The University of Kansas
School of Social Welfare
Office of Aging and Long-Term Care

Increasing Nursing Facility Discharge
For Older Kansans Who Use Medicaid
And Have Mental Health Diagnoses

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Executive Summary

The Kansas Department on Aging (KDOA) contracted with the University of Kansas School of Social Welfare’s Office of Aging and Long Term Care (OALTC) to conduct a study about nursing facility (NF) residents using Medicaid with mental health diagnoses who have discharged to the community. The purpose of this study was to provide KDOA with detailed information on strategies that have been utilized in Kansas to successfully discharge NF residents who use Medicaid and have mental health diagnoses. The information gathered in this study and provided in this report has widespread application for KDOA in working to increase the rate of successful NF discharges in Kansas.

The research design for the study utilized a concurrent mixed methods approach to meet project objectives and answer our research questions. We examined quantitative data using the Minimum Data Set (MDS) 2.0 from July 2005 through June 2008. To learn about successful discharge strategies, we conducted qualitative interviews with NF staff across Kansas who have helped successfully discharge nursing home residents with mental health diagnoses to the community to learn about successful discharge strategies. Qualitative and quantitative research methods complemented each other, which improved the breadth and range of our investigation and contributed to recommendations for increasing discharge rates in Kansas.

MDS Analysis

The study sample included individuals who were admitted to an NF and discharged to the community at least once from July 2005 through June 2008, had a mental health diagnosis (i.e., anxiety, schizophrenia, or bipolar disorder), and used Medicaid insurance. Findings confirm that 720 residents with mental health diagnoses and a wide variety of other characteristics and attributes discharged from the NF to the community during the study period. Many adults with anxiety (69.0%), bipolar disorder (21.8%), and/or schizophrenia (20.4%) who use Medicaid successfully discharged from the NF to the community; some had multiple mental health diagnoses. Upon entry, these adults were anticipated to have both short-term NF stays (46.1%) and long-term NF stays (17.2%); others were uncertain about length of stay (36.7%). Seventy-three adults with mental health diagnoses who use Medicaid (10.1%) discharged to the community after residing in the NF for 6 months or more. These adults discharged from NFs in urban (56.3%), mid-size (13.6%), and rural (12.6%) settings across all 11 PSA regions.

Wide range of characteristics and attributes. The 720 adults with mental health diagnoses who use Medicaid and who successfully discharged from the NF to the community had a wide range of characteristics and attributes. These adults were 20 to 100 years old ($m=64.7$ years; $SD = 15.4$). Some adults (35.0%) were independent in late loss ADLs (i.e., bed mobility, toilet use, transferring, eating); others used extensive assistance with bed mobility (41.8%), toilet use (29.6%), transferring (31.8%), and
eating (66.8%). Many of these adults had one or more chronic diseases (e.g., hypertension (62.5%), depression (54.9%), diabetes (36.8%).

**Transition patterns.** The patterns analysis indicated the majority of adults who have mental health diagnoses and use Medicaid who discharge from the NF to the community do **not** enter a cycle of repeated NF re-entries and discharges. From the time of their base admission, 61.1% discharged from the NF to the community and did not re-enter the NF over the course of the study and 6 month follow up period. The vast majority (97.4%) experienced only 1-3 NF stays over the course of the study period and through the end of the 6 month follow-up. In addition, 75.9% of the adults who use Medicaid and have diagnoses of anxiety, bi-polar disorder, and/or schizophrenia had a last documented residence in the community.

Certain diagnoses were related to higher risk of multiple NF admissions and discharges. These included: depression, emphysema/ COPD, diabetes mellitus, cerebrovascular accident/stroke, hypertension. Specifically, data indicated that adults without diagnoses of depression, arthritis, emphysema/ COPD, diabetes mellitus, cerebrovascular accident/stroke, or hypertension had over 3 times the odds of experiencing only one NF event. Individually, informal supports such as living with others or having daily contact with friends and relatives in the year prior to NF admission were not statistically significant predictors of NF transitions. However, having access to informal supports predicted NF discharge and re-entry patterns depending on age groups. Thus, there was some evidence that different types of informal support may have varying effects for adults of different ages. Research reinforces these findings, stating older adults often prefer to live alone and enjoy contact from family, friends, and neighbors, while living in the environment in which they feel most comfortable (Hooyman & Kiyak, 2011).

**Successful Discharge Strategies from NF Staff Involved in Discharge**

We completed in-depth interviews with NF staff members from various NFs across the state. All those selected for interviews had extensive experience with discharging persons to the community. We asked NF staff about discharges during the study period as well as other more recent discharges. Specifically, we asked about strategies they considered most effective for ensuring successful discharge, how they approached discharge for Medicaid residents with specific diagnoses (e.g., anxiety, bipolar disorder, schizophrenia), and how they helped discharge residents who re-entered the NF following a previous discharge.

**Most effective discharge strategy.** Nursing facility staff involved in discharge discussed what they considered the most effective strategy for ensuring successful discharge from the nursing facility to the community. About half of the NF staff members who were interviewed emphasized discharge strategies focused on formal community services and supports, and the other half emphasized strategies related to
informal supports. Specifically, staff members stated that helping residents enroll and utilize HCBS waiver services was the most critical strategy for discharge. Other NF staff members mentioned the importance of helping the person to identify a case manager to work with the person in the community, from either the Area Agency on Aging (AAA) or a Community Mental Health Center (CMHC). Many NF staff persons discussed that working with the person who is discharging to identify and solicit the help and support of informal supports (e.g., family members or friends, neighbors, and/or religious group members available on a regular basis) was critical to discharge. Of particular importance was involving the resident and family members from the beginning of the transition process. Staff members found that identifying church support, for meeting emotional needs and for helping with home modifications, was often very important to those with mental health diagnoses. Others stated that good communication with the family was especially important, which can be established by initially meeting with the resident and family members for a detailed assessment about discharge goals upon entry into the NF. Finally, staff mentioned the importance of identifying a professional to monitor informal supports to avoid instances of abuse and exploitation.

**Successful strategies.** Based on NF staff members experiences in discharging nursing facility residents with mental health diagnoses, many strategies were used to help successfully discharge this population. Based on individuals’ characteristics and attributes, NF staff suggested working with persons who discharge and their informal support persons to help them understand physical and mental health diagnoses & related behaviors and their treatment regimens as well as the consequences of not adhering to medication and treatment recommendations. This was deemed the most helpful strategy for avoiding hospital entries and NF re-entries, as this empowered persons and family members to work toward successful discharge.

To address the physical environment of the discharge location, NF staff recommended conducting a team evaluation of the discharge location along with the person and their informal support persons, in order to make safety and psychosocial recommendations. This strategy was recommended as particularly important for ensuring a safe discharge, as professionals can make recommendations for persons and caregivers within the context of the discharge location.

NF staff also identified the importance of consulting with the person who is discharging to identify and solicit the help and support of informal support persons, while also working with informal support persons to identify concerns about being a caregiver and supportive resources to help them. This strategy was identified as an especially supportive strategy for ensuring caregivers can provide anticipated support, which contributes to a successful discharge and helps to avoid NF re-entry for the person using Medicaid. Additionally, NF staff found that gaining a breadth of knowledge about available community supports and engaging in activities that build relationships and networks with other NF and community
professionals was important for ensuring a successful discharge. This strategy was recommended to help ensure persons who discharge are able to access needed community supports in a timely, efficient manner, which can be particularly challenging for those who utilize Medicaid and have mental health diagnoses.

Finally, many of the NF staff who were interviewed stated that their NFs encouraged consistent, supportive discharge processes that helped ensure successful discharge. These processes included using proactive discharge techniques (e.g., follow-up phone calls); utilizing detailed discharge forms; and providing ongoing training about mental health diagnoses, community resources, and policy regulations related to discharge to NF and community staff. These strategies were discussed as important for setting discharge goals and ensuring NF staff members from various disciplines are involved in the discharge process, which can contribute to increased discharge rates for persons using Medicaid who have mental health diagnoses.

**Overall Recommendations for Increasing Discharge Rates**

Based on the findings from the MDS analysis and interviews with NF staff about successful discharge strategies, we provide recommendations for strategies to help increase rates of successful NF-to-community discharges for NF residents using Medicaid who have mental health diagnoses. The following is a summary of the recommendations for strategies to use to increase discharge rates for nursing home residents with mental health diagnoses in Kansas:

- Increase awareness that people using Medicaid with mental health diagnoses can and do successfully discharge from the NF to the community.
- Provide information on physical and mental health diagnoses, self-management, treatment, and specific community resources to residents and other key people (e.g., family, NF staff members, and community agency professionals) involved in discharge.
- Involve social workers and mental health professionals who have expertise in working with older adults in the discharge process (to the extent possible).
- Work with individuals who are discharging to develop a system of informal and formal supports prior to discharge. Ensure that these supports can be sustained after discharge.
- Use proactive techniques (e.g., helping residents develop goals to work towards discharge; providing residents with detailed, comprehensive discharge forms; conducting home evaluations prior to discharge; and providing follow-up contact to residents) to help prevent challenges in the community and avoid NF re-entry.
- Take advantage of technology for gathering information and providing support to persons who discharge.
- Work to ensure continuity of care across NF and community settings.
Introduction

Purpose
The Kansas Department on Aging (KDOA) contracted with the University of Kansas School of Social Welfare’s Office of Aging and Long Term Care (OALTC) to conduct a study about nursing facility (NF) residents using Medicaid with mental health diagnoses who have discharged to the community. The purpose of this study was to provide KDOA with detailed information on strategies that have been utilized to successfully discharge NF residents who use Medicaid and have mental health diagnoses. The information gathered in this study and provided in this report will have widespread application for KDOA in working to increase the rate of successful NF discharges in Kansas. This report describes findings from this study, which was funded from August 1, 2009 to June 30, 2010 (FY10).

Research Objectives
This study focused on Kansas NF residents who use Medicaid, have discharged to the community, and have mental health diagnoses. The research design for the study utilized a concurrent mixed methods approach, meaning that we examined quantitative data and simultaneously gathered qualitative data to meet project objectives and answer our research questions. Qualitative and quantitative research methods complemented each other, which improved the breadth and range of our investigation and contributed to recommendations for increasing discharge rates in Kansas. We met with KDOA to develop the research design and define key variables of interest in the study.

As part of this study, we identified five objectives:
1. To describe the sample of NF residents who use Medicaid, have discharged to the community, and have mental health diagnoses.
2. To identify discharge strategies (e.g., identification of specific community supports) that have been used in NF-to-community transitions.
3. To delineate the transition patterns of individuals who discharged from an NF to a community setting (e.g., no re-entry, re-entry, re-entry and subsequent discharge).
4. To develop materials (e.g., success scenarios and suggestions for increasing NF discharge) for dissemination to professionals working with NF residents who use Medicaid and discharge to the community.
5. To submit a final report to KDOA that documents findings and provides recommendations.

To complete these five objectives, the study included quantitative analysis of Minimum Data Set (MDS) 2.0 data for a sample of NF residents who use Medicaid, have mental health diagnoses, and discharged to the community. We described the breadth and range of characteristics and attributes (e.g., age, gender, functional status, lived alone) of this group of residents (to fulfill Objective 1) and examined
the transition patterns from an NF to a community setting (to fulfill Objective 3). Through qualitative analysis, we investigated discharge strategies that have been used in NF-to-community transitions (to fulfill Objective 2). Based on our research findings, we also developed informational Discharge Briefs that KDOA can disseminate to persons who are discharging, their informal supports, NF staff members, and/or community agency professionals (to fulfill Objective 4). Finally, as a synthesis of the findings from FY09 and FY10 research, we made recommendations for the use of successful discharge strategies that have widespread applicability for helping to increase rates of successful NF discharges for Medicaid recipients with mental health diagnoses (to fulfill Objective 5).

**Report Overview**

This report has three sections and an appendix. The findings of the report are organized around key research/policy questions as well as levels of an ecological model. We utilized five levels of an ecological model (individual characteristics and attributes, physical environment, informal supports, community services, and societal norms and social policies) to guide our analysis and to explain our findings. See Figure 1 on page 43 and accompanying narrative, which illustrates and explains the ecological model used in this study. In addition, it may be helpful to review the definitions of terms used in the report before and/or while reading the report. (Refer to the Glossary of Key Terms on page 112 of the report). The Overall Study Recommendations and Discharge Briefs are presented in Sections I and II to help increase use of the report findings and to give an overall synopsis of the findings from the various research objectives. Section III provides further detail on the research findings.

Section I, the Overall Study Recommendations section, includes implications for practice and policy related to mental health, NF discharge, and Medicaid. The recommendations are made across levels of the ecological model, and we point out the relevant levels for each recommendation. Many of the recommendations build on the recommendations from the FY09 report, providing more detailed information on why the recommendations are important and how Kansas could implement the recommendations to help increase discharge rates. We recognized that NFs and communities have differing resources and may not be able to implement all of the recommendations we offer. We hope NFs and communities can implement some of the recommendations and glean helpful information from the others to increase successful discharges for this population.

Section II of the report includes the Discharge Briefs. These briefs, numbered 1 through 5, were developed for KDOA to disseminate to residents who are discharging from the NF to the community, their informal support persons, and NF and community professionals to help increase rates of successful discharges. At KDOA’s request, we designed the briefs for use by residents and their informal support persons rather than only NF and community professionals, as a way to ensure residents’ involvement.
throughout the discharge process. The briefs may help increase the pool of successful discharge strategies used to help residents with mental health diagnoses who use Medicaid discharge to the community. The briefs can be copied and disseminated to relevant persons or provided on a website for more widespread access.

Section III provides the Detailed Research Findings. In the first part of Section III, we describe a sample of Medicaid NF residents with mental health diagnoses who discharged to a community setting, discuss their transition patterns, and examine factors related to one discharge versus multiple discharges; this includes findings that meet Objectives 1 and 3. In the second part of Section III, we identify discharge strategies described by NF staff members who have helped Medicaid residents with mental health diagnoses successfully discharge to a community setting; this includes findings that meet Objective 2. We also describe discharge strategies from other states’ transition programs.

The ‘Appendices’ to the report include: Appendix A—project deliverables and their location within the report, Appendix B—detailed methodology for Objectives 1-3, Appendix C—an example of a discharge summary form used by NF staff members that other NFs could use, Appendix D—a description of some of the federal and state programs and policies that influence discharge to the community.
Section I: Overall Study Recommendations

This section provides our recommendations for strategies to help increase rates of successful NF-to-community discharges for NF residents using Medicaid who have mental health diagnoses. We begin with a summary of the recommendations. The narrative following the summary provides additional detail for each recommendation. NFs, community agencies, NF residents who use Medicaid, and others involved in NF-to-community transitions can utilize strategies from the recommendations that best fit within their community context. We have included insightful quotes from NF staff members who have helped successfully discharge the target population to the community. We also incorporated boxes indicating the ecological levels of influence for each recommendation to correspond with the ecological model (see page 43) we used in conducting this research.

Summary of Recommended Discharge Strategies

- Increase awareness that people using Medicaid with mental health diagnoses can and do successfully discharge from the NF to the community.

- Provide information on physical and mental health diagnoses, self-management, treatment, and specific community resources to residents and other key people (e.g., family, NF staff members, and community agency professionals) involved in discharge.

- Involve social workers and mental health professionals who have expertise in working with older adults in the discharge process (to the extent possible).

- Work with individuals who are discharging to develop a system of informal and formal supports prior to discharge. Ensure that these supports can be sustained after discharge.

- Use proactive techniques (e.g., helping residents develop goals to work towards discharge; providing residents with detailed, comprehensive discharge forms; conducting home evaluations prior to discharge; and providing follow-up contact to residents) to help prevent challenges in the community and avoid NF re-entry.

- Take advantage of technology for gathering information and providing support to persons who discharge.

- Work to ensure continuity of care across NF and community settings.
Increase Awareness that People using Medicaid with Mental Health Diagnoses Can and Do Successfully Discharge from the NF to the Community

“We’ve written discharge plans for several residents, though, that maybe at that time, we didn’t think that they could go home. And they can surprise you.”

In Kansas, persons using Medicaid who have mental health diagnoses have discharged from NFs to private homes, apartments, and assisted facilities following various lengths of stays. In fact, the 720 individuals identified in this study represented a diverse group of NF residents who successfully discharged to the community. These individuals ranged in age from 20 to 100 years. The sample’s physical and cognitive health attributes represented a broad range of functioning in activities of daily living and cognition as well as various physical health diagnoses (e.g., hypertension, depression, diabetes). Furthermore, residents discharged from NFs located in urban and rural counties as well as from NFs located in each of the 11 Planning Service Areas (PSAs) in Kansas. Many of these individuals had informal supports such as daily contact with relatives or close friends and a support person positive toward discharge; however, not all individuals who discharged to the community had these informal supports. Upon admission, many of the individuals in this study were predicted to have long-term NF stays (defined as more than 90 days) and several individuals discharged after being in the NF for 3 months or longer. (See Section III, Analysis of MDS Data starting on page 44 for details on these findings). Additionally, the majority of these individuals only experienced one NF admission and community discharge within the 3 ½ year period we analyzed. (See Section III, Analysis of MDS Data starting on page 56 for details on this finding). Our findings provide evidence that this population can continue to successfully discharge from the NF to the community. Because such a diverse group of individuals discharged, it opens the possibility of discharge for many NF residents using Medicaid who have mental health diagnoses.

**Possible residents to target for discharge.** In addition, findings from the NF staff interviews indicate that working towards discharge for all Medicaid residents with mental health diagnoses, regardless of whether they are projected to have a long-term stay or short-term stay (defined as less than 90 days), can be a helpful discharge strategy. (See Section III, Interviews with NF Staff on page 101 for

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**Ecological Levels of Influence:**

- **Individual Characteristics & Attributes** (e.g., desire to return to the community, unique physical and mental health needs)
- **Informal supports**
- **Societal Norms & Social Policies** (e.g., norms such as encouraging NF buy-in to discharge goals).

*(See page 41 for further explanation of the ecological model used in this study).*
details on this finding). Though NF staff members stated that residents projected to have short-term stays are more often targeted with early discharge planning, a few of the NF staff members we interviewed worked towards discharge with all short-term and long-term residents who indicated a preference to return to the community. Interestingly, approximately 20% of those who discharged in our sample discharged following long-term stays. Considering all residents with a preference to the return to the community, whether they are projected to have short-term or long-term stays, may ensure the inclusion of additional persons who NFs might not necessarily include with early discharge planning. Preference to return to the community can be documented on the MDS admission assessment Section Q.1.a. Related to our quantitative findings, 84.4% of those who discharged indicated a preference to return to the community on Section Q.a. Thus, preference to the return to the community is a good starting point for identifying discharge candidates, as currently done with the Kansas Money Follows the Person program. (See the box on page 76 for Strategies for Determining Which Residents to Target for Discharge from Other States’ Transition Programs for other additional possibilities).

Identifying those with access to informal support persons may be an additional target population for discharges. Having access to informal support persons, as indicated on the MDS admission assessment as having daily contact with relatives and close friends (Section AC.1.s.) or living with others (Section AB.3.s.) was shown to predict successful discharges depending on the age of the person discharging. (See Section III, Analysis of MDS Data starting on page 63 for details on this finding). This does not suggest that persons without informal supports cannot discharge, as additional formal services and supports can help this population to successfully discharge. (See Section III, Interviews with NF Staff on page 90 for details on discharging without access to informal supports). However, access to informal supports may be an another consideration for additional residents to target for discharge. (See the box on page 85 for Strategies for the Use of Informal Supports from Other States’ Transition Programs for further possibilities).

**Early discharge planning.** To facilitate discharge for Medicaid residents with mental health diagnoses, it is important to collaborate with the resident and caregivers to identify discharge options and choices that meet individual needs and preferences. Similar to an approach used in New Jersey’s discharge program (Eiken, 2003), one strategy to get discharge planning started upon admission in the NF is to have AAA case managers complete pre-admission assessments (e.g., CARE assessment) for the residents. This would help alleviate the burden of NF staff members and encourage early discharge planning for more residents. In addition, NF staff members and/or AAA case managers should work closely with the resident to identify and develop discharge goals upon their admission into the NF. A multidisciplinary team can work with the resident to identify and support his or her unique physical health, mental health, and psychosocial needs. If the resident prefers it, family members or other informal
support persons should also be a part of all discharge-related activities. This will ensure that individuals’ support systems are utilized throughout the discharge process, which can increase chances for successful NF discharge to the community. (See Section II, Discharge Brief 3—Informal Assistance on page 33 and Section III, Interviews with NF Staff on pages 87 and 102-103 for further information).

**Successful strategies and scenarios.** As documented, there are multitudes of discharge strategies for ensuring persons with mental health diagnoses can receive the supports they need in the community, regardless of physical health conditions or personal circumstances. NF staff members and community agency professionals can use these identified strategies (as described throughout Section III, Interviews with NF Staff, summarized on pages 67-68) to increase discharge for persons with mental health diagnoses to the community and help to ensure they live successfully in the community following an NF stay. Providing success stories to NF staff members and community agency professionals about persons who have discharged with mental health diagnoses and discharge strategies that have been used could help increase discharge rates (refer to Section II, Discharge Briefs on pages 24-42).

**Provide Information on Physical and Mental Health Diagnoses, Self-Management, Treatment, and Specific Community Resources to Residents and Other Key People (e.g., families, NF staff members, and community agency professionals) Involved in Discharge**

“[We provide information] so that they understand what to expect... explaining over all the diagnoses, behaviors associated with those, medications that they’re on, why they’re on them, how they might interact with each other. The thing that would offer a level of comfort [is] to know this is not unusual behavior.”

“Mental health training [would help with discharge]. Probably just some basic awareness of what to look for as far as what kinds of behaviors are displayed with people that have bipolar or schizophrenia.”

Results from the MDS analysis (Section III, Analysis of MDS Data on pages 60-62) indicate that there is a statistically significant association in which adults without diagnoses of depression, arthritis, emphysema/ COPD, diabetes mellitus, cerebrovascular accident/stroke, or hypertension are more likely to experience only one NF entry and discharge versus multiple NF re-entries. These relationships are supported by findings in the literature (Egede, 2007; Katon, 1996; Reynolds, Haley, & Kozlenko, 2008). Supplementing these findings, results from qualitative interviews (Section III, Interviews with NF Staff starting on page 7) suggest that adherence to medication and treatment recommendations for self-management of chronic physical health and mental health conditions upon discharge may be an additional factor here. Helping people discharge with the various diagnoses mentioned above may require specific
strategies that can seem overwhelming to individuals, if they are not provided adequate information about their diagnoses, treatments, or available community services.

**Information on diagnoses and treatments.** The transitional period before discharging from an NF to the community provides an important window of opportunity to work with residents and their informal support persons and provide them information about physical and mental health diagnoses and treatment. Ensuring individuals and their informal support persons have the information they need can help promote the continued health and well-being of individuals for both recent diagnoses and chronic diagnoses. For more complex treatment recommendations, such as administering self-injected insulin shots and managing oxygen tanks, hands-on assistance from a nurse and/or physical and occupational therapists can help ensure persons and their family members are confident in managing chronic health conditions while living in the community. It can be helpful for NF staff members to model these treatments, and then monitor and guide persons and their family members as they perform these procedures themselves. (See Section III, Interviews with NF Staff starting on page 69 for details on findings related to diagnoses and treatments). Based on our research findings, certain physical health diagnoses require specific consideration and information, namely cerebrovascular accident/stroke, diabetes mellitus, emphysema/COPD, dementia/Alzheimers, and renal/kidney failure. Certain strategies can also be used to help those with mental health diagnoses of anxiety, schizophrenia, and depression. (See Section III, Analysis of MDS Data on pages 61-62 and Interviews with NF Staff on pages 69-73 for details on these findings).

Being direct and emphasizing the importance of this information can prevent NF re-entry and may provide information about what the individuals see as main barriers to living in the community. For example, NF staff should take the time to help individuals and their caregivers learn about the importance of adhering to medical treatments and medicine regimens, as well as identify personal concerns and barriers that may result in noncompliance. (See Section III, Interviews with NF Staff on pages 73-76 for details on this finding). It has been found that individuals are more likely to adhere to their treatment if they have thorough knowledge of their illness and its symptoms (Agarwal, Sharma, & Kumar, 1998). Taking the time to understand individual preferences, circumstances, and concerns can also contribute to compliance with treatment and medication recommendations. Two of the Discharge Briefs were

**Ecological Levels of Influence:**
- **Individual Characteristics & Attributes** (related to the self-management of specific diagnoses)
- **Informal Supports** (to help support adherence to medication and treatment)
- **Community Services** (knowledge of various community options)
- **Societal Norms & Social Policies** (e.g., Chronic Disease Self-Management Program)

(See page 41 for further explanation of the ecological model used in this study).
specifically designed for persons who are discharging and their informal support persons (see Section II, Discharge Briefs 2 and 3 on pages 30-35). Providing these briefs to them prior to discharge may improve rates of successful discharges for this population.

**Information on community services.** In addition to learning about diagnoses and treatment, individuals and informal support persons can benefit from knowing what formal, community supports are available to them. Each community varies in the services that are available, with rural areas tending to have fewer providers and urban areas tending to have more waiting lists. However, most communities do have several formal, community supports available, as evidenced in the NF staff interviews. (See Section III, Interviews with NF Staff on pages 83-84 for more information on rural versus urban areas). Yet, the variety of community services available and the different mix of services they provide can be confusing and overwhelming to individuals. Social workers and other social services staff members should be able to identify community providers and understand their services and eligibility requirements, in order to help persons discharge from the NF to the community. The KDOA resource book, “Explore Your Options,” provides an excellent starting point for individuals to identify community services. In addition, NF social workers can assist individuals and their families in pinpointing the precise formal, community supports that may be beneficial to their unique circumstances and provide them with the tools needed to initiate these services. (See Section III, Interviews with NF Staff on pages 93-98 for details on findings about important community supports. Also see Section II, Discharge Brief 4 starting on page 34). Many of the NF staff members who were interviewed emphasized the importance of utilizing HCBS-waiver services to meet the individual needs of those who discharge. Other important services discussed included: Meals on Wheels, home health (for the first 100 days after discharge), Lifeline, and Community Mental Health Centers (CMHCs). (See Section III, Objective 2 on pages 90-93 for more information).

KDOA’s chronic disease self-management program, Kansans Optimizing Health Program (KOHP), is developing a state-wide infrastructure that increases awareness and supports older adults in their efforts to manage their chronic disease diagnoses and maintain their health status. As AAAs implement KOHP, it will be easier for people who use Medicaid and have mental health diagnoses to access these evidence-based programs. As this population more effectively manages their chronic disease diagnoses, NF re-entries should decrease. To take full advantage of KOHP, we recommend that case managers for Medicaid FE-waiver customers receive information to share with older adults. We also suggest that the people trained to facilitate KOHP receive basic information on depression in older adults, as this was shown to interact with chronic disease diagnoses and contribute to NF re-entry. (See Section III, Analysis of MDS Data starting on page 59 for details on this finding).

**Staff training.** NF staff members and community agency professionals must have sufficient knowledge, themselves, in order to help individuals and their families understand health conditions,
treatments, and various options of community resources. NF staff members that we spoke with were confident that their NFs provided sufficient, ongoing training for their staff members. However, the staff members we interviewed were from NFs who have successfully helped discharge Medicaid residents with mental health diagnoses, and therefore may not be representative of NFs in general. Furthermore, even among the NF staff members we interviewed, additional training and education was suggested. In particular, training in mental health, community resources, and policy regulations were identified as essential for successfully discharging persons using Medicaid who have mental health diagnoses. NF staff members stressed that training in mental health was not only important in helping individuals and their families understand mental health diagnoses, but that it was also important in being able to successfully work with this population. (See Section III, Interviews with NF Staff on pages 106-107 for details on staff training).

**Involve Social Workers and Mental Health Professionals with Expertise in Working with Older Adults in the Discharge Process (to the Extent Possible)**

“I think the critical piece here in our building is that [we] really [have] a team approach … it’s about involving the whole team. And the more people who have a vested interest in this person returning home, the more successful it’s going to be. It’s about involving every member of our interdisciplinary team and getting their input, and then making them a valued part of the process."

As evidenced in our research, many NF residents who discharged to the community had multiple physical and mental health, safety, and psychosocial needs. Therefore, utilizing a multidisciplinary team of qualified personnel throughout the discharge process is important for ensuring continued progress in the NF and for planning for continued support once living in the community. This utilizes the strengths of each of the disciplines involved to increase the likelihood of success for the individual who is discharging to the community. In addition to the individual discharging and informal support persons, discharge teams often include: social workers or other social services staff members; nurses; occupational, physical, and speech therapists; dieticians; mental health professionals; primary care doctors; and community agency professionals, such as representatives from Area Agencies on Aging (AAAs), CMHCs, home health agencies, or home care
agencies. Involving qualified personnel throughout the discharge process is a ‘proactive’ technique in itself. ‘Proactive’ techniques are further discussed on page 15. (See throughout Section III, Interviews with NF Staff starting on page 64 for more information on use of a multidisciplinary team and specifically for home evaluation purposes starting on page 79).

For helping Medicaid recipients with mental health diagnoses discharge from the NF to the community, some of the NF staff members interviewed for the study specifically discussed the importance of including social workers, due to their education and emphasis on advocating for the individuals. In addition, NF staff members stated that identifying mental health professionals with specialized training and experience in aging can be especially helpful for this population.

Social workers. The American Geriatrics Society and the American Association of Geriatric Psychiatry (2003) have stressed the important role that NF social workers have in supporting the mental health needs of residents. Research funded by Centers for Medicare and Medicaid Services (CMS) found that social workers can be especially helpful for “addressing discharge planning needs with a resident-centered context“ (NASW, 2006, pg. 3). Findings from the NF staff members’ interviews support the inclusion of social workers, stating that social workers are confident and prepared to assist with discharging persons to community settings immediately upon taking the job. Due to their education, social workers are trained to have a resident-centered approach to their work and can serve as a bridge between the individual they are working with and doctors or related entities such as hospitals or health agencies, which contributes to successful discharge for persons using Medicaid who have mental health diagnoses. (See Section III, Interviews with NF Staff on pages 103-104 for details on this finding).

Unfortunately, there is currently a shortage of MSW students specializing in aging, at less than 4% of current students, and the shortage is expected to become much more acute (Niedens, 2008). Therefore, continuing to identify and implement strategies to encourage more social work and psychology students to focus their education in geriatrics is extremely important. Increasing the number of MSWs specializing in aging would benefit NF residents and aid the NF discharge process for those using Medicaid.

Mental health and aging. Related to mental health, NF staff members interviewed in this study expressed concern about a lack of professionals with knowledge and training for working with older adults. Indeed, the Alzheimer’s Association Heart of America Chapter has documented the shortage of both social workers and psychiatrists with specialized geriatric training throughout the state (Niedens, 2008). Furthermore, in Kansas, fewer than 10 out of 27 CMHCs provide specialized services for the senior population (Denny, 2010). The Four County Mental Health Center of Independence, KS provides an excellent model of Senior Outreach Services (SOS). A main goal of this SOS is to provide proper community support in order to counter unnecessary NF placements (Denny, 2010). The Johnson County Mental Health Center, based in Mission, KS, provides another good example. This CMHC has three
aging specialists, including one that is nursing facility-based. It is recommended that CMHCs throughout the state add or strengthen mental health services specifically designed for the aging population. (See Section III, Interviews with NF Staff on pages 97-100 for more information about CMHCs). Another option would be to increase the utilization of AAAs for meeting the mental health needs of older adults living in the community in order to increase chances for successful community living. Specifically, persons using Medicaid with mental health diagnoses who discharge from the NF to the community could benefit through the use of Peer Support Programs available in a number of AAAs across Kansas.

**Work with Individuals Who are Discharging to Develop a System of Informal and Formal Supports Prior to Discharge and Ensure Supports Can Be Sustained After Discharge**

“[Those] most successful would be [those that] have the support needed to return to the community, and by support I mean they have either family members that are available to check on them daily or some type of home health or mental health [care to] make sure they are set up with appointments and follow-up with appointments.”

Identifying supports, both formal and informal, is important for meeting individuals’ needs in the community upon discharge from the NF. When persons reside in the NF, there are many services, including medication management, personal care assistance, and meal preparation, that are included in most plans of care. Therefore, it is important to identify if replacement community supports are needed for those moving from the NF who value and depend on these services. Working with the resident to identify potential informal caregivers and the precise supports that they are able to provide can increase success. It was found that the type of informal support that best predicts only one NF entry differed by age for this population. This is another reminder that listening to individual preferences for services and supports increases the chances of positive outcomes. After identifying what informal support is available, it is then important to consider what formal services can fill in the gaps for the individual or the informal caregivers. For those without access to informal supports, identifying a solid system of formal, community supports is necessary. Informal and formal supports are part of a system, and careful coordination and planning is required to ensure that the support system will function as a whole. (See Section III, Interviews with NF Staff on pages 66-67).
Informal supports. Our research findings indicate that the strongest predictor of having one NF admission and discharge versus multiple NF re-entries was the resident having access to informal supports in his or her environment prior to entering the NF. (See Section III, Analysis of MDS Data on pages 61-62 for details on this finding). This finding confirms that informal support persons are an important component for successful discharge to the community for persons using Medicaid with mental health diagnoses. As supported by findings from interviews with NF staff members (Section III, Interviews with NF Staff starting on page 84), using discharge strategies that include informal support persons throughout the discharge process and identifying supports for informal caregivers is especially important. Based on these findings, we recommend that Medicaid policies be developed that provide funding to support and expand informal support systems for individuals using Medicaid who have mental health diagnoses. This could be done in collaboration with AAAs who have initiatives focused on caregiving that can be utilized and strengthened, such as the National Family Caregiver Support Program. Ensuring caregivers have access to the KDOA “Kansas Caregiver Guide” may also be important. It follows that creating systems to support informal caregivers could lead to fewer individuals experiencing multiple NF transitions, and possible shorter stays if NF re-entries do occur.

Sometimes informal supports may be apprehensive about discharge for the individual. When this happened in Wisconsin, centers for independent living provided success stories to informal support persons and connected them to individuals and their caregivers who had already made successful transitions (Eiken, Stevenson, & Burwell, 2002). Providing the Discharge Briefs in Section II to those involved in discharge can help assure people that discharge is possible when a system of supports is made available.

Formal supports. In most circumstances, formal community supports complement informal support. Thus, it is important that informal and formal supports are able to work together. This is best accomplished by beginning the relationship between informal and formal support people prior to actual discharge. As NF staff members develop discharge plans, they should specifically inquire who will be responsible for meeting the individuals’ needs, whether it be the individuals themselves, informal support person(s), or community providers. In addition, some of the NF staff members who were interviewed discussed the importance of having community supports, such as AAA or CMHC case managers, monitor the care provided by informal support systems. (See Section II, Discharge Brief 4 on pages 34-36 and Section III, Interviews with NF Staff on pages 93-94 for details on this finding). This was suggested in order to ensure that caregivers do not become strained or overburdened and that individuals receiving care do not fall victim to abuse or exploitation.

Identifying supports to help Medicaid recipients who have mental health diagnoses manage their medication is particularly important. Individuals who discharge should work with NF staff members or
AAA case managers to identify a system for medication monitoring. For example, informal support persons could monitor medication usage through the use of an electronic pill box or a written chart. In addition, formal community services could be identified to assist with medication, such as a home health nurse or medication aide. (See Section III, Interviews with NF Staff on page 72-75 for more information).

Using strategies to help those discharging locate housing in the community is also an important component of successful discharge and often one of the most challenging tasks. As discussed in Section III, Interviews with NF Staff on pages 78-79, identifying methods for exploring housing options or improving the availability of housing options in the community for the target population is recommended. Identifying and/or continuing to promote supportive housing options could provide a community-based option for individuals with mental health diagnoses that want to live independently, but require some daily support tailored to fit their needs.

**Use Proactive Techniques (e.g., helping residents develop discharge goals, providing residents with comprehensive discharge forms, conducting home evaluations prior to discharge, and providing follow-up contact to residents) To Help Prevent Challenges in the Community and Avoid NF Re-Entry**

“Seeing a resident in their own environment can really give you a different perspective on that resident. People act kind of differently sometimes when they’re in a facility, versus when they’re in their own environment. They may follow all the safety cues for us, but then when they get home, they maybe leave the walker behind. And [the team] can spend an hour or two at somebody’s home making recommendations. And I think we’ve been really successful with that.”

“And then we always, of course, make routine follow-up calls after a couple of weeks of discharge. . . Sometimes people won’t call you, but if you call them, then the questions kind of start to come out.”

When persons discharge from the NF to the community, the system of supports for assistance and monitoring that were available in the NF no longer exist. This can potentially pose challenges for successful community living without an adequate system of informal and formal supports. NF staff members who have successfully discharged Medicaid residents with mental health diagnoses into the community included in this study (Section III, Interviews with NF Staff) recognized that ensuring an adequate system of informal and formal supports requires a number of proactive techniques. Proactive in this context means ‘taking the initiative by acting rather than reacting to events.’ The specific proactive steps discussed by NF staff members who were interviewed included discharge goals, comprehensive discharge forms, home evaluations, and follow-up phone calls. We recommend that KDOA encourages NFs to incorporate these proactive techniques into their discharge plans, as these techniques can help
avoid NF re-entry and thus reduce potential costs for Medicaid. AAAs could also be encouraged to aid NF staff members in completing these tasks.

**Discharge goals.** Upon admission to the NF, discharge planning for both long-term and short-term residents can begin by learning whether or not persons are interested in returning to the community. This allows discharge planning to begin immediately, with setting goals for discharge being the first crucial step. Setting discharge goals empowers residents and their family members to work toward making discharge possible and encourages rehabilitation progress. Furthermore, it is important to align individual and family goals and ideas about community living, as the individuals and families sometimes have very different ideas about discharge. Helping to mediate situations or learning family concerns can help individuals and families to work towards the same plan. Beginning discharge planning early also allows ample time for identifying and implementing the proper supports that will be needed for successful community living. (See Section III, Interviews with NF Staff on pages 75-77 for details on these findings). Utilizing the *Discharge Briefs* (see Section II starting on page 22) early in the discharge process can help with setting discharge goals, working with individuals and family members, and identifying informal and formal supports.

**Comprehensive discharge form.** Utilizing a comprehensive discharge form ensures that a system of formal and informal supports is identified and utilized. It should be noted that not all NFs included in this study used discharge forms, but those that did found such documentation to be very useful for the NF staff, the individuals, and their families. Some NF staff members purchased generalized discharge forms from a medical supply company and then designed an additional form that provides information on local resources. An example of such a form is provided in Appendix C. We are not recommending that all NFs use the same discharge form or forms, rather we are recommending that NFs identify and/or create forms tailored to the individuals they assist and to the communities to which they discharge individuals.

After examining the forms NF staff members provided to us and talking with them about the forms’ contribution to successful discharge, we have some suggestions for the discharge forms. First, the forms should be designed for use by individuals who are discharging and their informal support persons.

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**Ecological Levels of Influence:**
- **Individual Characteristics & Attributes** (e.g., personalized discharge goals)
- **Physical Environment** (e.g., home evaluations)
- **Informal Supports** (e.g., helping align resident and family goals)
- **Community Services** (identification of needed supports)
- **Societal Norms & Social Policies** (e.g., NF policies of using discharge forms and conducting follow-up calls)

*(See page 41 for further explanation of the ecological model used in this study)*.
The forms should minimize medical jargon and have instructions for sharing a copy with the family or other support persons. Second, the forms should emphasize personal preferences and self-determination for the individual who is discharging. Examples include prompting to explore resident preferences, resident goals for discharge, and family goals for discharge, and highlighting that the resident will have several options for services upon discharge. Third, the discharge documentation should include information to assist in planning for diverse physical and mental health, safety, and psychosocial needs. For example, the discharge plans could contain information on home health care, home care, medical equipment, home modifications, medications, nutritional and dietary needs, transportation supports, therapy services, and recreational and leisure pursuits. Finally, an interdisciplinary team should be utilized in making decisions about the forms and what to include on the forms provided to individuals in order to ensure that all of these considerations are taken into account. (See Section III, Interviews with NF Staff on pages 104-105 for additional information about discharge forms).

**Home evaluations.** Conducting home evaluations prior to discharge was a standard practice in several of the NFs included in this study that have successfully discharged Medicaid residents with mental health diagnoses. Home evaluations are an important preventative discharge strategy for identifying support needs. A multidisciplinary team can accompany the individual and their informal support persons to their community residence (e.g., private home or apartment) to assess the home environment and make recommendations concerning home modifications and adaptive equipment. Each team member provides recommendations based on their area of expertise (e.g., physical therapist—how to transfer in and out of bed or to the toilet, occupational therapist—where to place of rugs or furniture to maximize mobility, nurse—how to perform insulin checks, and social worker—to assess relationships with others in the home and consider overall psychosocial well-being). It is important to time the home evaluations appropriately, so that they occur late enough in the rehabilitation process to understand what the individual’s needs are, but early enough in the discharge process to allow for the time necessary to complete home modifications and order equipment. Some NF discharge staff members indicated that they conduct the home evaluations about two weeks before discharge. More detailed information about home evaluations can be found on pages 79-82.

**Follow-up phone calls.** A few NF staff members indicated that they conduct follow-up calls as a standard practice for all individuals who have recently discharged into the community. Staff members found that individuals sometimes realize they could use assistance with something they had not realized or that informal caregivers sometimes become overwhelmed following discharge because the care they are providing was more than they anticipated. Therefore, post-discharge follow-up phone calls can be an appropriate time to reevaluate the needs of individuals. These calls could be completed by NF staff members or AAA case managers—someone who the individual and their caregivers trust. If NF staff
member made the phone calls, this would allow them to receive feedback that could help them tailor discharge strategies for future residents. Providing follow-up phone calls to individuals and their informal caregivers is especially important for those moving to communities with few resources or to areas where they might have difficulties accessing services. (See Section III, Interviews with NF Staff on pages 105-106 for more information).

Take Advantage of Technology for Gathering Information and Providing Support to Persons Who Discharge

“When I started here, I didn’t have the Internet and [I said], ‘How am I supposed to find resources when I don’t have the Internet?’ …I do think technology is an important tool … I’m on a listserv right now of nursing home social workers. The organizer is out of Iowa and it’s helpful. People will come up with an issue [and other people will give suggestions] and they share (assessment) tools on there.”

During discharge, NF staff members often have primary responsibility for identifying formal supports, working with informal support persons, and facilitating teamwork. To this end, the Internet has been an extremely useful technology. Many of the NF staff involved in discharge who were interviewed in this study conduct Internet searches to find affordable medical equipment for residents or to learn more about community service providers.

E-mail and listservs. As discussed by NF staff members who were interviewed, e-mail can be used to improve ease of communication with family members, members of the multidisciplinary team from the NF, and community agency professionals. Further, some NF staff members suggested that e-mail listservs can be helpful for sharing knowledge and ideas about discharge strategies with other NF staff members and community agency professionals. As suggested by NF staff members, developing a state-wide listserv for Kansas NF staff and community agency professionals to share ideas and problem-solve might help make discharge more possible. One NF staff member utilized a national listserv for NF staff and found this resource to be very useful. However, she expressed a desire for a

Ecological Levels of Influence:
- **Individual Characteristics & Attributes** (e.g., use of Internet to meet individual needs and preferences)
- **Physical Environment** (e.g., use of interactive pillboxes and webcams to ensure safety of the home)
- **Informal Supports** (e.g., accessing information and communicating with NF staff)
- **Community Services** (e.g., networking and sharing ideas with various professionals)
- **Societal Norms & Social Policies** (e.g., policies for ensuring Internet access or developing professional listservs, norms regarding the use of the Internet)

(See page 41 for further explanation of the ecological model used in this study).
listserv specific to Kansas aging professionals, as many questions and concerns are specifically related to state policies and services. Several other NF staff members agreed that a state-wide listserv would be useful. (See Section III, Interviews with NF Staff on page 92-93 for details on the use of e-mail and the Internet for helping ensure successful discharge).

Unfortunately, not all NFs have Internet access and/or professional e-mail accounts that they can use for this purpose. Even in working to obtain participants for this study, we found a number of NF staff members did not have access to the Internet and/or did not utilize e-mail. Therefore, ensuring NF staff and community agency professionals have access to professional e-mail accounts and exploring the option of establishing a state-wide listserv for sharing ideas among professionals may be helpful options for improving discharge rates.

We make these recommendations about the Internet and use of e-mail carefully, as ensuring privacy and confidentiality is a primary concern when utilizing these types of technology for the purposes suggested above. Some NF staff members or community agency professionals may be apprehensive about using the Internet and e-mail in their work due to concerns about privacy and confidentiality for their clients. This is a critical concern. It is crucial that NFs utilize adequately secured and protected Internet networks and that professionals learn ethical ways to share information via e-mail or the Internet.

**New technology.** Different types of innovative technology can also be of assistance to individuals who are discharging to the community. New technological devices can help to monitor individuals living in the community or to manage their medication. A study by the National Institute on Aging suggested that older adults are less likely to miss medications when using electronic pillboxes (Mozes, 2008). There are many varieties of these pillboxes. One NF staff member discussed an interactive pillbox that dispenses pills by opening a drawer at the correct time. If the individual does not close the drawer, a support person is notified. Other electronic pillboxes beep, announce the number of pills to take, and explain how to ingest certain pills. (See Section III, Interviews with NF Staff on page 73 for more information).

Another NF staff member suggested web camera technology to families as one way they can better monitor their older adult family member. Some older adults have found Internet and e-mail technology to be useful, in learning about their medical conditions or in reducing isolation. A similar use can now be found in cellular phones; there are newly developed cellular phone applications that act as “a therapist in your pocket.” These applications track individuals’ moods throughout the day, offer helpful tips and exercises, and can produce long-term charts and graphs that can deepen mental health providers’ understanding of the individual (Trudeau, 2010). During the discharge process, NF staff members can assess whether individuals and their family members are comfortable using technology and have access to
such technology. If they do have access, it is important to determine if they need training on how to use these devices or help finding credible support groups online.

**Work to Ensure Continuity of Care Across Nursing Facility and Community Setting**

“[With] this one person in particular that I’m thinking of, this person had a caseworker [from the CMHC]. The caseworker would come in once a week and talk with her and take her out into the community. They would go shopping, you know, gradually re-introducing them to the community ... which really works for the best, because they’re panicky when they’ve been in such a controlled environment.”

As individuals transition from the NF to the community, it is important to maintain a continuity of care across these different residences. With each transition, there is a risk of service lapse and thus, increased anxiety. Prior to entering the NF, many individuals had already established primary care linkages with physicians and/or psychiatrists. Several NF staff members interviewed who have successfully discharged residents stressed that it is important to offer incoming residents the choice of continuing to use their private healthcare providers. Alternatively, it may be helpful for residents to continue to use healthcare providers utilized while living in the NF once they return to the community. Many NFs employ in-house physicians and psychiatrists that also work privately. In such instances, NF staff members should inform discharging residents that they can continue to use those medical providers in the community, if they so desire. This is important, as data indicates that there is a strong correlation between increased interaction with a personal physician and medication adherence (Keckley, 2003). (See Section III, Interviews with NF Staff on pages 98-100 for details on this finding).

If individuals plan to use new services once they are discharged to the community, it is helpful to initiate these services prior to actual discharge. For example, NF staff told us that it is very helpful if residents can meet with caseworkers from the AAA or CMHC while they are still residing in the NF. Establishing these relationships early can ease the anxiety associated with the transition and also better ensure that the individual will continue with these services once in the community. However, limitations to this strategy do exist for people receiving Medicaid, because community providers cannot bill for services that NFs are expected to provide while the person is an NF resident. In particular, a few of the

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**Ecological Levels of Influence:**

- **Individual Characteristics & Attributes** (e.g., reducing anxiety)
- **Community Services** (e.g., health providers providing services across NF and community settings)
- **Societal Norms & Social Policies** (e.g., policies to support or prevent community providers from providing services across settings)

(See page 41 for further explanation of the ecological model used in this study).
NF discharge staff were very concerned about the inability to draw on CMHC services while individuals reside in NFs. While avoiding a duplication of services is important to controlling budgets for public expenditures, if a short-term overlapping of services just prior to discharge was allowed, it is possible that long-term savings would occur as community living would be more successful. However, this structure is not currently in place. When community services cannot be provided for residents living in NF, it is important that there is sufficient planning to allow these services to begin immediately upon discharge.

The recommendations delineated above were based on findings from our study. We also developed *Discharge Briefs* for use by persons who are discharging from the NF to the community, their informal support persons, NF staff members, and community agency professionals. These strategy briefs, which fulfill Objective 4, can be found in Section II of the report. Section III of the report contains *Detailed Research Findings* that provides further details from the research we conducted to fulfill Objectives 1-3.
Section II: Discharge Briefs

Five *Discharge Briefs* were designed to help older persons who use Medicaid and have mental health diagnoses transition from the NF to the community. Staff members of NFs who have helped older persons with diagnoses of anxiety, bipolar disorder, or schizophrenia successfully discharge from the NF to the community suggested and use the discharge strategies discussed in these briefs. We developed these *Discharge Briefs* in consultation with representatives from KDOA. A representative from a Consumer-Run-Organization (CRO) in Kansas also reviewed these briefs, finding the information to be “right on target” for helping persons with mental health diagnoses successfully discharge to the community. These briefs can be printed, copied, and disseminated to relevant individuals or uploaded onto a website for individuals to access.

- Discharge Brief 1—*Successful Discharge Scenarios*
- Discharge Brief 2—*Diagnoses and Follow-Up*
- Discharge Brief 3—*Informal Assistance*
- Discharge Brief 4—*Community Supports*
- Discharge Brief 5—*Essential Elements for Successful Discharge*
Discharge Brief 1: Successful Discharge Scenarios

The following brief, Discharge Brief 1—Successful Discharge Scenarios, is intended for NF staff members to use to help facilitate discharge for Medicaid residents with mental health diagnoses. The case examples used in the brief are based on actual discharges. The information was provided by NF staff who have successfully discharged Medicaid residents to the community; however, the names and details of the cases were changed to protect confidentiality.
Discharge Brief 2: Diagnoses and Follow-Up

The following brief, Discharge Brief 2—Diagnoses and Follow-Up, can be used by individuals using Medicaid with mental health diagnoses to help them work towards a successful discharge from the NF to a community setting.
Discharge Brief 3: Informal Assistance

The following brief, Discharge Brief 3—Informal Assistance, can be used by family, friends, and other community members as they help individuals using Medicaid with mental health diagnoses discharge from the NF to the community.
Discharge Brief 4: Community Supports

The following brief, Discharge Brief 4—Community Supports, is designed for community agency professionals and NF staff members to use while helping individuals using Medicaid with mental health diagnoses plan for discharge from the NF to the community.
Discharge Brief 5: Essential Components for Successful Discharge

The following brief, Discharge Brief 5—*Essential Components for Successful Discharge*, can be used by NF staff members to facilitate discharge for residents using Medicaid with mental health diagnoses to the community.
Section III: Detailed Research Findings

Study Framework

This study utilized an ecological model as a framework for understanding discharge strategies at multiple levels (e.g., individual, community, society). The ecological perspective focuses on how people and environments shape each other and recognizes that many systems interact to influence outcomes (e.g., NF discharge to the community). The ecological perspective highlights various components of people’s environments including social networks, organizations, communities, and public policies (Richard, Potvin, Kishchuk, Prlic & Green, 1996; Sanders, Fitzgerald, & Bratteli, 2008). This perspective addresses daily competence and recognizes that discharge is a multi-dimensional occurrence best understood as the outcome of transactions overtime between the person and environment (Green & Sullivan, 2004).

We used an ecological model to consider how the various systems interact to enable NF discharge. In addition, the ecological model helped us identify discharge strategies that capitalize on people’s strengths to overcome systemic barriers. Figure 1 provides a pictorial representation of the ecological model we used for this project. In this model, NF discharge to the community is the outcome. There are five systems, or levels, of potential influence to the outcome.

Figure 1. Ecological Model for NF Discharge to the Community

At the first level are the individual characteristics and attributes that influenced discharge for those reentering the community. These include gender, mental health diagnosis, income status (using
Medicaid), etc. Focusing on this first level helped tailor strategies based on specific resident attributes and circumstances. At the second level, we considered strategies that addressed the physical environment. The physical environment includes features of the community, neighborhood, and physical structure of the home (e.g., urban/rural, available housing, specialized group living, continuing care retirement communities (CCRCs)). Third, we concentrated on strategies that identified, utilized, and sustained informal supports. Informal supports for community living include assistance and encouragement from family, friends, and neighbors. Fourth, we identified strategies that addressed service needs in the community (e.g., home health, mental health, transportation, meals). Finally, we considered strategies for addressing societal norms that mitigated against discharge (e.g., stigma) as well as strategies that are influenced by social policies (e.g., HCBS waiver, Older Americans Act).

As we worked to identify specific strategies for discharging NF residents to the community, the ecological model guided our selection of variables that represented demographic characteristics and other attributes for the Analysis of MDS Data as well as the selection of questions to ask during Interviews with NF Staff. Finally, this model helped organize the presentation of the findings from the study.

Analysis of MDS Data

Adults With Mental Health Diagnoses Who Use Medicaid and Discharged from the Nursing Facility to a Community Setting, and Their Transition Patterns (Objectives 1 & 3)

This section describes adults who discharged at least once from an NF to a community setting, had mental health diagnoses, and used Medicaid (Objective 1). It also examines the patterns of NF discharge and re-entry patterns for these adults (Objective 3). Findings confirm that residents with mental health diagnoses and a wide variety of other characteristics and attributes have discharged from the NF to the community. Knowing the relationships between type of discharge pattern and ecological factors from different individual and environmental levels (e.g., demographic characteristics, informal supports, community services) point to successful strategies for transitioning NF residents to the community. The findings also provide important background information that will be be integrated with information on discharge strategies provided by NF staff members (Objective 2). We distilled these findings to create the Overall Study Recommendations. Implementation of new and more effective strategies will increase the number of NF residents with mental health diagnoses who are able to discharge to community settings. Ultimately, this will result in a decrease in Medicaid expenditures.

Table 1 lists variables from MDS data by ecological level. We describe and report the demographic characteristics and other attributes of the sample within the framework of the ecological model on pages 47-54. This approach gave us a comprehensive understanding of the environments of
those discharging from NFs. It also provided a structure for the research design for completing Objective 3.

Table 1. The Ecological Model\(^1\) Applied to Demographic Characteristics and Other Attributes in the Minimum Data Set

<table>
<thead>
<tr>
<th>Individual Characteristics and Attributes</th>
<th>Physical Environment</th>
<th>Informal Supports</th>
<th>Community Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preference to return to the community</td>
<td>Rural/urban status prior to discharge</td>
<td>Daily contact with relatives/close friends</td>
<td>Discharged with home health or AL/RHC services</td>
</tr>
<tr>
<td>Age at time of discharge</td>
<td>Planning Service Area (PSA)</td>
<td>Support person positive towards discharge</td>
<td>Residential services received in previous 5 years</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td>Lived alone</td>
<td>Prior NF stay, Residential facility (AL, RHC, etc)</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td>Marital status</td>
<td>MH/psychiatric setting, MR/DD setting</td>
</tr>
<tr>
<td>Functional status (activities of daily living)</td>
<td></td>
<td></td>
<td>Location immediately prior to NF admission</td>
</tr>
<tr>
<td>Cognitive status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnoses:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Alzheimer’s disease or other dementia,</td>
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<td></td>
<td></td>
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<tr>
<td>Arthritis, COPD/Emphysema,</td>
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<td></td>
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<tr>
<td>Diabetes mellitus, Depression,</td>
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<td></td>
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<tr>
<td>Cardiovascular accident (stroke),</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hypertension, Severe Mental Illness,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MR/DD</td>
<td></td>
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<tr>
<td>Fell in past 30 days</td>
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<td></td>
<td></td>
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<tr>
<td>Medication Use:</td>
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<td></td>
<td></td>
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<tr>
<td>Total number, Antipsychotic, Antianxiety</td>
<td></td>
<td></td>
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</tbody>
</table>

\(^1\)See pgs. 41-42 for an explanation of the ecological model and its application to this study.

First, we present the specific characteristics and attributes of a sample of individuals with diagnoses of anxiety, bipolar disorder, and/or schizophrenia who discharged from the NF to the community. This includes individuals’ specific mental health diagnoses, average length of stay in the NF prior to discharge, and frequencies of the specific demographic characteristics and other attributes. Next, we describe prominent NF discharge and re-entry patterns and indicate how groups with similar demographic characteristics and other attributes are associated with different transition patterns.
**Summary of Main Findings**

- 720 adults with anxiety (69.0%), bipolar disorder (21.8%), and/or schizophrenia (20.4%) who use Medicaid successfully discharged from the NF to the community; some had multiple mental health diagnoses.
  - Upon entry, these adults were anticipated to have both short-term NF stays (46.1%) and long-term NF stays (17.2%); others were uncertain about length of stay (36.7%).
  - 73 adults with mental health diagnoses who use Medicaid (10.1%) discharged to the community after residing in the NF for 6 months or more.
  - These adults discharged from NFs in urban (56.3%), mid-size (13.6%), and rural (12.6%) settings across all 11 PSA regions.
- The 720 adults with mental health diagnoses who use Medicaid and who successfully discharged from the NF to the community had a wide range of characteristics and attributes.
  - These adults were 20 to 100 years old ($m=64.7$ years; $SD = 15.4$).
  - Some adults (35.0%) were independent in late loss ADLs (i.e., bed mobility, toilet use, transferring, eating); others used extensive assistance with bed mobility (41.8%), toilet use (29.6%), transferring (31.8%), and eating (66.8%).
  - Many of these adults had one or more chronic diseases (e.g., hypertension (62.5%), depression (54.9%), diabetes (36.8%).
- Nearly all, 97.4% of the 615 adults in the subgroup for the NF discharge and re-entry patterns analysis experienced 1-3 stays in an NF
  - From the time of their base admission, 61.1% discharged from the NF to the community and did not

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**Methodology for Objective 1**

Data from the Minimum Data Set (MDS) 2.0 provides comprehensive information about older adults at admission to an NF, quarterly and annual reassessments, and upon discharge. These data allowed us to study the characteristics of a sample of residents who entered into and discharged from Kansas NFs and long-term care units (LTCUs). The sample included 720 individuals who:

1) were admitted to an NF and discharged to the community at least once July 2005 through June 2008,
2) had a mental health diagnosis, and
3) used Medicaid insurance.

We used data from July through December 2008 for follow up. This gave us an additional 6 months to track NF re-entries and discharges following the individuals’ base admission.

We conducted univariate analyses (i.e., frequency, range, mean, and standard deviation) to provide a description of the overall sample as well as the subset aged 65 years and older. This allowed us to describe the breadth and range of the sample’s demographic characteristics and other attributes at the time of the earliest NF admission and discharge that occurred following July 1, 2005. Note that records showed evidence of prior NF admission(s) for 105 of these 720 adults. (See Appendix B for detailed methodology.)
re-enter the NF over the course of the study and 6 month follow up period.²

- Certain diagnoses were related to higher risk of multiple NF admissions and discharges. These included: depression, emphysema/ COPD, diabetes mellitus, cerebrovascular accident/stroke, hypertension.

- Having access to informal supports predicted NF discharge and re-entry patterns depending on age groups; age groups alone were not a statistically significant predictor of these transitions.

*How many people discharged from the NF to a community setting with each of the mental health diagnoses? (Objective 1)*

**Number of NF Residents Using Medicaid Who Discharged to the Community in the Sample**

Between July 1, 2005, and June 30, 2008, there were 720 people³ who received Medicaid, had a diagnosis of anxiety disorder, manic depression (bipolar disorder), or schizophrenia, and discharged to a community setting. Among those who discharged to the community, 69.0% \( (n = 497) \) had a diagnosis of anxiety disorder, 21.8% \( (n = 157) \) had a diagnosis of bipolar disorder, and 20.4% \( (n = 147) \) had a diagnosis of schizophrenia. There were 75 individuals \( (10.4\%) \) with more than one mental health diagnosis, which we illustrate with overlapping circles in Figure 2. For example, 27 individuals in the total sample \( (3.8\%) \) reported both an anxiety disorder and bipolar disorder. Among those who discharged, 372 individuals \( (51.7\%) \) were aged 65 years and older. For those aged 65+, 84.1% \( (n = 313) \) had a diagnosis of anxiety disorder, 10.2% \( (n = 38) \) had a diagnosis of bipolar disorder, and 11.3% \( (n = 42) \) had a diagnosis of schizophrenia. Figure 2 illustrates the unduplicated percentage of individuals with one mental health diagnosis or a specific combination of mental health diagnoses for the population 20-64 years of age as well as for those aged 65 years and older. As shown in Figure 2, a higher proportion of individuals 65+ had a diagnosis of anxiety disorder than the total sample, whereas the total sample had higher proportions of diagnoses of bipolar disorder and schizophrenia.

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² Some of the adults may have died while living in the community.
³ There were a total of 3,488 individuals using Medicaid who discharged to the community during the study timeframe.
What was the average length of stay in NFs for Medicaid individuals with mental health diagnoses who discharged from the NF to the community? (Objective 1)

Length of Stay in NFs

Following their primary admission, individuals spent, on average, 83 days in the NF before discharging to a community setting. The length of stay for individuals ranged from 0 to 997 days (2.7 years),\(^4\) with 539 individuals (74.9%) discharging within 90 days and 647 individuals (89.9%) discharging within six months. Almost 96 percent of the discharges \((n = 690)\) occurred within one year of admission to the NF. Figure 3 highlights the number of individuals by age group (20-64 and 65+) who discharged within one year of NF admission in 30-day increments.
Although not displayed in Figure 3, 30 individuals using Medicaid (4.2%) discharged after residing in the NF for one year, three of which discharged after residing in the NF for two years. Upon admission, 332 of the 720 individuals in the sample (46.1%) were projected to have a short-term NF stay (i.e., less than 90 days). Yet 539 individuals (74.9%) discharged within 90 days. There were 264 individuals (36.7%) with an uncertain discharge status at admission and 124 individuals (17.2%) were not projected to discharge within 90 days. In addition, it is important to note that 608 individuals (84.4%) indicated a preference to return to the community at the time of their NF admission, and 112 individuals (15.6%) did not indicate a preference to return to the community. Yet all 720 individuals did, in fact, return to a community setting.

What is the breadth and range of demographic characteristics and other attributes among individuals who use Medicaid, have mental health diagnoses, and have discharged from the NF to a community setting? (Objective 1)

Demographic Characteristics and Attributes

The 720 individuals identified in this study represented a diverse group of NF residents who successfully discharged to the community. These individuals ranged in age from 20 to 100 years. The sample’s physical and cognitive health attributes represented a broad range of functioning in activities of daily living and cognition as well as various physical health diagnoses. Residents discharged from NFs located in urban and rural counties as well as from NFs located in each of the 11 Planning Service Areas (PSAs). Many of these individuals had informal supports such as daily contact with relatives or close
friends and a support person positive toward discharge; however, not all individuals who discharged to the community had these informal supports. In addition, the utilization of community services both prior to NF admission and following NF discharge varies for the individuals in the sample. In the next sections, we describe in some detail the many characteristics and attributes of individuals who successfully discharged from the NF to the community.

Individual Characteristics and Attributes

Individuals who discharged from the NF ranged in age from 20 to 100 years, with an average age of 64.7 years ($SD = 15.4$). For those aged 20 to 64, the average age was 51.7 years ($SD = 9.4$), and for those aged 65 and older, the average age was 76.8 years ($SD = 8.4$). Approximately seventy percent of the sample was female and thirty percent was male. In addition, the majority (88.5%) was White, non-Hispanics. Table 2 highlights these demographic characteristics for the total sample as well as variations present when examining only those aged 65 years and older.

<table>
<thead>
<tr>
<th>Table 2. Demographic Characteristics for Medicaid NF Residents with Mental Health Diagnoses Who Discharged to the Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Sample ($N = 720$)</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Average age at time of discharge</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>$64.7$ ($15.4$)</td>
</tr>
<tr>
<td>n (%)</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Gender$^1$</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Race/ethnicity$^1$</td>
</tr>
<tr>
<td>White, not of Hispanic origin</td>
</tr>
<tr>
<td>Black, not of Hispanic origin</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

$^1$ Totals do not equal 720 due to missing values: Gender ($n = 2$), Race/ethnicity ($n = 12$).

In addition to demographic characteristics, we examined multiple physical and cognitive health attributes of individuals at the time of their admission assessment. It is important to note that individuals’ physical and cognitive health status might reasonably change in the NF, especially for those who enter the NF for short-term rehabilitation. Yet it is helpful to understand these attributes in order to facilitate successful discharges to the community.

We examined the functional status of individuals by calculating the RUG-III Activities of Daily Living (ADL) Index, which is based on four late loss ADLs: bed mobility, toilet use, transfer, and eating (Fries et al., 1994). The RUG-III ADL Index ranges from 4 (independent) to 18 (dependent). The average score for the total sample was $8.9$ ($SD = 4.5$) and the average score for those aged 65+ was
slightly higher at 9.5 \( (SD = 4.3) \). In the total sample, there were 252 individuals (35.0\%) with a RUG-III ADL Index score of 4 at admission, indicating that they were independent or required only supervision in order to complete each of the four late loss ADLs. Figure 4 highlights individuals’ self-performance with each of the late loss ADLs used to calculate the RUG-III ADL Index. As illustrated in Figure 4, there were a number of individuals needing extensive or complete assistance with toilet use, bed mobility, and transferring who discharged to the community.

**Figure 4. Self-Performance in Late Loss ADLs for the Medicaid NF Residents with Mental Health Diagnoses Who Discharged to the Community (\( N = 720 \))^1**

<table>
<thead>
<tr>
<th>Bed Mobility</th>
<th>Total</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toilet Use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Totals do not equal 720 due to missing values: Toilet use (n = 1), Transfer (n = 3).

To examine individuals’ cognitive status, we utilized the Cognitive Performance Scale.\(^5\) Overall, 472 individuals (65.6\%) had intact or borderline intact cognitive performance whereas 15 individuals (2.1\%) had severe or very severe cognitive impairment. Table 3 highlights the cognitive status of individuals in the total sample as well as those aged 65 years and older.

Table 3 also highlights the number of individuals in the sample with specific physical and mental health diagnoses, the number of individuals who fell in the past 30 days, and medication usage. Approximately one in eight Medicaid individuals who discharged from the NF to a community setting had Alzheimer’s disease or another dementia diagnosis (\( n = 97, 13.5\%) \). In addition, 265 individuals

\(^5\) The Cognitive Performance Scale specifies individual’s cognitive status, ranging from 0 (intact) to 6 (very severe impairment). This scale is based on the following MDS items: a) comatose, b) short-term memory, c) cognitive skills for daily decision making, d) making self understood, and e) eating self-performance (Morris et al., 1994).
(36.8%) had diabetes mellitus and 395 individuals (54.9%) had a diagnosis of depression. There were 259 individuals who fell within the past 30 days (36.0%). The number of medications taken by these individuals at admission ranged from 0 to 46, with the average individual taking 13.4 medications. Based on the standard deviation, we found that 95% of the individuals in the sample were taking between 2.2 and 24.6 medications. Finally, there were 300 individuals (41.7%) taking antipsychotics at least once a week and 349 individuals (48.5%) taking antianxiety medications at least once a week.

Table 3. Physical and Cognitive Health Attributes for Medicaid NF Residents with Mental Health Diagnoses Who Discharged to the Community

<table>
<thead>
<tr>
<th>Total Sample (N = 720)</th>
<th>Older Adults (n = 372)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cognitive status</strong></td>
<td><strong>n (%)</strong></td>
</tr>
<tr>
<td>Very Severe Impairment</td>
<td>4 (0.6)</td>
</tr>
<tr>
<td>Severe Impairment</td>
<td>11 (1.5)</td>
</tr>
<tr>
<td>Moderately Severe Impairment</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Moderate Impairment</td>
<td>126 (17.5)</td>
</tr>
<tr>
<td>Mild Impairment</td>
<td>107 (14.9)</td>
</tr>
<tr>
<td>Borderline Intact</td>
<td>202 (28.1)</td>
</tr>
<tr>
<td>Intact</td>
<td>270 (37.5)</td>
</tr>
<tr>
<td><strong>Diagnoses</strong></td>
<td></td>
</tr>
<tr>
<td>Alzheimer’s Disease or Other Dementia</td>
<td>97 (13.5)</td>
</tr>
<tr>
<td>Arthritis</td>
<td>192 (26.7)</td>
</tr>
<tr>
<td>COPD/Emphysema</td>
<td>242 (33.6)</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>265 (36.8)</td>
</tr>
<tr>
<td>Cardiovascular Accident (Stroke)</td>
<td>80 (11.1)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>451 (62.6)</td>
</tr>
<tr>
<td>Chronic Disease Co-morbidity(^1) (Range 0-5)</td>
<td>1.7 (SD 1.1)</td>
</tr>
<tr>
<td>Depression</td>
<td>395 (54.9)</td>
</tr>
<tr>
<td>History of Severe Mental Illness(^2)</td>
<td>172 (23.9)</td>
</tr>
<tr>
<td>Mental Retardation/Developmental Disability</td>
<td>50 (6.9)</td>
</tr>
<tr>
<td><strong>Fall in Past 30 Days</strong></td>
<td>259 (36.0)</td>
</tr>
<tr>
<td><strong>Medication Use</strong></td>
<td></td>
</tr>
<tr>
<td>Average Number of Medications (Range 0-46)</td>
<td>13.4 (SD 5.6)</td>
</tr>
<tr>
<td>Antipsychotics (1-7 days/week)</td>
<td>300 (41.7)</td>
</tr>
<tr>
<td>Antianxiety (1-7 days/week)</td>
<td>349 (48.5)</td>
</tr>
</tbody>
</table>

\(^1\) Number of chronic diseases: arthritis, COPD Emphysema, Diabetes mellitus, Cardiovascular accident (stroke), and hypertension.

\(^2\) We identified those with a history of severe mental illness by a positive response to MDS item AB9.
Physical Environment

Based on the county-level urban influence codes\(^6\) (UIC) assigned to each NF, we found that there were individuals residing in NFs in all types of counties who discharged to a community setting. As displayed in Figure 5, there was a large concentration of discharges for individuals residing in NFs in the most urban counties \((n = 199\) in UIC 1, \(n = 206\) in UIC 2) as well as for NFs in counties considered more midsize \((n = 98\) in UIC 5) and more rural \((n = 91\) in UIC 8). However, there were discharges occurring in NFs throughout the urban influence code continuum, which highlights the capacity of individuals in urban as well as rural areas to discharge from the NF to community settings.

**Figure 5. Number of Medicaid Individuals with Mental Health Diagnoses who Discharged From NFs to the Community, By Rurality of the NF \((n = 715)\)^1,2**

![Bar graph showing the number of Medicaid individuals with mental health diagnoses who discharged from NFs to the community, by rurality of the NF.](image)

1 Total does not equal 720 due to 5 missing values.
2 Comparing the number of discharges in different urban influence codes should be avoided due to variations in population and number of NF beds.

We also examined the number of Medicaid individuals with mental health diagnoses who discharged to a community setting by Planning Service Area (PSA). As indicated in Figure 6, there were community discharges from NFs in each of the 11 PSAs.

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\(^6\) The 2003 urban influence codes published by the Economic Research Service of the U.S. Department of Agriculture measure rurality by assigning all U.S. counties to a 1 to 12 scale with 1 = the most urban and 12 = the most rural (U.S. Department of Agriculture, Economic Research Service, 2003).
Figure 6. Number of Medicaid Individuals with Mental Health Diagnoses who Discharged From NFs to the Community, By PSA of the NF ($n = 715$)$^1,2$

![Bar chart showing the number of Medicaid individuals aged 20-64 and 65+ by PSA.]

$^1$ Total does not equal 720 due to 5 missing values.
$^2$ Comparing the number of NF discharges in different PSAs should be avoided due to variations in population and number of NF beds.

**Informal Supports**

Next, we examined potential informal supports available to individuals who discharged to the community. For those who discharged, 534 individuals (74.2%) had daily in-person or telephone contact with relatives or close friends in the year leading up to NF admission. In addition, 500 individuals (69.4%) had a support person positive towards discharge at the time of admission. In contrast, there were 181 individuals (25.1%) who discharged that did not have daily contact with relatives or close friends in the year prior to NF admission, and 220 individuals (30.6%) who discharged without an indicated support person positive towards discharge. Table 4 highlights these findings as well as individuals’ living arrangements immediately prior to NF admission and their marital status at admission.
Table 4. Informal Supports for Medicaid NF Residents with Mental Health Diagnoses Who Discharged to the Community1

<table>
<thead>
<tr>
<th></th>
<th>Total Sample (N = 720)</th>
<th>Older Adults (n = 372)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily contact with relatives/close friends</td>
<td>534 (74.2)</td>
<td>288 (77.4)</td>
</tr>
<tr>
<td>Support person positive towards discharge</td>
<td>500 (69.4)</td>
<td>250 (67.2)</td>
</tr>
<tr>
<td>Lived alone2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>327 (45.4)</td>
<td>162 (43.5)</td>
</tr>
<tr>
<td>Yes</td>
<td>311 (43.2)</td>
<td>160 (43.0)</td>
</tr>
<tr>
<td>Another NF</td>
<td>81 (11.3)</td>
<td>49 (13.2)</td>
</tr>
<tr>
<td>Marital status2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>106 (14.7)</td>
<td>62 (16.7)</td>
</tr>
<tr>
<td>Widowed</td>
<td>198 (27.5)</td>
<td>175 (47.0)</td>
</tr>
<tr>
<td>Divorced</td>
<td>235 (32.6)</td>
<td>101 (27.2)</td>
</tr>
<tr>
<td>Separated</td>
<td>12 (1.7)</td>
<td>2 (0.5)</td>
</tr>
<tr>
<td>Never married</td>
<td>165 (22.9)</td>
<td>30 (8.1)</td>
</tr>
</tbody>
</table>

1 This data was collected on the MDS admission assessment.
2 Totals do not equal 720 due to missing values: Lived alone \(n = 1\), Daily contact \(n = 5\), Marital status \(n = 4\).

Community Services

The final component of the ecological model examined utilizing MDS data was community services. The data on community services available on the MDS admission assessment and discharge tracking form are limited. In particular, we note that the MDS does not indicate whether individuals utilized the Home- and Community-Based Services Frail Elderly Waiver (HCBS-FE), which is of particular interest since this study, focuses solely on individuals with Medicaid. Thus, we briefly present the available MDS information on community services here and will further explore the utilization of community-based services when describing discharge strategies (Objective 2).

Of the 720 Medicaid individuals with mental health diagnoses who discharged to the community between July 2005 and June 2008, 572 individuals (79.4%) discharged to a private home or apartment and 148 individuals (20.6%) discharged to an assisted living or residential health care (AL/RHC) facility. The data on community services provided by the MDS discharge tracking form is focused on home health and AL/RHC services. Based on this information, we found that 459 individuals (63.8%) discharged from the NF to the community with home health \(n = 311\) or AL/RHC services \(n = 148\). Overall, 681 discharged from the NF without an anticipated return, whereas 34 individuals discharged with a return anticipated. Additionally, five individuals discharged to the community prior to the completion of their admission assessment, so their anticipated return was not recorded.

Among those who experienced a discharge from the NF to a community setting, 226 individuals (31.4%) had an NF stay in the five years leading up to their primary admission and discharge.
Immediately prior to admission, 478 individuals (66.3%) were in an acute care hospital and 109 individuals (15.1%) were admitted from a private home. Table 5 highlights residential services received by individuals in the five years prior to NF admission as well as the location of individuals immediately prior to admission.

Table 5. Community Services Received Prior to NF Admission for Medicaid NF Residents with Mental Health Diagnoses Who Discharged to the Community

<table>
<thead>
<tr>
<th></th>
<th>Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N = 720)</td>
</tr>
<tr>
<td></td>
<td>n (%)</td>
</tr>
<tr>
<td>Residential services in previous 5 years</td>
<td></td>
</tr>
<tr>
<td>Nursing facility stay</td>
<td>226 (31.4)</td>
</tr>
<tr>
<td>Residential facility (AL, RHC, group home)</td>
<td>106 (14.7)</td>
</tr>
<tr>
<td>MH/psychiatric setting</td>
<td>57 (7.9)</td>
</tr>
<tr>
<td>MR/DD setting</td>
<td>8 (1.1)</td>
</tr>
<tr>
<td>None of the above</td>
<td>378 (52.5)</td>
</tr>
<tr>
<td>Location immediately prior to NF admission</td>
<td></td>
</tr>
<tr>
<td>Acute care hospital</td>
<td>478 (66.3)</td>
</tr>
<tr>
<td>Private home</td>
<td>109 (15.1)</td>
</tr>
<tr>
<td>Nursing home</td>
<td>47 (6.5)</td>
</tr>
<tr>
<td>Psychiatric hospital</td>
<td>38 (5.3)</td>
</tr>
<tr>
<td>Assisted living</td>
<td>21 (2.9)</td>
</tr>
<tr>
<td>Rehabilitation hospital</td>
<td>16 (2.2)</td>
</tr>
<tr>
<td>Other</td>
<td>12 (1.7)</td>
</tr>
</tbody>
</table>

What are the prominent transition patterns between NFs and community settings? (Objective 3)

Transition Patterns Between NFs and Community Settings

Prominent Patterns. The number of NF to community discharges mostly ranged from 1-5, though one individual experienced seven discharges, and one other experienced eight discharges. This confirms that some individuals experience what some NF staff members refer to as a “ping pong pattern.” However, the vast majority (97.4%) of those who have mental health diagnoses and use Medicaid experienced 1-3 stays in an NF from their base admission up through the 6 month follow up period ending December 31, 2008.
Four prominent transition patterns emerged from these data on number of discharges, re-entries, and last documented residence. These patterns reflect the number of times that individuals discharged from an NF, re-entered an NF, and whether the last residence documented at the end of the 6 month follow-up period was an NF or the community. These patterns included the transitions listed below.

1. One transition: discharge from the NF to the community (last documented residence: community)
2. Two transitions: discharge from the NF to the community, and re-entry into an NF (last documented residence: NF)
3. Three or more transitions with the last documented residence in the community
4. Three or more transitions with the last documented residence in the NF

Figure 7 illustrates the percent of people who experienced each type of transition. Regardless of the number of discharges, the percentage of adults whose last documented residence was the community was higher than the percent whose last documented residence was the NF. Over half ($n = 376, 61.1\%$) of the individuals experienced only one NF admission followed by a discharge to the community (transition pattern 1). Another 91 people (14.8\%) had multiple NF admissions and discharges, with the last documented residence in the community by the end of the 6 month follow-up period. Thus, a full 75.9\% of this often considered impossible-to-discharge group of people who used Medicaid and had mental health diagnoses did discharge from NFs and did not have record of re-entry into an NF by the end of the follow-up period.

**Methodology for Objective 3**

For the Objective 3 analysis, the sample included 615 individuals who:
1) were admitted to an NF and discharged to the community at least once July 2005 through June 2008,
2) had a mental health diagnosis,
3) used Medicaid insurance, and
4) the earliest admission record following July 1, 2005 was the first NF admission in our records.

MDS data for answering Objective 3 research questions did not include 105 individuals from the sample of the 720 adults described earlier. We omitted these 105 adults who had mental health diagnoses and used Medicaid because they also had a record of NF admission or discharge prior to July 1, 2005. Since the remaining 615 individuals had no prior record of an NF stay, we were more confident in the accuracy of our ability to match these adults to a transition pattern.

We used data from July through December 2008 for follow up. This gave us an additional 6 months to track NF transitions after we stopped adding NF admissions and re-entries.

Analysis of individual incidence of NF-to-community discharge and community-to-NF re-entry led to the identification of different transition patterns. We used descriptive and bivariate analyses to describe prominent patterns. Finally, we used logistic regression techniques to predict how groups with similar demographic characteristics and other attributes were associated with different transition patterns. (See Appendix B for detailed methodology.)
We examined these patterns specifically for adults over age 65 (see Table 6). Differences in the distribution of adults over age 65 by transition patterns were not statistically significant, except for the second pattern. Older adults ($n = 74$, 24.7%) experienced the second pattern (discharge from the NF to the community with a re-entry into an NF) more often than we would expect to find by chance ($\chi^2 = 20.41; df = 3; p < .001$). We also examined last documented residence by age. A higher percentage of older adults than younger adults had a last documented residence as an NF at the end of the study period ($\chi^2 = 21.54; df = 1; p < .001$). Thus, differences in the last documented residential location (i.e., NF, community) for younger and older age groups were also statistically significant. In the logistic regression model, age was not significant after accounting for other factors such as access to informal supports and length of time in the study (reported below).
Table 6. Number of Medicaid NF Residents with Mental Health Diagnoses who Experienced Prominent Discharge Patterns (N = 615)

<table>
<thead>
<tr>
<th>Pattern</th>
<th>Total Sample</th>
<th>Ages 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>1. Discharge from the NF to the community</td>
<td>376 (61.1)</td>
<td>160 (53.5)</td>
</tr>
<tr>
<td>2. Discharge from the NF to the community, NF re-entry</td>
<td>118 (19.2)</td>
<td>74 (24.7)***</td>
</tr>
<tr>
<td>3. Three or more transitions, community was last documented residence</td>
<td>91 (14.8)</td>
<td>44 (14.7)</td>
</tr>
<tr>
<td>4. Three or more transitions, NF was last documented residence</td>
<td>30 (3.4)</td>
<td>21 (7.0)</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>615 (100%)</strong></td>
<td><strong>299 (100%)</strong></td>
</tr>
</tbody>
</table>

***p<.001

What was the average length of time spent in the NF prior to discharge, and did this vary for individuals experiencing different transition patterns? (Objective 3)

Length of Time in NF Prior to Discharge Based on Different Transition Patterns

As reported in Objective 1, individuals spent an average of 83.9 days in the NF before discharging to a community setting, with length of NF stay ranging from 2 to 997 days (2.7 years). We used ANOVA to assess the average length of NF stay for each transition pattern by ages 65+ and <65. Any observed differences between age groups were not statistically significant at the level of p < .05. Across transitions, the average length of stay varied from 58 to 93 days, but these also were not significant at the level of p < .05. Thus, the length of stay in the NF before discharge is not associated with being younger or older than age 65, nor with the type of transition pattern.

For those who re-entered the NF following their primary discharge, what was the average length of time spent in the community prior to re-entry? (Objective 3)

Average Length of Time in the Community Prior to NF Re-Entry

We examined the length of time spent in the community between an individual’s primary community discharge and their first NF re-entry. Adults in transition pattern 1 were not included, because they did not re-enter an NF up through the 6 month follow up period. There were 213 individuals who
met this criterion. Therefore, we examined the length of time spent in the community between community discharge and NF re-entry for the 213 individuals with multiple NF admissions. On average, individuals spent 198 days in the community from the date of their first community discharge to their first NF readmission identified in this study time frame. The length of time in the community ranged from 0 to 1,114 days (3.1 years). The length of time in the community was only slightly lower for those aged 65 years and older, with a reported 183 days in the community between discharge and re-entry.

Are there significant differences in the demographic characteristics and other attributes of individuals in the prominent transition patterns? (Objective 3)

Differences in Demographic Characteristics and Other Attributes for Individuals in the Prominent Discharge Patterns

We used logistic regression techniques to determine if targeted factors from different levels of the ecological model predicted NF to community discharge patterns. We compared those who experienced only one transition from the NF to the community (Discharge Pattern 1) with those who experienced “multiple transitions” (Discharge Patterns 2-4). Discharge Patterns 2-4 include: discharge from the NF to the community with re-entry into an NF (stayed in NF), three or more transitions that ended in the community, and three or more transitions that ended in the NF. The adults in this study experienced varying numbers of days in the NF following admission, and this may have influenced results. Therefore, we included length of time that individuals spent in the study as a control variable. Thus, findings presented here provide information on the likelihood of different factors predicting one transition versus multiple transitions when accounting for the length of time that individuals spent in the study.

We were especially interested in the following:—age, informal supports, depression, and chronic disease diagnoses. We explored these factors due to the potential for discharge strategies to be targeted toward informal supports and the management of chronic disease and depression diagnoses. Furthermore, FY09 and FY10 interviews with NF staff members indicated the importance of informal supports and disease management for working towards successful discharge from the NF to the community, specifically for adults with mental health diagnoses who use Medicaid. Within each category from the ecological model, we present these results, and then describe other significant findings.

Individual Characteristics and Attributes

In this study, some characteristics and attributes are given—everyone in the sample had a mental health diagnosis and used Medicaid. Understanding other characteristics (e.g., age, gender) and attributes

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7 There were 239 individual who met the criterion; however, admission assessment data for 26 individuals was missing.

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(e.g., functional level) of these adults who successfully discharged from the NF to the community is helpful for Medicaid program planning, and we provided this information above. However, we wanted to know more. As we have found in past research (Chapin, Baca, Macmillan, Rachlin, & Zimmerman, 2009; Sergeant, Ekerdt, & Chapin, in press), the statistical significance of individual characteristics such as age and gender diminishes as we consider other factors such as the availability of community supports. Supports and services from other spheres of the adult’s ecological environment provide valuable information for planning interventions that address multiple aspects of individuals’ environments.

**Functional level.** In addition to individual characteristics, we also examined attributes such as functional level. We used the RUG index to assess the relationship of functional level to NF discharge patterns. Initially, the RUG index appeared to predict discharge patterns for people with mental health diagnoses who use Medicaid (OR = .96, Wald = 4.20, \( p < .05 \)). However, when we also considered interactions between informal support indicators and age, the RUG index was not statistically significant (OR = .97, Wald = 2.28, \( p = .13 \)) when controlling for length of time in the study. This implies that the informal supports intervene in, or mediate, the relationship between functional levels as measured by the RUG index and NF discharge patterns, particularly for certain age groups. Findings related to functional level were both very interesting and provide support for interventions (e.g., peer support models) that strengthen and expand informal support systems.

**Chronic disease and depression diagnoses.** Depression and other individual chronic disease diagnoses (e.g., arthritis, emphysema/ COPD, diabetes mellitus, cerebrovascular accident/stroke, hypertension) were not statistically significant when entered into the analysis individually. That is, these individual diagnoses were not associated with NF to community transition patterns. However, there was a significant interaction between a diagnosis of depression and presence of one or more chronic diseases (OR = 3.32, Wald = 4.90, \( p < .05 \)). We conducted follow-up tests to understand exactly what this means for adults with mental health diagnoses who use Medicaid.

To understand the interaction between depression and chronic disease diagnosis in relation to discharge patterns, we looked specifically at persons who experienced multiple NF admissions and discharges with Discharge Patterns 2-4 (n = 239). This analysis can help to understand which specific diagnoses should be targeted with particular discharge strategies. We found that for people with a chronic disease diagnosis, the probability of experiencing multiple NF transitions was about equal for those with or without depression diagnoses. On the other hand, for people without a chronic disease diagnosis, the probability of experiencing multiple NF transitions was much higher for those with depression (\( \chi^2 = 6.90, \text{df} = 1; \ p < .01 \)). Therefore, a diagnosis of chronic disease and/or depression increases the probability of multiple NF events, while absence of both a chronic disease and depression diagnosis does not.
Next, we wanted to know if we could confirm a relationship between transition patterns and individual diagnoses, rather than for an overall “presence of a chronic disease.” Though the numbers of people in the diagnosis sub-groups were small, two specific diagnoses were noted. Individuals with diagnoses of cerebrovascular accident/stroke or diabetes were overrepresented among those with multiple NF transitions when depression was not present ($\chi^2 = 17.76, df = 5; p<.01; \chi^2 = 11.06, df = 5; p=.050$, respectively). Therefore, encouraging adults with mental health diagnoses who use Medicaid to participate in chronic disease prevention or self-management programs, specifically geared toward managing stroke or diabetes, will potentially decrease NF admissions and readmissions.

We also wanted information on number of chronic disease diagnoses for the sample of 615 adults who had an originally targeted mental health diagnoses and used Medicaid. We wanted to know if the number of diagnoses (0-5) were related to only one NF admission and discharge or multiple NF entry and re-entry patterns. There were significant findings for the group of individuals with four different chronic disease diagnoses ($n = 35$). Of these 35 adults, 54.3% experienced only one NF event, and 45.7% experienced multiple NF admission and re-entry transitions. A higher percentage of people than expected (95%) experienced only one NF event, and had both four chronic disease diagnoses and a diagnosis of depression ($\chi^2 = 16.647, df = 5; p<.01$). Interestingly, having three or fewer chronic disease diagnoses and/or depression was not related to NF transition patterns, further showing that individuals with mental health diagnoses can and do discharge even if they have multiple chronic disease diagnoses.

**Other Characteristics and Attributes.** The majority of individual characteristics other than age (e.g., gender, race/ethnicity, marital status, rural/urban, PSA) were not significant predictors of NF discharge patterns. We also assessed the relationship between other attributes and NF discharge patterns, but they were not statistically significant. Attributes that did not distinguish between 1 NF admission and discharge versus multiple NF transitions included score on the cognitive performance scale, dementia diagnosis, presence of a chronic disease, co-morbidities among chronic diseases, depression, SPMI, MRDD, a fall within the past 30 days, number of medications, antianxiety medication, and antipsychotic medication. In addition to the above diagnoses, the NF resident’s desire to return to the community did not predict NF discharge patterns. These findings reiterate that individuals with a wide variety of characteristics and attributes can and do successfully discharge to the community. This includes adults who use Medicaid and have a designation of SPMI. In this study, SPMI did not distinguish between only one or multiple NF discharge patterns.

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8 The sub-groups of those with individual diagnoses within the sample were too small to confirm statistical differences.
9 Only 2 adults who had mental health diagnoses and used Medicaid also had 5 different chronic disease diagnoses. Both of these individuals also had a depression diagnosis; one experienced only one NF event and one experienced multiple NF admission and re-entry transitions.
Informal Supports

As we suspected, the strongest predictors of one NF admission and discharge were whether or not the person discharging from the NF had access to informal supports in his or her environment. The implication for Medicaid policy is that initiatives to support and strengthen the informal support networks of adults with mental health diagnoses will likely result in fewer people who use Medicaid that fall into the pattern of multiple transitions in and out of NFs.

Informal support systems also interacted with age groups (i.e., <44 years, 45-59 years, 60-74 years, 75+ years) to predict NF discharge patterns. Therefore, having access to informal supports upon admission into the NF (i.e., daily contact with friends and neighbors and living others) were predictors of NF discharge patterns for certain age groups. We found people in the youngest two age groups who lived with others and had daily contact with friends and relatives prior to NF admission were more likely to experience only one NF event than the 75+ group who did not have access to these informal supports (<44 years: OR = 5.67, Wald = 4.70, p < .05; 45-59 years: OR = 2.41, Wald = 3.88, p < .05). However, the NF discharge patterns of people ages 60-74 years who had access to informal supports were not statistically different than the 75+ comparison group (p = .145). Furthermore, only 31.8% of adults ages 45-59 who did not have daily contact with friends or relatives prior to their NF admission experienced only one NF event. The percentage of adults (51.4%) in the same age range who did have this daily contact was significantly higher ($\chi^2 = 11.11; df = 1; p < .01$). Smaller differences were observed in the age groups that were above 60 years old and above. These were not statistically significant.

Thus, access to informal supports prior to entering the NF was a predictor of only one NF admission and discharge for the age groups that were less than 60 years old in this sample. One explanation for this is that relatively higher mortality, which was not measured in this study, could be a factor in the non-significant finding for the 60-74 age group (e.g., Halpert & Zimmerman, 1986). On the other hand, the 75+ group may have life histories of being healthier (without disease and disability), which helps to explain their advanced age (Hooyman & Kiyak, 2011). Another explanation might be that some of the people who provide informal supports to those in the 60-74 age group may be less able to provide physically demanding tasks (e.g., transfers) due to their own physical health disabilities, which would explain why access to informal supports did not influence their NF transition patterns. Additionally, if the older group (75+) is comparatively healthy, many may have chosen to live alone while “aging in place,” rather than moving in with family members. This is increasingly the preference of older adults, as living alone maintains a sense of independence and privacy (Hooyman & Kiyak, 2011). Therefore, living alone may not indicate a lack of access to informal supports for this group.
Summary

There were 720 people receiving Medicaid who had a mental health diagnoses and who discharged from an NF to a community setting over the three-year study period (July 2005 to June 2008). On average, these individuals discharged to the community after residing 83 days in the NF between their primary admission and discharge. At admission, 332 individuals were projected to have a short-term stay, whereas 124 individuals were not projected to have a short-term stay. We did not have information on projected discharge of 264 individuals. Thus, although many in the sample entered the NF for short-term rehabilitation, not all who discharged to the community utilized the NF in this capacity. In fact, 73 individuals in this sample discharged after residing in the NF for six months.

Overall, the sample varied in terms of the three diagnostic types (anxiety disorder, bipolar disorder, and schizophrenia), suggesting that individuals with all three diagnoses are able to discharge. Moreover, individuals ranging in age from 20 to 100 were able to successfully discharge to a community setting. Some individuals receiving Medicaid were independent in the late loss ADLs of bed mobility, toilet use, and transferring, whereas other individuals who discharged to the community needed extensive or complete assistance in order to perform these ADLs. In addition, there were individuals with cognitive impairments and Alzheimer’s disease or another dementia diagnosis who returned to the community as well as individuals with intact cognitive functioning. Community discharges occurred in urban and rural areas of the state as well as in all 11 PSAs. Furthermore, there were some individuals with indicators of informal support and others without these informal supports. Yet, all 720 individuals in this sample did, in fact, discharge from the NF to a community setting.

The patterns analysis indicated the majority of adults who have mental health diagnoses and use Medicaid who discharge from the NF to the community do not enter a cycle of repeated NF re-entries and discharges. The vast majority (97.4%) experienced only 1-3 NF stays over the course of the study period and through the end of the 6 month follow-up. In addition, 75.9% of the adults who use Medicaid and have diagnoses of anxiety, bi-polar disorder, and/or schizophrenia had a last documented residence in the community. Some of these adults may have died while living in the community. Additional research with death data would provide this information.

Depression interacts with the presence of a chronic disease diagnosis to increase the likelihood of multiple NF admissions and re-entries. Data indicated that adults without diagnoses of depression, arthritis, emphysema/ COPD, diabetes mellitus, cerebrovascular accident/stroke, or hypertension had over 3 times the odds of experiencing only one NF event. Multiple co-morbidities (4 or more) plus depression are also predictors of multiple NF discharge and re-entry patterns, and individual chronic disease diagnoses play a role as well.
Informal support systems interacted with 4 targeted age groups (i.e., <44 years, 45-59 years; 60-74 years; 75+ years) to predict NF discharge and re-entry patterns. Individually, informal supports such as living with others or having daily contact with friends and relatives in the year prior to NF admission were not statistically significant predictors of NF transitions. There was some evidence that different types of informal support may have varying effects for adults of different ages. Research reinforces these findings, stating older adults often prefer to live alone and enjoy contact from family, friends, and neighbors, while living in the environment in which they feel most comfortable (Hooyman & Kiyak, 2011).
Interviews with NF Staff

Strategies for Discharging Medicaid Residents with Mental Health Diagnoses to the Community

(Objective 2)

The main goal of Objective 2 was to identify successful discharge strategies that have been used in NF to community transitions. The findings indicate that a wide variety of discharge strategies across multiple levels of influence have been used to help Medicaid residents with mental health diagnoses discharge to the community. Building on the findings from Section 1 (Analysis of MDS Data), Kansas NF staff members reported that using discharge strategies across multiple levels aids in successfully discharging the target population to the community and that decisions about the use of discharge strategies are made based on individual circumstances. Further, NF staff members stated that certain discharge strategies help to prevent NF re-entry. The results from Section III of the report provided the basis for the development of the Discharge Briefs, which can be found on page 22 of Section II. Overall, the strategies presented in Section III inform Medicaid policy and practice, as NF and community staff who use (and continue to use) these strategies have the potential to increase the rate of successful NF discharges for Medicaid residents with mental health diagnoses.

Throughout Section III, we also incorporate programmatic strategies and for increasing NF discharge from other states’ discharge programs and from research literature. We gathered much of this supplemental information through a review of case studies from the first federal initiative for discharging NF residents to the community, the Nursing Home Transition Demonstration Grants (further discussed in Appendix D). This initiative is the only one that has been systematically evaluated across states and provides information about what works to overcome barriers. Our goal in reviewing these case studies was to identify strategies from other states in order to build on the discharge strategies identified by NF staff members in Kansas.

Below we present the discharge strategies recommended by NF staff members who have helped successfully discharge Medicaid residents with mental health diagnoses to the community. First, we begin with a preview of the main findings. Second, we discuss what NF staff indicated as most critical to discharge. Third, we provide a narrative that provides further detail about recommended discharge strategies and relevant quotes from the interview participants. This information is organized based on levels of the ecological model as discussed on page 41. We conclude with a summary of the key strategies for discharging Medicaid residents with mental health diagnoses to the community.
What strategies have been used to discharge NF residents who use Medicaid, and have mental health diagnoses to community settings?

Summary of Main Findings

- Work with persons who discharge and their informal support persons to help them understand physical and mental health diagnoses & related behaviors and their treatment regimens as well as the consequences of not adhering to medication and treatment recommendations.
  - This was deemed the most helpful strategy for avoiding hospital entries and NF re-entries, as this empowered persons and family members to work toward successful discharge.
- Conduct a team evaluation of the discharge location along with the person and their informal support persons, in order to make safety and psychosocial recommendations.
  - This strategy was recommended as particularly important for ensuring a safe discharge, as professionals can make recommendations for persons and caregivers within the context of the discharge location.
- Consult with the person who is discharging to identify and solicit the help and support of informal support persons while also working with informal support persons to identify concerns about being a caregiver and supportive resources to help them.
  - This strategy was identified as an especially supportive strategy for ensuring caregivers can provide anticipated support, which contributes to a successful discharge and helps to avoid NF re-entry for the person using Medicaid.

Methodology for Objective 2

In order to identify the successful strategies used in the process of discharging persons with mental health diagnoses from the NF to the community (Objective 2), we conducted an in-depth interview study of NF staff members who had experience in discharging such residents to the community.

Research Design

The study focused on Kansas Medicaid NF residents with mental health diagnoses who were discharged to the community during the 42-month period, July 1, 2005 through December 31, 2008. We completed in-depth, semi-structured interviews with eleven NF staff members from ten NFs, including six social service directors, four social services staff members, and one Director of Nursing/Administrator. All those selected for interviews had extensive experience with discharging persons to the community.

The interviews were conducted face-to-face or by phone and ranged in length from 21 minutes to 77 minutes, with an average of 47 minutes. This interviews were completed between February and April 2010.

We asked NF staff about discharges during the study period as well as other more recent discharges. Specifically, we asked about strategies they considered most effective for ensuring successful discharge, how they approached discharge for Medicaid residents with specific diagnoses (e.g., anxiety, bipolar disorder, schizophrenia), and how they helped discharge residents who re-entered the NF following a previous discharge. Each interview was audio-recorded and transcribed verbatim. Interviews were coded and analyzed using the ecological model presented on page 41 as a guide. (See Appendix B for detailed methodology.)
• Gain a breadth of knowledge about available community supports and engage in activities that build relationships and networks with other NF and community professionals.
  o This strategy was recommended to help ensure persons who discharge are able to access needed community supports in a timely, efficient manner, which contributes to successful discharge.
• Establish a consistent, supportive discharge process that includes using proactive discharge techniques (e.g., follow-up phone calls); utilizing detailed discharge forms; and providing ongoing training about mental health diagnoses, community resources, and policy regulations related to discharge to NF and community staff.
  o These strategies were discussed as important for setting discharge goals and ensuring NF staff members from various disciplines are involved in the discharge process, which can contribute to increased discharge rates for persons using Medicaid who have mental health diagnoses.

Most Critical for Discharge

NF staff members who were interviewed discussed the use of multiple discharge strategies across levels of the ecological model. Before we describe these various strategies, we begin by sharing what the interviewees deemed most critical for successful discharge. In answering the question, “What strategy do you consider most effective for ensuring successful discharge from the nursing facility to the community,” about half of the NF staff members who were interviewed emphasized discharge strategies focused on formal community services and supports, and the other half emphasized strategies related to informal supports. As this quote summarizes, the key is working with the person who is discharging to identify the support needed, either through formal or informal sources or a combination of the two.

“[Those] most successful would be that they have the support needed to return to the community, and by support I mean they have either family members that are available to check on them daily or some type of home health or mental health [care to] make sure they are set up with appointments and follow-up with appointments.”
– Director of Nursing from a small facility (58 or fewer beds)

Of the staff who emphasized formal community services, two staff members stated that helping residents enroll and utilize HCBS waiver services was the most critical strategy for discharge. Related to HCBS waiver services, the importance of having a worker for person care services (bathing assistance) was discussed. Other NF staff members mentioned the importance of helping the person to identify a case manager to work with the person in the community, from either the Area Agency on Aging (AAA) or a Community Mental Health Center (CMHC). It was important to identify case managers to work with the person to coordinate and monitor 1) physical and mental health care, particularly self-directed service providers, 2) medication usage, and 3) proper nutrition. Related to this, NF staff members also
emphasized the importance of connecting persons who are discharging to AAA services in general (e.g., Meals on Wheels) and ensuring continued mental health services through use of CMHC services, support groups, or a community psychiatrist. Further, staff emphasized the importance of helping the person identify transportation to appointments and encouraging the person to develop a system to ensure needed medication is taken.

Many NF staff persons discussed that working with the person who is discharging to identify and solicit the help and support of informal supports (e.g., family members or friends, neighbors, and/or religious group members available on a regular basis) was critical to discharge. Staff members emphasized various strategies related to informal supports. Of particular importance was involving the resident and family members from the beginning of the transition process. One staff member found that identifying church support, for meeting emotional needs and for helping with home modifications, was often very important to those with mental health diagnoses. Specifically, one staff person stated that good communication with the family was especially important, which she established by initially meeting with the resident and family members for a detailed assessment about discharge goals upon entry into the NF. Finally, one staff member mentioned the importance of identifying a professional to monitor informal supports to avoid instances of abuse and exploitation.

In the following sections, we describe in some detail the strategies used by NF staff in working with Medicaid residents with mental health diagnoses who discharge to community settings, within the framework of the ecological model, as further described on pages 41-42.

Individual Characteristics and Attributes

NF staff discussed many discharge strategies related to individual characteristics and attributes for Medicaid residents with mental health diagnoses who have discharged to the community. Though residents who discharge from NFs have improved health conditions from when they first entered the NF, most continue to need assistance with managing chronic health conditions and mental health needs once they live in the community. According to NF staff, those discharging with particular physical health and mental health diagnoses require certain considerations based on their individual circumstances. As further described in this section, the discharge strategies suggested by NF staff include: planning for physical health needs, alleviating mental health symptoms, promoting medication and treatment adherence, avoiding adherence barriers, and helping align resident and family goals.

Planning for Physical Health Needs

In planning for physical health needs in the community for residents with mental health concerns, NF staff members indicated that it was helpful to provide specific information to persons with particular
diagnoses. As discussed, a number of considerations should be taken into account for persons who discharge with dementia, COPD, diabetes, and kidney/renal failure.

“COPD is one of those really high education level diagnoses. Diabetes is huge [for education]. And the other one that I know, we do a lot of education with somebody on dialysis.”
– Social worker from a large facility (more than 85 beds)

Alzheimer’s and other dementias. NF staff members indicated concern about over-medication and under-medication for persons with dementia, so working with them to identify a system for medication monitoring was highly recommended. Without a way to record whether pills have been taken, short term memory loss may contribute to a potential overdose on medication, and as the disease progresses, it becomes increasingly important for caregivers to assist with medication distribution.

“If you have somebody with a little bit of dementia or somebody with Alzheimer’s going home . . . if they miss one meal, it could affect them. If they miss a pill, it could affect them. So it’s really a circle of needs that they need to work together.”
– Social service director with 20+ years experience

Further, it is recommended to provide information to persons and their caregivers on potential safety concerns, such as cooking hazards, getting lost, and falling. Concerns about getting lost can be decreased by using alarms and items that obscure the appearance of doors. Since this disease can compromise balance, the use of a bath aide can help with preventing falls that often occur in the bathroom. Depending on the functional level of the resident, Lifeline can also be a good resource in case of falls.

The resident and caregiver should be made aware of Alzheimer’s/dementia support groups in the area, for these can greatly reduce stress. Also, notifying the caregiver of day programs and respite care can give the caregiver time to relieve stress, restore energy, and promote balance in life, thereby increasing community tenure for the person who discharged from the NF.

Diabetes. NF staff also emphasized the importance of working with persons with diabetes who discharge to the community to ensure they understand their condition and treatment regimen. Especially for persons with a new diagnosis, the amount of necessary care and technicalities can seem overwhelming. It was recommended that NF staff members work to ensure persons who are discharging and their families know how to handle insulin (need for refrigeration, how to take it orally, how to inject using a syringe), to choose the correct diet (consult with registered dietician, use Meals on Wheels), and to change dressings. Meals on Wheels can deliver food tailored specifically to those with diabetes, which can help to ensure proper diet and also simplify the person’s life. According to NF staff members, helping persons learn to change dressings was especially important, as home care providers often only visit once a day and sometimes cannot aid with dressing changes because they are not qualified to do so. Further, it is important to encourage persons to check their skin and see a podiatrist routinely. Before
NF staff members discussed that nurses would ask residents and/or family members to demonstrate correct care for their diabetes, which helped residents and family alleviate anxiety about completing the various tasks without outside assistance.

“We would do diabetes training before they left. If they needed, if she was newly diagnosed, we would get her set up with her own Accu-Chek machine . . . [and] do some training with her kind of Accu-Chek machine versus our kind.”
– Social worker from a small facility

“It can be as simple as just finding out if somebody can do their own insulin injection. Can they do their blood sugars? Can they draw it up?"
– Social service director from a large facility

In order to ensure residents who discharge to the community with diabetes can manage their disease, NF staff members also found it important to ensure that persons have a vision check, as persons need to be able to see the gradations of the syringe.

NF staff members also discussed the importance of helping those with diabetes identify physical and occupational therapists as well as services provided by a nurse or other qualified medical personnel. Staff members also encouraged the resident to notify a home health nurse to aid in ordering diabetic supplies. Knowing that a nurse would be available ensures follow-up with treatment recommendations and provides an avenue for further information about managing diabetes at home, if needed. One NF staff person discussed the importance of ensuring the person had access to a nurse to assist when difficulties arise in assisted living facilities. Due to regulations in assisted living facilities that staff persons cannot give injections, not being able to give self-injections could lead to hospital or NF re-entry.

COPD. For persons with COPD who are discharging to the community, NF staff indicated the importance of helping persons identify a specialist doctor, such as a pulmonologist, and a primary care doctor in the community to help ensure they can get all the services they need once they live in the community. It is also essential to help persons who discharge acquire the necessary medical equipment for the home. For persons who discharge, obtaining portable oxygen tanks and corresponding wheel chair clips that hold the tanks is important for excursions outside the home.

Further, because COPD is deemed a “high education” disease, persons and their family members should be provided information about the disease process, oxygen tank use, furnace safety, and dangers of smoking. Providing information about the potential for over-medication is also important, since over-medication often occurs because people think that more medication will make breathing easier. NF staff also noted that signs of anxiety or depression could be exacerbated by COPD. Engaging the resident in stress-relieving exercises may improve these symptoms.

“I know a lot of our residents, if they don’t come in on oxygen and we discharge them home on oxygen, [that] can be one of the most anxiety producing [occurrences]!”
– Social worker from a facility in an urban area
**Kidney/renal failure.** For residents with kidney/renal failure, providing information to help manage the disease at home was recommended. One NF staff person indicated that those with dialysis have a team that aids in providing care, which ensures residents with kidney/renal failure will get the care they need once they live in the community.

“[T]hey have a whole team at dialysis. They have a social worker there, and a nurse, and a doctor who can make sure everything’s going okay, that they’re getting to their appointments, that everything’s going okay at home, and that type of staff. It’s kind of a safety net for the resident after us as well to know that we’re turning them over to that team, or turning them back over to that team.”
— Social service director from a facility in an urban area

**Alleviating Mental Health Symptoms**

When helping to discharge persons with mental health diagnoses, NF staff members indicated that one of the most important steps is to work with persons and their doctors to ensure that medication is up-to-date and that possible side effects and drug interactions are discussed. Staff members also suggest connecting persons with AAA or CMHC case managers in order to monitor mental health symptoms and ensure needed services are available and utilized.

“I think that’s necessary [having a case manager], especially if their mental health issues are affecting their own life. They need that follow-up at home that [the NF] can’t really provide [once they are living in the community].”
— Social worker from a facility in an urban area

NF staff members indicated that anxiety symptoms sometimes subside once the resident returns home due to increased comfort level. However, it was also indicated that transitions can invoke more anxiety. As a first step to helping alleviate anxiety, NF staff suggest working with the person to have a psychiatrist evaluate the effectiveness of prescribed medication. Because overdosing can be a concern due to anxiety coupled with possible short-term memory loss, encouraging the person to have someone available to monitor medication usage is important.

To further reduce anxiety, it was also suggested to encourage the person who is discharging to see the same primary care doctor in the community that he or she saw while in the NF. Due to funding and practice limitations, this might not be possible. In these situations, it is important to help the person identify a primary care doctor in the community before discharge and ensure the person has an appointment with the doctor within two weeks of discharge.

Anxiety may also be abated by introducing the person to Meals on Wheels (which might reduce the stress of preparing meals); a 24-hour alert system (e.g., Lifeline); individual therapy; and/or breathing treatments (e.g., inhalers). NF staff mentioned that encouraging the person to identify a friend with whom to participate in ongoing one-on-one activities can also decrease anxiety while living in the community.
Finally, some NF staff members found that residents felt less anxious when they knew a trusted family member or friend would be responsible for paying bills and managing finances. If the resident requests it, helping enlist the trusted person as a durable power of attorney can help reduce anxiety related to banking and finance responsibilities.

“Some of them have family members that take legal responsibility. If you can get a family member to take legal responsibility, that’s great. Guardianship. Doesn’t mean [the person] can’t live on their own. It just means that that person has everything go through the [guardian]. For finances. But I’ve heard that that can be a very anxiety-provoking thing in the community, is that people have so many things they have to think about. So having the guardian thing seems like that would be something that would help.”
– Social worker with 8 years experience

NF staff members found that helping persons with schizophrenia develop a system for medication management was especially important. Weekly, and perhaps daily, monitoring was recommended. In addition, encouraging the person to see a psychiatrist often is important for ensuring that prescribed medications are up-to-date. Even for those who take medications, NF staff members suggested working with the person who is discharging to solve potential behavioral challenges and develop coping skills to manage symptoms. Ensuring that mental health services will continue after discharge, perhaps through mental health case management, was also suggested. Further, knowing past histories of drug and alcohol addictions was recommended, as addiction challenges may return once the person moves away from a structured environment. In these situations, NF staff members often recommended an assisted living facility or supportive housing to the person discharging from the NF.

For persons with bipolar disorder, NF staff members suggested to persons that they seek services through a mental health center or private practice and continue with follow-up appointments. Encouraging the person who is discharging to get involved in a supportive group that helps cope with depression/anxiety can help adjust to living at home. Staff members also stated being straightforward about the importance of adherence with medication and treatment often helps.

Promoting Medication and Treatment Adherence

Medication and treatment non-compliance costs about $100 billion each year due to resulting “hospitalization, complications, disease progression, premature disability and death” (Khan, 2004, p. 42). NF staff concurred on the absolute importance of promoting treatment adherence and service usage for residents with mental health diagnoses who discharge to the community. As such, NF staff members stated that non-adherence to medication and treatment recommendations can lead to re-entry into hospitals or NFs.

As discussed by NF staff, of utmost importance to helping residents and informal caregivers and supports prepare for community living is providing them information on physical and mental health
conditions and treatments. In fact, this was discussed as the most helpful strategy for avoiding hospital entries and re-entries into NFs. One staff member specifically emphasized the importance of using a direct approach and having the resident assist in determining what they need to avoid re-entry into the NF, particularly for those residents with discharge and re-entry patterns.

“I think probably the BEST strategy for those most difficult ones is education. With the [residents] themselves. I think I have a more direct approach than most people. I think I’m sensitive, but I think it’s important in situations to be open and say, ‘I’m worried about you. This is the fourth time you’ve been here in the last two months. What’s going on? What do YOU think I could do that would be the most helpful for you?’”

– Social service director from a facility in an urban area

**Medication.** Research shows that prescription drug compliance among the elderly may range from only 33 to 66 percent (Ballantyne, 2005). To combat non-adherence, nearly all NF staff emphasized the importance of working with the residents and family member to establish a system for medication monitoring.

“Having a program set-up to be sure they have got their medications, that they’re going to get them on a regular basis, and that they’re actually taking them, is going to be very important.”

– Social worker with 15+ years experience

NF staff gave a number of examples of strategies they had recommended to persons to develop a plan for monitoring medication usage. For example, a couple of staff members mentioned an electronic, interactive pillbox that beeps as a reminder to take medication as especially helpful. For one resident, staff members helped the person purchase a pillbox with reminders that beep, using a credible website that provides medical equipment. In this instance, the pillbox was affordable (approximately $30) and the resident and family members deemed the purchase necessary for successful community living.

“We found [an affordable pill box with an alarm] online ... We do research like that all the time, try to find something new, something creative that’s going to be able to make someone more successful, particularly if they don’t have family that live close by... Sometimes we’ll get information from some of the home health agencies, something they’ve seen or tried, or somebody else has had. And it’s an adventure in creativity.”

– Social service director from a facility in an urban area

For persons whose medication usage needs to be strictly monitored, NF staff members suggested the use of a pillbox that sends an automatic reminder call to the person or to another party identified by the person (e.g., family member or nurse) if medication is not taken at the intended time. Additional technology, including web cameras and other sensor devices, can ensure medication compliance and provide peace of mind for the person and his/her caregiver. When electronic pillboxes are not an option or not desired, NF staff suggested the use of a weekly pill container filled by a caregiver along with a written chart, in order to monitor medication usage.
“If not wanting that little gadget, I would recommend a pill counter with the containers. The daughter might come in every three days and refill it. And then I’ve had people make a chart, where you have to look at the time and check off when you took [medications]. Then have the daughter come in a few days [a week] and check on it.”

– Social worker from a large facility

For persons with memory difficulties, research supports these ideas and also suggests telemonitoring, online medication monitoring, prescribing the least amount of medications, synchronizing dosing schedules, and adapting dosing schedules to personal routines (Arlt, Lindner, Rösler, & Von Renteln-Kruse, 2008).

**Treatment.** Related to treatment adherence, NF staff members emphasized the importance of ensuring persons who discharge with mental health diagnoses learn about oxygen usage, smoking, diet, physical therapy regimens, and equipment use. Further, NF staff members discussed the importance of talking with persons about utilizing recommended community services, such as mental health services and case managers.

Because not adhering to treatment recommendations can lead to NF re-entry, NF staff emphasized providing information to residents and family members not only on the importance of adhering to treatment regimens but also on the possible consequences of non-adherence. NF staff found that education empowered residents and their family members to take charge of their situation, which contributed to increased adherence.

“[How to] increase compliance? When we work with [residents in physical] therapy, we sit down and talk about why [the therapy is important]. Sometimes it’s just a matter of patient education. Be it the social work, therapy, or nursing or usually a combination of us, it usually just comes down to education.”

– Social worker from a small facility

Without this information, family members may be less apt to assist with and encourage recommended treatments because they do not understand the importance of the treatment and the ramifications of non-treatment. Providing the information before discharge helps ensure that families are active in encouraging residents to follow treatment recommendations. Over the long term, NF staff find that education helps to avoid hospital entry and NF re-entry.

“Family education is a big one, too, especially if they live right there in the home. Some families are very hands on; they’re here all the time asking questions. And some families are like, ‘you do it, and I’ll see you whenever they’re discharged.’ And families are enablers [in this sense, saying:] ‘They don’t need thickened liquids at home. They cough, and it’s fine.’ Well, [the resident] is going to get aspiration pneumonia from that.”

– Social worker from a facility in an urban area

**Avoiding Adherence Barriers**

With adherence related to medication recommendations, NF staff discussed that it is important to also consider how the individuals using Medicaid who are discharging to the community can get and pay...
for their medications, as the cost of medication can lead to non-adherence. Therefore, it is important to work with the person to establish how insurance will pay for the medication and ensure the presence of financial support. Further, helping the person to develop a plan for ordering prescriptions and getting them delivered on a regular, scheduled plan avoids situations where people might question whether to buy medication or another item.

“Cost becomes an issue. I think it’s very important to be sure that they have either insurance or support to buy those medications, or to have them provided [to avoiding them having to] choose between eating and buying the medication...”
– Social service director from a large facility

To help ensure adherence with treatment recommendations, NF staff noted the importance of learning about potential barriers to service use for this population. Therefore, it is crucial to help the person to identify a workable plan for transportation to Community Mental Health Centers or other health appointments. NF staff have also found that helping the person to create a supportive treatment and appointment schedule based on individual personality traits and daily habits can help to avoid adherence difficulties. As such, it is recommended to work with the person to consider how time of day, mood, and physical limitations might influence adherence.

“Maybe they’re refusing therapy, but maybe it’s really the wrong time of day.”
– Social worker from a facility in a rural area

**Helping Align Resident and Family Goals**

Because residents and families sometimes have different ideas and expectations when it comes to discharge, NF staff members suggested taking extra time to listen to what both the person and family members are saying.

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**Strategies for Determining Which Residents to Target for Discharge from Other States’ Transition Programs**

In our review of strategies from other states, states used various strategies for determining which residents to target for discharge. Some states, like Pennsylvania and Vermont, used MDS data fields to determine possible residents for discharge. Pennsylvania noted the number of occupational therapy days, residents’ short-term memory abilities, the desire to live in the community, and availability of informal support after discharge (Eiken & Heestand, 2003). Vermont analyzed some of these same issues and additionally noted RUG Special Rehabilitation or Clinically Complex scores, incontinence issues, and Cognitive Performance Score (Eiken, Hatzmann, & Asciutto, 2003). Wisconsin determined resident eligibility by whether the resident was “ready to move,” thereby not needing skilled services, having the ability to signal for help, having a support system, and showing the ability to do some of the work required in the transition. Independent living staff also worked with residents to set realistic, long term goals for living in the community. This helps overcome the concern that many residents and their families would underestimate the level of assistance they would need in a home or apartment (Eiken, Stevenson, & Burwell, 2002). In New Jersey, program staff determined eligibility by reviewing resident charts and pre-admission screening reports and interviewing NF staff and residents themselves (Eiken, 2003).

As we understand it, the Kansas Money Follows the Person Program (MFP) obtains resident information for those who meet eligibility requirement for length of time in the NF as well as having marked ‘yes’ for “Resident expresses/indicates preference to return to the community” (Section Q) on the MDS form. Then, letters are sent to the NFs and the residents who qualified to inform them about the MFP program (Schwarz, 2010).
“You’d be surprised how many times the [resident] and the family member aren’t wanting the same thing.”
– Social service director from a large facility

NF staff members discussed that individuals with mental health diagnoses may be apprehensive about drawing on community supports. Furthermore, some NF staff members have found that individuals with mental health diagnosis sometimes choose to move away from the NF before community supports are in place. Importantly, one NF social services director and social worker had some suggestions for avoiding these difficult situations. She recommended sitting down with the resident and family upon NF admission to outline personal goals for discharge. Doing this helps residents and family see that discharge is possible, if certain goals are met and supports put in place. Also, providing information to persons and family members about safety concerns prior to discharge can help. One NF staff member found that these strategies helped support resident self-determination while also ensuring safety.

“I think one of the primary things that we have to do is initially sit down with the resident and the family from the beginning, and outline what their personal goals are going to be as far as discharge.”
– Social worker from large facility

Because there can be tension between what the resident wants and what the family or other support persons prefer, NF staff members mentioned that they often served as the mediator or would call an ombudsman to assist when difficulties arose beyond what they felt they could handle.

“We also have a lot of family bickering to help mediate. And we have the ombudsman that we use when we cannot solve [problems].”
– Social worker with 15+ years of experience

As one NF staff person discussed, getting to know the family members and providing some mediation can help prevent unfortunate situations, such as admission into an inpatient mental health hospital.

“I try to heed those things off. Usually, when someone’s admitted, I can maybe foresee something. I can’t always, but occasionally. I think ‘this is probably going to be a little bit more complicated than most. If I develop a good relationship with the family and residents, sometimes I can do a little mediation.’ ”
– Social service director from a facility in an urban area

As another example, one NF social services director and social worker discussed a situation where a daughter wanted her mother, the NF resident at the time, to sell her house in order to qualify for Medicaid so that the mother would stay in the NF longer. However, the mother wanted to move home to receive home and community-based care. The daughter said the house was not livable. To help mediate the situation, the social worker went out to the home to complete an assessment. Though the house was not in the best condition, the social worker helped to get the needed home modifications to make the house safe for the mother to return to it. In the end, the mother did move home, where she received
HCBS-FE waiver services, which in the long term, met the mother’s wants while also saving Medicaid dollars from being spent on NF care.

Understanding family situations can help align discharge goals and helps families become involved with discharge as much as they are willing and able. Although getting to know families and family situations takes time and effort, doing so helps in ensuring successful, safe discharge for Medicaid residents with mental health diagnoses.

“We circle around as a team and get really involved with families, get to know them, provide that one-on-one. They become more trusting. Therefore, they seem to open up with some things we don’t really always want to know, but it does help.”

– Social service director from a facility in an urban area

While NF staff members confirmed the importance of self-determination (i.e., that residents have the right to determine their care level and location and that residents can leave the NF when they choose), NF staff identified a number of situations where resident decisions caused concerns related to personal safety and that led to eventual NF re-entry. When residents do discharge without plans of action or a physician’s approval and safety is a concern, NF staff have found that notifying Area Agency on Aging case managers about the situation often helps.

“It’s their right to go home and their right to accept or refuse services... [I]f we know maybe they’re working with the Area Agency on Aging, a lot of times they have case managers through them, and so we’ll give them a heads up to say so and so is going back home and these are the things that they’ve agreed to or they are not agreeing to.”

- Social worker from a large facility in a rural area

In certain situations, NF staff found that calling Adult Protective Services (APS) was an option. Though APS may not be able to help with preventing a problem, contacting APS does ensure that someone has been notified of the situation and can monitor for severe difficulties.

Physical Environment

NF staff members who have helped successfully discharge residents with mental health diagnosis discussed various discharge strategies concerning the physical environment for Medicaid residents. In order to help persons prepare for discharge, NF staff members found that it was beneficial to assist persons in locating housing and/or helping to adapt the physical environment to fit their needs.

Considering housing options based on individual preferences, the availability of informal support, and housing unit qualifications is necessary, in order to help the person transition to the community and support a successful discharge. As further detailed in this section, the discharge strategies related to physical environment considerations include: exploring housing options based on individual preferences and qualifications, conducting team home evaluations in the community environment, ensuring proper
home modifications and medical equipment are in place prior to discharge, and considering differences in community supports for rural versus urban areas.

Exploring Housing Options Based on Individual Preferences and Qualifications

In considering the community environment for Medicaid residents about to discharge, NF staff members talked about exploring housing options. NF staff members stated that meeting residents’ preferences for community living was of utmost importance for successful discharge. Related to this, it was important to consider individual circumstances and qualifications, such as physical and mental ability, income or monetary support, and availability of informal support when exploring housing options with the person discharging. Housing options most often discussed were private apartments or homes, subsidized apartments, or assisted living facilities.

NF staff members talked about housing limitations for Medicaid residents with various health qualifications. For example, NF staff members discussed the issue of subsidized housing not accepting persons with dementia diagnoses. Similarly, NF staff members referred to assisted living facilities not admitting persons who need help with injecting insulin. Knowing housing regulations helped in identifying housing options that worked to meet the needs of those discharging to the community.

“It can be as simple as just finding out if somebody can do their own insulin injection. That’s a major role on part of whether or not they can go to assisted because assisted has their own regulations given by the state that says what they can and can’t do. One of those things is they can’t give injections. So if you have a diabetic who is independent in all other ways, but they can’t give their own injections... Then they have to move to skilled for that reason.”

– Social service director from a facility in an urban area

To help with identifying appropriate housing, NF staff members would contact housing representatives to discuss the person’s health conditions, after receiving the person’s permission. This helped to
make decisions about units to ensure the environment was suitable for the person being discharged. For example, if the person used a wheelchair, housing representatives would identify first-floor units, units with lower carpet, and/or units with wider doorways. In a number of occasions, NF staff members also found that housing representatives, such as apartment property managers or trailer park managers, were willing to help get lumber, build ramps, or make needed modifications to doorways and bathrooms to ensure the person could move into the unit. Working with the person who is discharging to utilize the housing manager often helps get the needed modifications, and importantly also ensures that the home modifications are approved by housing management.

In working with the resident to plan for discharge, NF staff members also discussed the importance of considering waiting lists. As Medicaid residents who discharge have few monetary resources, housing options are often limited. Particularly in urban areas, NF staff members found that waiting lists for housing units made it especially difficult to help persons discharge from the NF and that persons often continued living in the NF because of waiting lists. Knowing about areas that have waiting lists was helpful for NF staff members in making recommendations to residents and family members about housing options.

“‘It’s challenging to find housing in the community with the Kansas Medicaid recipient. There are some places that you have to be on subsidized housing to get into. And it doesn’t take a long time to get an appointment scheduled and to get down there. It’s just waiting for the funds to become available.’”

– Social worker from a medium facility (between 59-85 beds)

Finally, one NF staff member discussed an agency that can help older adults and their families identify housing options. Agencies, such as this one, can help with the difficult task for exploring housing options, particularly for those who use Medicaid.

“A Place for Mom [http://www.aplaceformom.com/] is actually a nationwide agency that helps peoples find appropriate placement for older adults, whether it be with a mental health condition or not. But they, it’s really pretty cool, because it’s free to the family and the resident. It’s a free service. So I use it a lot with Medicaid residents, actually.”

– Social services director from a large facility

Conducting Team Home Evaluations in the Community Environment

An essential element of successful discharge for those using Medicaid and moving to independent housing is conducting home evaluations. According to NF staff members who have helped to discharge Medicaid residents with mental health diagnoses, conducting team home evaluations in the discharge location helps the NF team work with the person and, if needed, identify what supports might help the person be successful once they are in the community environment. Ensuring the resident and informal support persons are part of the home evaluation is absolutely necessary.
“Seeing a resident in their own environment can really give you a different perspective on that resident. People act kind of differently sometimes when they’re in a facility, versus when they’re in their own environment. They may follow all the safety cues for us, but then when they get home, they may leave the walker behind. And [the team] can spend an hour or two at somebody’s home making recommendations. And I think we’ve been really successful with that.”
– Social service director from a Continuing Care Retirement Community (CCRC)

**Prior to Discharge.** NF staff found it necessary to complete the home evaluation within two weeks of discharge. Importantly, this helps guarantee the safety of the environment, as the person’s current health condition is the focus of the evaluation. Further, evaluations also help to work with the informal caregivers to ensure they are comfortable with planned support tasks, such as helping with transfers and using medical equipment.

“Safety becomes our watch word, because anybody can be discharged. Can they be discharged safely? Because ethically we have a responsibility to see that if we’re discharging, we’re discharging to a safe environment.”
– Social services director from a large facility

NF staff members also reported that home evaluations are an excellent strategy for preventing, rather than reacting to, difficulties with community living. Thus, home evaluations are especially important for avoiding NF re-entry.

**Team approach.** Staff members expressed that a thorough home assessment, in which the resident, informal support persons, physical and occupational therapists, a social worker, and a nurse are present, can prevent falls and other negative events and help ensure the environment is suitable. The use of a team approach is important, as each team member has separate contributions.

“Everybody that goes home is offered the opportunity to have us go [do a home evaluation]. It’s not mandatory that they go. We have had occasions where families have declined that option. But most of our families are more than willing. And with every discharge, we go and then our therapy team (physical, occupational, and speech therapists and a social worker) as well as a nurse. So it’s really prioritized for all of the different disciplines.”
– Social worker from a facility in an urban area

For example, nurses can provide training on how to do treatments for physical health conditions or how to use health equipment. Physical and occupational therapists help to ensure safety and accessibility by making recommendations for needed home modifications and medical equipment.

“I request that the therapists that are going out to see them in their home. They make recommendations for how they could rearrange it to make it safer for them to get through the house. Things, easy things, like maybe you don’t want a rug here because it makes you more likely to trip and break your other hip. Or, you know, you might need to widen this doorway so you can get your wheelchair into the toilet. Occupational therapists, especially, do a good job at that. That’s kind of their specialty.”
– Social services director from a large facility

Some of the NF staff members emphasized the importance of including a social worker during the home evaluation.
evaluations. Social workers attend the home evaluations in order to make psychosocial recommendations. The importance of social workers in the discharge process is further discussed on pages 103-104.

“[As a social worker], I wouldn’t feel comfortable sending someone home without being involved in that process for my discharge planning side. I think it adds a safety net for our facility in that that just gives you another set of professional eyes. And when I’m going, I’m looking at some of the interaction between the other people that may be living at the home. We’ve been surprised in seeing family members that we didn’t know were living at the home. Plus, too, I think seeing a resident in their own environment can really give you a different perspective on that resident.”
– Social worker with 8 years of experience

Additionally, as this quote emphasizes, social service staff involved in discharge also take part in the home evaluation in order to help identify needed community services and supports, based on the recommendations from nurses and physical and occupational therapists.

“We come back and make written recommendations to the family and to the resident. And if there’s something that we feel that the physician needs to know, or if, we’ve walked into occasionally to a home where it just didn’t look like that person could return there safely, just because of the home layout and those types of things. We were able to call AAA and get some services set up to get some grab bars installed and those types of things for residents whose families couldn’t help them with that.”
– Social worker from a facility in an urban area

Unsafe conditions. For persons moving to a previous home, NF staff talked about hoarding and infestations as potential concerns. Conducting home evaluations can help in identifying these situations and working with the person to decide what needs to be done to make the environment healthy and safe before discharge. This helps to provide an environment less conducive to health risks (e.g., falls, disease from bacteria).

As reported by NF staff members, hoarding often occurs among persons with mental health diagnoses. To help with this, NF staff members suggested the use of services that help organize and discard possessions. However, as this quote emphasizes, paying for these services can be difficult, unless family or other sources can provide support. Important to Medicaid policy is that, without help in these situations, persons using Medicaid have less chance of discharging to the community.

“Something I think worth mentioning is how prevalent hoarding is with older adults. And I deal with that a lot, older adults with mental health issues and hoarding. Even if they are able to live independently, maybe their home isn’t livable. The grief they experience when they can’t go home, because of the attachment they have with the items and things in their homes, and that’s difficult...A lot of these folks really need someone who can help them pack, and do those things, who can go through all of their possessions meaningfully... [H]ired services, all their staff members are trained to help older adults meaningfully go through their clutter and possessions. They have a lot of grief training. I think they do a lot of framing of special things. It’s sensitive. It’s good. Their services are great, if you can pay for it.”
– Social service director from a large facility
In addition, NF staff members found that home evaluations also helped in identifying unsafe conditions related to having a neglected living space, such as bug infestations and expired foods or medications. Because the home may have been sitting dormant since the person moved into the NF, it is necessary to identify these concerns in order to ensure the home is safe for the person upon discharge.

“We’ve walked in several times and found homes with infestations of various kinds, and those types of things that we would certainly want to know about before we sent this resident home. We would want to try and take care of that and address that the best we could.”
– Social service director from a CCRC

**Ensuring Proper Home Modifications and Medical Equipment Are in Place Prior to Discharge**

After conducting the home evaluation to determine necessary home modifications and medical equipment, NF staff members discussed the importance of working with the person who is discharging to ensure these are in place and available upon discharge to the community. The NF staff members often relied on a base of knowledge about the companies and agencies that can provide this equipment as well as how to make the acquisition of such equipment financially feasible. Some NF staff members also identified churches and other volunteers willing to help provide home modifications or equipment.

Technology was talked about as a monitoring tool. Helping the person who is discharging identify appropriate technological aides can help reduce anxiety associated with no longer having the 24-hour monitoring and assistance available at the NF (i.e., the call light). The majority of NF staff members talked about providing information about Lifeline services to persons discharging to a private home or apartment.

“Somebody who’s been in a facility for a year, and used to being able to use a call light to call for help, and if they get into difficulty, probably would benefit knowing, and it would decrease anxiety, to know there was at least an alert available [such as Lifeline], if they got into trouble.”
– Social worker from a large facility

NF staff members also talked about the importance of staying on top of new technological developments. Innovative technology provides great potential for improving community living, such as web cameras that allow family members to monitor the individuals from afar and electronic, interactive pill boxes. NF staff members would learn about these new technological options through internet research or professional connections and would, in turn, provide the information to persons and their family members about these options and how to obtain them at no or low cost. See pages 92-93 for further research findings on the use of technology.

**Considering Differences in Community Supports for Rural Versus Urban Areas**

Related to the physical environment of persons who discharge using Medicaid, NF staff members talked about differences in community supports for rural versus urban areas. Importantly, all NF staff members cited multiple community supports available to those who discharge, regardless of where they
resided. However, rural areas often did not have waiting lists for available services, and informal support persons were often more readily accessible and available. On the other hand, some NF staff members did find that rural areas have fewer formal community supports than urban areas.

In rural communities, some staff members had concerns that there were not as many community providers available. For example, certain community providers could not travel to residents who live in rural areas.

“The services are fewer and far between. Like I can get home health out there (to rural areas), but I might not be able to find a home health speech or one with the social services that I like to have.” – Social worker from a facility in an urban area

“[I]f they’re going to a rural area then they’re going to have fewer choices of what’s available. Like even Meals on Wheels, sometimes their routes only go so far. And so they might have less options on what they have available. So that is a little bit more of a challenge.” – Social worker from a facility in a rural area

In rural areas where there were concerns about the availability of community services and providers, NF staff members found that contacting discharge staff from hospitals and professionals from county health departments often helped in getting needed services for those discharging. Because these areas might not have listings in the “Explore Your Options” book or have as much information available on the Internet, hospitals and county health departments were noted as the best resource for information.

“And one thing that I’ve learned is that if somebody’s discharging to a rural area, I call the closest hospital and I ask them who they use, because I know their social workers have to do discharge planning.”
– Social service director from a facility in an urban area

Some NF staff found it beneficial to encourage a person who is discharging to move into a more resource-rich area if the proper resources, depending on individual circumstances and needed supports, are not available in their original community. In one example, an NF staff member encouraged a person to move to the county next to his or her previous county because of the availability of a Community Mental Health Center that provided Senior Outreach Services.

In urban communities, there may be more community service providers available. However, NF staff members often found that these providers could not meet the needs of the Medicaid population, leading to waiting lists. In particular, there were concerns in urban areas that CMHCs were overloaded with clients and that there was a shortage of medical providers (e.g., primary care physicians) with openings for those who use Medicaid as their payer source. This is further discussed on pages 97-100. In the end, it is important to consider individual circumstances, rather than geography, when helping a person discharge to the community; both rural and urban areas can be viable discharge locations, depending on individual needs and supports.
Informal Supports

Discussing one of the most critical aspects of successful discharge, social support provided by informal support persons and groups often helps Medicaid residents with mental health diagnoses discharge to the community. Social support is provided in various forms, including instrumental (e.g., help with a problem, donated goods), informational (e.g., advice, recommendations), appraisal (e.g., constructive feedback, behavior affirmation), and emotional (e.g., empathy, reassurance, caring). In many situations, having access to informal support can be the difference between a successful discharge and continued stay in an NF.

“I think it’s helping them identify who can help them in the community or what kind of support they’re going to have in addition to agency support. I think they’re going to be much more successful if they do have a friend or a neighbor or someone that adds that extra level of support.” – Social worker from a large facility

Because of this, NF staff members discussed multiple discharge strategies they used to help persons discharge to the community related to informal supports. NF staff members often recommended that persons utilize informal supports to provide assistance with various tasks, as detailed in Table 7. For those without access to informal support, discharge may be more difficult, but it is not impossible. Therefore, NF staff also talked about strategies for helping those without informal supports get the assistance they need to make community living successful. In this section, the discharge strategies related to informal supports emphasized by NF staff members who have helped successfully discharge Medicaid residents with mental health diagnoses include: identifying multiple sources of informal support that may be available; involving informal caregivers in each phase of the discharge process; providing information to informal caregivers on the resident’s physical and mental health conditions & treatments and caregiver support; and presenting options for those without access to informal support.

### Table 7. Assistance from Informal Support Persons

- Regular face-to-face contact
- Daily phone calls
- Transportation to appointments (e.g., medical, hair) and activities (e.g., social events)
- Housekeeping
- Laundry
- Grocery shopping
- Yard work
- Home modifications (e.g., building a ramp)
- Household donations
- Financial assistance (e.g., paying bills, acting as legal guardian)
- Medication management

Strategies for the Use of Informal Supports from Other States’ Transition Programs

Many states found that informal support was important to aiding successful transitions. Arkansas required that participants have informal support available in the community in order to participate (Schaefer & Eiken, 2003b). Wisconsin’s program also required existing support systems for residents to be classified as “ready to move” (Eiken, Stevenson, & Burwell, 2002). Michigan discovered that informal support was also affordable; participants often chose their families or friends as ‘paid’ providers due to the difficulties in finding providers from service agencies (Eiken, Burwell, & Ascutto, 2002). In our review, none of the state discharge programs specifically provided caregiver support, either through training or ongoing assistance. However, they may have referred them to the National Family Caregiver Support Program.
Identifying Multiple Sources of Informal Support That May Be Available

When attempting to identify and solicit the help and support of family members, neighbors, and community groups, NF staff members found that it was especially helpful to encourage the person discharging to talk with people and groups he or she was involved with prior to discharge. Contacting and working with informal support persons helps in identifying how they plan to contribute and what gaps need to be filled with other community services.

“Knowing what kind of support they have in the community is real important. Do they have family that can check on them a couple times a week? Do they have someone that calls them every day? Do they have a neighbor that comes by and takes care of this or that? How do they get to their medical appointments?” – Social worker from large facility

Because formal community services may not be able to provide around-the-clock care and monitoring for residents who discharge, informal support persons are often relied on to provide that regularly needed assistance.

“A lot of times it’s family. So it’s almost always family and friends that do the 24-hour supervision.”
– Social worker a facility in an urban area

Further, NF staff talked about the importance of getting to know volunteers in the community willing to help older adults. In one particular community in a rural area, NF staff knew volunteers willing to drive older adults to appointments or activities, so prior to discharge, they would connect the person who is discharging with these volunteers. Two NF social service staff members even discussed having NF staff members bring in donations to help persons who were discharging and did not have necessary household goods to make the move possible.

“And facility staff actually took up a collection of towels, blankets, furniture, and set her up. Cookware, dishes, you know, just everything you can think of. Even the folks that don’t have very much themselves will come up with help for what they see as [an opportunity for] our people to go out and have another chance. It’s amazing what they will do. Not that they should have to do that, but they do it.”
– Social service staff with 15+ years experience

Helping the person identify religious groups can also be especially helpful, as these groups can often provide both tangible assistance and emotional support to those with mental illness.

Strategies for Identifying Informal Supports from Other States’ Transition Programs

Some state transition programs used unique ways to find informal supports for participants. Wisconsin CILs convinced guardians and informal caregivers of their importance by supplying success stories to reluctant guardians and connecting them to those who made successful transitions (Eiken, Stevenson, & Burwell, 2002). Colorado worked with residents currently in the hospital, for they discovered it was easier to educate family members and hospital social workers about providing informal support until HCBS services began, since they are gathered in this setting (Holtz & Eiken, 2003).
“I’ve found that for a lot of folks with mental health [diagnoses] that church support is something that they rely on a lot. And I think that’s been very helpful in both getting things done as far as home modifications but also providing that [emotional] support.”
– Social worker from a facility in an urban area

When informal support people are acting as full-time caregivers, identifying supports for them is also important, which will be further discussed on page 89.

Involving Informal Caregivers in Each Phase of the Discharge Process

As discussed by NF staff members, encouraging residents to request that informal caregivers take part in regular care plan or other interdisciplinary team meetings, especially meetings involving discharge planning, can be especially helpful. This aids in setting discharge goals and determining supplemental, formal services needed to ensure successful discharge. One NF staff member who was interviewed talked about the importance of having regularly scheduled meetings with all those involved. This helps with ensuring everyone is involved with planning for discharge from the very beginning.

“And we have care plan meetings with the residents and the families. And those are done every 12 weeks for each resident here in long term care. When they’re ready to be discharged, we always have a discharge meeting prior...a week or two before...just to make sure the family and the resident understands what our concerns might be, and they can keep us up-to-date on the progress they’ve made and home improvements and services.”
– Social worker from a CCRC

Furthermore, when setting up community services, NF staff members encouraged persons who were discharging to have informal support persons help make phone calls to establish community services. This aids in developing supportive relationships between the individual who is discharging, informal support persons, and the community providers. Finally, NF staff members noted that informal support persons’ level of engagement in discharge activities can be indicative of whether or not a person will actually follow through on promised support. Therefore, involving the informal support persons throughout the discharge process helps to ensure the resident has a better chance of success living in the community.

“If we absolutely can’t get a family in here, and they tell me that they’re going to be the caregiver in the community, that’s kind of a red flag for us. That makes us go, ‘Okay, are they really going to be able to provide the support this resident needs... if they can’t come here for a 15 minute meeting?’ Or do we need to get more outside resources to help support that family and resident?”
– Social worker from a facility in an urban area

Providing Information to Informal Caregivers on the Resident’s Physical and Mental Health Conditions & Treatments and Caregiver Support
In order to help persons avoid re-entry following discharge to the community, many NF staff members found that providing information to informal caregivers about mental health diagnoses and behaviors, physical health conditions and treatment, and community services was especially helpful. In fact, nearly every NF staff member who was interviewed discussed this discharge strategy.

**Mental health.** As the following quotes reiterate, a number of NF staff talked about helping family members learn about mental health diagnoses and related behaviors, thus avoiding questions from informal support persons such as, “Why is he/she being so difficult?”

“[We provide information] so that they understand what to expect because frequently the medical profession doesn’t go a very good job explaining over all the diagnoses, behaviors associated with those, medications that they’re on, why they’re on them, how they might interact with each other. The thing that would offer a level of comfort [is] to know this is not unusual behavior.” – Social worker with 10+ years experience

Furthermore, NF staff members found that helping families and other support persons learn the difference between a mental health symptom and something “out of the ordinary” was helpful for identifying when they might need call for help. As this NF staff member discusses, sometimes mental health diagnoses can manifest in ways that families need guidance with in handling behaviors.

“So our taking it in stride and helping them to see that [certain behaviors are] not unusual, is not even unacceptable... we just need to help [the parent or loved one] express themselves in an appropriate and private manner.” – Social service director with 15+ years experience

Related to this, NF staff suggested being honest and forthright about health conditions and behaviors with persons and family members helps them be realistic about planning for needed community-based services, such as a psychiatrist or respite care.

**Physical health.** Related to physical health conditions, a number of NF staff members discussed the importance of providing information to informal caregivers about physical health conditions and showing them how to complete important medical treatment tasks. As a suggestion from NF staff members, it has been helpful to have a nurse demonstrate to residents and/or support persons how to perform a health care task, watch them try it on their own, and then, provide recommendations and suggestions to help. The following example relates to physical therapy and the use of equipment, but could also be applied to other tasks related to physical health conditions, such as giving insulin, changing an oxygen tank, or using a feeding tube.

“If we have residents here that are working in [physical] therapy, a lot of times the family and the friends will go to the therapy session to watch what the therapist is doing. Especially if they’re being discharged and they’re sending [the resident] home with some sort of instructions on how to continue doing therapy in the home. Also, to see how they’re doing with their transfers or especially if they’re using a piece of equipment that’s different than they’ve used before, whether it’s a wheelchair or a walker or a cane or something like that.” – Social worker from a facility in a rural area
**Caregiver support.** NF staff emphasized the importance of providing resources for caregiver support groups or websites to help alleviate caregiver stress. Since informal support persons are particularly important for discharge, many NF staff found that they needed to take extra time to ensure caregivers received the support they need. The following two quotes from social services staff discuss support groups. In addition, respite care, such as using an occasional care provider or adult day care, was also suggested.

“I’ll have them come in and sit down, and we will go over (if they have the Internet) websites to go to for caregivers. There are diagnosis-related caregiver websites, like for Alzheimer’s care or stroke care. Depending on what they need, I’ll do that.”
– Social worker from a facility in an urban area

“That caregiver often feels a lot of guilt if they’re not able to provide the type of care they need at home. I don’t do the same thing every time [to help them]. It’s pretty individualized. I have a lot of support group information that I give out for caregivers. I have a list of caregiver support groups in the area. I just copied and pasted [information] off several different websites that I went to and found.”
– Social service director from a large facility

One social services director/social worker told a story about a lesson she had learned from one situation in which a resident discharged and returned multiple times. This was a situation where the NF staff member was told that care providers from a community service agency were turned away multiple times when they would attempt to provide services for the person who discharged. Furthermore, the NF staff member was told that the person would not attend outpatient mental health therapy as recommended. Eventually, after three discharge and NF re-entry occurrences, the NF staff member identified that it was the daughter who would turn away the caregivers or not take the family member to her appointments due to the daughter’s own mental health issues. Therefore, looking back on the unfortunate situation, the NF staff member wishes that she had gotten more involved with the family member and helped her identify needed mental health support services and/or support groups when the staff member was first helping to discharge the resident, which may have helped avoid the re-entries that did occur.

**Presenting Options for Those Without Informal Support**

For individuals without access to informal support persons, NF staff members found it helpful to encourage individuals to utilize AAAs, CMHCs, and/or assisted living facilities. NF staff emphasized the importance of helping the person identify a AAA or CMHC case manager, particularly a social worker with aging and mental health training, to ensure needs are being met through various formal services.

“Almost always there is [informal support]. And if not, then we do look to make referrals to community mental health centers and the Agency on Aging.”
– Social worker from a facility in an urban area
As this social worker discusses, identifying a community service agency that can provide the individual with an actual social services staff person, rather than only health care providers, is especially important for ensuring adequate support in the community.

“I try to use home health companies with social services [for] people I know could be at risk or who really have minimal support at home. [The resident] might tell me “no” [to services], but when they get home and realize how hard it is and that they’re struggling, that home health social worker can come in and continue to work with them.”
– Social worker from a small facility

Additionally, staff found that assisted living facilities and supportive housing might be good options due to their ability to provide wraparound services and regular monitoring.

“We don’t send a lot of people that don’t have the informal support. If they don’t have that, then we find that they do better with the bundled services in assisted living, and that’s our recommendation to them.” – Social service director from a CCRC

Community Services

All NF staff members involved in discharge cited the importance of including formal community services in discharge planning. In general, NF staff members who have helped successfully discharge Medicaid residents with mental health diagnoses had very in-depth knowledge of the community supports that were available to help assist individuals living in the community. In most cases, NF staff members discussed including the use of community services throughout the discharge planning process. As further detailed in this section, the discharge strategies related to community services considerations include:

- gaining a breadth of knowledge about available community services;
- building relationships and networks with fellow NF staff and community service professionals;
- utilizing community supports that are available for daily monitoring & assistance and recreation;
- working closely with Area Agencies on Aging and Community Mental Health Centers;
- and providing continuity of care across nursing facility and community settings.

Gaining a Breadth of Knowledge about Available Community Services

Most NF staff members had a breadth of knowledge about the services available in their community—local, state, and national services. See Table 8 for a list of services that were referred to in the interviews. NF staff members who have helped successfully discharge Medicaid residents with mental health diagnoses into the community also had a basic understanding of the specific services provided by various community supports, the procedures for initiating these services, and eligibility requirements.

“It’s real important to be able to know what your community resources are and to be able to advocate for the residents to get them set up. I just think the more we know about the community and ... the different programs and how they work, the better we’re going to be [able] to help the patient.” – Social worker from a Southeast Kansas facility
To the extent that they are available, NF staff members encouraged persons who were discharging to involve representatives from the various community service agencies in discharge planning (e.g., meetings with NF staff members and informal support persons). This taught persons about the community supports available and helped secure community support before discharge.

**Building Relationships and Networks with Fellow NF Staff and Community Professionals**

Sharing resources and networking with fellow NF staff members and community professionals was discussed as an important component for helping persons who are discharging identify effective community resources. As such, NF staff members regularly made calls, held meetings, attended conferences or workshops, and used internet communication technologies to expand their knowledge of community resources.

**Meetings and events.** Attending meetings and events was found to be a helpful in networking with other NF staff members and community support professionals to find useful information. In turn, NF staff members stressed that they are more than willing to share their knowledge with others. As the following quotes emphasize, developing relationships with community service professionals is essential for successful discharge planning. Doing so can make qualifying for services more efficient for persons who are discharging, which may improve the likelihood that persons discharging into the community will utilize community supports.

“We [are] so good with the community. We can push HCBS through pretty quick with them because they know us so well. ...So I think community relationships, we have a real good, strong relationship with most of the community workers that are involved with discharging, funding for the elderly ... and Medicaid patients.”

– Social service director/social services designee with 20 years experience

“Hands on, one-on-one, calling people, getting acquainted, making friends, being sure they know who you are and you know who they are, is probably the most helpful thing that we do ... the old saying is, it’s not what you know, it’s who you know. It’s absolutely true, because if you need

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something and you don’t know where to go, you can usually call an acquaintance, friend, that you’ve made in another agency that you’ve helped with something and say, I really need your help with this, and sometimes by able to get assistance that you might not have been able to get before. It’s through personal contact. You interact, and you serve on committees, and you go to meetings, and you try to be sure that you make yourself available as well as accessing other people. ” – Social worker with 15+ years experience

NF staff members discussed various avenues for building relationship and networks with NF staff and community professionals. Hospitals and hospice organizations often offered trainings. Some NF staff attended community provider luncheons or workshops, or even invited community providers into the NFs to distribute information to NF staff members and residents. NF staff also attended Area Agency on Aging meetings, where they met other professionals to share ideas and collaborate.

“The collaboration is really just kind of a win-win for everyone… There’s a lot of things, especially here in this area, that you can go to, which is where I meet most of my people. I meet a lot of resources from other places and we collaborate together. Hospices do a lot of CEU type things, and a lot of people in the community go to them …. I don’t go to all these brown bag lunch series, but I try to go to as many as I can.”
– Social service director from a large facility

“Well, it’s just a part of the job description, you know? I need something, I call, and I’ve been involved in Area Agency Expos, and got acquainted with the staff through sharing ideas and activities and social services … They share ideas…. They have a district meeting of all the activity directors for social services. They get together once a month for a day of sharing and presentation in regards to something that would be helpful in the nursing homes.”
– Social service director from a facility in a rural area

Use of technology. NF staff members also found internet technology to be useful for communication and information sharing. For example, e-mail can make communication across providers more efficient. Furthermore, Internet searches can be used to identify and locate community providers, and email listservs can facilitate idea-sharing.

While one NF staff member in particular commended a national list serve that she participated in, she noted the creation of a listserv that was specific to Kansas would help NF staff members identify local resources and better understand state policies. Several other NF staff members agreed that a listserv for NF staff in Kansas would be useful. However, as discussed by a few of the NF staff member we interviewed, Internet access is not readily available in all NFs.

“When I started here, I didn’t have the internet and I’m like, ‘How am I supposed to find resources when I don’t have the internet?’ .... I do think technology is an important tool ... I’m on a listserv right now of nursing home social workers. The organizer is out of Iowa and it’s helpful. People will come up with an issue [and other people will give suggestions] and they share (assessment) tools on there.’”
– Social worker from a small facility
Access to the Internet and e-mail can also streamline communication between NF staff members, which is helpful for discharge planning.

“You can’t do this business without Internet access ... I mean we use it all the time. E-mail is one of our primary means of communication within the building, because you can communicate with a dozen people at the same time, in the blink of an eye.”
– Social Service Director with 15+ years experience

In addition, one NF staff member found that e-mail helped them communicate with family members.

“E-mail has become a great source of communication with our families, instead of them having to do a voicemail or put on hold... they have our e-mails. We have theirs. We can communicate, which I love, because you’re not interrupting their day...you keep that open communication.”
– Social service designee with 10+ years experience

**Utilizing Community Supports that are Available for Daily Monitoring & Assistance and Recreation**

In our review of the community services discussed during the interviews, NF staff member frequently discussed the importance of supervision and monitoring for older adults living in the community and their situations, medicine management (previously discussed at length on pages 72-74), practical in-home supports, and recreational opportunities. Ideally, plans for utilizing and/or receiving these kinds of services are made so that they are immediately available upon moving back into the community.

**Supervision & monitoring.** As described by NF staff members, a very important task of formal community providers is to monitor the general health and safety of NF residents who discharge to the community. In addition to informal supports, case managers or homecare providers could be looked upon to provide consistent monitoring of residents. Ideally, community support providers develop a good relationship with their client and meet with them on a regular, consistent basis to be best able to identify any concerning changes in their physical and mental health.

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**Strategies for Filling Gaps of Community Programs from Other States’ Transition Programs**

Often, states used programs to supplement other programs. For example, when some Wisconsin participants had bad credit and therefore experienced trouble finding an apartment, they were referred to the Wisconsin Coalition for Advocacy, which connected them to attorneys doing pro bono work (Eiken, Stevenson, & Burwell, 2002). Since Wisconsin lacked thorough public transportation, an independent living center combated this issue by using transition grant money to buy a van, which provided transportation to those who returned to the community (Eiken, Stevenson, & Burwell, 2002). In Michigan, CILs sometimes paid for the transition period between residing in the NF and beginning to receive services in the community (Eiken, Burwell, & Ascutt, 2002).
“If they have the home health of some sort, that you’ve got someone that’s going in and can really see how that patient is doing or … if they see that things are declining, that they can give a heads up or even say to the resident, ‘You know what, I’ve noticed that you’re not doing as well,’ or, ‘I’ve noticed that you’re aching or you’re moaning every time you get up,’ or, ‘You’ve been missing your medication,’ or, ‘You’re wearing the same clothes every day,’ if their mood is declining. So that they can either talk to the resident about it or notify a family member or even call the physician’s office to kind of catch it before it really escalates.” – Social worker from a large facility

In addition, monitoring to ensure individual safety in regard to abuse, neglect, and exploitation is important for successful discharge. One NF staff member was concerned that there is little accountability and monitoring of home care providers and agencies, especially compared to the regulation of nursing homes. She is concerned that there is a higher risk for abuse and exploitation and there is a lack of a back-up system to deal with workers who do not show up. A more common concern across NF staff members who were interviewed was that family members and friends who serve as self-directed service providers may take advantage of the persons they assist. NF staff members who were concerned about these kinds of issues contacted AAA case managers or Adult Protective Services to let them know of the potential problems.

“And what I see as kind of a hindrance is a lot of times they’ll pick a relative or a friend of a friend or a friend who likes getting paid to do the services, but before you know it, they’re sitting on the sofa watching a soap opera drinking iced tea and not really doing what they’re there to do.” – Social worker from a facility in a rural area

Assistance. NF staff members found that community providers were also important for providing daily assistance sometimes required for successful living in the community, such as meals, housekeeping, and transportation. To this end, Meals on Wheels can be important, in providing regular nutritious meals that meet the person’s dietary restrictions. Home care services may also be important in providing these types of services, often accessed through the HCBS waiver.

The transition from 24-hour monitored care in the NF to periodic community services can result in high risk for error and poor outcomes, especially with medications. It has been shown that those who file a Medicaid claim for depression and live in the community are less likely to receive antidepressants than those who do so in NFs; therefore, the transition to the community could reduce access to medications (Strothers, Rust, Minor, Fresh, Druss, & Satcher, 2005). The need for access to medication in the community should be carefully assessed. Ensuring that needed medication for physical and mental health conditions is available should be central to discharge planning efforts for NF residents, especially those with mental health diagnoses.

States attempted to ensure that medical needs were met in the community through a number of avenues. Colorado recognized medication continuity’s importance by listing medication monitoring in its top five most necessary services (Holtz & Eiken, 2003). In Arkansas, a physician’s indication that a resident’s medical needs could be met in the community was necessary before the transition could occur (Schaefer & Eiken, 2003b). Michigan also consulted medical professionals to learn how to overcome transition barriers related to the resident’s medical condition (Eiken, Burwell, & Ascuitto, 2002). When Michigan encountered difficulties when seeking Medicaid authorization for medical equipment, it used grant funds to purchase its own supply of equipment (Eiken, Burwell, & Ascuitto, 2002).
“It’s someone there to help, can do shopping, can do errands, can take them to doctor’s appointments, can do simple housekeeping, [and] can help prepare meals. It’s someone that’s there to help make sure that their needs are being taken care of.”
– Social worker from Southeast Kansas

Financial planning may also be important, as persons using Medicaid are on a limited income. NF staff members involved in discharge or community-based case workers can help persons who discharge create a budget. To this end, NF staff members who have helped successfully discharge Medicaid residents with mental health diagnoses often worked with persons to determine eligibility for various types of assistance, and often worked with Social and Rehabilitative Services (SRS) staff members. Helping the residents and informal support persons understand exactly what, if any, co-insurance payments are required is especially necessary. Further, for those using Medicaid as a supplement to Medicare, being clear about qualifications for services related to showing health progress or number of days also helps avoid difficulties with community living. NF staff members also tended to know where to look to find affordable goods and services, including community charitable services.

**Recreation and companionship.** Recreational and leisure community services were discussed as important for ensuring psychosocial needs of persons who discharge from NFs with mental health diagnoses are met. NF staff members found that these services can decrease isolation and improve mental health. Senior centers and CMHCs often have recreational opportunities available. Current programs through AAAs, such as Senior Companions or Peer Support programs, may be able to provide needed companionship to Medicaid residents with mental health diagnoses who discharge to the community. Further, religious organizations, such as churches, also provide recreational and socialization activities.

“[W]e know that physical health and emotional health go hand-in-hand, and so it’s important for them to be able to get out and do things they’re used to doing and not isolate. And so we try and make sure they have those connections too.”
– Social worker from a large facility in a rural area

There is concern that transportation services are widely available for meeting medical needs, such as transportation to doctor appointments, but that transportation is not always available for recreational and leisure opportunities. While various community organizations provide recreational activities, persons who discharge may not be able to secure transportation to these events. In some areas, NF staff members stated that recreational transportation was available and seen as a great resource. For example, one of the CMHC’s was able to provide such transportation through a “New Freedom Grant.” NF staff also found that some home care services supply recreational transportation, and in urban communities, NF staff members would provide information to persons about public transportation options to help them pursue recreational and leisure interests.
Working Closely with Area Agencies on Aging and Community Mental Health Centers

In helping persons utilize community supports that ensure the health, safety, and psychosocial well-being, NF staff members who have helped successfully discharge Medicaid residents with mental health diagnosis commonly cited Area Agencies on Aging (AAAs) and Community Mental Health Centers (CMHCs) as valuable community services. A major benefit of both AAAs and CMHCs is that they can provide case managers for persons who discharge. Case managers can provide consistent oversight and may be able to take primary responsibility for medical management and financial management. NF staff members stated it was important to ensure case managers from one of these agencies was actively involved in discharge planning throughout the discharge process.

Area Agencies on Aging. Nearly every NF staff member interviewed discussed the importance of using Area Agency on Aging (AAA) services.

“Everybody who I’ve discharged has had a referral to AAA in one way or another—whether it be through case management or through the Explore Your Options (book), or getting help setting up their Medicare [Part] D plan. I think that’s a central place for our residents to get information.”
– Social service director from a CCRC

Kansas AAAs serve seniors in all 105 counties in Kansas through 11 different regional agencies (http://www.k4a.org). As NF staff discussed, these agencies are often the source of the knowledge about community resources, and, furthermore, they use AAA as the “go-to” source to get answers to questions or to locate resources. As such, AAAs are the “single point of entry” to initiate services for seniors (http://www.k4a.org).

Importantly, NF staff often worked with persons to contact AAAs prior to discharging in order to proactively identify and initiate services that will be essential to community living. The most commonly cited services provided by AAA include case managers, Meals on Wheels, and assistance with home modifications.

“I call the Agency on Aging all the time saying, ‘Can you do this? Can you do that? I know that there are often times that we need things like ramps built and there are some home modification programs available through the county or state or city.’”
– Social worker from a small facility

Many NF staff members also talked about using the ‘Explore Your Options’ resource book to identify appropriate services and also often provided persons and their family members with a copy of this book. As these three quotes emphasize, the ‘Explore Your Options’ books are highly recommended to aid with discharge and are utilized by NF staff members, residents, and family members. This resource book is especially helpful for persons using Medicaid, as the book can help with identifying providers and services that accepted Medicaid as a payer source.

“I use a lot of these Explore Your Options books, all the time; I mean there’s a number for everything in there.”
“We are blessed in having the Area Agency on Aging right here in town, and being able to access their Exploring your Options book.”
– Social service director with 15+ years experience

“We give them [residents and their informal support persons] a booklet-- Explore your Options. That’s from the Area Agency on Aging, and that has a lot of good and helpful information in it.”
– Registered Nurse from facility in a rural area

Workshops hosted by the AAA were also cited by NF staff as a good educational resource. NF staff members were entirely positive about the assistance that AAAs provide and found AAA involvement to be an essential element of successful discharge. When case managers are involved, they help to ensure a successful discharge for Medicaid residents with mental health diagnoses who discharge to the community and utilize HCBS waiver services to an assisted living facility or to an independent home or apartment.

“AAA, we’ve been involved with them since I’ve been here, in various ways. We have a case manager who handles all of our HCBS residents in assisted living. She’s an excellent resource. Any time a resident’s getting ready to go back to an HCBS apartment here, we call the case manager for them and they come out and assess them, make sure their care needs haven’t changes, and assist with their level of care changes in assisted living. And make sure that they’re getting all of the services that they need. So we work really closely.”
– Social worker from a large facility

Community Mental Health Centers. NF staff members discussed the importance of having Community Mental Health Centers widely available throughout the state. In fact, there are currently 27 licensed CMHC’s providing services in over 120 locations, including every county (http://www.acmhck.org). As discussed by NF staff members, CMHCs are often accessible for persons who discharge, even in rural areas, so they can be an excellent resource for those with mental health diagnoses.

“There are a pretty good splattering of Community Mental Health Centers. So if people do need follow-up in that (rural) area. We definitely put them in contact with those places. Most counties have one, if not one that’s close enough by that people are willing to go to that if they feel like they need it.”
– Social worker from a small facility

NF staff members often relied on CMHCs for community support. Commonly cited CMHC services that NF discharge use include case managers, individual therapy, group therapy, support groups, educational programs, and recreational opportunities.

NF staff members identified some limitations in CMHC services. One potential downfall was that there seems to be state-wide differences in the degree to which NFs and CMHCs can collaborate to provide care for NF residents. In particular, some CMHCs were able to come into the NF to provide...
ongoing therapy or support to residents with mental health diagnoses while others provided services to NF residents who travelled to the CMHC. Both approaches were helpful for ensuring residents could receive consistent, continuous mental health care while living in either the NF or the community. However, some NFs found that some CMHCs could not provide services for the NF residents, possibly due to a lack of available funding or workload issues. In these situations, NF staff members found it more difficult to discharge because of the lack of consistent providers and services. Another pressing concern is that there is a lack of mental health providers that specialize in geriatrics. One social service staff member, employed in a urban area, was very concerned about the decline of CMHC services due to funding cuts and heavy workloads.

Providing Continuity of Care across Nursing Facility and Community Settings

As discussed above, NF staff emphasized that it is important to provide consistent, continuous care across NF and community settings in order to successfully discharge Medicaid residents with mental health diagnoses. Providing a continuity of care can reduce the anxiety associated with residential transitions and can also better ensure that necessary services are being received without disruptions.

Doctors and mental health professionals. Related to this, NF staff members discussed that it is important for persons with mental health diagnoses to utilize primary care doctors and/or mental health providers across both NF and community settings. Because the resident has already established a relationship with these providers, providers that have a history with the individual are in a better position to observe changes in the physical or mental health. To help with this, in some instances residents were given the choice of continuing to use primary care providers or mental health practitioners in the NF that they used in the community or continuing to use providers and practitioners from the NF once they moved to the community. Furthermore, providing a continuity of care can avoid duplication of services, which can save money over the long term, particularly for Medicaid.

Due to funding limitations, NF staff mentioned that providing a continuity of care can be difficult but that it is possible, if providers’ practices are designed to serve both NF and community clients. For example, some NF’s employ physicians, psychiatrists, and other health professionals that also practice privately who can continue to see persons after they have discharged into the community. Therefore, identifying providers with this capability may be especially important.

AAAs and CMHCs. Building on this, NF staff members also aimed to initiate relationships between persons and community service agencies prior to discharge. This was a common practice between NFs with successful discharges and AAAs. AAAs tended to meet with persons prior to discharge to explore their options and set up services. When CMHCs were also able to initiate services or
meet with residents prior to discharge, it was helpful for assisting residents early on in the discharge process.

“In this one person in particular that I’m thinking of, this person had a caseworker [from the CMHC]. The caseworker would come in once a week and talk with her and take her out into the community. They would go shopping, you know, gradually re-introducing them to the community ... which really works for the best, because they’re panicky when they’ve been in such a controlled environment. When you get them out, they always say they want to leave. They want to go home, they want to live independently; but the actually reality is it’s very fearful and it tends to make them very anxious to get out there.”
– Social worker from a large facility

NF staff talked about the importance of providing a structure that allows CMHC staff to begin working with residents, especially those expected to discharge soon. Some NF staff members expressed that CMHC staff were once able to provide this service on a consistent basis, but are no longer able to do so because of budget cuts, stating that CMHCs cannot bill Medicaid for services NFs are expected to provide while the person is a resident. While avoiding a duplication of services is important to controlling budgets for public expenditures, if a short-term overlapping of services just prior to discharge was allowed, it is possible that long-term savings would occur as community living would be more successful and that anxieties associated with residential transitions could be eased. Further, residents with mental health diagnoses who are discharging may be more likely to use CMHC services once in the community. As this structure is not currently present in all areas, NF staff members stressed that they often make referrals to the local CMHC to ensure that services will begin immediately after discharge.

“The Community [Mental] Health Center that I work [with] has an SOS program, it’s Senior Outreach Services. And they provide case management to individuals over the age of 60 who have a mental health diagnosis, such as depression... So they can’t really receive those services while they’re in the nursing home, but once they go back into the community they can.”
– Social worker from a facility in a rural area

NF services. Continuity of care can be enhanced when NF services are available throughout the transition period. Some NFs are part of a larger organization with a campus of care that provides a variety of services for older adults, including independent living and assisted living residences. NF staff members found these types of organizations to be especially helpful for those with mental health diagnoses, in that they can provide a structured environment and continuity of care. Even when the Medicaid resident is discharging to a community environment separate from the NF organization, one NF staff member cited support groups that the NF offers for both their residents and the wider community, which can aid in providing continuity of services.
Social Norms & Social Policies (NF Policies and State/Federal Policies)

NF staff members have identified several strategies for successfully discharging Medicaid residents with mental health diagnoses into the community, as highlighted throughout this section of this report. Many of these strategies are incorporated into discharge processes that are typically used for all residents in these NFs that are interested in discharge. Therefore, NF staff members recommended that NFs establish in-house policies that support successful discharges. In this section, in-house policy suggestions include: establishing a discharge process using elements of various discharge strategies, utilizing a comprehensive discharge form, and providing ongoing training to NF and community staff about mental health and community resources. Discharge processes and considerations take place in a larger policy context, in which state and federal policy regulations as well as the availability of policy supports guide community living. For the population of NF residents in this study, Medicare and Medicaid guidelines are of the utmost importance. Therefore, in this section, the final suggestions from NF staff members related to social policies includes: working within policies of various social programs.

Establishing a Discharge Process Using Elements of Various Discharge Strategies

NF staff members who have helped to successfully discharge Medicaid residents with mental health diagnoses into the community have established careful and deliberate discharge procedures.

“We want to be able to do safe discharges. We want to have a good reputation. We don’t want somebody ending up going back to the hospital a week after we discharge him and say, ‘Yeah, they didn’t help me at all.’” – Social worker with 10 years experience

There was a wide range in the amount of time spent on discharge duties as reported by the NF staff members in our sample, ranging from an NF staff member who estimated that she spent only 2-5% of her time on discharge related tasks to another who estimated that she spent 75-80% of her time on such tasks. Despite this range, many successful discharge strategies and common themes emerged from the interviews. Several successful discharge strategies have been mentioned throughout this report, including providing information to individuals who discharge and their informal support personals on health conditions and treatments; planning for physical and mental health needs; identifying formal community supports for monitoring, daily assistance, and medication management; and supporting continuity of care across NF and community settings.

Therefore, incorporating these elements into a standardized discharge process to the extent that they are feasible for their community is recommended. Standardized discharge procedures set common expectations concerning discharge and better ensure that essential elements and supports will not be overlooked. In addition to the elements of successful discharge highlighted above, successful discharge planning begins upon admission, includes a team of qualified personnel, utilizes comprehensive discharge forms, and incorporates proactive involvement.
Discharge planning upon admission. NF staff members emphasized the importance of beginning discharge planning at admission for all residents. Early planning gives ample time to set up services and supports, coordinate schedules, address concerns, and complete physical and occupational therapy. Furthermore, early discharge planning also makes it clear to residents that discharge is a possibility and provides them a goal to work towards.

“It takes a long time to set up a discharge plan, but if we know from the get-go that that’s their plan, that gives us a lot more time to think through all the options and to explore what’s going to be available for them. So I think having that conversation initially is really important.”
– Social worker from a large facility

“When someone first comes in, if we think there’s any chance of discharge, we’re really staying on top of that. We’ll put a discharge goal on their Care Plan so that we’re checking in.”
– Social worker from a facility in a rural area

Some NF staff members stated that there was a difference between the way they initiate discharge with their short-term rehabilitation residents and their long-term residents. Although some staff members seemed more confident about discharging short-term residents, it was emphasized that long-term residents can discharge as well, especially when there is ample time to establish a discharge plan.

“The discharge plan begins at the beginning for everyone. The ones that are here short-term are usually a lot higher functioning initially . . . than the ones that are in here long-term and discharged. But we have a lady here right now that’s been here, she admitted here in September, and she’s going home at the end of this month [March].”
– Social worker from a medium facility

However, many of the NF staff did not differentiate in discharge planning for the short-term and long-term residents.

Strategies for Ensuring NF Buy-In For Discharging Residents to the Community from Other States’ Transition Programs

To promote and help implement successful discharge to the community, many states found it necessary to take steps to ensure that NFs support discharges. Therefore, many transition programs attempted to promote the NF industry’s buy-in by emphasizing that these programs simply provide an additional option for older adults, and that some older adults may choose to remain in the NF. Thus, consumer choice and motivation must be determined and considered when developing transition programs (Kasper & O’Malley, 2006; Matzo & Bernsee, 1990; Sohng, 1996). As briefly discussed in the FY09 report, capitalizing on opportunities to consistently instill the message that home and community-based care is possible for all may help increase NF buy-in to transition programs. In Oregon, additional personal outreach from program officials to NFs helped to build community confidence. Wisconsin found that NFs were especially cooperative after being informed that “people have the legal right to leave” (Eiken, Stevenson, & Burwell, 2002, p.7). In a number of states, NFs were concerned that transition program facilitators were licensing surveyors in disguise. To help combat this concern, New Jersey discharge program counselors gave presentations to the NF staff to emphasize that they were there to help them, not to report deficits to the state or replace NF discharge planners (Eiken, 2003). In order to support their goal to help the NF staff, the counselors aided in completing some of the Pre-Admission screening duties. Vermont’s approach was similar; by involving NFs early in the process and conducting meetings with NF staff, the program was able to ease concerns of program facilitators reporting licensing issues to the state (Eiken, Hatzmann, & Asciutto, 2003).
These staff members stressed the importance of considering each resident’s needs and goals individually, and not assuming that certain types of residents can or cannot discharge. Indeed, approaching all newly admitted residents about potential discharge goals can better identify residents who would like to work towards this goal.

“We start off with their voiced goal [rather than short-term versus long-term]. So whatever their voiced goal is. If they’ve come to us from assisted living or independent living, or from their home, we kind of automatically assume that their discharge goal would be to return home [regardless of short-term versus long-term designation].”
– Social service director from a large facility

“We’ve written discharge plans for several residents, though, that may at that time, we didn’t think that they could go home. And they can surprise you... so we like to start off with that initial interview and ultimately try to get them to understand what they need to do to meet the criteria to either go to an assisted living or return home.”
– Social worker from a facility in an urban area

Use of personnel. NF staff members who have helped successfully discharge Medicaid residents with mental health diagnosis recognized the diversity of residents’ support needs, and therefore included a variety of personnel in discharge planning. Therefore, successful discharge planning is viewed as a team approach, in which NF staff meet regularly with residents, their families, and various personnel, include social workers, physical and/or occupational therapists, speech therapists, physicians, nurses, dietary aides, mental health professionals, and community-based professionals. Team work is essential in both ensuring progress towards recovery is being made while in the NF and that proper supports and arrangements will be available once in the community.

“Everybody who has an active discharge plan is discussed almost on a daily basis. And the interdisciplinary team would be dietary, our executive director, nursing, and rehab, and activities as well ... just to make sure that if any other discipline has a concern about this resident going home that we can get that address ... and make the types of recommendations they would need to be successful at home.”
– Social worker from a large facility

“[Regular meetings] gives the family and the residents an opportunity to hear from all the different disciplines as well as to alter their goal. I’ve had a lot of residents come in saying, ‘I really want to go home.’ Well, as we get 30 or 60 days into therapy, we start to find out that maybe assisted living is going to better meet their needs. And that gives us the opportunity to explore that option with them and their family, with the whole disciplinary team being there. And that way, they can ask questions and make some decisions about their plan of care.”
– Social service director from a CCRC

NF staff members who have helped successfully discharge Medicaid residents into the community expressed the importance of including aging and mental health professionals in the interdisciplinary team. However, some NFs also expressed concerns about a shortage of mental health providers or geriatric specialists in their area. This corresponds with nationwide statistics stating that only 3% of psychologists
primarily specialize in geriatrics and less than a third have any graduate training in geriatrics (Niedens, 2008).

“We have to make sure they’re going to receive some kind of psychiatric help on the outside; not lots available out there ... especially for Medicaid residents.”
— Social service designee from a facility in Central Kansas

We interviewed both social workers and social services designees (SSDs). Some social workers expressed that their professional social work education gave them confidence to work with persons and their family members on discharge goals and planning. Some felt it was critical for NFs to utilize social workers for purposes of discharge, in order to, as one social worker stated, “not [be] an advocate necessarily of the facility or of the nurses, but [to be] an advocate of each patient.” A few of those with a social work education stated that they felt confident in their job capabilities within the first year of their job comparing it to SSDs who might take a number of years of the job to feel as confident. These statements were certainly not made to discount the value of social services designees, simply to state the significance of a social work education for helping to ensure NF staff members know how to advocate for persons so that they could receive needed supports.

“A lot of nursing facilities have SSDs. They don’t have someone with a degree in social work. . . I think utilizing a social worker is very important and I think it’s done a lot for this facility. . . I do think my training has been beneficial. . . So I think the importance of just the professional background is a big deal. . . Had I not had that education, I think I would have completely failed in this position.”
— Social worker from a facility in an urban area

**Comprehensive discharge summary form.** Some NF staff members stated that using a standard discharge summary was useful for ensuring successful discharges. Three NF social service workers provided us examples of their structured, discharge documentation. Names for the various discharge forms we saw included: Post-Discharge Plan of Care, Discharge Summary/Post Discharge Plan, and Discharge Planning Assessment. These brief 2-page forms typically included a comprehensive summary of discharge needs, instructions, and follow-up contact information across medical, psychological, functional, and social domains. Detailed information often included options for the variety of types of community services and medical equipment. These forms often came from third party sources, which are available at a cost to NFs.

Three common themes across the NFs’ documentation seemed to help facilitate successful discharges. First, the forms were planned for use by the resident and his or her family. For example, the forms minimize medical jargon and have instructions for sharing a copy with the family. Two of the NFs’ discharge documentation included signature lines for the resident and his or her family following statements of being fully informed about discharge plans. An example of these statements is: “These
discharge instructions have been reviewed with me in a language I understand. All questions have been answered to my satisfaction. I have received the medications or written prescriptions as indicated above.”

A second related theme was that all forms included an emphasis on the resident’s preferences and self-determination. Examples included prompts to explore resident preferences, resident goals for discharge, family goals for discharge, and highlighting that the resident will have several options for services upon discharge. One of the example forms contained a section entitled “Discharge Planning Assessment,” which was obtained through a third party source. This form was completed by the social service worker soon after the resident’s admission to the NF as a means to prompt formal assessment of discharge needs and goals of both the resident and his or her family. It also included over a page of open space to document ongoing planning notes. Such a form can (1) help facilitate proactive discussions between resident and family members to negotiate goals for discharge; (2) ensure previous formal service use and informal supports are catalogued, and (3) identify specific tasks for discharge well in advance.

As a third theme, the discharge documentation included planning for the diversity of physical and mental health, safety, and psychosocial needs. For example, the discharge plans often contain information on home health care, home care, medical equipment, home modifications, medications, nutritional and dietary needs, transportation supports, therapy services, and recreational and leisure pursuits. An interdisciplinary team, as described above, is utilized to ensure that all of these considerations are taken into account. In one instance, the NF had a single discharge summary that all disciplines within the NF would complete, each with a designated section. Thus, instructions from the social worker, nurse, dietician, and other personnel would be combined and easily accessible to the resident. At this NF, in addition to a Discharge Planning Assessment, the social worker developed a discharge summary with specific information about local community resources. She used the form to talk with residents and families about their options and to help them contact resources within the community. A de-identified copy of this form is included in Appendix C.

“This (discharge summary) is something that I developed... I think that a big part of discharge planning is education. Families and residents don’t know what services are available to them. They don’t know how to get them... So I try to be as concise as possible on this form with the typical things that might be set up when they discharge.”
– Social service director from a large facility

Finally, though a number of the nursing facilities had comprehensive discharge summary forms for helping discharge residents to the community, it is understood that this is not consistent across NFs in Kansas. As indicated by one NF staff member, “Not every nursing home actually has a discharge assessment.” NF staff members who were successful at discharge found that having these forms improved the efficiency of discharges and also provided residents and families with materials to take home, which helped avoid NF re-entry.
Proactive techniques. Many of the strategies already included throughout the report include examples of proactive (meaning taking the initiative by acting rather than reacting to events) involvement, including promoting medication and treatment adherence, contacting community providers prior to discharge, assessing the home environment, and providing persons and their family members information about community resources. Additionally, it was found that some NF staff members who have helped successfully discharge Medicaid residents with mental health diagnoses have a policy of being available for follow-up calls with persons who discharge or their families. Some of these staff members make it clear to persons who discharge and their families that they are more than willing to accept follow-up calls, while others initiate the follow-up calls themselves. Either way, NF staff members have found follow-up calls to be very useful in identifying problems and sharing resources.

“And then we always, of course, make routine follow-up calls after a couple of weeks of discharge, just to make sure that they’ve contacted anyone that they were supposed to contact or that we thought would be helpful . . . A lot of times, I get kind of general questions... It’s amazing. Sometimes people won’t call you, but if you call them, then the questions kind of start to come out. And you know, we don’t ever want them to think that just because they’re discharged doesn’t mean – you know, they’re not technically our resident, but we’d be more than happy to get them pointed in the right direction for resources.”
– Social service director from a large facility

Other NFs make sure that phone numbers are readily accessible for the residents and family members for when they return home, in anticipation that they might not remember to use the various hand-outs or pamphlets they are given if an emergency arises.

“[W]e still get calls, too. I can get calls, you know, two or three months later, you know? ‘Mom was at your nursing home, and now we’re having questions.’ So we can still send them to the correct resources in the community. So I think it’s important to establish that relationship.”
– Social service director from a large facility

“We make sure that they have a telephone and that they know how to use it, that they have any kind of emergency numbers, or if it’s a family member, and our phone number. We have a card ... we tape it right to the phone or have them write [it] where it’s easily accessible.”
– Director of Nursing with 10+ years experience

Providing Ongoing NF and Community Staff Training about Mental Health and Community Resources

Many NF staff members stated that they would welcome staff training on a variety of discharge issues. When asked about training to help increase NF discharge to the community for NF residents who use Medicaid and have mental health diagnoses, NF staff members indicated that training on mental health behaviors, available community services and resources, understanding policy regulations, and discharge strategies for helping those with mental health concerns would be especially helpful. As these various quotes emphasize, NF staff members believe that ongoing training is needed, finding they would
benefit with increased information about discharge processes or mental health diagnoses. Further, because community resources and policy guidelines are constantly changing and evolving, ongoing training addressing these topics would be helpful.

“I would love to have more training, more discharge training, for folks with mental health issues. In school, I didn’t even know I was going to work here, so they obviously don’t go over discharge planning or things. So this is something that I kind of learned on my own. If there were trainings for better ways that I could discharge folks with mental health issues and more resources, I would love to go to that.”
– Social worker from a large facility

“I think probably... mental health training. Probably just some basic awareness of what to look for as far as what kinds of behaviors are displayed with people that have bipolar or schizophrenia.”
– Registered Nurse from a facility in a rural area

Some were confident about their own staff members’ knowledge, due to experience and good communication with other nursing homes, but they did suggest training that might help other NFs increase their discharge rates for this population.

“Our facility does a training every year for social service staff and nursing on Medicare benefits so that we are really up-to-date with if there’s been any changes about that so that we can best help our residents utilize that resource or program.”
– Social worker from a facility in a rural area

“I think there are a lot of facilities who don’t know all the services that are available. I mean, I’m sure there are services we don’t know are available, but having done [discharge] for so long, it’s going to be less likely. But I think there are a lot of facilities that don’t have each other to bounce things off of that could benefit from training. Everything from dementia, depression, anxiety, bipolar, schizophrenia, knowing what they’re likely to encounter in the community, the biases that are out there in the community.”
– Social service director with 15+ years of experience

Working Within Policies of Various Social State/Federal Programs

Community living for older adults has become a prominent public policy goal. Government programs have been expanded to meet this goal, such as adding HCBS services to the Medicaid program. In addition, new programs have been developed to transition residents out of NF and back into the community. See Appendix D for background information about some of the federal and state programs and policies related to discharging NF residents. While these new policy efforts aimed towards community living are very noteworthy and promising, there exist persistent barriers and limitations in utilizing these supports. Policy barriers and gaps were a very common source of frustration among NF staff members involved in discharge.

Overall, the expansive knowledge of policy regulations held by NF staff members helped them to navigate the public system and to educate residents and their family members about policy resources and procedures. In some instances, simple administrative changes may help overcome shortfalls in policy
implementation. While NF staff members would ultimately like to see more funding allocated to
government assistance programs, they have also developed some innovative methods for overcoming
policy gaps and barriers.

**Working knowledge of policy regulations.** As persons discharge into the community, many will
rely on a variety of public programs to provide community supports and health services. While these
public programs are essential to successful community living, they are also very complex and ever-
changing. It is important that discharge staff members have an adequate working knowledge of how
public programs operate; such as what will and will not be covered by Medicare, Medicaid, and other
public programs. For instance, Medicare will only cover home-health care on a very short-term basis
under specific conditions. Through the HCBS-FE waiver, Medicaid will provide long-term in-home
personal care under specific conditions. NF staff members who have helped successfully discharge
Medicaid residents understood policy regulations very well and knew who to contact when questions
arose. Furthermore, they made it a point to help residents and their families understand and navigate the
system.

“So there are quite a few Medicare guidelines, quite a few volumes, if you want to get technical
about it. So keeping them informed of all of that, involving [persons who discharge] as much as
possible in returning to the level [of care] that they want to go back to.”
– Social worker with 10+ years of experience

“We try to be realistic. We also look at their financial situation for them just to see whether
finances are going to be a burden, because there’s Medicare that will pay a certain number of
days, and then, do you have co-insurance to cover the rest? Because if you start paying $137.50
a day for many days, that adds up pretty quickly, and you have a bill staring you in the face
where they thought — most of the people are told incorrectly [that] you have 100 days that
Medicare is going to pay for. That’s what people at the hospital tell them. That’s incorrect. So
they do have 100 days, but Medicare pays 20 days 100 percent; then whether they or their
insurance … or Medicaid is going to have to pay that co-pay. So providing them with that
information is extremely important.”
– Social service director with 15+ years of experience

NF staff members also understood eligibility requirements and application processes, and, therefore, were
able to assist residents and their families with these procedures.

“We like to start off with that initial interview and ultimately try to get them to understand what
they need to do to meet the criteria, to either go to an assisted living or return home …. And of
course, with Medicaid residents, trying to get them to understand where the payment issues lie
and what service they might qualify for.”
– Social worker from a large facility

**Policy issues.** There are some administrative barriers that can interfere with successful transitions
into the community, such as CMHCs not being able to bill for mental health services when NFs are
expected to provide them. Likewise, HCBS services cannot begin until after a resident has been officially

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discharged from an NF. As a result, home-care services are not always immediately available to former
NF residents who have recently moved into the community.

“The biggest barrier there is they can’t get the services as soon as they go home, [meaning] the
day they go home, because they have to actually be discharged from the facility to be coded over
for the Home and Community Based Service Waiver.”
– Social service director with 10 years experience

In these instances, NF staff members recommended that policymakers consider allowing for
HCBS and CMHC services to overlap with NF services for a short period immediately before
discharge.

Limitations in the types or amount of community-based services that can be received
through either Medicare or Medicaid is a common source of frustration among NF staff members.
The lack of adequate funding, for Medicaid in particular, was also a common complaint. As these
various quotes emphasize, cuts to HCBS services, limits to the number of HCBS customers in
assisted living, and limits to the number of Medicaid patients home health agencies or primary
care doctors will take make discharge to the community often more difficult for NF residents who
use Medicaid. Nearly every NF staff member who was interviewed communicated some type of
policy limitation.

“If you could find 24-hour care at home for somebody, that would increase the discharge, but
unfortunately that’s not there. Even HCBS has been cut back 10%. There’s no night service no
more at HCBS. So that’s been, I think in turn, increases census for the nursing homes because
people aren’t going to be able to make it at home without that night service.” – Social service
director with 20 years experience

“[I]t is so difficult to find … medical providers that accept Medicaid. In fact, there’s only one
home health agency that I know of in the whole area …. They’re the only ones I know that will
accept Medicaid, and then usually they’ll say, “Well, if we accept Medicaid, will you send us two
Medicares with is so we can offset the cost?’”
– Social service director from a facility in an urban area

“It’s also been kind of concerning and difficult to establish primary care physicians for some of
our residents. A lot of physicians aren’t accepting people whose primary is Medicare and second
is Medicaid. And there’s really limited dental care for them as well. So that’s been a concern for
our discharge planning.”
– Social service director from a CCRC

**Overcoming policy gaps.** Several NF staff who have helped successfully discharge Medicaid
residents with mental health diagnoses into the community have found ways to overcome policy gaps. A
common strategy is to identify and rely on charity, volunteer, or non-profit services. In fact, one NF that
was a CCRC had a private fund of donations to ensure that residents using HCBS waiver services could
access their independent apartments and assisted living facility.
“We have a fund that keeps people in their level of care. It's a private fund through donations. So that a really nice benefit in the continuum of care here .... We're a not-for-profit, and so a lot of our stuff is done through donations. We have what’s called a Good Samaritan fund, which allows our residents to remain whether in independent living or assisted living... They don't have to move just because they’ve run out of money.”
– Social Worker from a large facility

In one community, there is a hospital that provides a free loan closet for durable medical equipment, such as walkers and wheelchairs. At least one NF staff member was sure to keep herself aware of the date and location of the annual free dental clinic. Several NF staff members also indicated that they helped persons contact their churches to seek donations or volunteer labor to work on home modifications. NF staff members often found that landlords were willing to make home modifications above and beyond ADA requirements, as further discussed on pages 78-79. Finally, NF staff members themselves sometimes donated used goods or their own time to help persons preparing to discharge secure the goods they need for their new household.

**Summary**

In summary, discharge strategies across multiple of the ecological levels of influence have been used to help successfully discharge persons who use Medicaid and have mental health diagnoses to the community. The most useful strategy for avoiding hospital re-entries and NF re-entries was to help persons who discharge and their informal support persons understand physical and mental health diagnoses, related behaviors, and their treatment regimens, as well as the consequences of not adhering to medication and treatment recommendations. In order to support a safe discharge, conducting a team evaluation in the discharge location along with the resident and their informal support persons was recommended. Having NF professionals (i.e., a nurse, physical and occupational therapists, and a social worker) make safety and psychosocial recommendations within the context of the discharge location helps to ensure the home environment can meet the needs of the person who is discharging.

In line with findings from the Analysis of MDS Data, consulting with the person who is discharging to identify and solicit the help and support of informal support persons was discussed by most NF staff members who were interviewed. Informal support persons can provide needed tangible assistance and emotional support, which can be critical for a successful discharge. Further, working with informal support persons to identify their concerns about being a caregiver was also suggested for avoiding NF re-entry for persons using Medicaid, as this can help them identify formal services and supports to help them with their caregiver duties (e.g., support groups, respite care). In order to ensure persons who discharge are able to access needed community supports in a timely, efficient manner, NF staff suggested gaining a breadth of knowledge about available community supports and engaging in
activities that build relationships and networks with NF and community professionals. The use of technology was suggested as one method to help these efforts.

Finally, in considering discharge strategies across the multiple levels of influence (i.e., individual characteristics and attributes, physical environment, informal supports, and community services), it is recommended to establish a consistent, supportive discharge process that presents persons who are discharging and their informal supports with a variety of options to help make discharge successful. In doing this, using proactive discharge techniques (e.g., follow-up phone calls), utilizing detailed discharge forms; and providing ongoing training about mental health diagnoses, community resources, and policy regulations related to discharge to NF and community staff were discussed as important. These strategies help with setting discharge goals, ensuring NF staff members from various disciplines are involved in the discharge process, and contributing to increased discharge rates for persons using Medicaid who have mental health diagnoses.

**Conclusion**

Together, the FY09 and FY10 reports provide detailed information about transitioning NF residents using Medicaid with mental health diagnoses to the community. The FY09 report presented perspectives of NF staff and key stakeholders on discharges from the NF to the community, current approaches from a review of the literature, program building strategies from discussions with Money Follows the Person programs in other states, and an understanding of the mental health status of older adults who use Medicaid from a quantitative analysis of CARE Level I data. The FY10 report presents findings from analyses of MDS data in which we described a sample of residents who use Medicaid and have mental health diagnoses who successfully discharged to the community and provided information about transition patterns. It also contains a wealth of information from interviews with NF staff members on strategies that have been used to help this population successfully discharge. We synthesized information from all these sources to identify specific strategies for successful discharge and to develop strategy briefs and ideas for next steps in increasing rates of successful discharge. Section I, *Overall Study Recommendations*, and Section II, *Discharge Briefs*, of this FY10 report serve as a culmination of the findings from FY09 and FY10 research, providing KDOA with information that can be used to increase NF discharge rates for older adults who use Medicaid and have mental health diagnoses.
Glossary of Key Terms

Nursing Facility (NF): Any place or facility operating 24 hours a day, seven days a week, caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who, due to functional impairments, need skilled nursing care to compensate for activities of daily living limitations (http://www.agingkansas.org/LongTermCare/FacReports/Provider_Catagory_Def.htm). This includes long term care units of hospitals.

Resident Using Medicaid: An individual who had a Medicaid number (MDS item AA7) prior to the time of discharge to the community.

Nursing Facility Discharge to the Community: A move or transition for an NF resident out of the NF to a community setting for any length of time (as evidenced by answers 1, 2, or 3 to MDS item R3a).

Discharge Strategy: Services or other practices related to transitioning a resident from an NF to a community setting described by NF staff.

Informal Support: Support and resources provided by persons associated with the person receiving care that are typically provided without monetary gain. Persons providing informal support can include, but are not limited to, family, friends, neighbors, or members of a religious community.

Formal Supports and Services: Support and resources provided by the government, private agencies, or individual contractors. Examples of formal supports include, but are not limited to, visiting nurses, personal care attendants, case workers, AAAs, CMHCs, and charities.

Transition Pattern: Incidence of NF-to-community discharge and re-entry to the same or different NFs.

Primary Admission and Discharge: The first occurrence of an NF admission and discharge for individuals who have a mental health diagnosis upon admission and a Medicaid number prior to an NF discharge to the community.

Mental Health Diagnosis: A diagnosis of anxiety disorder, manic depression (bipolar disease), or schizophrenia (as indicated by a positive response to MDS items I1dd, I1ff, or I1ge).
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