LOMA LINDA UNIVERSITY
School of Nursing

Improving Care Transitions and Self-Efficacy Levels in SNF Patients and Caregivers

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BACKGROUND

- Nearly one in five hospitalized Medicare beneficiaries became patients at skilled nursing facilities (SNF) for rehabilitative services
- These patients are at an increased risk for death, rehospitalizations, and emergency department use after SNF discharge
- Transitional care is a patient-oriented service that aims to improve care continuity, facilitate safe transfers between healthcare settings, and reduce the risk of poor outcomes in such at-risk populations with the overall goal to educate patients and caregivers about preventing rehospitalizations and addressing the underlying roots of poor outcomes
- Self-efficacy training has also shown to improve rehospitalization rates in community-dwelling adults with chronic conditions, and higher self-efficacy levels may have association with lower levels of frailty in community dwelling older adults
- The Project Lead (PL) recruited 10 patients and caregiver groups at a local SNF with medium to high risk for readmissions to conduct self-efficacy training and an evidence-based transitional care management intervention to improve care transitions from SNF to home

PICOT QUESTION

In skilled nursing facility (SNF) patients and caregivers, does self-efficacy training and implementation of a Transitional Care Model approach to discharge follow-up lead to increased quality of transitional care from SNF to home and improved self-efficacy levels in disease/treatment management compared to current practice over the course of six months?

THEORETICAL FRAMEWORK

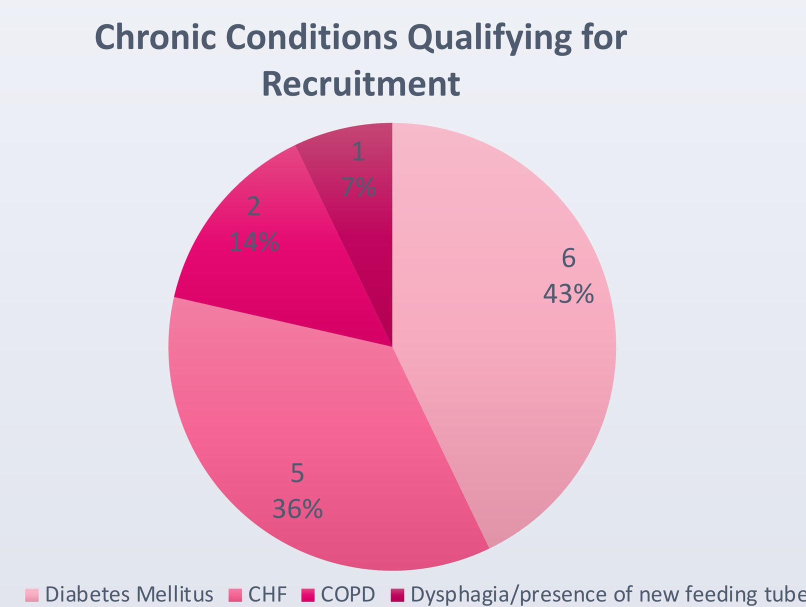
Transitions Middle-Range Theory, Self-Efficacy Theory and the Iowa Model of Evidence-Based Practice guided the development of the intervention

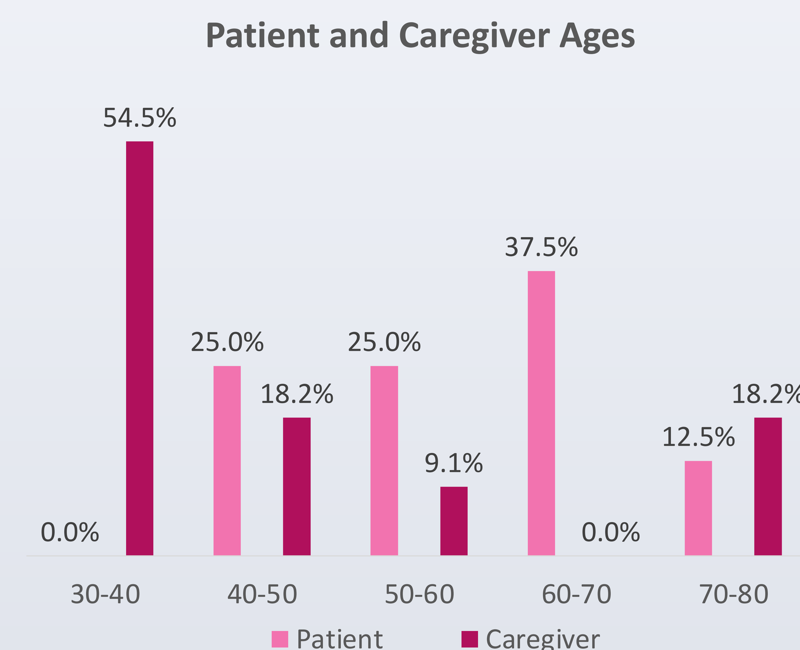
OBJECTIVES

- To assess SNF's transitional care metrics before intervention
- To tailor and implement a self-efficacy education program for SNF patients and caregivers
- To assess for change in the level of self-efficacy levels after training
- To assess for change in the transitional care metrics compared to baseline after self-efficacy training
- To collaborate with the Transitional Care Management (TCM) team after SNF discharge to provide patient and caregiver support throughout the transition period

SAMPLE DEMOGRAPHICS

- Project Lead recruited a convenience sample of 10 patients and 14 caregivers from a population of patients participating in rehabilitation in a mid-sized Southern California SNF





PROCESS

- **Phase I:** For baseline measures - assess the current quality of care transitions from SNF to next care setting using Care Transitions Measure-15 (CTM-15) tool in patients and caregiver groups and additional metrics
- **Phase II:** Assess the current levels of patient and caregiver self-efficacy levels in a convenience sample of 10 patient and caregiver groups using Chronic Disease Self-Efficacy Scale and PROMIS Self-Efficacy for Management of Chronic Conditions Tool
- Conduct self-efficacy training with the sample using self-efficacy education concepts adopted from Kate Lorig's self-management program, Kramer 2020 © patient education handouts, and teach patients and caregivers nursing skills pertinent to their healthcare conditions
- **Phase III:** Connect patients and caregivers with the Transitional Care Management team during SNF admission with the team continuing follow-up after SNF discharge. Complete post-intervention assessments of self-efficacy levels and quality of care transitions using the Chronic Disease Self-Efficacy Scale, PROMIS Self-Efficacy for Management of Chronic Conditions Tool, and Care Transitions Measure-15 (CTM-15) tool

POST-INTERVENTION RESULTS

- The data showed a significant 8.18 % increase in levels of self-efficacy in medication and treatment management. This survey assessed patients' ability to take their own medications, manage side effects, follow prescribing provider's directions, remember important directions about medication, ability to obtain medication supply, and other components
- There was a significant 21.5% increase in levels of self-efficacy in chronic condition management. This survey assessed patients' ability to get information about the disease, obtain help from the community, family, and friends, communicate with physicians, and manage symptoms
- There was a 20% increase in quality of care transitions (CTM-15) scores

Care Transitions Measure (CTM-15)

	Group				% of difference in median scores	P-value
	Pre		Post			
	Valid N	Median (Min - Max)	N	Median		
CTM Score	15	61.9 (19.1 - 91.11)	10	74.4 (60.0 - 100.0)	20.2%	0.002

The Patient-Reported Outcomes Measurement Information System (PROMIS) Self-Efficacy for Managing Chronic Conditions Tool (Medication and Treatment)

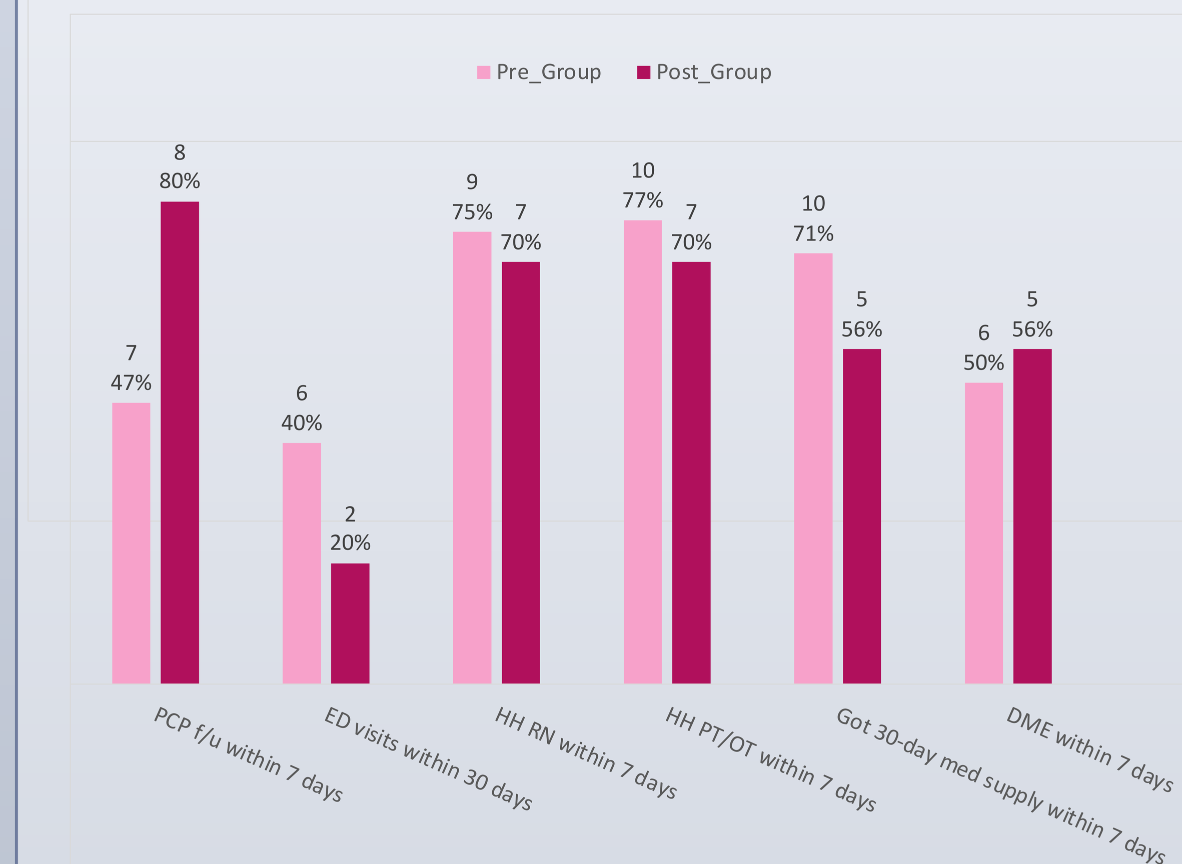
	Time		% of change in mean score	P-value
	Pre	Post		
Mean ±SD	50.11 ± 6.12	54.21 ± 4.80	8.18%	0.005
* Paired t-test				

The Self-Efficacy for Managing Chronic Diseases (CDSES)

	Time		% of change in mean score	P-value
	Pre	Post		
Median (Min - Max)	7.9 (3.9 - 9.7)	9.6 (7.3 - 10.0)	21.5%	<0.001**
** Wilcoxon Signed Ranks Test				

Results (cont'd)

- There was an observed decline in the timeliness of obtaining home health services, durable medical equipment, and a 30-day supply of medications
- There was an observed increase in follow up with primary care providers within 7 days of SNF discharge and a decline in ED visits and rehospitalizations



STRENGTHS/AREAS FOR IMPROVEMENT

Strengths:

- High participation rate - all patient and caregiver groups completed self-efficacy training and post-discharge follow up with Transitional Care Team

Challenges:

- Convenience sampling increases risk for bias, as patients/caregivers with lower compliance may have opted out of participating in the project
- Small sample size/ not enough time to recruit a larger sample size
- Surveys took long time to complete which was burdensome to some patients and caregivers

NEXT STEPS

- Allow more time for intervention completion
- Look for validated surveys that are shorter/take less time to complete
- The surveys are about perceived patient confidence – would be useful to assess for actual changes in behaviors following SNF discharge
- SNF case management team needs to arrange home health follow-up and durable medical equipment delivery prior to discharge date to avoid gaps in home safety and follow-up care

REFERENCES

Available upon request

CONTACT INFORMATION

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