

# **Nursing Facility Diversion: Mobilizing Residents, Families and Resources to Facilitate Return to Community Living**

The Report of the Turner Geriatric Clinic-Social Work and Community Programs  
Nursing Facilities Transition Grant

Final Report  
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**“Home is a lot better than where I was. When I got home, I thought, ‘God, I hope I make it. I hope we can make it together’ it was scary for me to leave, because I didn’t know if I could manage, but we are in good shape...for the shape we’re in! Without (my family’s) help, though, I would not be here today.”**

**Mrs. A., home after 183 days in the hospital  
and 212 days in the nursing facility**

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## INTRODUCTION

Established in 1976, Turner Geriatric Clinic is the outpatient program of the University of Michigan Health System-Geriatrics Center. Our goal is to help adults over the age of 60 lead healthier and more satisfying lives. Turner Geriatric Clinic provides comprehensive multidisciplinary geriatric assessment, as well as ongoing primary care for older adults. In the past year, over 20,000 patient visits were recorded. The Turner Clinic has provided quality patient care, health and wellness promotion activities, learning programs and community resource information for over twenty-five years. All of our staff has special training and an interest in working with older adults. Patients are seen by caring primary care physicians and specialists who are among the most accomplished researchers and educators in the field of Geriatrics and Aging. We are pleased that our clinical program has been recognized as one of the country's "Ten Best" Geriatrics Programs by *U.S. News and World Report*.

The Turner Geriatric Clinic-Social Work and Community Programs have achieved a national reputation for client-centered care. Using strength-based assessment and care planning methods, Turner Clinic social workers form enduring relationships with clients and families, meeting the challenges of aging, chronic and acute disease, loss, and functional change with creative allocation of services and resources to meet client goals. As stated in The Delicate Balance: Case Studies in counseling and care management for older adults, a textbook written by the clinical social workers at Turner Geriatric Clinic, "Knowing and respecting the client are hallmarks of compassionate caregiving....thorough client-centered assessment, a willingness to listen to client wishes and family perspectives, and an attempt to tailor care and services to an individual situation are reflected in high-quality service delivery. Time spent in relationship formation paves the way for open communication, ongoing modification of the care plan, and, most important, a relationship of trust among client, family and care (provider)." (1)

In the fall of 2001, Turner Geriatric Clinic agreed to participate in implementation of the Nursing Facilities Transition Grant. This was a three-year grant with an initial start date of 9/28/01 and an end date of 9/27/04. Effective 3/1/02 through 9/27/04, Turner Geriatric Clinic Social Work Department provided the following services under the *Diversion Component* of the grant. This component intended to establish a hospital-community liaison at University of Michigan Health Systems (UMHS) to assist in the diversion of hospital inpatients from potential nursing facility placement to community living.

- Work with hospital staff to identify UMHS inpatients at risk for nursing home placement, upon hospital discharge, due to lack of housing options and/or adequate community support services. Develop a screening tool that can be used by hospital staff to readily identify such "at risk" patients.
- Supplement normal discharge planning for this "at risk" group of patients by providing resources for alternative placement or community placement, as clinically appropriate.

- Work with other community agencies and the *Transition Component* of this initiative to develop an information and referral system which will triage patient need and inform patients and their families of community living options and community support services.
- Develop a tracking system for monitoring UMHS patients discharged to nursing homes in Michigan.
- Support individuals who cannot be diverted from nursing facility placement to assure that the nursing home placement is a short-term option and that a community alternative is developed.
- Collaborate with nursing facility personnel to identify resources to maximize the potential for return to the community for those individuals who could not initially be diverted from nursing home placement.
- Gather information on promising practices from current hospital-community agency relationships that reduce inappropriate nursing home placement due to lack of housing options or community support services.
- Work with Michigan Department of Community Health (MDCH) staff to access housing and service options and relocation assistance resources, including the last-resort transition fund component of this initiative.
- Work with the Michigan State Housing Development Authority's Community Housing (MSHDA) Initiative to divert patients from potential nursing facility placements into community living at MSHDA supported housing.
- Work with the *Educational Component* of this project to assure that knowledge obtained from the grant effort is disseminated in the community.
- Identify barriers to community placement of hospital patients and work with the *Evaluation Component* of this project to capture the "lessons learned" from this effort in order to facilitate the replication of the project.
- Participate in all planning meetings and trainings necessary for successful implementation of the grant goals and objectives.
- Provide all reporting documentation (including programmatic and fiscal) as required by the Michigan Department of Community Health.

The target goal set by MDCH for participants identified and tracked over the course of the Diversion project was 100. For the purposes of this project, *diversion* was defined as:

**DIVERSION:** A process of preventing inappropriate nursing facility placement for persons at risk, by thorough assessment of functional status and needs, timely referral to appropriate resources and services, education and support of persons at risk and their family, friends and advocates, and follow-up to assure utilization of services and monitor for changing needs.

Persons at risk for inappropriate placement in nursing facilities include individuals with compromised functional status; including physical impairments, cognitive impairments, and psychological limitations. Factors such as limited family and social supports, compromised financial status, legal issues, and inadequate housing place persons at risk for nursing facility placement.

Those at risk for inappropriate nursing facility placement may reside in the community, but are struggling to manage their needs. They may be in the hospital with an acute illness, or an exacerbation of a chronic illness, and under consideration for nursing home placement. They may be in a nursing home for a rehabilitation stay under Medicare or other insurance, but lack a coordinated effort to return to the community.

#### Changes in the State of Michigan during the course of the Diversion Project

In the initial Systems Change Grant Proposal to the Center for Medicare and Medicaid Services (CMS), a key issue was lack of affordable, available, safe housing for those at risk for inappropriate nursing facility placement. While this was less of a concern with our participant population, most of whom entered the project with intact housing; it remained a problem in other components of the state-wide grant.

A major source of support to participants desiring to return to community living, the Michigan Medicaid Waiver Program, evaporated when the State closed the program in December of 2001 due to budget constraints. This placed a greater emphasis on creative acquisition of services than had been anticipated in the original proposal.

An additional change in State government during the course of the grant was the election of Jennifer Granholm as Governor of the State of Michigan in November, 2002. The Granholm Administration has increased the role of the Michigan Long Term Care Work Group, and has supported its emphasis on person-centered planning, a model of consumer directed provision of services.

Despite leadership and staff changes at the MDCH and MSHDA level, the Turner Diversion Project staff were kept informed, and remained committed to the State-wide effort in Transition and Diversion from inappropriate nursing facility placement.

#### **PROJECT IMPLEMENTATION**

After goals for the Turner Geriatric Clinic Diversion Component had been identified with the MDCH staff, Turner project staff was employed. Staff to the project included one .5 FTE master's social worker, Alene Blomquist, to identify and enroll hospitalized persons with anticipated nursing facility placement plans as participants (\*), and one full time master's social worker, Andrea Carroll, to monitor the nursing facility stay of enrolled participants, and facilitate community return. Project oversight and clinical supervision was provided by Katherine Supiano. Ruth Campbell, Associate Director for Social Work and Community Programs, was Principal Investigator under the University of Michigan Institutional Review Board (IRB).

*(\*)For the purposes of this report, the person placed in a nursing facility, or potentially placed in a nursing facility will be referred to as a participant, rather than subject, client, resident or patient, as is commonly referenced by location.*

While the project was under final IRB review, Ms. Carroll established contact with the administrators and social workers of the 28 nursing facilities that receive most transfers from UMHS (an additional 6 nursing facilities were later included). These facilities included nursing facilities in Washtenaw, Wayne, Genesee, St. Clair, Lenawee, and Livingston County (some participants additionally resided in Sanilac, Huron, Jackson and Ingham counties). Considerable effort was made to meet with and explain the project to nursing facility leadership and staff, enlisting their support, ensuring ready access to participants and their families, and to obtain Minimum Data Set (MDS-RAI) records for participant tracking. This time investment was well worth the effort, and our project staff enjoyed effective working relationships with facility staff, and was regarded as a support to their efforts.

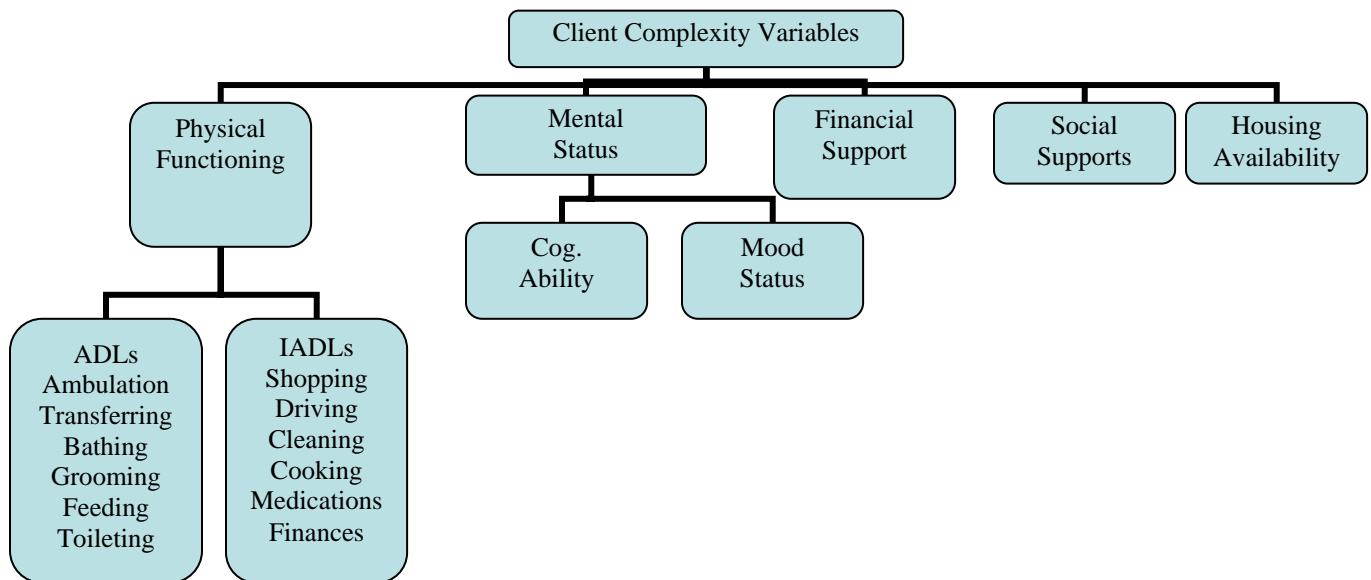
### Identification of inpatients

The University Hospital at the University of Michigan Health System is a large, tertiary care teaching hospital. The inpatients receiving care represent a greater level of medical/surgical acuity and complexity than found in the typical community hospital. Given these characteristics of its inpatient population, the University Hospital is a high utilizer of Medicare-insured ECF beds. For example, in FY 2003-2004, the University Hospital had:

- An average of 1,174 adult medicine admissions per month.
- An average of 2,388 adult admissions (excluding Psychiatric, Rehabilitation, Obstetrics, or Research) per month.
- An average of 155 Adult ECF placements (defined as ECF, Sub-Acute, Long Term Acute Care, Inpatient Hospice) per month.

Project attention focused on participants who were expected transfers to Nursing Facilities (ECFs), most typically under Medicare, for a rehabilitation stay, but because of other factors of patient complexity, were likelier to remain in the nursing facility as a permanent placement. Potential participants were identified as those with 1) significant medical concerns and impaired physical functional status such as deficits in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) which warranted skilled nursing facility placement; and 2) at least one other complicating variable such as, impaired cognitive functioning, poor mood status, limited financial support, inadequate social supports, or inadequate housing (see chart below).





### Enrolling inpatient participants

The inpatient social worker assigned to this project, Ms. Blomquist, screened potential participants using existing UMHS discharge planning software. For the purpose of this project, and under the direction of MDCH staff, the project excluded persons who were hospitalized from a nursing facility where they had been a resident for >2years as these were considered "transition," not "diversion" situations.

Considerable time was spent explaining the project to potential participants and their families, answering questions and obtaining informed consent.

Several barriers in recruiting hospital inpatients to become participants emerged, including those limiting our ability to obtain informed consent, including:

- Difficulty communicating with patient (language barrier, acute psychiatric condition, ventilator status, isolation precautions, frequently out of room for tests/treatments.)
- Patient wants only their advocate (DPOA) to give consent.
- Rapid turnaround from admission to discharge.

Other barriers resulted in a refusal to sign informed consent, including:

- Patient/family suspicious of signing a document, participating in research, allowing use of medical records.
- Aversion/denial to nursing facility discussion.
- Anger directed at Federal/State government regarding how tax dollars are spent.
- Patient/family overcome with emotion.
- Patient/family did not want to consider diversion effort.
- Concern that Project staff involvement will upset nursing facility staff.

After obtaining consent, an exhaustive chart review was conducted. Ms. Blomquist met with the patient and family to identify participant goals, determine existing housing, and review financial and social supports. Collaboration with hospital discharge planners and social workers led to diversion decisions, or goals for the nursing facility stay.

Ms. Blomquist wrote thorough assessments and transferred participants to the outpatient social worker assigned to the project, Ms. Carroll.

#### Monitoring and serving participants in the nursing facilities

Upon transfer to the nursing facility, Ms. Carroll notified the facility and provided copies of consent documents to obtain nursing facility medical records. Depending on the participants' personal goals and progress, Ms. Carroll met with or communicated with the participants, family members and nursing facility staff at intervals, and attended care conferences as appropriate. The frequency and duration of contact varied widely according to the goals of the participants, and clinical needs as identified by Ms. Carroll.

Among the many challenge and barriers in this process were those affecting data collection, including:

- Difficulty in initially contacting administrators of participating nursing facilities to familiarize them with project.
- Turnover of administrators and social workers at participating nursing facilities, requiring reorientation of new staff to project goals and procedures.
- Difficulty in obtaining information from contact persons in nursing facility due to limited time in their heavy daily schedules.
- Contact person not returning phone calls.
- Contact person not available due to care conferences.

- Hesitation on part of nursing facility to reveal information, MDS data.
- Participating nursing facilities distributed over a wide geographic area.

Other aspects of the participants' situations made relationship formation and executing the plans challenging, including:

- Participant was cognitively unable to express his/her needs.
- Family members difficult to reach by telephone or in person at the nursing facility.
- Participants not in their rooms due to therapy, receiving nursing care at time of visit or out of facility for appointments.
- Participant was too ill to discuss needs.
- Participant died shortly after entering nursing facility.

Despite these challenges, Ms. Carroll formed close working relationships with most participants and their families, friends and advocates. She was able to do this without alienating the nursing home personnel who might have viewed her as a threat to their procedures or scrutinizing of their work. Instead, Ms. Carroll carefully positioned herself in a role which complimented and supported staff efforts. At her first visit to each facility, she provided the facility social worker with a complementary copy of the Turner Clinic Resource Guide, Where to Turn, and provided support to overworked staff as appropriate. Particularly in facilities caring of residents whose homes were far from the facility, nursing facility social workers appreciated her knowledge of services and resources in other communities.

## PROJECT FINDINGS

Over the course of the project, 118 participants were enrolled, and 90 of these were transferred to nursing facilities for monitoring and service, as described below:

Participants w/signed consent	118
Participants who died at UMHS before discharge to nursing facility	3
Participants w/signed consent discharged from UMHS to location other than nursing facility (in-patient rehabilitation hospital, other hospital, or home)	25
<b>Participants w/signed consent discharged to nursing facilities</b>	<b>90</b>
Died in nursing facility (7)	
Died in UMHS after nursing facility (4)	
Died in hospital other than UMHS (2)	
Died in hospice residence (3)	
Died at home with hospice (5)	
Died after returning home (7)	

Returned home, later returned to nursing facility and died (2)  
 Currently in hospice residence (0)  
 Currently home (51)  
 Currently re-admitted to hospital (0)  
 Currently being followed in nursing facilities (9)

### Characteristics of participants

Of the 118 participants enrolled in the project, 80 were female, 38 were male, consistent with the overall demographics of an elderly population with a higher proportion of females, and females living alone. The majority of participants were without a spouse; 47 widowed, 17 single, 10 divorced, and 44 married. The participant population was predominately Caucasian (89%). As Tables 1 and 2 indicate, participants spanned a wide range of ages and education levels.

Table 1

Age	
Age Range	Number
<65	20
65-75	28
76-85	48
>85	22

Table 2

Education	
Ed. Status	Number
Unknown	3
Elementary	2
High School	50
Vocational	21
College	29
Grad School	13

Prior to hospitalization, most participants were insured under Medicare with supplemental insurance. Seven participants had private insurance, and the remainder was funded under Medicaid, Disability, or Worker's Compensation.

Table 3

<b>Payor Source</b>	
<b>Insurance</b>	<b>Number</b>
Medicaid/Effective at admit	3
Medicare + Medicaid	8
Medicare + Supp Ins	96
Medicare Disability	2
Private Insurance	7
Worker's Compensation	2

A representative range of participant length of stay (LOS) at UMHS was obtained. Many participants experienced brief hospitalizations, typically representing acute illnesses, or acute exacerbations of chronic illness with rapid discharge to a nursing facility (n=40). Others had moderate stays of 6-14 days (n=50), and another 28 had lengthy stays of greater than 2 weeks. One participant, who will be detailed in case study later in this report, had a length of stay of 183 days.

Table 4

<b>Length of stay-Hospital</b>	
<b>Days</b>	<b>Number</b>
<=5	40
6-10	33
11-14	17
15-20	13
21-24	8
25-30	1
31-60	5
>90	1

Most participants had urgent or emergent hospitalization with admission through the Emergency Department. Of the 86 participants hospitalized for acute illness, the majority experienced an acute episode of an underlying chronic illness, or an acute illness in addition to one or several chronic illnesses.

Table 5

Reason for Hospital Admission	
Reason	Number
Accident/Injury	16
Acute Illness	86
Chronic Illness	7
Disability	2
Scheduled Surgery	7

In addition to the demographic information on the 118 enrolled participants, assessments were done to identify barriers to a return to community living. The most prevalent housing barrier (n=15) was support available in the pre-hospitalization residence was inadequate for the participants' needs, or the housing structure was inadequate for a direct return home. Another barrier to direct discharge to home was insufficient family support; either the needed family member was geographically too far away to provide support (n=8), was emotionally unable to provide the needed support (n=4), or was physically unable to provide the needed support (n=23). For 29 participants, no family member to provide assistance for the participant at home could be identified during the hospital stay. Insufficient financial resources were another barrier to direct discharge home. For some participants, obtaining waiver services (during the State of Michigan hiatus in the Medicaid Waiver program) was a problem. For others, a delay in obtaining Home Health Help from Michigan Family Independence Agency was a factor. For many (n=30) who had been receiving formal or informal assistance in the home, that level of help was inadequate for the post-hospitalization level of care.

The overall complexity of the participants' needs was the most substantial variable in determining the necessity of nursing facility placement. In addition to identified needs in family support, financial support and housing adequacy, the majority of the participants had critical levels of acute and chronic illness, and most typically, a mood (n=24) or cognitive impairment (n=24) or both (n=2).

## **NURSING FACILITY DIVERSION PARTICIPANT PROFILES**

Of the participants at risk for nursing facility placement who were discharged directly home, we would like to highlight two case examples. In a later section of this report, selected UMHS "Best Clinical Practices" which impacted the diversion of University Hospital patients from nursing facility placement will be presented.

### **Challenge of mental status changes**

Mrs. B is an 82 year old African American woman who was discharged home after seven days in the hospital. Multiple factors indicated that nursing facility placement was likely.

She was admitted for delirium related to E. coli urinary tract infection/UTI, which complicated an existing dementia. Mrs. B was delusional and aggressive at admission. During treatment, she returned to her baseline level of functioning, but visual hallucinations persisted after her recovery from the UTI. Her thought process was coherent and logical most of the time, with occasional disorientation, some memory impairment, and paranoid delusions evident. Discharge was planned with delirium in partial remission. During discharge discussions Mrs. B had visual hallucinations and was aggressive toward her daughter M., displaying paranoid thinking about M. wanting to harm her. Given her age and physical status, Mrs. B was at high risk to retain the impaired thinking, or take an extended period to clear from delirium.

Multiple medical and social problems:

Multi-infarct vascular dementia (with delirium residual described above).

Incontinence and chronic urinary tract infections.

Insomnia with symptoms of sleep deprivation including irritability, paranoia.

Type II Diabetes—food issues such as appropriate choices, preparation or delivery.

COPD—shortness of breath on exertion.

Hypertension—blood pressure required home monitoring.

Chronic anemia.

Osteoporosis.

History of falls.

Participant lived with her husband, who was frail with dementia and unable to provide care. Daughter M. helped with personal care and activities of daily living, while still working outside the home. M. arranged a privately paid caregiver to be with her parents when she was at work. Mrs. B was ambulatory at home, but had recent falls. M. was very tired of managing her parents' care, and resentful of two other sisters for not being more involved. One sister, A. lived locally, and the other lived in out of state. M. wanted to confer with sisters about assisted living or nursing facility for both parents.

The daughters were confused, frustrated, and hostile to each other and toward staff, compounded by their long-term sibling controversies, and the pressure to make fast decisions. They all required much support and education on the medical and emotional handling of Mrs. B and assistance with sorting out solutions without bitter argument.

Medical and therapy staff developed a summary of discharge needs. Medication was prescribed for all illnesses and behaviors. Nursing provided appropriate education including medications, bowel and bladder training, home blood pressure monitoring.

The psychosocial component was critical to help the family develop into a clear-thinking united team to make decisions, including their goal to avoid nursing facility placement and set up effective home care, in the context of financial challenges. It was understood that Mrs. B had a higher probability of cognitive clearing from delirium, if she were in a more familiar (home) environment.

Diversion interventions pertinent to Mrs. B's condition and their decision to take patient home:

- Attention to family dynamics and communication in this stressful situation.
- Educate family members to provide care sensitively and safely.
- Explain dementia: behavior, care, medication and caregiver stress.
- Relaxation techniques to promote Mrs. B's rest and sleep (and that of caregiver.)
- Safety precautions and exercise to maintain strength and reduce fall risk.
- Community resources for companions and personal caregivers; explanation of payment.
- Food delivery of some meals to home/identification of which family member will prepare and shop for food.
- Medication management system; identification and education of family.
- Referral to adult day service setting.

The daughters finally came to an agreement that the daughter from out of state would come to help for a defined period. Local daughter A would move into parents' home for a defined period. Daughter M would have a break for a defined period, giving the family more time to arrange a long term plan for what tasks they could share, and what services their parents could afford. They would use the UMHS Turner Geriatric Clinic for primary care and social work assistance.

### **Challenge of catastrophic illness**

Mrs. Y. is a 66 year old Caucasian woman who was discharged home after five days in the hospital. Multiple factors indicated that nursing facility placement was likely.

She was admitted from an outside hospital with respiratory failure, to be assessed for lung transplant. She had a primary recent diagnosis of untreatable idiopathic pulmonary fibrosis with UIP/usual interstitial pneumonia and progressive dyspnea. Any movement created a challenge for her breathing, and she spoke in halting sentences.

Comorbidities included:

- Diabetes Mellitus, Type II
- Hypertension
- Recent breast cancer treatment
- Multiple gastrointestinal dysfunctions
- Obstructive sleep apnea w/sleep deprivation symptoms (couldn't use CPAP)
- Asthma
- Osteoporosis

Mrs. Y exhibited symptoms of anxiety and depression. Her pulmonary disease was diagnosed as end stage with progressive increase in oxygen required, and she was not a candidate for lung transplant. Medical staff presented the prognosis and anticipated progressive symptoms to Mrs. Y and spouse, and suggested that her needs would be better served in a care facility or hospice program. Mrs. Y and her husband were



understandably shaken emotionally, and required significant support and education before making any decisions.

Diversion interventions pertinent to Mrs. Y's condition and their decision to take patient home:

- Crisis counseling to manage emotions resulting from prognosis.
- Facilitate discussion of concerns previously not verbalized between Mrs. Y and spouse.
- Information on hospice philosophy, programs, and costs.
- Information on nursing facilities and home care, and costs.
- Information on companions, personal caregivers, and costs.
- Guidance on how family members can provide home care sensitively and safely.
- Ideas for home setup for caregiving and safety.
- Relaxation techniques to relieve participant stress and promote sleep.
- Information on helpful community programs and agencies to support normal daily needs.
- Options for ongoing counseling and support.

Mrs. Y and her husband declined hospice referral at that time, stating that they wanted to try to stay at home for as long as possible and participate in experimental treatments. Arrangements were made for home nursing care, medication, oxygen and other equipment to assist Mrs. Y in her severely debilitated state. Arrangements were also made for home social work visits for as-needed social services, and counseling/treatment for anxiety, depression, and monitoring antidepressant effectiveness. The hospital pulmonary clinic would be involved as primary follow-up medical care contact.

***What did it take to get these participants back to the community?***

In both of these situations, Ms. Blomquist, the discharge planner, and the social worker joined the participants in their stated goals of discharge to home. In each, the participant and family desired a choice with potential risk to the participant, and burden to the family. In the first situation, a participant's return home with residual mental status changes and paranoid thinking targeted at a family caregiver necessitated a high level of supervision and care, with uncertain prognosis. In the second situation, the participant required highly complicated home care with a desire to continue experimental treatment in the face of poor functional status and a poor prognosis. Yet in these situations, attentive listening, strategic goal planning, and creative service acquisition by Ms. Blomquist helped participant and family realize their goals. A concerted effort to arrange for hospital outpatient aftercare smoothed the transition home.

## PARTICIPANTS DISCHARGED TO NURSING FACILITIES

### Characteristics of participants discharged to nursing facilities

Of the 90 participants discharged from UMHS to nursing facilities, 5 were assessed upon nursing facility admission as needing general or intermediate care, 58 were identified as skilled rehabilitation stay appropriate, and 27 as skilled appropriate. The length of stay in the nursing facility participant population is detailed in Table 6.

Table 6

Length of Stay-Nursing Facility	
Days	Number
<=5	2
6-10	3
11-14	6
15-20	9
21-24	11
25-30	10
31-60	26
61-90	8
>90	15

In her initial assessment of participants, Ms. Carroll revisited their goals for care. Of the 90 participants detailed in Table 7, only 5 indicated a permanent stay in the nursing facility as their goal.

Table 7

Participant Goals	
Desired discharge destination	Number
Assisted Living	8
Home alone	17
Home w/family/others	46
Home with hospice	1
Permanent stay in nursing facility	5
Supported living (subsidized w/services)	11
Goal undecided	2

Whenever possible, and with the permission of participants, Ms. Carroll discussed long term goals with families, friends and advocates, encouraging them to articulate their goals for the participant.

Table 8

<b>Family Goals for Discharge</b>	
<b>Goal</b>	<b>Number</b>
Family has same goal as participants' goal	54
Assisted Living placement	6
Home w/family, then a supported living setting with services	1
Home with Hospice	0
No family	5
Permanent NF stay	8
Permanent NF -- Patient is terminal - keep comfortable at nursing facility	1
Permanent NF or AL	1
Placement in Adult Foster Care home or NF	1
Family member wanted participant to return home/participant uncertain	1
Family divided: spouse wants participant to return home; adult children want participant to remain in LTC	1
Goal unknown	11

Most family members (n = 54) had goals consistent with those of their participant. Many were uncertain about the goal, and this is not surprising, as the recovery prognoses of participants were in the early stages of formulation. Other family members identified goals of more dependent placement outcomes than those of the participants themselves. Ms. Carroll was able to assist many families and participants in formulating and revisiting goals as the placement proceeded. This dialogue helped participants and their families address changes in the participants' health and illnesses, rehabilitation targets met or unmet, unexpected events such as rehospitalization, and anticipated needs of the participants and their families for a safe and supported return home.

The initial functional status of participants was determined using the Minimum Data Set (MDS-RAI), and ongoing reassessments were drawn from quarterly reviews. For our purposes, key indicators were created to determine physical functioning, cognitive ability, and emotional stability. We used MDS item G1c "walking in room" as our key indicator for activities of daily living (ADL); with a G1c score of 2, 3, 4, or 8 = ADL low function and a score of 0 or 1 = ADL high function. We used MDS item G1g "dress self" as the key indicator of instrumental activities of daily living (IADL); with a G1g score of 2, 3, 4, or 8 = IADL low function, and a score of 0 or 1 = IADL high function. Tables 9 and 10 report the initial physical functional abilities of participants.

Table 9

<b>Physical Function-ADL</b>	
<b>ADL-Walk Room</b>	<b>Number</b>
High	21
Low	69

Table 10

<b>Physical Function-IADL</b>	
<b>IADL-Dress Self</b>	<b>Number</b>
High	12
Low	78

In terms of participants' cognitive abilities, we identified two key indicators: MDS item B2a, Short-term memory, and item B4, Cognitive skills. A score of 1 on item B2a = Low STM, a score of 0 = High STM ability. A score of 2 or 3 on item B4 = Low cognitive skills, a score of 0 or 1 = High cognitive skills. The cognitive ability of participants upon initial assessment in the nursing facilities is presented in Tables 11 and 12.

Table 11

<b>Cognitive Function-Short Term Memory</b>	
<b>STM</b>	<b>Number</b>
STM High	48
STM Low	42

Table 12

<b>Cognitive Function-Cognitive Skills</b>	
<b>Cog Skills</b>	<b>Number</b>
High	61
Low	29

We selected MDS item E2, Mood Performance, as the key indicator for emotional stability. A score of 2 = Low function mood performance, a score of 0 or 1 = High mood performance. The admission levels of emotional stability are presented in Table 13.

Table 13

Emotional Stability	
Mood Performance	Number
High	78
Low	12

It is noteworthy that the nursing facility MDS assessments discerned approximately the same levels of cognitive impairment (n = 26 in hospital report, vs. n =29-42 in nursing facility) as was identified in the hospital. Emotional needs however, were under-reported in MDS assessment (n = 26 in hospital report, vs. n =12 in nursing facility assessment); indicating that MDS assessments are less sensitive to this potentially serious comorbidity. Given the highly stressful nature of hospitalization and nursing facility placement, depression and anxiety of persons transferred to nursing facilities should be closely monitored and addressed, by nursing facility social workers for optimal clinical outcomes.

#### Participant discharge outcomes

Of the 90 participants transferred from UMHS to nursing facilities:

- 7 Died in nursing facility
- 4 Died in UMHS after nursing facility
- 2 Died in hospital other than UMHS
- 3 Died in hospice residence
- 5 Died at home with hospice
- 7 Died after returning home
- 2 Returned home, later returned to nursing facility and died
- 0 Currently in hospice residence
- 51 Currently home
- 0 Currently re-admitted to hospital
- 9 Currently being followed in nursing facilities

#### The impact of chronological age

Table 14 below shows the relationship between age of the 118 participants enrolled in the hospital and their length of stay in the hospital. In Table 15, the relationship between the age of the 90 participants in the nursing facility to their nursing facility length of stay is displayed.

Table 14

<b>Age by Length of Stay-Hospital n= 118</b>								
Age Category	<=5 days	6-10 days	11-14 days	15-20 days	21-24 days	25-30 days	31-60 days	>90 days
<65	3	6	3	4	1		2	1
65-75	12	10	1	3		1	1	
76-85	16	10	9	5	7		1	
>85	9	7	4	1			1	

Table 15

<b>Age by Length of Stay-Nursing Facility</b>				
Days in Nursing Facility	<65 years of age	65-75 years of age	76-85 years of age	>85 years of age
<=5	1			1
6-10			3	
11-14		1	4	1
15-20	2	3	2	2
21-24	2	2	4	3
25-30	1	2	4	3
31-60	4	6	12	4
61-90		3	3	2
>90	4	1	6	4

Advanced age alone does not appear to be a factor predictive of length of stay in either the hospital or nursing facility setting.

Table 16

<b>Discharge Outcome by Age</b>				
Housing Category	<65	>85	65-75	76-85
Adult foster care home		1		1
Assisted Living		5	1	2
Home Alone	2	1	4	8
Home with Family	4	6	11	20
Hospital	5	3	1	2
Other Outcome	2	3	1	3
Remain in NF	1	1		2

### The impact of hospital length of stay

It has long been recognized that even the best of hospitals are undesirable locations for older patients, who have a greater risk of iatrogenic illness, delirium, and complications of bed rest than younger patients. This recognition, combined with an effort to reduce

costs, and an increased willingness of nursing facilities to accept patients of greater acuity has substantially reduced hospital length of stay. We observed only a minimal relationship between hospital length of stay and length of stay in the nursing facility (Table 17). Our data set did not allow analysis of the impact of unscheduled readmissions to the hospital on clinical outcomes including eventual length of stay in the nursing facility. It may be assumed that unscheduled readmissions are a potential factor in both clinical outcomes and length of stay in the nursing facility; and this question is the subject of inquiry by the University Hospital length of stay committee (see “Promising Practices” section below).

Table 17

<b>Length of Stay Hospital by Length of Stay Nursing Facility</b>								
<b>Days in Nursing Facility</b>	<b>&lt;=5 hospital days</b>	<b>6-10 hospital days</b>	<b>11-14 hospital days</b>	<b>15-20 hospital days</b>	<b>21-24 hospital days</b>	<b>25-30 hospital days</b>	<b>31-60 hospital days</b>	<b>&gt;90 hospital days</b>
<=5		1	1					
6-10	2		1					
11-14	2	1	2	1				
15-20	3	1	1	1	2			1
21-24	1	7	1				2	
25-30	6	2	1	1				
31-60	9	7	3	3	2	1	1	
61-90	2	2	3		1			
>90	3	7	1	3	1			

The most important variables affecting length of stay in the nursing facility appear to be functional variables. Participants with poor ability to perform activities of daily living and instrumental activities of daily living realized much longer length of stay, and the greatest likelihood of permanent stay (Tables 18 and 19).

Table 18

<b>Length of Stay-Nursing Facility by ADLs</b>		
<b>Days in Nursing Facility</b>	<b>High ADLs</b>	<b>Low ADLs</b>
<=5		2
6-10	2	1
11-14	2	4
15-20	2	7
21-24	6	5
25-30	6	4
31-60	1	25
61-90	1	7
>90	1	14

Table 19

<b>Length of Stay-Nursing Facility by IADLs</b>		
<b>Days in Nursing Facility</b>	<b>High IADLs</b>	<b>Low IADLs</b>
<=5		2
6-10	2	1
11-14	1	5
15-20	2	7
21-24	2	9
25-30	3	7
31-60	1	25
61-90	1	7
>90		15

This result is to be expected, as tasks such as toileting, dressing, bathing and feeding are the most time intensive use of non-skilled service, and IADL performance maximizes independence. This observation raises concern about nursing facility residents who meet their basic rehabilitation targets under Medicare, but still require additional training and support for ADL and IADL performance. These participants may represent a significant population of concern; i.e., residents who reach the minimal rehabilitation targets, but could potentially languish in nursing facilities because the additional time and care for recovery of function is not covered under the Medicare skilled benefit. Most nursing facilities report staff shortages to be a major problem. When residents plateau in their skilled care rehabilitation, they typically transfer to “basic care” services. Unfortunately, for persons requiring assistance, it is more time efficient for nursing facility staff to “do” the task for the resident, dressing for example, than guide and teach the task. This is the situation where we find many participants with the potential of “being stuck” in permanent nursing facility placements.

We expected that poor performance on short term memory (STM) and cognitive skills (Tables 20 and 21) would also be predictive of longer length of stay in the nursing facility, but this was not the case. Perhaps because cognitive deficits were present prior to both hospitalization and nursing facility placement, they didn’t represent as much of a challenge as changes in physical functional status did. Cognitive impairment did affect discharge outcome however, as will be discussed below.



Table 20

<b>Length of Stay-Nursing Facility by STM</b>		
<b>Days in Nursing Facility</b>	<b>High STM</b>	<b>Low STM</b>
<=5	1	1
6-10	2	1
11-14	3	3
15-20	6	3
21-24	8	3
25-30	5	5
31-60	12	14
61-90	3	5
>90	8	7

Table 21

<b>Length of Stay-Nursing Facility by Cognitive Skills</b>		
<b>Days in Nursing Facility</b>	<b>High Cognitive skills</b>	<b>Low Cognitive skills</b>
<=5	1	1
6-10	2	1
11-14	3	3
15-20	6	3
21-24	9	2
25-30	8	2
31-60	17	9
61-90	4	4
>90	11	4

The findings on emotional stability (Table 22) do not suggest a relationship between low mood and length of stay in the nursing facility. As mentioned above, we observed that the MDS was less sensitive to mood variables, and that hospital reports of depression and anxiety were much higher. There are many other elements of “mood” which affect rehabilitation progress and these are highly individualized: dissatisfaction with the nursing facility environment for example, may be indicative of “poor emotional stability”, but highly motivating for an individual’s effort in rehabilitation. The nuances of these variables for different participants reinforce the value of good quality communication between participants and those persons advocating for their recovery and return home, including family members and professionals such as Ms. Carroll and the nursing facility staff.

Table 22

<b>Length of Stay-Nursing Facility Emotional Stability</b>		
<b>Days in Nursing Facility</b>	<b>High Mood</b>	<b>Low Mood</b>
<=5	1	1
6-10	3	
11-14	5	1
15-20	7	2
21-24	11	
25-30	9	1
31-60	22	4
61-90	8	
>90	12	3

#### Factors which affect discharge outcome

For the purposes of the following tables, discharge outcome refers to the first discharge of any participant. This includes discharge home, to hospital (readmission), or other outcomes including death or atypical relocation (motel). Because this is the first discharge, only 4 participants are identified as remaining in the nursing facility. Of the 90 participants represented in these tables, five returned to the nursing facility after their initial discharge, and four never left the nursing facility. Therefore, at this writing, 9 participants remain in the nursing facility.

Are there factors which impact discharge outcome? Advancing age, as previously reported in Table 15, was not predictive. Similarly, we found emotional stability (Table 23) was not predictive of outcome.

Table 23

<b>Discharge Outcome by Emotional Stability</b>		
<b>Housing Category</b>	<b>High</b>	<b>Low</b>
AFC	2	
Assisted Living	8	
Home Alone	14	1
Home with Family	35	6
Hospital	7	4
Other Outcome	8	1
Remain in NF	4	

Since “home with family” was the most frequent outcome for both participants with low or high STM, and for participants with both low and high cognitive skills (Tables 24 and 25), these measures were also not predictive. However, only three participants with low STM, and one participant with poor cognitive skills were discharged to “home alone.” Given the very high proportion of nursing facility residents with cognitive impairment, it

is essential that resources such as services for home supervision (of medications, for example), adult day programs and respite be available to facilitate community living for persons with cognitive impairments.

Table 24

<b>Discharge Outcome by Short Term Memory</b>		
<b>Housing Category</b>	<b>STM High</b>	<b>STM Low</b>
Adult foster care home	1	1
Assisted Living	3	5
Home Alone	12	3
Home with Family	21	20
Hospital	5	6
Other Outcome	4	5
Remain in NF	2	2

Table 25

<b>Discharge Outcome by Cognitive Skills</b>		
<b>Housing Category</b>	<b>High</b>	<b>Low</b>
Adult foster care home	1	1
Assisted Living	5	3
Home Alone	14	1
Home with Family	28	13
Hospital	5	6
Other Outcome	6	3

The most predictive factors of first discharge outcome are the physical functional variables: ADL and IADL performance (Tables 26 and 27). The majority of participants with low ADL and IADL performance returned to community living with a family member. Those returning to home alone required additional services to support community living. Of the participants remaining in the nursing facility as of the first discharge outcome, all had low ADL and IADL performance scores.

As was previously mentioned in discussion of nursing facility length of stay, an increased effort to facilitate progress in ADL and IADL performance during the nursing facility stay may shorten the duration of placement for many, and perhaps reduce the need for supported services in the community for some. Still, the resources targeted at supporting physical function in the home, particularly for individuals able to otherwise live independently and retaining the ability to summon help if needed, are essential.

Table 26

Discharge Outcome by ADLs		
Housing Category	High	Low
Adult foster care home		2
Assisted Living	2	6
Home Alone	6	9
Home with Family	11	30
Hospital		11
Other Outcome	2	7
Remain in NF		4

Table 27

Discharge Outcome by IADLs		
Housing Category	High	Low
Adult foster care home		2
Assisted Living		8
Home Alone	2	13
Home with Family	9	32
Hospital		11
Other Outcome	1	8
Remain in NF		4

### The impact of participant and family goals on discharge outcome

In Tables 7 and 8 above, participant and family goals were presented. As Table 28 shows, most participants achieved their goals, despite functional challenges and multiple needs. The goals of most families were consistent with those of participants, and were achieved or exceeded. Participants who were readmitted to the hospital, or had “other outcome”, defined as death or atypical move (two participants moved to motels), had more challenges to their goals. Again, the role of Ms. Carroll in addressing the changing needs and situations of participants proved essential in navigating the rehospitalization, hospice care, and housing goal issues.

Table 28

Discharge Outcome by Participant Goals							
Goals	AFC	Assisted Living	Home Alone	Home with Family	Hospital	Other Outcome	Remain in NF
Assisted living		5			2	1	
Home alone	1	1	6	3	2	4	
Home w/family/others	1	2	1	36	5	1	
Home with Hospice				1			
Permanent stay in Nursing Facility					1	2	2
Supportive Living			8	1			2
Goal undecided					1	1	

Table 29

Discharge Outcome by Family Goals							
Family Goals	AFC	Assisted Living	Home Alone	Home with Family	Hospital	Other Outcome	Remain in NF
Assisted Living		1	1	2	1	1	
Home w/family, then another supported setting				1			
Home with Hospice							
No family			3				1
Permanent Nursing facility				4	2	3	
Permanent NF -- Patient is terminal - keep comfortable at nursing facility						1	
Permanent NF or AL		1					
Placement in Adult foster care home or NF	1						
Family has same goal as participant goal		6	9	29	4	1	3
Family divided ;spouse wants participant to return home under his care; adult children wants participant to remain in LTC					1		
Family member wanted participant home/participant undecided				1			
Goal unknown	1		2	4	3	3	

### Helping people realize their goals: Returning home

Why did this many frail participants succeed in achieving their goal of returning home? While many variables contributed to this success, participant and family motivation, dedicated care of nursing facility staff, being noteworthy; the role that UMHS outpatient social worker, Ms. Carroll, assumed in the lives of participants is also a critical factor in our estimation. Using information from Ms. Blomquist which identified persons potentially at risk for an unnecessary permanent nursing facility placement, and continuing with a carefully executed transfer of care from the hospital to the nursing facility, Ms. Carroll was able to:

- Closely monitor progress in rehabilitation, daily care, and participant needs and goals.
- Collect accurate and timely data (MDS).
- Form close working relationships with participants, their families and advocates to establish discharge goals
- Provide family education, support and referral to informational services (Alzheimer's Association, Caring for Aging Relatives groups, etc.).
- Work to retain community housing, if at risk.
- Collaborate closely with nursing facility social workers and discharge planners to maximize options for return home.
- Serve as a sounding board when differences between participant and family goals emerge.
- Serve as an objective source of information when facility expectations/goals differ from those of participants and families.
- Function as the "link" between the participants, their families/friends and advocates, and the various professionals and service providers involved, each having their own criteria for providing assistance, as well as their own goals, agendas and personalities.
- Provide objective information, as well as hope and encouragement to participants and families.

### **NURSING FACILITY DIVERSION PARTICIPANT PROFILES**

#### Participants who permanently returned to the community from a nursing facility

#### **Challenge of cognitive deficit**

Mr. F is a 90 year old married Caucasian male who was discharged from the nursing facility to his private home after 86 days. He was admitted to the nursing facility for rehabilitation following hospitalization for episodes of hematemesis (vomiting).

Diagnoses:

Gastric ulcer  
Upper gastrointestinal bleed status post epinephrine and BICAP  
Helicobacter pylori positivity  
Atrial fibrillation  
Multi-infarct dementia  
New onset dysarthria and dysphagia possibly secondary to delirium  
Acute renal failure, resolved  
Leukocytosis

Comorbidities:  
Atrial fibrillation  
Multi-infarct dementia  
Benign prostate hypertrophy with elevated prostatic specific antigen  
Colonic Polypectomy  
History of shingles

History: Mr. F lived in a private home with his physically-disabled wife. The couple had two daughters, one of whom was a teaching professional. During this admission, one of the daughters worked actively with the nursing facility social work staff, advocating for his care and discharge plan. Although Mr. F is severely cognitively impaired, at no time would the family consider long-term placement for him. Consequently, the family worked diligently with social work to effectuate a discharge to home.

Diversion interventions by social work included arrangements for:

- Home health care nurse
- Home health care aide
- PT/OT
- Walker
- Wheelchair
- Commode
- Shower seat
- Referrals for 24-hour private duty nurse

Current status: Mr. F was able to live at home w/24-hour private duty care for 13 months before expiring.

Comments: Mr. F and his frail wife required 24-hour care. The family was adamant about keeping the couple together at home for as long as possible and actively pursued resources to keep them out of a nursing facility placement. Ms. Carroll accepted and supported this goal. She was able to provide the family with support and guidance, while helping them set limits to balance their caregiving responsibilities with other personal needs. If this couple did not have family support and financial resources to maintain 24-hour home care, they would certainly be candidates for permanent long-term care placement.

### **Challenge of inadequate family support**

Mrs. L is an 82 year old Caucasian widow who was discharged from the nursing facility to the community after 44 days. Mrs. L was admitted to the nursing facility for rehabilitation following hospitalization for a hip fracture and delirium.

Diagnoses:

R hip fracture

Delirium

Comorbidities included:

Memory loss

Major depressive disorder

Bipolar disorder

History of heart murmur

Elevated kidney function tests, with a BUN of 31 and creatine of 1.5 on 3/5/03, etiology undetermined

Hypertension

Hyperlipidemia

Decreased hearing in right ear w/hearing aid

Neuropsychometric testing 4/15/03

OA PSH

Cholecystectomy

History: Mrs. L lived independently in a private home. During her stay at the nursing facility, her daughter was undergoing cancer treatment and was unable to take her mother to appointments or otherwise assist in planning her care.

Diversion interventions by social work included arrangements for:

- Home health care nurse
- Home health care aide
- PT/OT
- Information re: emergency alert system (Lifeline)
- Referrals for private care

Current status: Immediately upon discharge from the nursing facility, Mrs. L lived with her daughter for approximately one week. She then returned to her own home in another city, where she currently lives alone.

Comments: Ms. Carroll was able to be a source of support and counseling to Mrs. L, who was essentially going through her convalescence alone. Not only was she trying to focus upon her own rehabilitation, Mrs. L was worried about her daughter, who was undergoing treatment for cancer at the same time. Mrs. L was able to be released from the nursing facility early because her daughter was well enough at the time of her



mother's discharge to take her into her home for a brief period before Mrs. L returned to her own home.

**Challenge of inadequate family support**

Mrs. M is an 83 year old Caucasian widowed female who was discharged from the nursing facility after 45 days. She was admitted to the nursing facility for rehabilitation following hospitalization for pain in her hip.

Diagnosis:

Right hip pain secondary to osteoarthritis

Comorbidities:

Hypertension

Torn left rotator cuff

Diverticulitis

Hiatal hernia

Major depressive disorder

Right breast CA diagnosed 4 yrs. ago

Cataract

Glaucoma

Blind in right eye

Basal cell carcinoma X3 of the nose

Complications: Constipation

History: Mrs. M lived independently in a condominium. She experienced a number of significant challenges and losses in her life. In addition to being a holocaust survivor, her husband died when their only son was a toddler. Her son passed away 11 years ago. She has no other family. Mrs. M cultivated a few close friendships with other seniors in the community in which she resides, some of whom assist her with shopping and transportation. She also relies heavily on a Turner Clinic geriatric social worker for assistance in times of need.

Diversion interventions by social work included arrangements for:

- Home health care nurse
- PT/OT
- Private companion/caregiver for ADL/IADL assistance
- Home delivered meals
- Emergency alert device (Lifeline)
- Installation of railing on interior stairs
- Coordinate services with existing supports, especially social work supports

Current status: Mrs. M continues to reside in her condominium alone. She does not drive and often depends upon her friends for transportation. She continues to rely heavily upon the Turner Clinic geriatric social worker for assistance with resources and emotional support.

Comments: While Mrs. M has the financial resources to purchase services she needs to remain in the community, she largely relies upon her friends, who are also elderly, for assistance. Ms. Carroll was able to coordinate the efforts of the nursing facility social worker with Mrs. M's geriatric social worker to avoid duplication of services upon her discharge. She continued to visit Mrs. M after her discharge in a supportive role to talk with her about her depression and address additional needs for other durable medical equipment.

### **Challenge of overwhelming medical complications**

Mrs. A is a 69 year old Caucasian married female who was discharged from the nursing facility to her home after 212 days. She was admitted to the nursing facility for rehabilitation following a 183 day hospitalization after contracting West Nile virus encephalitis.

#### **Diagnoses:**

West Nile virus encephalitis  
Clostridium difficile colitis with megacolon  
Abdominal compartment syndrome  
Demyelinating polyneuropathy  
Respiratory failure with failure to wean, status-post tracheostomy  
Hospital-acquired pneumonia and ventilator-associated pneumonias, recurrent  
Cortical blindness, likely secondary to West Nile virus encephalitis

#### **Comorbidities include:**

Congestive heart failure  
Coronary artery disease status post CABG  
Diabetes mellitus type 2  
Renal stones with ureteral strictures

History: Prior to contracting West Nile virus, Mrs. A was in another state with her husband of 40 years. They were preparing to move to Michigan when Mrs. A was hospitalized. They have two daughters, one local and other lives out of state. Mr. and Mrs. A have a very close relationship emotionally and professionally. They were lawyers with an office on their home property, but have retired due to her illness. At all times during her illness, Mr. A was diligent in his presence at her side.

During her prolonged hospitalization, she had the following multiple complications and was in and out of the intensive care unit six times: coma, respiratory arrest, SIADH, multiple intubations, dysphagia, hyponatremia, colectomy w/ileostomy with fulminate C Difficile colitis/toxic megacolon was found, sepsis, gallbladder removal s/p cholecystitis, PEG tube insertion for feeding, and new cortical blindness. Related to her multiple trachea intubations, she had periods of ventilator dependence but was able to be weaned after multiple attempts.

When Mrs. A entered the nursing facility, she was able to follow simple commands and communicate on a variable level with waxing and waning mental status. She was grossly disoriented typically except to person. Upon discharge from the nursing facility, Mrs. A was oriented to time, place and person; able to converse, feed herself and ambulate a short distance with a walker. She required assistance bathing, dressing, grooming, toileting, and transferring. She was dependent for shopping, food preparation, housekeeping, laundry, managing her meds, driving and handling finances.

Diversion interventions by social work included arrangements for:

- Home health care nurse
- Home health care aide
- PT/OT
- Durable medical equipment: walker, wheelchair, commode, shower bench, hand-held shower
- Medicare/Medicaid counseling
- Family consultation regarding community respite services
- Referrals to area caregiver support groups
- Private care management services
- Family consultation for future planning
- Referrals for private home health care agencies
- Referrals for private companion services
- Referrals for assisted living alternatives

Current status: One year after discharge from the nursing facility, Mrs. A is still living at home with her husband as her primary caregiver. While her physical and mental conditions have improved, she still requires extensive assistance with her ADLs and complete assistance with IADLs. Mr. and Mrs. A have experienced a substantial change in their financial situation because neither of them has worked since Mrs. A became ill. She continues to use all the durable medical equipment named above. Additionally, the following services are currently being utilized:

- Area Agency on Aging; 2 hr. respite/weekly
- Application pending for Medicaid Waiver program
- Outpatient PT/OT
- Emergency alert system w/vision impairment features
- Low vision magnification equipment

Comments: Mrs. A is able to live in the community following her long hospitalization and rehabilitation in a nursing facility because she receives 24-hour care from her spouse. She also has supportive daughters, one of whom is a local physician and who diligently advocates for her care, seeking reliable, appropriate community services, as necessary. During the period of time that Mrs. A was in the nursing facility, Ms. Carroll spent a significant amount of time with Mr. A talking about his caregiving role and his desire to “always be there” for his wife. The only time he took off was to recover from a respiratory problem. Ms. Carroll was able to support Mr. A in his caregiving goals, yet

offered some guidance about setting limitations and finding a balance in his life to avoid caregiver burn-out. In the months since her mother's discharge, Mrs. A's daughter has consulted with Ms. Carroll regarding additional community respite services.

Since this couple has been unable to work since Mrs. A became ill, they exhausted their savings in private pay care. Eventually, she applied for Medicaid coverage for the duration of her nursing facility stay. When she was discharged, they were able to purchase some services to supplement the home health care, but have recently applied for consideration under the Medicaid Waiver. If Mrs. A did not have a supportive spouse who was willing to undertake the extensive assistance required to keep her at home, she would have had to stay in the nursing facility with Medicaid.

### **Challenge of multiple hospitalizations and Challenge of inadequate family support**

Mrs. N is a 90 year old Caucasian widowed female who was discharged from the nursing facility to her apartment after 76 days. She was admitted to the nursing facility for rehabilitation following hospitalization for pain management relating to degenerative joint disease.

Diagnosis:

Back pain

Comorbidities:

History of coronary artery disease

History of myocardial infarction

Gastroesophageal reflux disease

Hypertension

Hypothyroidism

Diverticulosis

Degenerative joint disease

Collagenous colitis

Chronic renal insufficiency

Hiatal hernia

Chronic diarrhea

Anxiety/panic disorder

History: Mrs. N has lived alone in a senior high-rise apartment for the past 20 years. She has been a widow for 13 years. One of her sons lives in the area and another resides out of state; however, neither of them desires to be actively involved in her care. Mrs. N has received extensive support from a Turner Clinic geriatric social worker. She suffers from severe anxiety and has a history of frequent visits to the emergency room for pain-related complaints.

Diversion interventions by social work include:

- Home health care nurse, aide, PT/OT
- Individual counseling/support by geriatric social worker
- Counseling re: fears of living alone in the community
- Counseling re: supportive housing options
- Prescription assistance
- Assist with locating and moving to assisted living

Current status: In the 14 months following her nursing facility discharge, Mrs. N returned to the hospital emergency room 18 times, with 11 hospitalizations. She continues to receive extensive support from her geriatric social worker for individual therapy, and assistance with medical, social and housing issues. Mrs. N has nearly exhausted her savings and will be seeking low-income housing and resource options in the near future.

Comments: During her nursing facility stay, Mrs. N was extremely anxious about her care and future. Ms. Carroll was able to give Mrs. N extensive emotional support during her nursing facility stay, spending time talking with her about how she was able to overcome challenges in her life before. Ms. Carroll was also able to collaborate with Mrs. N's Turner Clinic geriatric social worker to coordinate and avoid duplication of services in connection with her care.

Mrs. N is only able to live independently in the community because she is currently in an assisted living environment. Additionally, she receives weekly support and counseling from a geriatric social worker. Since her family is not willing to assist with her care and future planning, Mrs. N depends upon this social work contact for extensive assistance. Mrs. N's savings are almost exhausted and her social worker is currently investigating long-term care placement in a Medicaid facility for her.

### **Challenge of living in wrong county**

Ms. W is a 24-year old Caucasian single female who was discharged from the nursing facility after 59 days. She was admitted to the nursing facility for rehabilitation following hospitalization for injuries sustained when she fell from a roof while intoxicated.

Diagnoses:

Chronic mild pancreatitis with acute pain

Back pain status post fall from roof in June 2002 with bilateral wrist fractures status post repair, and left calcaneal fracture status post open reduction and internal fixation, now in cast

History of polysubstance abuse

Bipolar disorder

Status post spinal fusion in November 2001 of L5-S1

Endometriosis

Comorbidities: None

History: Ms. W lived in the home of her mother and step-father, in an extremely conflicted family situation. Her step-father has been verbally and physically abusive toward her. Ms. W's sole income was Social Security disability.

During the time Ms. W was at the nursing facility, her mother indicated to social work staff that she did not believe her daughter should return to her mother's house. Accordingly, she received extensive assistance from social work and case management regarding:

- location of adequate subsidized housing
- availability of appropriate rehabilitative services
- substance-abuse counseling
- management of insurance issues and negotiation to extend benefits

Ms. W was eventually transferred to a hospital from the nursing facility. Since discharge planners in the hospital were not able to devote attention to finding Ms. W alternative housing, they focused on finding her a Medicaid bed at a facility near her home. Ms. W was not willing to go to a Medicaid facility and was subsequently discharged to her mother's home.

Diversion interventions by social include:

- Referral for ramp installation
- Wheelchair
- Bedside commode
- PT

Current disposition: Ms. W's physical condition improved in the months following her discharge from the nursing facility. She initially sought therapy to address her addiction issues, but discontinued her sessions due to lack of insurance. She eventually moved from the conflicted environment of her mother's home and now lives with another relative. She is still unable to work due to her injuries.

Comments: Ms. W's case illustrates an example of the need for adequate housing and services for persons of low income with disabilities. While Ms. W was in the nursing facility, staff there requested Ms. Carroll assist in locating appropriate housing for this participant. Ms. Carroll worked actively to locate low-income /subsidized housing and services for her in the county in which Ms. W lived. Unfortunately, there were no available housing vouchers in her county at that time. Despite numerous attempts by Ms. Carroll to get the voucher status changed, State agencies were not able to accommodate this participant.

Lack of adequate insurance was another complicating factor in Ms. W's care. While at the nursing facility, Ms. W was covered by private insurance; however the benefits under that policy were extended a number of times and finally exhausted during her stay there.

When she was taken to the hospital, discharge planners could not spend the time to find adequate housing and services for her and only attempted to find a Medicaid bed at a rehabilitation unit near her home. Ultimately, Ms. W returned to live in the conflicted environment of her mother's home, rather than seek treatment in a facility she believed would be "substandard."

### **Challenge of dying**

Mrs. R is a 76-year-old Caucasian widowed female who was discharged from a nursing facility to her home after 97 days. She was admitted to the nursing facility for rehabilitation after being hospitalized for altered mental status.

#### **Diagnoses:**

Altered mental status secondary to metabolic and medication complications

Hyponatremia

Over-diuresis as outpatient

Urinary tract infection

Diastolic heart failure

Failed atrial fibrillation, direct current cardioversion for chronic atrial fibrillation.

#### **Comorbidities:**

Glucose intolerance

Hypertension

Hypercholesterolemia

Mitral valve prolapse

Hypothyroidism

Depression

Chronic renal insufficiency

Chronic venous insufficiency

Hyperlipidemia

Osteopenia

Peptic ulcer disease status post esophagitis and gastric ulcers

**History:** Two weeks prior to hospitalization, Mrs. R was living in a new home, having moved to Michigan to be near her daughter, who is a physician. A son lives out of state.

During her nursing facility stay, Mrs. R experienced numerous issues involving her care. Particularly frustrating for her were repeated instances of long response times to her calls for toileting assistance. She would often wait so long that she ended up soiling or wetting herself before assistance arrived. Mrs. R accepted the fact that she was terminally ill, but became increasingly depressed as she realized that she would, most likely, die in the nursing facility without ever returning to her home. Her daughter was also frustrated because she could not care for her mother herself, and felt that she was getting inadequate care at the nursing facility. The decision to remove her mother from the nursing facility was made one afternoon when her daughter walked into Mrs. R's room to find her mother soiled and sobbing from embarrassment because her daughter had to see her in such a

mess. This “humiliating” experience prompted Mrs. R’s daughter to make whatever adjustments were necessary in her personal and work schedules to care for her mother at home. Prompt arrangements were made to have Mrs. R hospice certified and she was discharged to her home.

Diversion interventions by social work included:

- Care advocacy in the nursing facility
- Family counseling
- Hospice home health care

Current status: After her discharge from the nursing facility, Mrs. M’s son came in from out-of-state and joined his sister in arranging their mother’s 24-hour care. They alternated evening caregiving responsibilities and hired private caregivers for round-the-clock supervision. Mrs. R lived in her home under hospice care for approximately one month before she expired.

Comments: Ms. Carroll spent extensive time with Mrs. R discussing how she felt about her situation. Mrs. R had been very excited about moving to Michigan, living in her new home and spending more time with her family. She struggled with the fact that her illness required her to reconceptualize what the future held for her. While nursing facility staff was sensitive to the challenges Mrs. R faced and maintained that they were doing the best they could to address her physical needs, no one had the ability, or time, to merely sit down with her and talk about the emotional challenge of dying.

Ms. Carroll also met with Mrs. R’s daughter to discuss the emotional difficulties she was experiencing as a busy physician whose professional demands precluded her ability to care for her mother outside the nursing facility. The daughter was frustrated by the lack of care she perceived at the nursing facility, yet felt helpless to do anything about changing the situation. Ms. Carroll and Mrs. R’s daughter reviewed what would be needed to get Mrs. R home, the resources available to them and support the family could receive from hospice care and Turner Clinic. The daughter eventually took her mother out of the nursing facility and was able to care for her until she died. In a letter to Mrs. R’s physician, her daughter expressed her gratitude for Ms. Carroll’s guidance in assisting her in this difficult decision.

Complicated medical issues required 24-hour care for Mrs. R. If she could not have afforded private caregivers nor had family members advocating for her, she would have had no choice but to remain in the nursing facility until she died.

### **Challenge of inadequate housing**

Mr. W is a 58 year old Caucasian unmarried male who was discharged from the nursing facility to a motel after 24 days. He was admitted to the nursing facility for rehabilitation following hospitalization and surgical repair of non-healing injuries sustained in a recent car accident.



Diagnosis: Right subtrochanteric nonunion with hardware failure

Comorbidities: None

History: Mr. W lived alone in a tri-level home. He was employed as a security guard and had two brothers who lived in the area.

While in the nursing facility, Mr. W received PT and OT. His progress plateaued and he became ineligible for further rehabilitation benefits at the nursing facility under his insurance. Mr. W would not yet be able to navigate the stairs in his home, so he elected to move into a nearby motel until he could safely return to his home. He was not eligible for home health care benefits after he left the nursing facility.

Diversion interventions by social work include:

- Assistance locating a motel in his geographic area
- Assistance with insurance issues

Current status: Mr. W. lived in a motel for one month before returning to his home. He subsequently sold his home and now lives alone in a regular apartment.

Comments: Mr. W was able to afford the expense of a motel during his convalescence; however, he could not afford to pay privately for continued physical or occupational therapy. While Mr. W's decision to move into a motel and not pay for PT/OT potentially slowed his rehabilitation progress, Ms. Carroll supported his decision and assisted him achieving his goal to leave the nursing facility.

### **Challenge of overwhelming care needs**

Mr. P is a 72-year old Caucasian single male who was discharged from a nursing facility to his assisted living apartment after 30 days. He was admitted to the nursing facility for rehabilitation following surgical repair of a fractured hip, sustained in a fall in his apartment.

Diagnosis: Status post right hip fracture

Comorbidities

Coronary artery disease

COPD

History of CHF

Atrial fibrillation on coumadin

History of DVT/PE status post Greenfield filter placement in 1980

Seizure disorder, last seizure 20 years ago

Venous insufficiency

Prostate cancer status post XRT

Left lower extremity radiculopathy

Peripheral neuropathy of unclear etiology  
Osteoarthritis  
Urinary incontinence  
Hemorrhoids  
Decreased auditory acuity  
Legally blind  
Status post eye surgery  
Status post bilateral hernia repair

History: Mr. P lived alone in a senior assisted living apartment building, where he pays for multiple services. He has a sister who oversees his care and assists when needed.

Diversion interventions by social work:

- None – Mr. P returned to his assisted living apartment where he resumed his previous level of services, including:
  - Assistance w/bathing, dressing and toileting
  - Prepared meals
  - Laundry
  - Housekeeping

Current status: Mr. P. continues to live in his assisted living apartment, where he receives supportive services. His sister reports that, because of multiple medical problems, he requires 24-hour supervision, which is available to him at his current residence.

Comments: Due to overwhelming physical needs, Mr. P requires daily assistance with almost all of his ADLs and IADLs. While his sister is very involved, she cannot personally care for him in her home. Consequently, if he could not afford to live in an assisted living environment, he would certainly be a candidate for long-term care. His level of care would likely be beyond the scope of care available under the Medicaid Waiver.

***What did it take to get them back to the community?***

- Listening to participants and learning their goals.
- Listening to family members and learning their goals.
- Mediating disparities between participant and family goals.
- Advocating for the needs and preferences of participants, particularly when participants did not precisely meet eligibility criteria for services.
- Assisting in elaborating plan of care based on participants' strengths-based assessments.
- Assisting with early planning for anticipated needs in community.
- Obtaining services and/or making appropriate referrals.
- Providing sufficient information to community referral agencies to streamline care.

- Making appropriate contacts with participants, family and nursing facility staff to monitor progress modify goals and provide education and support.

In summary, Ms. Carroll assumed the responsibility of taking information from the hospital discharge team, participants, families, nursing facility, developing a care plan consistent with the stated goals of participants and families and linking the participant with appropriate community agencies. This role was especially helpful if a person was readmitted to the hospital and/or nursing facility, or needed resources beyond the service area of the facility. Her approach fostered participant self-reliance, supported personal autonomy and accepted reasonable dependency, while encouraging maximum independence.

***What did it take to keep them in the community?***

- Participants with a realistic outlook on their prognosis and awareness of how to summon help if needed.
- Well-educated, well-rested and well-supported family to care for the participant
- Financial resources to purchase services upon exhaustion of insurance benefits, and/or timely access to Medicaid Waiver benefits.
- Availability of follow-up assistance for troubleshooting and monitoring changing needs and adjusting a plan of care.
- Continuity of care with primary care providers and informal and formal community supports.

**Participants who returned to the community, then returned to the nursing facility**

**Challenge of overwhelming care needs**

Mrs. J is a 75 year old Caucasian widowed female who was discharged from the nursing facility to her son's home after 44 days. She was admitted to the nursing facility following hospitalization for complications following Gemzar therapy for cancer.

**Diagnoses:**

Coagulase-negative staphylococcal bacteremia

Mobile mass on the mitral valve

Status post non-ST elevation myocardial infarction

Long QT syndrome

Diabetes mellitus type 2

Cutaneous T-cell lymphoma

h/o NSVT and atrial ectopy

Candidal urinary tract infection

**Comorbidities:**

Diabetes mellitus type 2

Hypertension  
Chronic renal insufficiency  
Cutaneous T-cell lymphoma status post total body irradiation  
Hypercholesterolemia  
Hypothyroidism  
History of long QT syndrome

History: Mrs. J lived in the home of her unmarried son. Her son was laid off from work and was very involved in his mother's support, decision-making and caregiving. Their goal was for Mrs. J to have a short rehabilitation at the nursing facility and return home. Mrs. J was a retired teacher.

After discharge, Mrs. J was able to live at home with her son for approximately a month before requiring hospitalization and re-admittance to the nursing facility. Since that time, she has had multiple hospitalizations with discharge back to the nursing facility, where she currently resides. During her nursing facility stay, she fell and fractured her left femur. She is currently wheelchair bound. Her skin is often itchy and red, causing a great deal of discomfort and requiring lotion applications several times a day. Recently, she was also diagnosed with breast cancer.

Social Work interventions for diversion and in nursing facility included:

- Extensive assistance with insurance benefit extensions
- Home health care nurse, aide, PT/OT
- Family consultation
- Case management
- Caregiver counseling
- Caregiver support group referrals
- Medicaid application assistance
- Relaxation techniques to ease agitation and chronic itching

Current status: Mrs. J resides in long-term care facility covered by Medicaid. If we were to continue contact with this participant, we would monitor for appropriate hospice options pending treatment for breast cancer.

Comments: Mrs. J has an exceptionally close relationship with her son. He has been a vigilant caregiver who adamantly resisted suggestions that his mother was going to die of her illnesses. Resisting hospice intervention to this day, he is convinced that she will eventually get well and return to live with him in their home. He advocated for services in the nursing facility which would strengthen her for another round of cancer therapy. While well-intentioned, it is possible that he felt guilty that he could not care for his mother himself. Consequently, his insistence on certain treatments for his mother may not have been in her best interest. Ms. Carroll was able to spend time with Mrs. J's son and helped mediate a balance between what he felt everyone should be doing for his mother and his mother's own goals and coping threshold.

While Mrs. J has occasionally experienced some increase in strength, she has essentially been under skilled care for over two years. She would not be able to return to the community without 24/7 care. Her son is now employed full-time and cannot care for his mother's increasing needs at home. Until recently, her son has paid privately for her care in the nursing facility, but, eventually could not afford the care. Currently, Mrs. J's care is being covered by Medicaid.

### **Challenge of cognitive deficit**

Mr. H is an 85 year old Caucasian married male who was discharged from the nursing facility to an assisted living environment after 36 days. He was admitted to the nursing facility for rehabilitation following treatment at a local hospital for fracture of his right clavicle.

#### **Diagnoses:**

Right clavicular fracture status post fall  
Hyponatremia

#### **Comorbidities:**

Hyponatremia  
Dementia  
Traumatic brain injury, (eight months prior), epidural hematoma  
Anxiety  
History of subdural hematoma, 2001  
Prostate CA resection, 1990 w/XRT  
Bilateral cataract surgery, date unknown  
Appendectomy, 1991  
History of falls

History: Eight months prior to his clavicle injury, the subject had a left occipital epidural hematoma after a fall, at which time he suffered significant short-term memory loss and cognitive function impairment, along with gait instability. He suffered multiple falls over the next six to eight months. His wife and primary caregiver cared for Mr. H at home following this head injury, but it was becoming more difficult for her to meet his escalating care needs. Consequently, she was investigating alternative living arrangements for him. At the time of the fall that resulted in injury to his clavicle, Mr. H was on a respite stay at an assisted living facility while his wife was on a brief vacation.

Mr. H's wife was a vigilant advocate for her husband. Two of his three children lived out of town and did not assist in his daily care, but were supportive and responsive to Mrs. H. A son who lived nearby visited regularly and assisted with his father's care arrangements, on occasion.

During the time Mr. H stayed in the nursing facility, Mrs. H decided that she would not be able to care for him at home any longer. Mrs. H made arrangements for placement

with a local assisted living facility that offered care on their “memory loss” floor. The expenses of this assisted living facility were privately paid.

Diversion interventions by social work included:

- PT/OT
- Family counseling
- Care management
- Referrals for assisted living facilities

Current status: Mr. H resided in the community in an assisted living environment for seven months, at which time the facility became unable to accommodate his increased nursing needs and cognitive care. He currently resides in a long-term care facility, which is privately paid. Mr. H requires assistance with all ADLs, except feeding, and all IADLs. Mr. H’s family continued to utilize social workers for Medicare/Medicaid counseling and companion services; and social work care managers for periodic family consultation, long-term planning and placement assistance.

Comments: Ms. Carroll played a very active role in supporting this participant and his family. She regularly visited Mr. H in the original nursing facility, his assisted living apartment, and his current nursing facility. To assist the staff at the assisted living facility in working with residents with dementia, Ms. Carroll talked to them during a monthly meeting about working with persons with “difficult” behaviors. She also participated in locating another nursing facility when it becomes necessary for Mr. H to receive more care. Additionally, she has become a valued member of the family care team, attending care conferences, revisiting and supporting care goals and recommending changes that may be needed. Ms. Carroll has counseled Mrs. H with regard to setting caregiving limits to avoid burn-out. Mrs. H has heeded that advice and has called upon Ms. Carroll to “take over” whenever she goes away to ensure consistency in Mr. H’s care.

Due to his severe cognitive deficit, Mr. H needs assistance with almost all his ADLs and IADLs, requiring 24-hour care. If he could not afford to pay for his care, he would certainly be a candidate for Medicaid coverage in his long-term care facility. He will likely require Medicaid support, eventually.

**Challenge of dying**

**Challenge of inadequate family support**

**Challenge of overwhelming care needs**

**Challenge of inadequate housing**

Mr. D is a 57 year old Caucasian married male who was discharged from the nursing facility to a motel after 48 days. He was admitted to the nursing facility for rehabilitation after hospitalization for a urinary tract infection and weakness related to cancer therapy.

Diagnoses:

Urinary tract infection  
Metastatic pheochromocytoma  
Urinary retention  
Constipation

Comorbidities:

Hypertension with orthostatic changes  
GERD

Mr. D resided in a single-dwelling home which, at the time of admission, was undergoing extensive repair to eliminate a black mold problem. At that time, he was estranged from his wife and disabled daughter. His mother and brother lived in another city several hours away, and he received some support from several friends. He was a high school teacher.

While in the nursing facility, Mr. D regained strength through PT/OT. He was determined to continue aggressive chemotherapy, although his oncologist recommended against further treatment. Upon discharge, he moved into a motel while repairs were being made to his home. Mr. D was not eligible for Medicare because of his age, and benefits for home health care under his private insurance were exhausted. Anticipating future care needs, Mr. D was cautious about spending down his savings too quickly. He discontinued PT/OT. Consequently, he eventually lost strength, was again hospitalized and returned to the nursing facility within a month of his discharge.

He stayed in the nursing facility for approximately three months and was again discharged to a motel. At this time, he briefly returned to his teaching job. However, within a month, he became ill, was hospitalized and again returned to the nursing facility where he remained for approximately 16 months before expiring.

Interventions in nursing facility and for diversion by social work included:

- Negotiations with insurance carriers to extend benefits
- Transportation to multiple medical appointments
- Referral for outdoor ramp
- Arrangements for air quality analysis on his residence Referral for home delivered meals
- Referrals for private pay home health care, including nurse, aide, PT/OT
- Durable medical equipment, including wide-base wheelchair, walker, bath bench
- Research to identify contractors for home air quality analysis
- Extensive supportive counseling

Current status: Expired

Comments: Throughout most of his illness, Mr. D believed he would “beat” the cancer and aggressively refused suggestions that he accept the terminal nature of the disease.

For many months, he resisted his physician's suggestion to accept hospice care. He would not pursue Social Security disability because it was his desire to recover completely and return to work. When his medical benefits no longer covered his rehabilitation, Mr. D paid privately for his nursing facility care.

During this time, Mr. D's disabled daughter died. Although he and his wife were estranged, she eventually assisted Mr. D in handling some financial matters, including filing for disability and pension benefits under his teaching contract. She was not, however, willing, or able, to care for him at home.

Ms. Carroll worked extensively with this participant during his nursing facility stay. On numerous occasions, she visited with him when he was at the Cancer Center having his chemotherapy sessions. Visiting him there gave them the opportunity to talk more privately than in his room at the nursing facility, and helped him pass the time during the sessions. He often talked openly and willingly about his illness, sharing his emotions and hopes. Ms. Carroll was also able to support one of his close friends, who appeared to be the only person who visited Mr. D regularly, brought his mail, some favorite foods and personal items from his home. Ms. Carroll was able to talk with this friend about her caregiving role and feelings about the approach Mr. D was taking in dealing with his illness.

There were times when Ms. Carroll tried to help Mr. D understand the reality of the prognosis of his disease, without undermining his decisions and goals. Knowing that hospice care may have been a viable alternative to the pain Mr. D was experiencing made it emotionally difficult for Ms. Carroll to fully accept Mr. D's decision to pursue treatment. However, commitment to a person-centered approach to care enabled Ms. Carroll to support and assist Mr. D in the goals he desired. In the weeks before his death, Mr. D did accept hospice care at the nursing facility and was made as comfortable as possible.

Mr. D endured a long and difficult illness, which included multiple treatments for cancer, hospitalizations and nursing facility admissions. Because he required an extensive amount of care, but had no family to care for him at home, he spent thousands of dollars to pay for his care at a nursing facility. Had he not been able to afford this care, he would have received this care under Medicaid.

### ***Why did these participants return to the nursing facility?***

Participants in the Project who returned to the nursing facility experienced one or more of the following:

- Serious exacerbation of existing medical condition requiring frequent nursing care (exceeding Medicare skilled-home benefit)
- Progression of significant cognitive impairment (participant no longer recognizes or is comforted by their home environment)
- Caregiver exhaustion



- Participant's functional decline requiring frequent assistance with ADLs or IADLs
- Financial crisis: persons without adequate financial resources who might functionally qualify for assisted living, but need more support than provided under the Medicaid Waiver, would have to return to nursing facility Medicaid pending.

The return of participants to the nursing facility was almost always multi-factorial.

#### Participants who never left the nursing facility

##### **Challenge of inadequate housing**

##### **Challenge of inadequate low-income services**

##### **Challenge of inadequate family support**

Ms. O is a 40 year old Caucasian divorced female who has resided in a nursing facility for 50 months. She was admitted to the nursing facility after hospitalization for surgical removal of a right adrenal mass. Ms. O had rapidly progressing multiple sclerosis for approximately seven years.

Diagnosis:

Pheochromocytoma and intravaginal paraganglioma

Comorbidities:

Multiple sclerosis

History: Before being admitted to the hospital and then a nursing facility in Ann Arbor, Ms. O lived in a subsidized apartment in Clinton, MI. She was employed full-time until 1997, when she became disabled from MS. Her sole source of income is through SSI in the amount of \$841/month. She required assistance with all ADLs and IADLs. She also needed transportation to and from all medication appointments, many of which were at the University of Michigan Health Care System in Ann Arbor. Under the Medicaid Waiver, she received six hours of care per day, but when the State suspended funding for the Waiver program, her benefit was reduced to two hours per day, immediately prior to her hospitalization. While Ms. O had some family in the area, there were no family members directly involved in her care. However, her ex-sister-in-law agreed to act as primary caregiver when Ms. O became ill, and held her financial and medical power of attorney.

For four months, Ms. O resided in the Ann Arbor nursing facility, where she received PT/OT. During that time, her caregiver traveled almost daily from Tecumseh to visit and attend to Ms. O's needs. Since Ms. O was forced to relinquish her lease on the subsidized apartment, the caregiver and the nursing facility social worker asked Ms. Carroll to assist in finding another subsidized apartment and services so Ms. O might return to the community. Ms. Carroll worked with the Center for Independent Living and

State housing agencies to locate housing and services for Ms. O; however, housing vouchers were not available in the county in which Ms. O lived and services under the Medicaid Waiver were no longer available. Additionally, Ms. O's disease had progressed to a point where she now required 24/7 care.

With little chance that Ms. O would return to the community in the near future, the focus turned toward finding a Medicaid bed closer to her caregiver and family. She was waitlisted for a bed in a Tecumseh nursing facility and was eventually transferred there. Soon after her arrival at the new facility, staff had difficulty handling Ms. O's escalating emotional outbursts and defiant behavior, symptoms related to progressive MS. The facility threatened to discharge Ms. O. However, Ms. Carroll offered the staff there supportive information about care for this type of difficult behavior. She also investigated MS treatment training by UM staff specialists and offered that resource to the nursing facility staff. She communicated with the nursing supervisor regularly and even sent a letter to the staff there, commending them on the extraordinary effort they were making in caring for this participant. Eventually, the staff was able to adjust care for Ms. O and she has been residing there ever since. Recently, the caregiver reported that both Ms. O and the Tecumseh nursing facility staff have "gotten used to" each other.

Throughout Ms. O's participation under this project, Ms. Carroll has offered extensive support to Ms. O, her caregiver and nursing facility staff. She assisted in obtaining UM medical records for the caregiver to be given to a new physician. In addition to visiting Ms. O and the caregiver on numerous occasions at the nursing facility, she accompanied them to oncology appointments and to the emergency room. During one emergency room visit, she was able to assist in activating Ms. O's durable power of attorney.

Comments: Although suffering from MS, Ms. O was able to live independently in a state subsidized housing apartment with limited services for several years. However, when her illness progressed, State funding for supportive services was being drastically reduced and Ms. O was no longer able to receive care in the community. Consequently, she remains in a Medicaid facility and will, most likely, remain there until she dies.

### **Challenge of inadequate housing**

### **Challenge of overwhelming care needs**

### **Challenge of inadequate family support**

Mr. E was a 58 year old single African-American male who resided in a nursing facility in Detroit for approximately 14 months. He was admitted to the nursing facility after hospitalization for evaluation of severe diarrhea and weight loss.

Diagnoses:

Severe malabsorption

Pancreatic exocrine insufficiency

Lymphocytic gastritis

Lymphocytic colitis

Elevated gastrin level of uncertain significance  
Chronic pancreatitis  
Type 2 diabetes mellitus  
End stage renal disease, on hemodialysis  
Helicobacter pylori positive

Comorbidities  
History of deep vein thrombosis

Mr. E. resided briefly at a Detroit nursing facility at the time of his hospitalization. Prior to that period of time, he was homeless. He had no known family or close friends. He had no significant work history, and received income from the state of \$545/mo. He had a history of alcoholism. He required dialysis 3x week and transportation was arranged for him by the nursing facility to the east side of Detroit for such treatment. He was wheelchair bound at the time of initial assessment. In addition to the medical problems listed above, Mr. E had extremely poor eyesight.

During Ms. Carroll's initial assessment, the nursing facility director and social worker expressed concern that Mr. E would not be compliant with his diet, medication and dialysis regimen if he lived in the community. They felt that that he benefited from the care and extensive daily supervision he received at the nursing facility and would not survive if he returned to the community. The nursing facility social worker further stated that she was familiar with the housing options in the surrounding area and was certain that there were no barrier-free housing options there that would be able to meet his physical needs which would offer the type of personal services he required.

Mr. E indicated during his initial interview with Ms. Carroll that he enjoyed the people at the nursing facility, liked the care he received and especially appreciated having regular meals. However, he did say that he would like to be able to live independently once again. However, he admitted that he didn't know how he would take care of himself outside the nursing facility. For example, he didn't know how he would get to the store to buy groceries, get to his dialysis or medical appointments, buy medications, remember to take medications, or do his laundry.

Ms. Carroll worked with State housing agencies to identify possible housing for Mr. E. State agencies tentatively located potential barrier-free units in Trenton and Wyandotte. However, Mr. E wanted to remain in Detroit, since he was comfortable with the dialysis treatment center he was attending. Importantly, the State agencies could not readily identify transportation services that would enable him to get to his dialysis treatments three times a week from the downriver area.

During a subsequent care conference, the new interim director and social work director again expressed concerns regarding Mr. E's ability to survive in the community. His health continued to deteriorate steadily and Ms. Carroll chose not to pursue further housing investigation. Mr. E remained in the nursing facility for 14 months before requiring hospitalization. He died shortly after being admitted to the hospital.

Interventions on Mr. E's behalf include advocacy efforts regarding housing mentioned above. Additionally, Ms. Carroll attended care conferences, discussed his care plans at length with his nursing facility caregivers, and had several conversations with Mr. E regarding his wishes and care needs. While the staff at this nursing facility appeared to take a personal interest in Mr. E's care, it was nonetheless beneficial for them to know that an outside advocate was interested in his care as well.

Mr. E's case presented a complex ethical question for Ms. Carroll, i.e., using a client-centered approach, are we ethically bound to get someone who desires to go back to the community out of a nursing facility when we have evidence that living independently may not be in his best interest? The problem was frustrating because Mr. E had not been declared cognitively impaired; however, there was ample evidence that he had made poor choices throughout his life and had even more limited resources and ability to fend for himself now than ever before. Further, staff members at the nursing facility who were acquainted with him felt that he would not be able to survive in the community without constant supervision. While it is not unreasonable to assume that the nursing facility was interested in retaining Mr. E as a resident for reimbursement, they appeared very proud of being able to keep him healthy and "off the street." As such, they were genuinely protective of him and concerned for his well-being.

As it turned out, Mr. E was not willing to consider the housing options we were able to locate. Consequently, he remained in the nursing facility almost until he died. Mr. E may very well represent an appropriate nursing facility resident because no housing arrangement was satisfactory to him, or could offer him the supervision he required to ensure medical and dietary support he needed to live safely in the community.

### ***Why couldn't these participants go home?***

Participants remaining in the nursing facility experienced one or more of the following:

- Significant care needs warranting 24/7 nursing and/or medical care.
- Insufficient housing available to address medical complexity.
- Insufficient housing because of lack of appropriate voucher availability.
- Insufficient family support.
- Insufficient low-income services to provide 1) transportation to dialysis and medical appointments; and 2) frequent personal care needs (greater than every two hours).
- Participant desired to remain in nursing facility.

### **Costs**

In the original Systems Change Grant, the *Evaluation Component* was designed to be conducted by a separate evaluation team. In February 2004, the Turner Diversion Project staff was requested to perform the evaluation on the Diversion data. Cost analysis was

not in the initial design of this data set, but some comments on the time and effort expended by Ms. Carroll and Ms. Blomquist in assessing, formulating participant goals, establishing and revisiting plans of care, monitoring progress, arranging services, and providing education and support may be of value.

The most significant time investment was by Ms. Carroll. It was our observation that the nursing facility social worker arranged most of the skilled home care services available to participants, if discharge occurred while the participant was still rehabilitation-appropriate under Medicare. While her care and attention was available to all participants, Ms. Carroll focused most attention on addressing participant and family support and education, acquisition of informal or non-skilled resources (personal companions or adult day programs, for example), exploring atypical resources and services, arranging follow-up care with primary care providers, and hospice programs. This role addressed our primary concern that participants who were appropriately placed in the nursing facility, but did not achieve expected rehabilitation benchmarks would remain in the nursing facility without a concerted effort to arrange those services and family supports which enable a safe transition home.

An in-depth cost/benefit analysis of the overall State of Michigan-Nursing Facilities Transition and Diversion Project will be included in the final report. Some of this report will create a parallel comparison group to our Diversion Project population, with cost implications, and an examination of the CMS quality indicators.

#### Participant satisfaction with nursing facility placement and the return home

Perhaps as a result of their comfort in communicating with Ms. Carroll, participants and their families were forthcoming in their comments on the nursing facility experience. Most reported that their actual transfer to the facility had been smooth, though there were high levels of apprehension/dread and disappointment in the need for placement. Some participants were highly complimentary of nursing facility staff; particularly those they felt were caring and encouraging. In particular, participants appreciated nurses, aides, and PT/OT staff who could balance encouragement without being, in one participant's words, "too pushy."

Many of the complaints directed at the nursing facilities involved staff perceived to be uncaring. Other participants had upsetting experiences, for example, the death of a roommate, or a roommate who "wouldn't stop screaming"; that they felt had not been addressed by the staff. Others complained of short-staffing, delays in getting call-lights answered, or staff saying they would "come right back to help," but never did. Some participants and families reported episodes of poor care; teeth unbrushed, a diabetes regimen not followed, for example, but most felt communication was the largest problem. Several participants felt the staff did not give them enough information about what was going on, or gave the information to family members instead of (rather than in addition to) the participants themselves.

The participants who returned home reported high levels of satisfaction. Comments included gratitude of Ms. Carroll's involvement, and pleasure in recovery at home. One daughter stated, "Once we got him home, we knew he'd be okay. We worked with him daily to do the exercises, got him back to his own doctor, and changed him back to his (previous) diabetes treatment." Other participants reported improvement in overall mood upon return home.

The comments about the nursing facility experience are not new, and are those which State nursing facility inspectors, ombudsmen and committed nursing home personnel struggle with on an ongoing basis. That participants are more content in their home environment is no surprise, even those going home to die felt their goals were realized. Still, these comments bear repeating as they encourage all of us to rededicate ourselves to making the nursing facility stay more conducive to the rehabilitation effort, with better communication to facilitate understanding of care issues, and preparation for an optimal return home.

### **PROMISING PRACTICES: EXAMPLES OF "BEST CLINICAL PRACTICES" UNDERWAY AT UMHS, AND IN THE COMMUNITY TO REDUCE UNNECESSARY NURSING FACILITY PLACEMENT**

Over the three years that Turner Clinic Social Work and Community Programs staff has been involved with the Diversion Project, we have also participated in many other projects to enhance care of those at risk for inappropriate nursing facility placement within our patient population. With respect to inpatient care at University Hospital, we would like to highlight

- The Elder Life Delirium Prevention Program
- A new model for discharge planning teams
- A hospital renovation project to increase family access to long term care planning resources, and
- Initiatives in clinical staff education.

#### The Elder Life Delirium Prevention Program

The Elder Life Delirium Prevention Program (Elder Life) at the University of Michigan Hospital has demonstrated success in improving patient care for older patients at risk for developing delirium during their hospital stay.

Patients identified "as at risk" for developing delirium; i.e., those with elevated BUN/Cr++ levels (indicative of dehydration), baseline cognitive impairments, ADL impairments and fall risk, and with an anticipated length of stay > 3days were screened for enrollment. If appropriate for participation, Elder Life participants received an individualized program of cognitive, communication, mobility and hydration/feeding support provided by trained volunteers on the medical units, with the goal of maintaining cognitive and physical functioning throughout hospitalization.

In the Elder Life Program at University Hospital, we have demonstrated improvements in cognitive function, reductions in use of physical restraints, decreased frequency of falls, and a shorter length of stay. Two hundred forty elderly hospitalized patients have received Elder Life services, since the program's inception 18 months ago. The program is gradually being expanded through the hospital.

While the patients served in the Elder Life Program are not necessarily participants in the Nursing Facility Diversion Project (though there was population overlap), it is noteworthy that 25% of the 240 (n=60) persons enrolled in Elder Life may be considered Diversions from anticipated nursing facility placement (2).

#### Improvements to discharge planning

As one component of the UMHS effort to reduce Length of Stay (LOS) prior to anticipated discharge to extended care facilities, a pilot project with discharge planning teams is under evaluation on select medicine units. These teams consist of established physician/RN discharge planner/social workers to conduct daily discharge rounds on adult medicine patients of all ages, beginning upon hospital admission. The earlier assessment of patient needs and anticipated outcomes has facilitated earlier referral to community services. The available role of an in-house home health agency-visiting nurse assessor can potentially identify patients suitable for skilled home care, redirecting them from nursing facility placement if possible. This project continues under evaluation.

#### Structural modifications to improve patient/family resource access

An additional development in our effort to address length of stay issues included attention to the dilemma that many families seeking information on nursing facilities and alternatives to nursing facilities are not able to visit patients, or seek social work support during regular business hours. To address this, the University Hospital plans modifications to the Guest Assistance Program (GAP) Office, a component of the Department of Social Work, to arrange off-hours access to a patient/family resource area. This area would include a variety of printed materials on long-term care alternatives and access to internet based information on a specially designed computer terminal. This effort enhances our ability to get important resource information to families in the "hospitalization-before-the-hospitalization" leading to nursing facility stay, and can facilitate family-initiated follow-up contact with hospital social workers.

#### Clinical staff education

In the past three years, several noteworthy programs have addressed the knowledge clinical staff have on issues of aging and functional change. A three year "Comprehensive Program to Strengthen Physician Training in Geriatrics" funded by the D. W. Reynolds Foundation, under the leadership of Drs. Jeffrey Halter and Brent Williams has developed a faculty educator model to train faculty physicians in Emergency Medicine, Gynecology, Hematology/Oncology, Rheumatology, Pulmonary Medicine, Nephrology, Gastroenterology, Orthopedics, Physical Medicine and

Rehabilitation, Anesthesiology, General Surgery, Plastic Surgery, Urology, Endocrinology, and Thoracic Surgery. Trained by a Core faculty of UMHS-Geriatrics Center physicians, social worker and pharmacist, the faculty physicians in these specialties are trained in the essentials of geriatric medicine, and charged with conveying this content to resident physicians in their Resident Training Programs.

In addition to the Reynolds Program for Geriatric Medicine, Turner Geriatric Clinic Social Work staff have provided clinical education to nursing staff and social work staff on assessment and resources for the elderly and disabled.(3) These programs address the functional status of older adults and target geriatric syndromes and conditions; including, dementia, inappropriate prescribing of medications, incontinence, depression, delirium, iatrogenesis (including consequences of hospitalization and bed rest), falls, osteoporosis, sensory impairment, failure to thrive, immobility and gait disturbance, pressure ulcers, sleep disorders, and non-specific presentation of disease. These conditions are “red flag events” that can lead to functional decline, increased dependency, and poor clinical outcomes, including premature institutionalization.

Social Work staff at Turner Geriatric Clinic is participating in projects to enhance the care of older adults in the outpatient clinics and in community services. With respect to efforts in the Clinics and the community, we will describe

- The Housing Bureau for Seniors
- Silver Club Adult Day Program for Adults with Memory Loss
- Clinical social work assessment and intervention services
- Education programs sponsored by Turner Geriatric Clinic, and
- A collaborative community effort proposal under review by the Robert Wood Johnson Foundation.

#### The Housing Bureau for Seniors

As mentioned in the narrative above, very few of our participants were admitted to the hospital with their community housing at risk. Had these participants remained in the nursing facilities for extended periods of time, their homes and apartments would have been vulnerable, and retaining community housing was a critical goal for Andrea Carroll. An essential resource in this effort is the Housing Bureau of Seniors. The Housing Bureau for Seniors works throughout Washtenaw County to assist, enable, and empower older adults to live in appropriate and affordable housing. There are no fees for Housing Bureau services. Assistance is largely provided by trained volunteers. The Housing Bureau for Seniors is a community supported program of the University of Michigan Health System serving all of Washtenaw County. Important services within the Housing Bureau include; the Property Tax Foreclosure Prevention Program, the Elderly Eviction Prevention Program, the HomeShare Program matching seniors with housing with housemates, and Housing Counseling and Information services. (4)



### The Silver Club Adult Day Program

Adult day programs are a cost effective way to maintain older adults with functional limitations in the community. By providing supervised care, family caregivers remain able to keep many older adults home who would otherwise meet nursing facility care criteria.

Silver Club, the adult day service sponsored by Turner Geriatric clinic is a social enrichment program specifically designed to meet the needs of older adults with memory loss. This group meets at the Turner Senior Resource Center on Tuesdays, Thursdays and Saturdays, and at Brown Chapel, AME Church in Ypsilanti on Mondays and Wednesdays. All activities are appropriately adult-focused to stimulate memory and promote continued independence. Activities include exercise, music, horticulture, socialization and intergenerational sharing. Services include educational support for caregivers, and education and referral about other community services and resources. The Turner Geriatric Clinic Silver Club Program is a partner with Washtenaw County HelpSource Adult Day Program.

A nationally recognized program available at Silver Club, Coffee House, is an ongoing support group serving individuals in the early stages of memory loss. Members are encouraged to discuss their concerns, frustrations, experiences and observations with each other. Stimulating conversation encourages members to access feelings, release tension, and celebrate life. The group meets at the Turner Senior Resource Center on a continuous basis. Services include educational support for caregivers.(5)

### Clinical social work assessment and intervention

In a clinical service designed to help patients and their families understand, manage and anticipate the psychological and social dimensions of illness, the clinical social work staff have been providing Health and Behavior services under Medicare reimbursement. This service is defined as a social work encounter directed at assessing or intervening in the psychological, behavioral, emotional, cognitive and social factors relevant to the prevention, treatment, or management of acute or chronic physical health problems. The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatment. Health and Behavior intervention procedures are used to modify the psychological, behavioral, emotional, cognitive, and social factors identified as important to or directly affecting the patient's physiological functioning, disease status, health, and well-being. The focus of the intervention is to improve the patient's health and well-being using cognitive, behavioral, social and/or psychophysiological procedures designed to ameliorate specific disease-related problems.

Upon referral from physicians, the social worker is able to assist the patient (and their family, if the patient prefers) understand and navigate the issues relating to the illness(es), the need for treatment (if compliance issues are a concern), resources needed currently and in the future, and clarify the patients values, goals and wishes for care.

### Education programs sponsored by Turner Geriatric Clinic-Social Work and Community Programs

For over 15 years, the social work staff at Turner Clinic has conducted a six-week lecture series, “Caring for Aging Relatives” twice yearly. These programs are designed to help families plan ahead for the needs of their elderly relatives, and include an emphasis on family communication to understand the goals of the aging family member. These sessions are open to the public, and are well attended. We have also conducted the following groups and programs to support, educate and inform older adults, community members and professionals about issues of aging:

- African-American Alzheimer's Support Group
- Caring for Aging Relatives Support Group
- Caring For Your Mate Support Group
- Diabetes Support Group
- GLOW: Gays/Lesbians Older & Wiser
- Improving Your Memory Series
- Intergenerational Women's Group
- Low Vision Support Group
- New Outlooks Socialization Group
- Seniors Sharing Hearing Loss Support Group
- Senior Smoking Cessation Group/Stay-Quit Group (6)

### Collaboration between community providers of services to the elderly

As the findings of this Diversion Project suggest, effective communication and collaboration between community agencies is essential in coordinating service delivery to older adults and their families. Ruth Campbell, Associate Director for Social Work and Community Programs at the UMHS-Geriatrics Center has participated in this proposed project, currently under consideration for funding by the Robert Wood Johnson Foundation: The **Blueprint for Aging Services Partnership (BASP)** of Washtenaw County is a coalition of representatives from 41 public, private, and nonprofit organizations dedicated to enhancing the quality of life for older residents through collaborative planning and action. BASP members collaborate in the delivery of many services and in 2003, completed a 150 page strategic plan for long term care systems change and service innovations.

The BASP vision for the future of aging services is one where all citizens recognize themselves as stakeholders in the care of older persons, and are actively engaged in promoting and supporting programs for the aged. This community will be outspoken on behalf of aging issues, and more segments of the community, including remote areas of the county, social enclaves, and ethnic groups will be involved in programs that are fully accessible.

The BASP coalition will expand its membership and participation to facilitate:

- Creation of a Shared Point of Access for Long Term Care in the form of a web-based database of secured consumer information and community resource listings that will be utilized by agencies to manage and report consumer data; by consumers to access information on care options; by caregivers to monitor and plan for care; and by funding sources to evaluate program impact and identify unmet needs. The Shared Point of Access will feature secured e-mail and chat functions that facilitate real time consumer data.
  - Development of a Family Caregiver Support Plan that will be utilized to direct the expenditure of a dedicated source of local dollars to address caregiver needs.
  - Dedication of a Long Term Care Systems Change Workgroup to evaluate and implement specific recommendations from the BASP report for systems change and service innovations that address access issues and gaps in services.
  - Organization of coalition of advocacy groups, senior focused activities, and individual advocates to form the new Senior Advocates of Washtenaw. This formal coalition will take action on public policy proposals affecting the elderly, advocate for systems change, and engage in intense study of long term care issues and serve as an incubator for new approaches to long term care service delivery.
- (7)

## **RECOMMENDATIONS**

All diversion and transition activity must be built on principles of strength-based assessment and client-centered planning and care.

Strength based assessment focuses on individuals' abilities and goals. This approach does not ignore problems or deny deficits, but uses the person's strengths to guide the ultimate goals, plan of care, and interventions. Some important strengths to consider during assessment and care plan development are:

- Wisdom – ascribed meaning of life, values, insight gained from personal experiences.
- Resilience and adaptive ability - ability to cope with and recover from difficult situations over a lifetime.

- Sense of control – perceived mastery over one’s own situation.
- Support network – the emotional, social and physical support available when needed.
- Life Skills – skills the person has used to progress and survive in life.
- Financial resources

Client-centered, or “person-centered” planning is an approach which identifies the individual’s goals in the context of the situation, and attempts to maximize goals with appropriate available resources. Much of the success of clinical care is based on a careful “fit” between services and the person’s stated goals for well-being. Providing too many services can foster dependency, provoke resentment, and waste resources. Providing insufficient services places the person at risk and undermines trust.

### Recommendations to improve the prevention of avoidable nursing facility placement

The goal of prevention efforts is to maintain functional ability and maximize independence, even in the face of chronic or progressive disease.

#### 1. Increase the ability and role of the primary care provider and clinic:

Primary care providers should be well acquainted with recommended primary and secondary disease prevention care for disabled adults and the elderly. The US Preventative Services Task Force (USPSTF) has one such set of guidelines (8).

Attention to the risk factors of functional decline, including sensory losses, gait and mobility changes, incontinence, poor nutritional status, memory changes, depression, and decline in activities of daily living (9), and the implementation of treatment as appropriate is essential for prevention efforts. With attention to the social, financial, psychological and supportive care needs of the person, all aspects of well-being are addressed, and the person becomes more of a partner with the health care provider. Primary provider knowledge of and ease in referring to those professionals and programs which address these concerns is vital in quality preventative care.

#### 2. Promote early identification of persons with functional needs in the hospital:

Earlier identification of hospitalized patients with risk factors for increased dependency is consistent with the prevention goal of addressing all concerns in this hospital stay, which may lead to another hospital stay or inappropriate nursing facility placement. Most persons with unscheduled hospital admissions present with an acute health event. Among persons at high risk for nursing facility placement, there are often underlying chronic conditions or comorbidities to be assessed and treated. This is standard practice in quality health care. In addition however, the following concerns warrant assessment during the hospital stay:

- The person's goals for treatment and care: What are the person's long term goals and concerns for discharge? Is the person willing to follow the treatment course, as prescribed? Does the person understand all aspects of the treatment course, and who to contact with additional questions? Has the person named a medical advocate (durable power of attorney for health care) to assist with decision-making, if the person him/herself becomes unable to do so in the future?
- Social supports: Does the person have reliable and available persons to assist with daily life needs? Are support persons aware of these needs?
- Home environment: Is the residence safe and accessible for the person's current ADL/IADL abilities? Does it remain a financially viable option? Is a home safety referral indicated?
- Financial status: Does the person have adequate finances to meet their ongoing expenses, and the treatment/medications recommended? Is the person adequately insured?
- Cognitive ability: Does the person show evidence of good judgment? Is short term memory intact?
- Mood status: Does the person show signs of depression or anxiety?

Comprehensive assessment and intervention in these areas of concern during hospitalization is vital to avoid the failed discharge home, unnecessary hospital readmissions, avoidable nursing facility placement, poor health outcomes, patient frustration and sense of failure. Timely referral to community services agencies is the next step in this prevention effort.

3. Invite and promote better communication between the health care system and community service agencies. Much of the service delivery system for this at risk population is fragmented. As illustrated in the findings above, the transfer of care from one service entity to another in the health care and service continuum, and poor communication between them leads to poor outcomes for persons at risk. These concerns will be further elaborated, and recommendations made in the next section.

### Recommendations to improve diversion and transition from inappropriate nursing facility placement

1. The State of Michigan should create a process to identify persons at risk for inappropriate nursing facility placement.



WHO ARE the PEOPLE at RISK for INAPPROPRIATE NURSING FACILITY STAY?

Physically compromised (certain elderly, developmentally disabled)  
Mentally / cognitively impaired (persistent or intermittent mental illness / developmental disabilities/ neurological disorders ]  
Psycho/emotional (significant thought or mood disturbance/ substance abuse)  
Financial viability  
Limited social support network  
Loss of community supports and services including housing, caregivers and other supports



WHERE ARE the PEOPLE LOCATED and WHO IDENTIFIES THEM?

HOSPITALS	NURSING FACILITIES	HOUSING SITES	COMMUNITY
D/C Planners Social Workers Health care professionals Consumers Family Members Advocates	Social Workers Nurse Consumers Family Member OBRA Worker Advocates	Staff Landlord Consumers Family members Advocates	Community agency staff Health care providers FIA staff Waiver Agency staff Mental health system staff Centers for Independent Living staff Housing advocates Consumers Family members

Chart prepared by Carie R. Garrity

The persons listed above are the “first identifiers” of persons at risk for inappropriate nursing facility placement. These professionals, family members, consumers and advocates must be able to recognize the potential for functional decline, and other risk factors, and know how to refer for assessment and intervention. To be able to recognize the “red flags” in persons at risk, first identifiers must have knowledge of needs and resources. To be able to refer a person at risk for service, first identifiers must have a reliable assessment and intervention network.

2. The State of Michigan should create a model of education for consumers, providers and professionals to provide information on alternatives to nursing

facility placement, and services and resources including; housing options, community support programs, financing mechanisms, health care information, and family support materials.

This education initiative should;

- a. Identify and target the service population of persons at risk for inappropriate nursing facility placement (as above).
  - b. Provide information on the program and process of intake and assessment of persons at risk.
  - c. Provide information on eligibility criteria for services, or alternatives for those ineligible.
  - d. Provide a referral navigator to locate appropriate services including:
    - i. Housing
    - ii. Health care
    - iii. Family and social support
    - iv. Financial support services
- Describe monitoring, follow-up care, and grievance procedures.

The State of Michigan Nursing Facility Transition and Diversion Project is undertaking the development of an education program which includes these elements, and will be available in web-based learning modules and field trainings for professionals, and in a web-based format for consumers.

3. The State of Michigan should create a role and support mechanism for the "linkage" social worker responsible for Diversion and Transition programs. This role closely parallels the role of Ms. Andrea Carroll in the Turner Geriatric Clinic diversion Project we describe. To avoid creation of yet another level of service delivery, we recommend that this professional role be located within the Medicaid Waiver agent network, most typically within Area Agencies on Aging or Centers for Independent living.

What would this role include? The responsibilities of this role are already well developed in some Michigan counties, and are referenced in the Final Report of the Nursing Facilities Initiative Project. Our recommendations for the role of this social worker include:

- Conducting a comprehensive assessment
- Identifying the person's goals
- Conferring with the person, family (as appropriate), health care providers, service and housing providers to develop plan of care
- Providing assistance in making appropriate referrals for housing, social services, financial resources, and housing resources
- Remaining available according to stated plan to monitor needs and assure appropriate utilization.

Early identifiers and consumers would be educated to know of this professional, and refer at risk individuals. Those making referrals would also be incorporated into the changing plan of care as necessary, with the linkage social worker able to confer with hospital, nursing facility, community housing and community service professionals as needed to assure smooth transitions of persons across the health and social service continuum of care.

We bring two caveats to this recommendation: to adequately perform this role, and successfully execute this process,

- The process must be adequately staffed with well-trained, motivated professionals to maintain manageable caseloads which assure the **relationship of care**.
  - The process must be adequately funded to provide scope and access to necessary services. Those on lengthy waitlists, assisted by overworked staff remain at risk for unnecessary placement
4. The State of Michigan should partner with existing health care agencies and community organizations to create a process which fosters the continuity of care essential to assure positive clinical outcomes for persons at risk for inappropriate nursing facility placement. Much of this goal can be achieved with a well-executed education program as described in recommendations above, and a carefully designed process of early identification, assessment, intervention and monitoring. The various health care providers, housing programs, community service agencies, and government programs cannot provide quality service if each is only aware of its own scope. Understanding the goals, staff and roles, scope of services of each of these groups promotes the integrated service network which can prevent these potentially vulnerable Michigan citizens from “falling between the cracks” of the service delivery system.

## **LESSONS LEARNED IN THE NURSING FACILITY DIVERSION PROJECT**

The authors appreciate the opportunity to have participated in the Diversion Project, and are hopeful that our findings and recommendations are of value to the Nursing Facility Transition Initiative, the Michigan Department of Community Health, and the Centers for Medicare and Medicaid Services. We are confident that this effort has had a significant impact on the lives of many of our participants and their families. Much of what we have learned is proving fruitful in other areas of the University of Michigan Health System.

Our project would have benefited from a dedicated cost analysis component to this data set, as we are confident that Medicaid utilization was reduced, but future analyses of these participants and their service use is required to state that unequivocally.

We were also limited in our ability to use interval data, as our project used a continuous recruitment process. We were monitoring some participants who had been enrolled 2 ½ years ago and some a few months ago, limiting the comparison validity of their long term outcomes. We would consider identifying and tracking one month of UMHS discharges (n~150), and following them over the course of 12 months. Not only would that allow



discreet time-interval comparisons, but it would assist in answering the most fundamental question: what is the most clinically and fiscally appropriate use of a highly engaged social worker for this population? In this project, we made clinical decisions to enroll, assess, and intervene with higher complexity participants. In a world of limited resources, there are advantages to more precise targeting of resources.

In summary, we recommend prevention processes which are wide-ranging in scope, and focus on early identification and education. For diversion and transition processes, we recommend attending first to the persons' goals, use of functional parameters to measure progress and set care plan objectives and intervention with timely allocation of services. For all of our participants; clients, patients, residents, consumers, citizens... we recommend the time, compassion and knowledge of committed professionals to assist those in need in achieving their desire to return home.

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