a triangle with being, becoming, and belonging in the corner of the triangle and doing (in the middle), emerging from three dimensions-being, becoming, and belonging (see Figure 2). Additionally, the Model of Occupational Wholeness focuses on individuals' choices in their occupational participation based on their capacities, the resources of their environment, and social obligation that is meaningful and healthy to them (Yazdani et al., 2017). The significance of self-awareness is considered to foster individuals' recognition of what they do and if their needs of being, becoming, and belonging are being met (Cho, 2022; Yazdani et al., 2017). This model served this research project to address community-dwelling older adults' sense of wholeness in their occupational participation during discharge preparedness in a SNF setting and how SNF discharge preparedness impacts individuals' sense of being, becoming and belonging that leads to individuals' occupational choices, health, and well-being.

**Figure 2**

*A Hypothetical Triangle of 'Actual Doing' and 'Ideal Doing'*




*Note:* The black triangle illustrates the hypothetical ideal relationships between doing with being, becoming, and belonging. The green triangle illustrates the hypothetical actual relationships between doing with being, becoming, and belonging.

**Significance**

Many community-dwelling older adults hospitalized for illness received post-acute care in the SNFs before transitioning home. SNF-to-Home transitional care has been identified to prevent hospital readmissions after individuals return to the community throughout the literature (Simning et al., 2019; Weerahandi et al., 2019). Much literature indicated that physical, psychological, and social factors impacted an individual's successful discharge outcomes (Provencher et al., 2020); however, limited data were found about the extent of psychosocial factors such as self-efficacy and discharge preparedness affecting the transition and occupational participation. This project further identified how community-dwelling older adults perceive discharge preparedness in a SNF and how self-efficacy impacts their occupational participation and engagement after returning home.

**Summary**

Many community-dwelling older adults received transitional care in SNF after hospitalization to decrease hospital readmissions and increase older adults' quality of life after returning home. However, SNF's failure to provide adequate discharge planning and hospital readmissions have increased Medicare costs annually (Levinson, 2013). Many studies conducted discharge planning interventions and identified healthcare providers' perceptions of discharge planning to increase older adults' quality of life after returning home. However, a significant number of hospital readmission rates have not been reduced. Therefore, this proposed capstone project further examined community-dwelling older adults' perceptions of discharge preparedness and self-efficacy after receiving occupational therapy services in a SNF using the RHDS, and the GSES. ValMO and the Model of Occupational Wholeness theoretical framework identified community-dwelling older adults' self-perceived occupational performance and the effectiveness of occupational therapy education for discharge planning.

## Section II: Literature Review

This research study examined the perceptions of community-dwelling older adults' preparedness and self-efficacy after receiving occupational therapy services in a SNF to increase their quality of care and decrease hospital readmissions after returning home. SNF is a facility that provides skilled nursing care to patients who require medical, nursing, and rehabilitative services after hospitalization and before they transition to the community (Centers for Medicare & Medicaid Services, n.d.). Occupational therapy practitioners are the experts in supporting community-dwelling older adults to improve their quality of life in the SNF (Rafeedie et al., 2018). In 2016, AOTA announced its Vision 2025: "Occupational therapy maximizes health, well-being, and quality of life for all people, populations, and communities through effective

solutions that facilitate participation in everyday living" (AOTA, 2017b, para. 1). Numerous research studies on transitional care from hospital to home had a significant focus on discharge intervention programs to enhance older adults' experiences of transition to home in increasing their quality of life and decreasing hospital readmission. Additionally, a focus on the physical environment and healthcare providers' perceptions of older adults' discharge preparedness were well documented. However, many hospital readmissions remained unchanged after returning home from SNF in community-dwelling older adults. A shift from a healthcare professional's perspective to a client-centered practice to enhance clients' quality of care cannot be overlooked. Therefore, this research study focused on community-dwelling older adults' perception during SNF stay and how a client-centered practice understands clients' self-efficacy after receiving SNF discharge education from occupational therapy practitioners. Literature search involved search engines such as EKU libraries and Google Scholar. Terms for the literature review focused on transitional care for community-dwelling older adults, occupational therapy in SNF, transitional care discharge preparedness, and self-efficacy in community-dwelling older adults. The following literature review defined transitional care in a SNF, discharge preparedness, factors associated with discharge experiences in community-dwelling older adults, self-efficacy in occupational participation, and client-centered practice.

**Community-Dwelling Older Adults in SNF**

A SNF plays a significant role in providing care transitions to Medicare beneficiaries aged 65 or older after hospitalization and before the beneficiary transitions to home. Older adults aged over 65 years are qualified to receive Medicare services in SNFs (Angell et al., 2020). Healthy People 2030 (n.d.) indicated that "by 2060, almost a quarter of the U.S. population will be aged over 65 years old." Even though more than 1.7 million Medicare beneficiaries receive

post-acute care yearly in the SNF facility, limited research identified transitional care from hospital to SNF with a subsequent return home for older adults (Toles et al., 2014).

SNF provides skilled nursing care, rehabilitation, and other services to prepare Medicare beneficiaries to receive appropriate care and safely transition to home or other care facilities (Levinson, 2013). To participate in Medicare, SNFs need to meet the requirements, such as care plans during the inpatient stay and discharge planning, to increase the quality of care and assist Medicare beneficiaries in transitioning from one setting to another (Levinson, 2013). A post-discharge care plan must include Medicare beneficiaries' and families' preferences for continuous care after discharge, such as home health and caregiver services, and necessary education and instruction for beneficiaries to return home. However, researchers found that 31% of Medicare beneficiaries' SNF stays did not meet discharge requirements, costing Medicare approximately $ 5.1 billion for those beneficiaries staying in SNFs (Levinson, 2013).

**Discharge Preparedness in SNF**

Various research studies supported implementing intervention programs in SNFs to strengthen the discharge process for older adults transitioning from SNFs to home. For example, throughout the literature, SNF-to-Home transitional care has been identified to prevent hospital readmissions after individuals return to the community (Simning et al., 2019; Weerahandi et al., 2019). Additionally, Toles et al. (2014) suggested the importance of implementing interventions to support Medicare beneficiaries transitioning from SNF to home due to the high use of acute care after transitioning to home. However, Toles et al. (2014) conducted a cohort study on actual care visits after 30 days and 90 days post-discharge from SNFs. They found that 22% of older adults were readmitted to the hospital within 30 days, whereas 37.5 % were within 90 days after returning from SNFs. Therefore, Toles et al. (2014) proposed that different design and test

intervention programs for older adults transitioning from SNF to home were necessary to decrease hospital readmission rates.

To further explore discharge planning intervention programs, occupational therapy practitioners conducted many discharge planning intervention programs to enhance clients' transitional experiences from hospital to home. Crennan and MacRae (2010) suggested that a comprehensive discharge assessment could provide effective discharge planning to decrease hospital readmission, increase clients' quality of life, and increase collaboration and communication among discharge personnel. Additionally, timely information about the client's transfer to home care, adequate information about their functional status, cognitive potentials, and medical treatment were critical factors for successful experiences during the discharge transition (Eija & Marja-Leena, 2005).

Occupational therapy-led enhancement programs were one example of increasing clients' functional ability scores in activities of daily living (ADL) (Wales et al., 2018). Furthermore, Swanton and Britton (2017) found that hospital discharge consultation for hospitalized older adults with an intensive focus on the pre-discharge assessment, goal setting, pre-discharge home visits, and one-week post-discharge follow-up was more cost-effective than occupational therapy discharge planning. Therefore, further developing guidelines to assess the quality of occupational therapy pre-discharge assessment is essential to increase the quality of care for older adults' discharge planning. Swanton and Britton (2017) further emphasized that the increased comorbidity in older adults has increased the likelihood of hospital readmission and emergency department visits.

Factors associated with discharge experiences in community-dwelling older adults include physical and psychosocial factors. Several studies identified physical and psychosocial

factors related to older adults' experiences transitioning from inpatient to home. Physical environment factors included limited community resources, such as home health services, transportation in rural areas, environmental restraints, and expensive medical equipment. Physical, psychosocial, and occupational adjustments were equally crucial for discharge planning (Gage et al., 1996). However, researchers identified that healthcare professionals pay more attention to clients' physical needs than emotional and psychosocial well-being (Angell et al., 2020; Gage et al., 1996). In addition to psychosocial needs, older adults feel overwhelmed with the need to relearn things after transitioning home. As a result, they did not feel they fully participated in their daily occupation unless everything was accessible. To address older adults' psychosocial needs, Toledano-González et al. (2018) pointed out a correlation between psychological well-being and self-efficacy in activity participation. For instance, older adults aged over 65 years gradually withdraw from their roles and occupational participation. As a result, they felt a sense of low self-efficacy, resulting in a decreased quality of life (Toledano-González et al., 2018). Further, examining older adults' self-efficacy in their occupational participation after receiving occupational therapy services during transitional care in a SNF is necessary to promote community-dwelling older adults' quality of life.

**A Client-Centered Practice Self-Efficacy in Occupational Participation.**

The client-centered practice is widely considered in many healthcare settings to provide the best quality of care. However, the client-centered approach in discharge planning in a healthcare setting needed to be more consistent due to the constraints of healthcare policy with limited time, resources, and services (Crennan & MacRae, 2010; Durocher et al., 2015). In addition, the decision-making process for discharge planning in older adults transitioning to home prioritized safety rather than client-centered practice (Durocher et al., 2015). Therefore,

Crennan and MacRae (2010) emphasized that occupational therapy practitioners must provide a client-centered approach based on the client's unique needs and medical complexity. Furthermore, understanding the individual's perceptions of self-efficacy was more important than the healthcare providers' perception. Therefore, further assessing older adults' perceived self-efficacy for post-discharge activities before discharge home is essential to understanding the barriers and strengths (Gage et al., 1996). Self-efficacy is an individual's perception of capability and confidence in successfully performing tasks to reach optimal outcomes (Gage, 1994; Gitlin et al., 2006; Kalina et al., 2018). Additionally, individuals with high self-efficacy had greater motivation to change their health behaviors, engage in meaningful activities, and adjust to their disease (Kalina et al., 2018). Therefore, the individuals' actual performance and achievements were associated with their perceived self-efficacy in their occupational performance (Gage, 1994). After transitioning home, patients discharged from the hospital to home had the self-awareness to recognize their abilities and limits (Gage et al., 1996). In addition, those patients considered full participation in an occupation as the ability to access everyday occupation. Some patients felt that they have lost their independence and control in their occupation after they return home (Gage et al., 1996).

Moreover, patients could dress independently in the hospital but felt less confident performing self-care tasks after being discharged home (Gage et al., 1996). Difficulty performing functional ADLs and Instrumental Activities of Daily Living (IADLs) might impact the quality of life, poor self-efficacy, and high healthcare service utilization and cost in community-dwelling older adults (Gitlin et al., 2006). ADLs refer to "activities that are oriented toward taking care of your own body," such as dressing, toileting, and showering, and IADLs refer to activities that support individuals' daily life within their contexts, such as care of others, home, and health

management (AOTA, 2014). Gitlin et al. (2006) found that environmental and behavior modification interventions heighten self-efficacy and perceived functional difficulties in community-dwelling older adults. In addition, Spalding et al. (2022) identified a positive relationship among clients' occupational performance, satisfaction, and self-efficacy after clients received occupation-based group intervention focusing on IADLs in an inpatient rehabilitation setting. However, little was known about individualized client-centered intervention to increase community-dwelling older adults' self-efficacy. Further investigation into occupational therapy interventions for discharge preparedness and understanding the perceived discharge preparedness and self-efficacy of community-dwelling older adults may foster older adults' transition experiences from SNF settings to the home.

## Conclusion

Discharge preparedness in SNF significantly improves community-dwelling older adults' emotional and psychosocial well-being and self-efficacy in their activity participation to increase clients' quality of life in the community. Numerous studies have identified the importance of implementing discharge intervention for older adults transitioning to home; however, significant numbers of acute hospital readmissions were noticed after older adults returned home from SNF. Further examinations were performed on how community-dwelling older adults' perception of discharge preparedness improved the continuity of care in a SNF. This literature review was significant to support the need to understand community-dwelling older adults' perceptions of discharge preparedness in a SNF and their self-efficacy in daily occupational participation after receiving occupational therapy services.

## Section III: Methodology

### Project Design

This capstone project was a convergent mixed-method, pretest, and posttest design. This design selected participants admitted to a skilled nursing facility to address community-dwelling older adults' perception and self-efficacy during SNF discharge preparation. A convergent mixed methods design was used, including qualitative and quantitative data collected in parallel, analyzed separately, and then merged (Creswell & Creswell, 2018). This project used the Readiness for Hospital Discharge Scale (RHDS) instruments (Knier et al., 2014; Nurhayati et al., 2019) and the General Self-Efficacy Scales (GSES) to measure the patients' perceptions of readiness for discharge. In this study, quantitative data from RHDS and the GSES were used to test the theory of the Model of Occupational Wholeness and Value and Meaning in Occupations Model (ValMO) (Cho, n.d.-a; Cho, N.d. -b) that predicted that SNF discharge preparedness would positively influence the perception and self-efficacy of community-dwelling older adults at a SNF. The semi-structured interview questions aligned with the RHDS and the GSES explored the central phenomenon of community-dwelling older adults' experiences at a SNF using thematic analysis (TA) to analyze the themes based on the coding of the data and research questions (Braun & Clarke, 2022; Crosley, 2021). Using standardized instruments, quantitative and qualitative data was used to understand community-dwelling older adults' discharge readiness experiences.

The quantitative design involved participants who completed a pretest, posttest, and two-week follow-up to determine their experiences in discharge preparedness during their SNF stay (Creswell & Creswell, 2018). The qualitative design involved questionnaires that participants completed before discharge to home. This research design aimed to examine the discharge

preparedness in a SNF for community-dwelling older adults to promote quality of life for older adults and decrease hospital readmission. Participants received a community-dwelling older adults' perception of discharge preparedness and self-efficacy questionnaire along with incorporating pretest and posttest with the GSES to identify their occupational performance and RHDS tools to determine how participants feel about their preparedness to discharge home (Knier et al., 2014; Creswell & Creswell, 2018).

**Research Questions and Hypotheses**

**Questions:** Will an occupation-based discharge preparedness intervention change community-dwelling older adults' perceived self-efficacy and readiness for discharge at a skilled nursing facility (SNF)? What are community-dwelling older adults' perceptions of a discharge preparedness intervention at a SNF?

Directional hypothesis 1: An occupation-based discharge preparedness intervention will affect community-dwelling older adults' perceptions of discharge preparedness in skilled nursing facilities.

Null hypothesis 1: An occupation-based discharge preparedness intervention will not affect community-dwelling older adults' perceptions of discharge preparedness in skilled nursing facilities.

Directional hypothesis 2: An occupation-based discharge preparedness intervention will affect self-efficacy in occupational participation in community-dwelling adults in skilled nursing facilities.

Null hypothesis 2: An occupation-based discharge preparedness intervention will not affect self-efficacy in occupational participation in community-dwelling adults in skilled nursing facilities.

## Setting

This project took place in an 80-bed Medicare-certified local skilled nursing facility. Generation HealthCare Corporation manages the facility. The average stay is 20 to 30 days, and the facility is facilitated by an interdisciplinary team that includes occupational therapists, physical therapists, speech therapists, nurses, social workers, and a case manager. During inpatient SNF stays, patients participate in 5 days a week of occupational therapy, physical therapy, and speech therapy treatment sessions to regain their physical and occupational function before transitioning to home.

## Identification of Participants

For the population of this study, community-dwelling older adults who transitioned from hospital to SNF were purposefully selected. The participants received MOCA scores indicating normal or mild cognitive impairment and planned to return to the community after their SNF stay.

## Inclusion Criteria

Participants met the following criteria: 1) older adults aged 65 and older, 2) older adults who planned to return to home after SNF stay, 3) older adults' mental status from MOCA test, indicating normal or mild cognitive impairment, 4) older adults who are an English speaker, 5) older adults willing to participate in the study and sign informed consent.

## Exclusion Criteria

Participants were excluded from the study based on the following criteria: 1) older adults aged less than 65 years old, 2) older adults aged 65 or older who received MOCA scores indicating moderate or severe cognitive impairment, 3) older adults who do not speak English, and 4) older adults who would remain in the SNF as long-term care residents.

**Participant Recruitment Process**

Participants were purposefully selected after initial admission to the SNF setting. The facility administrator received a copy of the Institutional Review Board (IRB) approval through Smith Ranch Generation Healthcare Corporation as supported by Eastern Kentucky University before participant recruitment. Participants were recruited using a written script rehearsed by the primary investigator (PI) or on-site occupational therapy practitioners employed by Generation Healthcare at Smith Ranch full-time. Participants and caregivers of the participants received and completed a consent form.

**Data Collection**

This study used a convergent mixed methods design to compare the results after collecting and analyzing quantitative and qualitative data. Pre and post-test data were collected from participants at the SNF to identify community-dwelling older adults' perception and self-efficacy related to discharge preparedness in a SNF. The PI conducted semi-structured interviews on-site with the study participants. The one-to-one, face-to-face interviews were scheduled with each participant during their free time. The interviews were completed within three-time frames: three days after initial admission, 1 to 2 days before SNF discharge, and two weeks after phone call follow-up. All interviews were held in a private room in the SNF facility.

The semi-structured interview questions aligned with the RHDS and the GSES to provide perspective on community-dwelling older adults' experiences in SNF's discharge preparedness. Participants received the GSES upon admission to the SNF setting before discharge to home and two weeks follow-up. The RHDS served as quantitative instruments that were delivered to participants 1-2 days before returning home. A semi-structured questionnaire related to

participants' perceptions of occupational therapy services during SNF stay was delivered to understand their perceptions of discharge preparedness before their discharge.

**Data Analysis**

A convergent mixed-methods design was used to collect and analyze the qualitative and quantitative data aimed to discover trends from numeric instruments as well as emerging themes and descriptions from the participants' interviews to understand community-dwelling older adults' perceptions of discharge readiness in a SNF (Creswell & Creswell, 2018). Quantitative data from the study instruments were analyzed using descriptive statistics for frequency and percentage of responses and inferential statistics using paired t-tests compared pre and post-test scores with alpha set at .05 for the GSES instruments. The RHDS served as other quantitative instruments that were delivered to participants 1-2 days before returning home to understand participants' perception of discharge education at a SNF setting. The PI analyzed and transcribed the qualitative data from survey questionnaires and interviews using written notes to generalize emerging themes. Data analysis used the computerized program Excel to organize the data. During the coding process, the PI looked for frequent phrases or comments within each transcript. Categories or themes were organized based on the recurrence of the data. Based on the emerging themes and integration of the quantitative results, the PI formed a comprehensive meaning of community-dwelling older adults' perceptions and self-efficacy in discharge readiness during SNF stay.

**Trustworthiness**

The PI utilized multiple methods to support qualitative validity in this study. Validity procedures included the following: incorporating a detailed, thick description to convey the findings, acknowledging the researcher's biases, and presenting discrepant information and

perceptions (Creswell & Creswell, 2018). Researchers considered potential threats to internal and external validity. There is a variability of participants in each phase for many reasons during their SNF stay or after returning home, which might impact the study's internal validity (Creswell & Creswell, 2018). Researchers expanded recruitment with a large sample size to account for dropouts to reduce the impact of attrition. Because one of the instruments was used for the pre and post-test, participants might be familiar with the testing questions, potentially threatening internal validity (Creswell & Creswell, 2018). To minimize the threat of testing tools, the researcher administered the tests at discharge and two-week follow-ups to reduce potential inconsistencies that could impact outcome measures. Threats to external validity included the interaction of setting and treatment in which results could not be generalized to older adults in other settings. Additional research in new settings would determine the consistency of the study results (Creswell & Creswell, 2018).

**Ethical Considerations**

Ethical considerations were considered throughout the research study to ensure the best practices by researchers and the safety of participants. Before participants' recruitment, the PI completed Collaborative Institutional Training (CITI Program). Generation Healthcare Corporation at Smith Ranch Facility obtained a site agreement to conduct this study. Before conducting research, the PI submitted an IRB study proposal through Eastern Kentucky University. Once the IRB proposal was approved, the PI recruited participants based on inclusion criteria along with a required signed consent form before the PI conducted a semi-structured interview. The interview questions were adapted from the RHDS and GSES for the study's validity. PI's email was provided for participants to ask questions or concerns.

The study's purposes and benefits were explained to participants before starting the study to preclude a conflict of interest through a verbal recruitment script. The PI ensured that participants had the right to discontinue the study at any point. Participants' names and identities were not disclosed throughout the study. Additionally, rewards were not provided to participants throughout the study. Participants and stakeholders received a copy of the study results to gain the study's credibility. The study data was stored on a password-protected computer and an office with a lock key.

**Project Timeline**

| Project Steps | Start Date (duration) | Completion Date |
|---|---|---|
| Complete and submit the study's application for IRB approval. | November 2022 | December 2022 submission<br>Tentative date for IRB approval: January 2023 |
| Recruit participants from the facility | February to September 2023 | The end of August 2023 |
| Administer pretest survey and data collection | Within three days, SNF admission | January to August 2023 |
| Administer post-test survey and data collection | One-two day before discharging from a SNF | February to August 2023 |

| | | |
|---|---|---|
| Administer two weeks of posttest follow-up and data collection | Phone call follow-up after two weeks of discharging from a SNF | February to August 2023 |
| Data analysis | January to August 2023 | January to August 2023 |
| Complete and submit the final Capstone project report | January 2023 | November 2023 |

## Section IV: Results and Discussion

### Description

As described previously, this study consists of three phases: three days after initial admission, one to two days before SNF discharge, and two weeks after discharge with phone call follow-up. There was a total of 92 participants who completed the Phase I interviews, 61 participants completed Phase II, and 32 participants completed Phase III two-week post-discharge follow-up interviews. All participants were admitted to a SNF and returned to the community. Thirty-one participants did not complete the phase II interview due to a variety of issues: readmission to an acute hospital (N=2), discharge against medical advice (N=11), expired (N=1), early withdrawal from research (N=7), enrolled in hospice care (N=2), or a time constraint for research completion (N=8). The pre-and post-data collection was based on the 61 participants who completed phase I and II interviews, and the post-test and two-week follow-up data collection were based on the 38 participants who completed phase II and phase III interviews to identify community-dwelling older adults' perceptions and self-efficacy about discharge preparedness in a SNF.

Data was gathered in phase I; participants received the General Self-Efficacy Scale (GSES) within three days of admission to a SNF setting. GSES is a self-report–psychometric scale designed to assess each individual's emotion, optimism, work, and satisfaction with a belief to cope with various difficulties in their lives (Schwarzer & Jerusalem, 1995). GSES consists of four Likert-scale questions with a continuous scale ranging from 1-Not at all true to 4-Exactly true. In this phase, the participants were interviewed about their self-efficacy after being hospitalized.

In phase II, the data were gathered one to two days before participants were discharged from a SNF. Participants completed semi-structured interview questions aligned with the RHDS and GSES to provide perspective on community older adults' perception of discharge preparedness. The semi-structured interview questions were developed using a literature review and guided by the 4th edition of the Occupational Therapy Practice Framework (OTPF-4). It consists of four multiple-choice questions on participant demographics and four open-ended questions in the post-test only. The RHDS consists of 10 continuous Likert scales ranging from 1-None to 10-Always, and it was used for post-test data collection to identify community-dwelling older adults' perception of discharge readiness during SNF stay. The GSES was used for the post-test to compare admission and discharge.

In phase III, participants received a phone call and a GSES questionnaire after two weeks' discharge from the SNF to identify their self-efficacy after returning to their home environment. Following the completion of the three phases for all study participants, the results were merged to present a rich description of community-dwelling older adults' perceptions and self-efficacy in discharge readiness during SNF stay.

**Demographics of Participants:**

A total of 92 community-dwelling older adults who met inclusion criteria completed the phase I (pre-test) interview. Of the 92 community-dwelling older adults, 61 completed both phase I (pre-test) and phase II (post-test) interviews. Among the 61 participants, 12 were 65-75 years old, 42 were 75-85, and seven were over 85. Among all the participants who completed pre and post-tests, 54 % (N=33) were female, 46% (N=28) of participants were male, 36% (N=22) participants lived alone after returning home, 59% (N=36) of participants lived with family members, and 5% (N=3) of participants received caregiver support.

**Table 1**

*Demographics of Participants*

| ***Participants*** | ***61*** | |
|---|---|---|
| **Discharge Location** | | |
| Home | 61 | |
| SNF | 0 | |
| **Age Range** | ***Number of Participants*** | |
| 65-75 | 20% | (N=12) |
| 75-85 | 69% | (N=42) |
| >85 | 11% | (N=7) |
| **Gender** | | |
| Male | 46% | (N=33) |
| Female | 54% | (N=28) |
| Non-binary | 0% | (N=0) |
| **Home Support** | | |
| Alone | 36% | (N=22) |
| Family Members | 59% | (N=36) |
| Others | 5% | (N=3) |

The data was evaluated by analyzing the pre and post-test data results to illustrate a statistically significant improvement in the self-perceived GSES scale from initial evaluation to discharge. Tables 2 through 3 represent the information gathered for the overall scores of each participant related to the GSES scale on the pre and post-test surveys. The overall improvement in all pre-test/post-test scores was evaluated. Then, the mean, median, SD, and SE scores for the difference in scores and the paired samples t-test were assessed to evaluate the participants' perceived self-efficacy before and after SNF stay (see Table 2 & Table 3). The mean for all ten questions of GSES increased by 3.11 on the post-test from 31.44 to 34.54, indicating an overall increase in self-efficacy in the areas measured (see Table 2 & Figure 3)

**Quantitative Data:**

**GSES Pretest and Posttest Data:**

**Table 2**

*Differences of Pre-Test and Post-Test Mean, Median, SD, and SE*

| Descriptive | | | | | |
|---|---|---|---|---|---|
| | N | Mean | Median | SD | SE |
| Pretest | 61 | 31.44 | 32 | 5.6 | 0.71 |
| Posttest | 61 | 34.54 | 35 | 3.88 | 0.49 |

**Figure 3**

*Range of Change in Mean Scores for GSES Pre and Posttest*

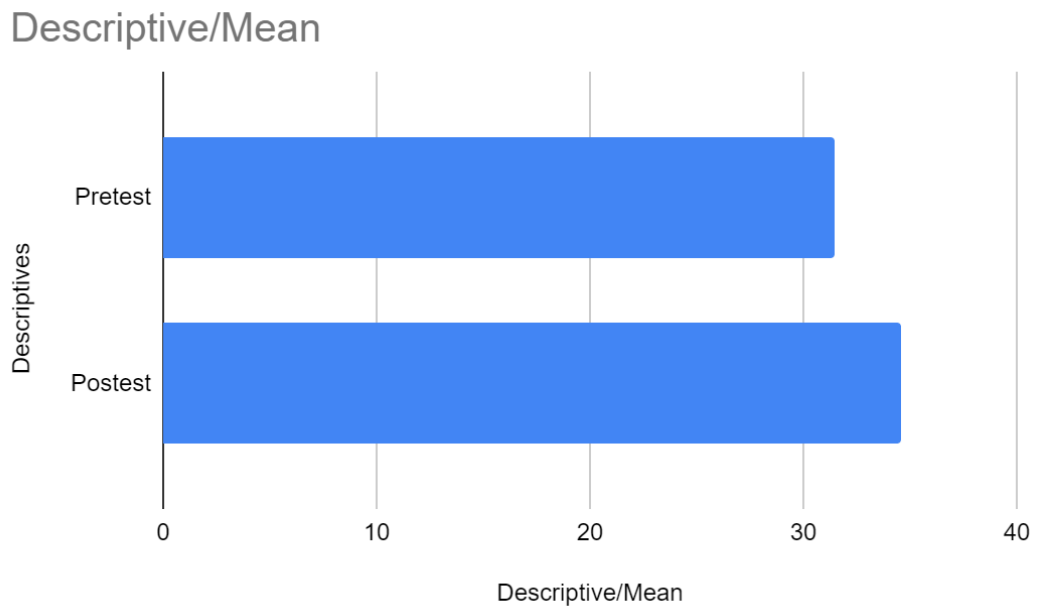



Table 3 represents the information gathered from the paired samples t-test about the change in participants' self-efficacy after a SNF stay. The mean difference between the pretest and post-test was 3.1, and a 95% confidence interval indicated a population mean difference range between 0.99 and 1.4. The probability value for Likert scale questions related to self-efficacy was found to be < .05, indicating that the difference between the pre and post-test scores was statistically significant and not likely due to chance.

**Table 3**

*Paired Samples T-Test*

| Paired Samples T-Test | | | | | | 95% Confidence Interval | |
|---|---|---|---|---|---|---|---|
| | Statistic | df | p | Mean difference | SE difference | Pre-test | Post-test |
| Pretest/Posttest | -4.34 | 60 | 0.000028 | 3.1 | 0.22 | 1.4 | 0.99 |

**Two Weeks Phone Call Follow-up.**

A total of 38 participants completed the two-week follow-up with GSES questionnaires. The mean for all ten questions of GSES increased by 1.77 on the post-test from 35.15 to 36.92, indicating an overall increase in self-efficacy in the areas measured (see Table 4). Table 5 represents the information gathered from the paired samples t-test about the change in participants' self-efficacy after participants returned home. The mean difference between the post-test and two-week follow-up was 1.7, and a 95% confidence interval indicated a population mean difference range between 1.3 and 1.4. The probability value for the Likert scale questions related to self-efficacy was found to be < .05, indicating that the difference between the post-test and two-week follow-up scores was statistically significant and not likely due to chance.

**Table 4**

*Differences in Post-Test and Two Week Follow-Up Mean, Median, SD, and SE*

| Descriptive | | | | | |
|---|---|---|---|---|---|
| | N | Mean | Median | SD | SE |
| Posttest | 38 | 35.15 | 36 | 4.19 | 0.61 |
| Two Week Follow-Up | 38 | 36.92 | 39 | 3.8 | 0.68 |

**Table 5**

*Paired Samples T-Test*

| Paired Samples T-Test | | | | | | 95% Confidence Interval | |
|---|---|---|---|---|---|---|---|
| | Statistic | df | p | Mean difference | SE difference | Post-test | Two Week Follow-Up |
| Post-test/Two Week Follow-Up | -2.3 | 37 | 0.01 | 1.7 | 0.07 | 1.3 | 1.4 |

**Participants' Perception of RHDS Post-Test Questions**

There were 61 participants who received RHDS post-test questionnaires prior to discharge to home from the SNF setting. The RHDS is associated with the quality of discharge teaching from healthcare professionals that can predict individuals' post-discharge coping difficulty and emergency room readmission after returning home (Marquette University, 2023). The RHDS post-test had eight questions with ten-point Likert scale answers to assess the participants' sense of discharge readiness. The average rating of all responses and median scores for all responses from the post-test can be seen in Table 6. From the data, the average of each question was scored between seven and eight, with close to the highest score being ten. The median score of each question (1, 3, 4, 5, 6, 8) was 9, whereas the median scores of questions 2 and 7 were 8.

**Table 6**

***Results to RHDS***

| Post-Test Questions | Q1 | Q2 | Q3 | Q4 | Q5 | Q6 | Q7 | Q8 |
|---|---|---|---|---|---|---|---|---|
| Average rating of all responses | 8.25 | 7.69 | 8.26 | 8.75 | 8.62 | 8.69 | 7.18 | 7.69 |
| Median scores for all responses | 9 | 8 | 9 | 9 | 9 | 9 | 8 | 9 |

**Qualitative Data:**

***Participants' Perception of Semi-Structured Interview Post-Test Questions***

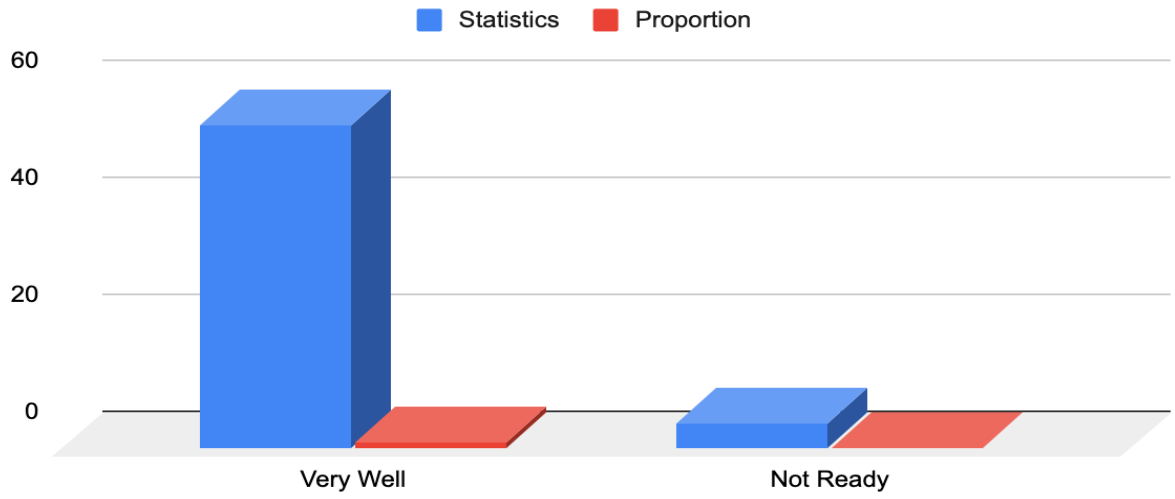
A total of 61 participants completed semi-structured interview questions further to identify discharge preparedness in relation to occupational therapy services. The items used for the analysis of semi-structured interview questions were:

**How do you feel you were prepared for home following your stay in the facility?**

*In the first qu*estion, 92% (N=55) of participants responded very well with how they felt they were prepared for home, whereas 6% (N=4) of participants did not feel they were ready to go home (see Figure 4).

**Figure 4**

*How Do You Feel You Were Prepared for Home Following Your Stay in the Facility?*



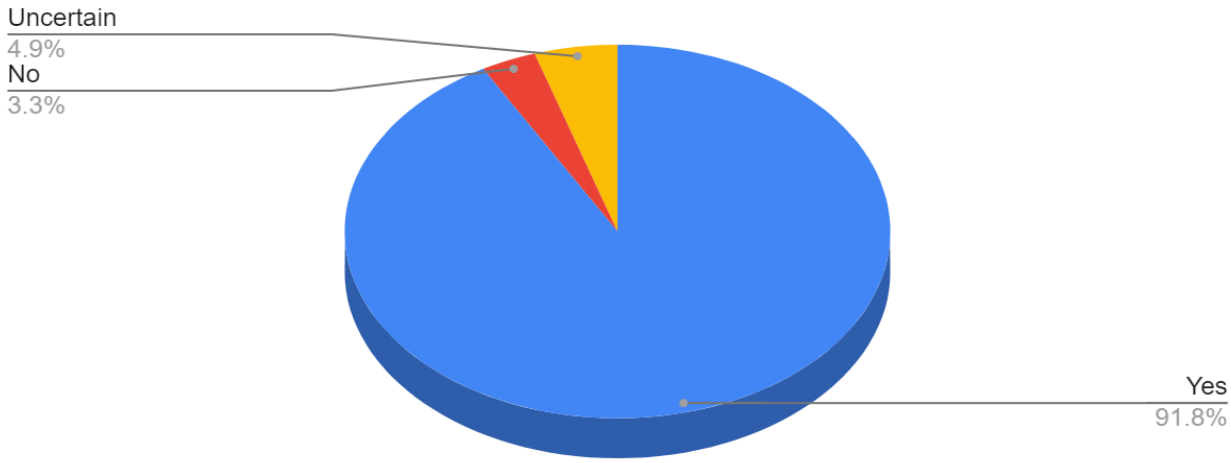

**Do you believe that the Occupational Therapy education that you received prior to discharge to home prepared you for actually being home?**

Additionally, 92% (N=56) of participants believed that the occupational therapy education they received prepared them for being home, whereas 3% (N=2) of participants did not

feel they were prepared for actually being home. Interestingly, 5% (N=3) of participants were unsure if occupational therapy education prepared them for being home (see Figure 5).

**Figure 5**

*Do You Believe that the Occupational Therapy Education that You Received Prior to Discharge to Home Prepared You for Actually Being Home?*




**What would you like to change about the preparedness from occupational therapy education in preparation for going home?**

Five themes emerged from ten categories when asked what they would like to change about the preparedness from occupational therapy education in preparation for going home. The ten categories include *nothing/happy about it, discussion with family and case managers, ADLs, IADLs, edema management/compression stocking education, session frequency, longer sessions, rheumatoid arthritis management, walking/exercises,* and *O2 education.* These categories were further collapsed to form themes. Five total themes emerged and are listed as follows: *happy about the education, discussion with the interdisciplinary team, occupation-based intervention, client-centered intervention,* and *treatment frequency* (see Table 7).

**Table 7**

*What Would You Like to Change About the Preparedness From Occupational Therapy Education in Preparation for Going Home?*

| ***Categories*** | ***Themes*** |
|---|---|
| Nothing/happy about it | Happy about It |
| Discussion with family and case managers | Interdisciplinary team discussion |
| ADL's | Occupation-based practice |
| IADL's | |
| Edema management/compression stocking | Client-centered based practice |
| RA management<br>Walking/exercises | |
| Oxygen management education (e.g., safe management of supplemental oxygen and maintaining appropriate oxygen saturation.) | |
| Session frequency | Intervention frequency |
| Longer session | |

The first theme, *happy about the education*, supported the occupational therapy service delivery in the SNF to serve clients who were discharged from an acute care hospital. A total of 62% of participants felt happy about the occupational therapy education preparing them for going home, and nothing else needed to be changed. The second theme, *Interdisciplinary team (IDT) Discussion*, was identified as one participant expressed she felt there was no communication on how to transition to home, especially regarding her medication regimen and follow-up appointments with her physicians after returning home. *Occupation-based intervention* is another theme that emerged from ten categories. Sixteen percent of participants expressed the need to practice more showering and preparing meals to go home. Another theme, *client-*

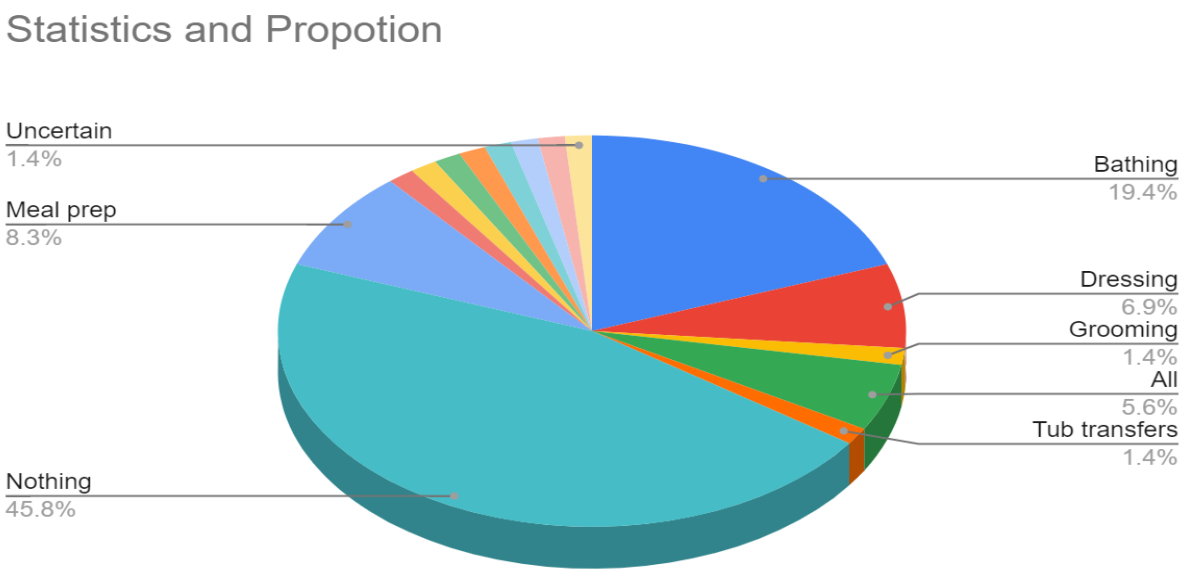
*centered Intervention*, emerged, with 8% of participants stating the need to focus on disease and impairment-related intervention. One participant stated that he would feel more independent if the OTP could teach him how to manage self-care with his Rheumatoid Arthritis. In contrast, another participant expressed that he would like to learn more about edema management, especially how to wear compression stockings. Lastly, the *treatment frequency* emerged from ten categories, with 4% of participants feeling that the increase in occupational therapy sessions might be beneficial in preparation for their return home.

**What areas of daily occupations (dressing, bathing, grooming, meal preparation, etc.) that you feel you need more help with after returning home?**

The majority of participants (45.8%) responded that they did not need any assistance when returning home. Approximately 19.4% of participants were concerned about needing some assistance for showering, 8.3% for meal preparation, and 6.9% for dressing (see Figure 6).

**Figure 6**

*What Areas of Daily Occupation (Dressing, Bathing, Grooming, Meal Preparation, etc.? What Do You Feel You Need More Help With After Returning Home?*




**Integrated Quantitative and Qualitative Results**

**Table 8**

*Merged/Integrated Qualitative and Quantitative Data*

| Topic | Quantitative Data | Qualitative Data- Sample Quotation |
|---|---|---|
| Self-Efficacy | <u>Increased self-efficacy</u><br>GSES scores:<br>Statistically significant improvements from pre to post on the GSES is 3.11<br><br>RHDS: *How physically ready are you to go home?*<br>Average score: 8.25, with close to the highest score being ten. | <u>Increased self-efficacy:</u><br>"I felt pretty confident."<br><br>"I can perform all tasks as before the injuries."<br><br>"I am in good shape."<br><br><u>Decreased self-efficacy:</u><br>"I feel not ready because of the swollen legs."<br><br>"I cannot go to the bathroom on my own." |
| Preparation for Discharge | <u>Increased preparation for</u> | <u>Increased preparation for</u> |

| | | |
|---|---|---|
| | discharge<br><br>RHDS results:<br>*Q1: How physically ready are you to go home? Scores: 8.25,* with close to the highest score being ten.<br><br>*Q3: How much do you know about problems to watch for after you go home? Scores: 8.26,* with close to the highest score being ten.<br><br>*Q4: How much do you know about restrictions (what you are allowed and not allowed to do) after you go home? Scores: 8.75,* with close to the highest score being ten. | discharge:<br><br>"I felt well prepared to go home."<br><br>"Much better than what I would have if I were myself because I appreciated it more."<br><br>"Ready to go home."<br><br>"Husband received training with ADL's assistance, so I am prepared."<br><br>"Adequately prepared,"<br><br>"Well prepared,"<br><br>Decreased preparation for discharge,<br><br>"I feel anxious,"<br><br>"I cannot go to the bathroom on my own."<br><br>"It would be better if my family and I had some discussion with a case manager or someone about what I need to know before going home."<br><br>"I wish I knew more about how to manage the oxygen equipment at home safely." |
| Readiness to complete ADLs after discharge | Increased confidence for completing ADLs at home<br><br>RHDS results: *How well will you be able to perform your* | Increased confidence for completing ADLs at home:<br><br>"I feel I can manage everything at home." |

| | | |
|---|---|---|
| | *personal care (for example, hygiene, bathing, toileting, eating) at home?*<br>The average rating score of all respondents was 8.69, with close to the highest score being 10. | "Very well."<br><br><u>Reduced confidence for completing ADLs at home:</u><br><br>"I felt I still needed some help for showering and dressing."<br><br>"I need help with tub transfer."<br><br>"It will be better if someone teaches me how to manage the feeding tube."<br><br>"I cannot go to the bathroom on my own."<br><br>"Know more about how to take a shower." |
| Readiness to complete IADLs after discharge | <u>Increased confidence for completing IADLs</u><br><br>RHDS result:<br><br>*How well will you be able to handle the demands of life at home?*<br>The average rating score of all participants was 8.62, with close to the highest score being 10.<br><br>*How much help will you have if needed with your medical care needs (treatments, medications) after you go home?*<br>The average rating score of all participants was 7.69, with close to the highest score being 10. | <u>Increased confidence for completing IADLs:</u><br><br>"I can do everything."<br><br><u>Reduced confidence for completing IADLs:</u><br><br>"I have concerns about going back to work, learning to operate doors, and navigating the hallway in a real home environment."<br><br>"I need help with meal preparation and shopping."<br><br>"Need help with laundry."<br><br>"I wish I knew some tips on being in my kitchen."<br><br>"I need someone around to help me manage IADLs." |

Both quantitative and qualitative data were integrated into four topics: self-efficacy, preparation for discharge, readiness for completing ADLs, and readiness for completing IADLs. In the first topic, self-efficacy, the quantitative data in the GSES scores increased by 3.11 on the posttest from 31.44 to 34.54, and the overall rating score of each question in the RHDS questionnaire from all participants was from 7.18 to 8.75. In the examples presented in Table 8, when asked *how physically ready are you to go home, the overall rating score was* 8.25. Compared to qualitative data from interview questionnaires, when asked about *how they can physically perform and complete their daily self-care,* participants expressed, "I felt pretty confident" and "I can perform all tasks as before the injuries," whereas some participants stated that "I cannot go to the bathroom on my own."

The second topic, preparation for discharge, in the quantitative data of RHDS questionnaires, the average score in the question such as *how much do you know about problems to watch for after you go home was 8.26.* For instance, participants reported, " I felt well prepared to go home" and "much better than what I would have if I were myself because I appreciated it more," however, some participants expressed that "I feel anxious about going home" and "I wish I knew more about how to manage the oxygen equipment at home safely."

The third topic included readiness to complete ADLs after discharging to home. In the quantitative data of RHDS questionnaires, for example, *how well will you be able to perform your personal care*, participants expressed that "I feel I can manage everything at home" and "I can do everything," whereas, some participants expressed the need for help for showering, dressing, and tub transfers. The fourth topic included readiness to complete IADLs after discharging to home. In the question of *how well will you be able to handle the demands of life at home* from quantitative data of RHDS, participants stated, "I can do everything," whereas some

participants expressed a reduction of confidence in completing IADLs, for instance, participants expressed “I wish I knew some tips on being in my kitchen,” and “ I have concerns about going back to work, learning to operate doors, and navigating the hallway in a real home environment.”

**Discussion**

The purpose of this study is to examine the perceptions of community-dwelling older adults’ preparedness and self-efficacy after receiving occupational therapy services in a SNF to increase their quality of life and decrease hospital readmissions after they return home. Based on the ValMO Model, the researcher understands how each participant’s occupational value influences their daily occupational choice and the relationship between their occupational value and meanings during SNF discharge preparedness (Persson et al., 2001). The ValMO Model proposes an interaction among the person, task, and environment, allowing participants to build an overarching experience of meaning during their SNF stay. Participants expressed the need for change to focus on more ADL (e.g., showering), and IADL (e.g., meal preparation) was associated with the meanings they perceived (Persson et al., 2001). The Model of Occupational Wholeness theoretical framework consists of four dimensions: doing, being, becoming, and belonging (Yazdani et al., 2017). It focuses on individuals’ choices in their occupational participation based on their capacities, the resources of their environment, and social obligation that is meaningful and healthy to them (Yazdani et al., 2017). During discharge preparedness in the SNF setting, participants met the occupational wholeness by recognizing their needs to be in the SNF environment, participating in daily occupations that allowed them to become independent and lead to their occupational choice, health, and well-being in order to return to their community**.**

The descriptive data analysis shows that community-dwelling older adults have increased their self-perceived self-efficacy in occupational performance and satisfaction from occupational therapy services in a SNF. Receiving occupational therapy intervention led to a statistically significant increase in self-efficacy scores between the pre-test, post-tests, and two-week phone call follow-up. Based upon the semi-structured open-ended questions, RHDS, GSES, and the statistical analysis of the pre-test, post-test, and two-week phone call follow-up scores, strong evidence shows the significance of occupational therapy services in supporting discharge planning for community-dwelling older adults in a SNF.

The results of the qualitative and quantitative data examined the community-dwelling older adults' perception of discharge preparedness, self-efficacy, and readiness for completing ADLs and IADLs after discharge were merged and integrated.

### *Community-Dwelling Older Adults' Perceived Self-Efficacy*

Self-efficacy plays a significant role in each individual's life. Self-efficacy refers to individuals' confidence in their ability to manage their situations. Individuals with higher self-efficacy are more likely to have an increased health status for health behavior changes, enhanced quality of life, and increased motivation to participate in meaningful occupations (Kalina et al., 2018). Older adults aged 65 years and older who experienced illness also experienced a decrease in the sense of self-efficacy and increased depression, resulting in reduced quality of life (Kalina et al., 2018; Toledano-González, 2018). The results of this study showed both the improvement and reduction of self-efficacy in community-dwelling older adults' self-efficacy from GSES scores, the RHDS post-test questions, and open-ended questionnaires. The quantitative data in the GSES scores increased by 3.11 on the posttest from 31.44 to 34.54, and the overall rating score of each question in the RHDS questionnaire from all participants was from 7.18 to 8.75.

For instance, the average score of RHDS in the question of *how physically ready are you to go home was* 8.25, with close to the highest scores being 10; however, participants have some concerns about how they can physically perform and complete their daily self-care. For instance, some participants expressed, “I felt pretty confident,” "I am able to perform all tasks as before the injuries", and “I am in good shape. " In contrast, others expressed, “I feel not ready because of the swollen legs” and “ I cannot go to the bathroom on my own.” The reduction of self-efficacy in community-dwelling older adults’ self-efficacy further confirmed the Whitehall et al. (2021) study with the finding that older adults who received healthcare services in the inpatient setting are more likely to have lower self-efficacy and poorer health promotion behaviors, possibly resulting from their need for extended rehabilitation outside their home environment.

Although there was some evidence showing the reduction of self-efficacy in community-dwelling older adults, the present research study found that older adults’ self-efficacy increased from initial admission to discharge after receiving discharge education from occupational therapy professionals in a SNF. Similar to other previous research (Wong et al., 2019), the current study demonstrated increased older adults’ self-efficacy after receiving occupation-based intervention programs that focus on ADLs, IADLs, and medication management. These results further confirm a correlation between older adults’ self-efficacy and occupational participation after receiving occupational therapy services during transitional care in a SNF. Occupational therapy practitioners can significantly promote older adults’ occupational participation to increase their psychosocial well-being and a sense of being, becoming, and belonging in their community.

***Community-Dwelling Older Adults' Perceived Discharge Preparedness in the SNF***

An effective discharge planning is crucial to enable older adults to have a safe discharge arrangement and increase their quality of life. The results of this study showed both positive and negative responses to discharge preparedness in the SNF from the RHDS and open-ended questionnaires. In the quantitative data of RHDS questionnaires, for instance, when asking participants *How much do you know about problems to watch for after you go home,* the average of total score was 8.26, meaning that participants positively perceived discharge preparedness in the SNF. In the qualitative questionnaire, participants expressed, "I felt pretty confident," "I felt well prepared to go home," and "much better than what I would have if I were myself because I appreciated it more."

On the other hand, participants expressed their concerns about being prepared for discharge to home. For instance, participants expressed that "I feel anxious," "it would be better if my family and I had some discussion with a case manager or someone about what I need to know before going home," and "I wish I knew some tips on being in my kitchen," and "I wish the treatment time can be longer and more often so I can be fully prepared." The result of this study further affirmed the importance of interprofessional collaboration among healthcare professionals and clients in discharge planning to promote client-centered practice in healthcare settings (Atwal & Caldwell, 2003). IDTs in a SNF can encourage collaborative problem-solving, allowing safe transitions and bidirectional communication among clients and healthcare professionals (Treiger & Lattimer, 2011). Occupational therapists working with geriatric populations in the inpatient setting have a significant role in discharge planning for older adults to ensure they can manage their daily living activities in their own home environment following discharge (Lilja et al., 2020).

Additionally, treatment frequency and duration were concerns of the participants who received skilled occupational therapy intervention. Participants feel a 45 to 50-minute treatment session each day, five days a week is not enough to prepare them to return home. Because of the implementation of the patient-driven payment model (PDPM) in the SNFs, which focuses on Medicare beneficiary's clinical and functional characteristics rather than the volume-based service, SNFs reported a significant reduction in individual therapy utilization. However, the researchers examined the relative effects of PDPM implementation and found no changes in the length of SNF stay, community discharge rates, or SNF readmission (U.S. Center for Medicare & Medicaid Services, n.d.; Zhang et al., 2022). Even though the frequency and duration of treatment intervention may not be changed immediately due to policy changes to PDPM, occupational therapy practitioners can utilize the treatment time with client-centered and occupation-based intervention to provide sufficient treatment to support clients' optimal outcomes.

### *Community-Dwelling Older Adults' Perceived Readiness to Complete ADLs and IADLs After Discharge*

The occupation-based and client-centered interventions were deliberate during the interview. The occupational therapy practice framework (OTPF-4) supports occupation-based and client-centered practice (AOTA, 2020). The results of this study showed both the strengths and weaknesses of discharge readiness of community-dwelling older adults to complete ADLs and IADLs in the SNF from the RHDS and open-ended questionnaires. In the quantitative data of RHDS questionnaires, the average scores were between 7.69 and 8.62, with close to the highest score being 10, meaning that the majority of participants have a positive perception of discharge readiness to complete ADLs and IADLs in the SNF. For example, participants expressed that "I feel I can manage everything at home" and "I can do everything."

In contrast, some participants expressed the need for assistance for ADLs and IADLs. For instance, participants stated, " I will be better if someone teaches me how to manage the feeding tube," "I felt I still needed some help for showering and dressing," "I need help for meal preparation and shopping," and "I have concerns about going back to work, learning operating doors, and navigating the hallway in a real home environment. Although the present study reveals that the majority of participants have a positive perception of discharge readiness to complete ADLs and IADLs, the discharge education by occupational therapy practitioners can be improved to understand clients' needs in pre-discharge education, such as working on more showering and meal preparation in preparing them to return home independently. The occupation-based approach is critically used in the SNF to bring therapeutic processes, enhance client outcomes, and avoid disability in older adults. In changing the culture of SNF to be an occupation-centered practice, occupational therapy practitioners should establish an occupation-focused practice to promote the therapist-client relationship (Rafeedie et al., 2018; Star & Herman, 2022). Applying client-centered practice to understand client preferences can foster autonomy and promote social and occupational justice (Durocher et al., 2015). Additionally, participants expressed the importance of educating them on incorporating compensatory and remedial techniques with their physical limitations for their daily occupational participation, such as oxygen tube and compression stocking management.

Occupational therapy practitioners play a unique role in service delivery in transitional planning from one setting to another, such as SNF to home. Occupational therapy practitioners possess the skills to facilitate clients' transitional experiences to ensure clients' safety, well-being, and optimal outcomes (AOTA, 2020). The results of the RHDS post-test reveal that discharge planning from occupational therapy practitioners in the SNF prepares them both

physically and psychologically to feel confident about managing and handling the demands of their lives after discharge. For instance, from the current study, PI identified that most participants felt they were physically ready and understood the restrictions and problems to watch after returning home. Additionally, the participants felt they could handle the demands of life at home and perform their personal care routines such as hygiene, bathing, toileting, and eating.

**Strengths and Limitations**

**Strengths:** The results of this study examine community-dwelling older adults' perceived self-efficacy and readiness for discharge after receiving occupational therapy services at a SNF and disclose the effectiveness of occupational therapy services to facilitate community-dwelling older adults' self-efficacy and readiness for discharge to their communities. Validity and trustworthiness were supported through credibility and dependability through the interview process. Using a mixed method research study not only reveals the pre-test, post-test, and two-week follow-up data on how community-dwelling older adults' self-efficacy changed through the occupational therapy intervention process but also discovers deeper insights of the participants on how OT practitioners actually prepare them to return to the community. Another strength is that the questionnaires used in this study were standardized assessments and developed from best-evidence literature. Additionally, the data collection was over a prolonged period from January to August 2023 and from a broad range of complex diagnoses of participants and a large number of participants (N= 92), which can present the real phenomenon of the participants' experiences. Furthermore, this research study used multiple assessment tools to identify community-dwelling older adults' perceived discharge readiness, and the results were consistent between the data and the findings. Lastly, the outcome measure of using GSES scales

to test community-dwelling older adults' self-efficacy from pre-test, post-tests, and two-week follow-up represents a statistical significance, indicating the importance of occupational therapy interventions in the SNF setting to enhance clients' self-efficacy in preparing them to return home.

**Limitations:** The results of this study may not be transferable to other situations or locations as this study is conducted in one SNF in Northern California. Additionally, one of the inclusion criteria is that participants' cognitive levels are normal or mild cognitive impairment and plan to return to the community after their SNF stay; therefore, the results of this study did not apply to older adults with moderate to severe cognitive impairment. Furthermore, during the data collection, a variability of participants in each phase was identified. Ninety-two participants completed the initial interview; however, only 61 participants completed the post-test, and 38 participants completed two-week follow-up interviews due to multiple reasons; therefore, the results did not represent the whole participants' involvement.

**Implications for Practice**

Occupational therapy practitioners have advanced knowledge in transitional care in the SNF setting to ensure clients' safety, psychosocial well-being, and optimal outcomes. OTPF-4 pointed out that occupational therapy practitioners have pivotal roles in educating clients about using new equipment, adapting an occupation, providing caregiver training, modifying environmental barriers, or determining the appropriate settings for transitional care during the occupational therapy intervention process to ensure clients' safe and effective discharge planning (AOTA, 2020). This study promotes the importance of occupational therapy practice in focusing on client-centered, occupation-based, and interprofessional collaboration to enhance community-

dwelling older adults' self-efficacy, psychosocial well-being, and quality of life through their occupational participation and engagement.

**Future Research**

This research study's findings highlight the need for further research in several areas. Because this study was only conducted in one SNF organization, further studies to include various SNFs among different organizations will serve as a generalization to other settings and populations. With the increased numbers of community-dwelling older adults living alone (14.7 million) and older adults who live alone are more likely to be poor (Kaplan, 2023), further research on the health disparities (e.g., homeless or poor) transitional care experiences are needed to determine if the study results can be translated into different populations and settings. Additionally, this study was conducted with one group pre-test, post-test, and two-week follow-up; therefore, the results may not be generalizable to other populations. Therefore, further research on the control and intervention groups is recommended to examine the effectiveness of occupation and client-centered interventions associated with community-dwelling older adults' self-efficacy in promoting older adults' psychosocial well-being. Lastly, the previous research suggested a positive correlation between older adults' self-efficacy with health behavior and quality of life. Due to this study mainly focusing on a two-week follow-up after participants return home, further research to examine 30, 60, and 90-day follow-ups may serve a clear understanding of community-dwelling older adults' self-efficacy changes over time that may impact an individual's quality of life.

**Conclusion**

This capstone provided evidence supporting the outcome measures during clients' transitional care in occupational therapy practice to promote an individual's psychosocial well-

being and achieve optimal outcomes (AOTA, 2020). The quantitative and qualitative data analysis indicates that occupation-based discharge preparedness intervention changes community-dwelling older adults' perceived self-efficacy and readiness for discharge at a SNF. The quantitative results of the pre-tests, post-tests, and two-week phone call follow-up reveal a statistically significant ($p<0.05$) improvement in community-dwelling older adults' self-efficacy, which suggests that occupation-based discharge preparedness fosters older adults' self-efficacy in preparing them to return to the community. Additionally, the semi-structured interview and RHDS reveal community-dwelling older adults' sense of readiness for discharge at a SNF. The results of the qualitative study emerged with five themes: *happy about education, discussion with the interdisciplinary team, occupation-based intervention, client-centered intervention,* and *treatment frequency.* The implication of this study indicates occupational therapy interventions are a catalyst of discharge planning in the SNF to promote community-dwelling older adults' self-efficacy and readiness for discharge to home.

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# Appendices

## Appendix A: IRB Approval

## Consent to Participate in a Research Study

Community-dwelling older adults' perceived self-efficacy and readiness for discharge after receiving occupational therapy services at a Skilled Nursing Facility (SNF).

EKU
Institutional Review Board
Protocol Number
5056
Approval Valid
1/23/23-12/31/23

## Key Information

You are being invited to participate in a research study. This document includes important information you should know about the study. Before providing your consent to participate, please read this entire document and ask any questions you have.

**Do I have to participate?**
If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering. If you decide to participate, you will be one of 150 people (maximum number) in the study.

**What is the purpose of the study?**
The purpose of the study is to examine the perceptions of community-dwelling older adults' preparedness and self-efficacy after receiving occupational therapy services in an SNF to increase their quality of care and decrease hospital readmissions after they return home.

**Where is the study going to take place and how long will it last?**
The research procedures will be conducted at Smith Ranch Skilled Nursing Facility in San Rafael, CA. You will need to be admitted to this facility during the study and meet inclusion criteria. The one-to-one, face-to-face interview will schedule with each participant during their free time. The interviews will be completed within three-time frames, three days after initial admission, 1-2 days before SNF discharge, and two weeks after phone call follow-up. All interviews will be held in a private room in the SNF facility. Each interview session will take about 20-30 mins to complete. The total amount of time you will be asked to volunteer for this study is one hour over the next few weeks and months.

**What will I be asked to do?**
This project will use the adapted Quality of Discharge Teaching (QDTS), Readiness for Hospital Discharge Scale (RHDS) instruments, and Self-Efficacy Scales to measure the patients' perceptions of readiness for discharge. Participants will receive a community-dwelling older adults' perception of discharge preparedness and self-efficacy questionnaire along with incorporating pretest and posttest with self-efficacy scales to identify their occupational performance and QDTS and RHDS tools to determine how participants feel about their preparedness to discharge home.

Three-time frames that participants will receive the questionnaires after signing an informed consent to participate in the study.

1. Within three days after initial admission: participants will receive a pre-test on Self-Efficacy Questionnaires.
2. One-two days before turning home: participants will receive a post-test on Self-Efficacy Questionnaires, Adapted Quality of Discharge Teaching, Readiness for Hospital Discharge Scale,

and a community-dwelling older adults' perception of discharge preparedness and self-efficacy questionnaire.

3. Receive two weeks follow-up phone call: post-test on Self-Efficacy Questionnaires.

**Are there reasons why I should not take part in this study?**

Participants could be excluded from volunteering such as 1) adults less than 65 years old, 2) older adults aged 65 or older who receive MOCA scores indicating moderate or severe cognitive impairment, 2) older adults who do not speak English, and 3) older adults who will remain in SNF as long-term care residents or who were not admitted to the facility where the research is conducted.

**What are the possible risks and discomforts?**

If the research involves minimal risk to the subject, include the following statement:
To the best of our knowledge, the things you will be doing have no more risk of harm or discomfort than you would experience in everyday life.

**What are the benefits of taking part in this study?**

You are not likely to get any personal benefit from taking part in this study. Your participation is expected to provide benefits to others. This research design aims to examine the discharge preparedness in an SNF for community-dwelling older adults to promote quality of life for older adults and decrease hospital readmission.

**If I don't take part in this study, are there other choices?**

If you do not want to be in the study, there are no other choices except to not take part in the study.

Now that you have some key information about the study, please continue reading if you are interested in participating. Other important details about the study are provided below.

## Other Important Details

**Who is doing the study?**

The person in charge of this study is Shih-Ni Lai at Eastern Kentucky University. She is being guided in this research by Dr. Leah Simpkins, and Dr. Renee Causey-Upton.

**What will it cost me to participate?**

There are no costs associated with taking part in this study.

**Will I receive any payment or rewards for taking part in the study?**

You will not receive any payment or reward for taking part in this study.

**Who will see the information I give?**

Your information will be combined with information from other people taking part in the study. When we write up the study to share it with other researchers, we will write about this combined information. You will not be identified in these written materials.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information or what that information is. Include the following statement if the data will not be recorded with identifying information: The information that you provide will be stored on the primary researcher's laptop, which is password protected and kept in her office when not in use, which has a lock and key.

**Can my taking part in the study end early?**
If you decide to take part in the study, you still have the right to decide at any time that you no longer want to participate. You will not be treated differently if you decide to stop taking part in the study.

The individuals conducting the study may need to end your participation in the study. They may do this if you are not able to follow the directions they give you, if they find that your being in the study is more risk than benefit to you, or if the University or agency funding the study decides to stop the study early for a variety of reasons.

**What happens if I get hurt or sick during the study?**
If you believe you are hurt or get sick because of something that is done during the study, you should call Shih-Ni Lai at 415-680-0967 immediately. It is important for you to understand that Eastern Kentucky University will not pay for the cost of any care or treatment that might be necessary because you get hurt or sick while taking part in this study. Also, Eastern Kentucky University will not pay for any wages you may lose if you are harmed by this study. These costs will be your responsibility.

Usually, medical costs that result from research-related harm cannot be included as regular medical costs. Therefore, the costs related to your care and treatment because of something that is done during the study will be your responsibility. You should ask your insurer if you have any questions about your insurer's willingness to pay under these circumstances.

**What else do I need to know?**

You will be told if any new information is learned which may affect your condition or influence your willingness to continue taking part in this study.

We will give you a copy of this consent form to take with you.

## Consent

Before you decide whether to accept this invitation to take part in the study, please ask any questions that come to mind now. Later, if you have questions about the study, you can contact the investigator, Shih-Ni Lai at 415-680-0967 or email: Shihni_lai@eku.edu. If you have any questions about your rights as a research volunteer, you can contact the staff in the Division of Sponsored Programs at Eastern Kentucky University at 859-622-3636.

If you would like to participate, please read the statement below, sign, and print your name.

*I am at least 18 years of age, have thoroughly read this document, understand its contents, have been given an opportunity to have my questions answered, and voluntarily agree to participate in this research study.*

_____
Signature of person agreeing to take part in the study Date

_____
Printed name of person taking part in the study

_____
Name of person providing information to subject

**Appendix B: Generalized Self-Efficacy Scales (GSES)**

# GENERALIZED SELF-EFFICACY SCALE

GL assessment
the measure of potential

**Name:** .....

**Date:** ..... **Record Number:** .....

| | | Not at all true | Barely true | Moderately true | Exactly true |
|---|---|---|---|---|---|
| 1. | I can always manage to solve difficult problems if I try hard enough. | 1 | 2 | 3 | 4 |
| 2. | If someone opposes me, I can find means and ways to get what I want. | 1 | 2 | 3 | 4 |
| 3. | It is easy for me to stick to my aims and accomplish my goals. | 1 | 2 | 3 | 4 |
| 4. | I am confident that I could deal efficiently with unexpected events. | 1 | 2 | 3 | 4 |
| 5. | Thanks to my resourcefulness, I know how to handle unforeseen situations. | 1 | 2 | 3 | 4 |
| 6. | I can solve most problems if I invest the necessary effort. | 1 | 2 | 3 | 4 |
| 7. | I can remain calm when facing difficulties because I can rely on my coping abilities. | 1 | 2 | 3 | 4 |
| 8. | When I am confronted with a problem, I can usually find several solutions. | 1 | 2 | 3 | 4 |
| 9. | If I am in a bind, I can usually think of something to do. | 1 | 2 | 3 | 4 |
| 10. | No matter what comes my way, I'm usually able to handle it. | 1 | 2 | 3 | 4 |

**Appendix C: Community-Dwelling Older Adults' Perception of Discharge Preparedness and Self-Efficacy Questionnaire**

My name is Shih-Ni Lai and I am an occupational therapist working at a skilled nursing facility. I am currently working on my Doctorate of Occupational Therapy degree at Eastern Kentucky University. I am conducting a research project for my degree titled: Community-dwelling older adults' perceived self-efficacy and readiness for discharge preparedness after receiving occupational therapy services at a skilled nursing facility (SNF). I am researching the dwelling older adults during inpatient SNF stay in an attempt to understand if occupational therapy education is effectively provided to community-dwelling older adults prior to their discharge back to home. I would appreciate your participation in this survey, but know that your participation is completely voluntary and you may stop at any time. If you have any questions, you may contact me at Shihni_lai@mymail.eku.edu.

By selecting Yes to this question, you are acknowledging participation in this survey.

Yes

No

1. Do you plan to go home after the Skilled Nursing Facility stay?

Yes

No

Unsure

2. How do you identify yourself?

Female

Male

Non-binary

Other

3. What age groups are you currently in at the time of this survey?

65-75 years old

75-85 years old

>85 years old

4. Do you live alone or with family members?

Alone

Family member(s)

Others

5. How do you feel you were prepared for home following your stay in the facility?

6. Do you believe that the Occupational Therapy education that you received prior to discharge to home prepared you for actually being home?

Yes

No

Uncertain

7. What would you like to change about the preparedness from Occupational Therapy education in preparation for going home?

8. What areas of daily occupations (dressing, bathing, grooming, meal preparation, etc.) that you feel you need more help with after returning to home?

## Appendix D: Readiness for Hospital Discharge

**READINESS FOR HOSPITAL DISCHARGE SCALE -- ADULT FORM ©**

Please fill in the circle next to your answer. The answers are on a 10-point scale from 0 to 10. The words below the number indicate what the 0 or the 10 means. Pick the number between 0 and 10 that best describes how you feel. For example, circling number 7 means you feel more like the description of number 10 than number 0 but not completely.

| | |
|---|---|
| 1. How physically **ready** are you to go home? | 0 1 2 3 4 5 6 7 8 9 10<br>Not ready Totally ready |
| 2. How would you describe your **energy** today? | 0 1 2 3 4 5 6 7 8 9 10<br>Low energy High energy |
| 3. How much do you **know about problems to watch for** after you go home? | 0 1 2 3 4 5 6 7 8 9 10<br>Know nothing at all Know all |
| 4. How much do you **know about restrictions** (what you are allowed and not allowed to do) after you go home? | 0 1 2 3 4 5 6 7 8 9 10<br>Know nothing at all Know all |
| 5. How well will you be able to **handle the demands** of life at home? | 0 1 2 3 4 5 6 7 8 9 10<br>Not at all Extremely well |
| 6. How well will you be able to **perform your personal care** (for example, hygiene, bathing, toileting, eating) at home? | 0 1 2 3 4 5 6 7 8 9 10<br>Not at all Extremely well |
| 7. How much **help** will you have if needed with your **personal care** after you go home? | 0 1 2 3 4 5 6 7 8 9 10<br>None A great deal |
| 8. How much **help** will you have if needed with your **medical care** needs (treatments, medications) after you go home? | 0 1 2 3 4 5 6 7 8 9 10<br>None A great deal |

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