# A Statewide Model for Transitioning Nursing Home Residents to the Community

Presenters:

Krista Boston, J.D. – Director, Consumer Assistance Programs, MBA

Darci Buttke, MPP – Care Transitions Policy Analyst, MBA

Greg Arling, PhD – Purdue University

Rosalie Kane, PhD – University of Minnesota

Kathryn Hyer, PhD - University of South Florida

# Returning people to Community

In July 2015 - Return to Community was one of ten award winners at the State Government Innovation Awards from the University of Minnesota School of Public Affairs.  The top three winners were video taped for the ceremony.

Meet Ernie, a Veteran:
http://www.mnaging.net/en/News/SGIA.aspx

# Objectives for Today

- Participants will be able to describe key features of the Return to Community Initiative (RTCI)

- Participants will be able to list the programmatic strengths and weaknesses of the RTCI

- Participants will be able to identify elements of the RTCI that could be potentially generalized to other settings

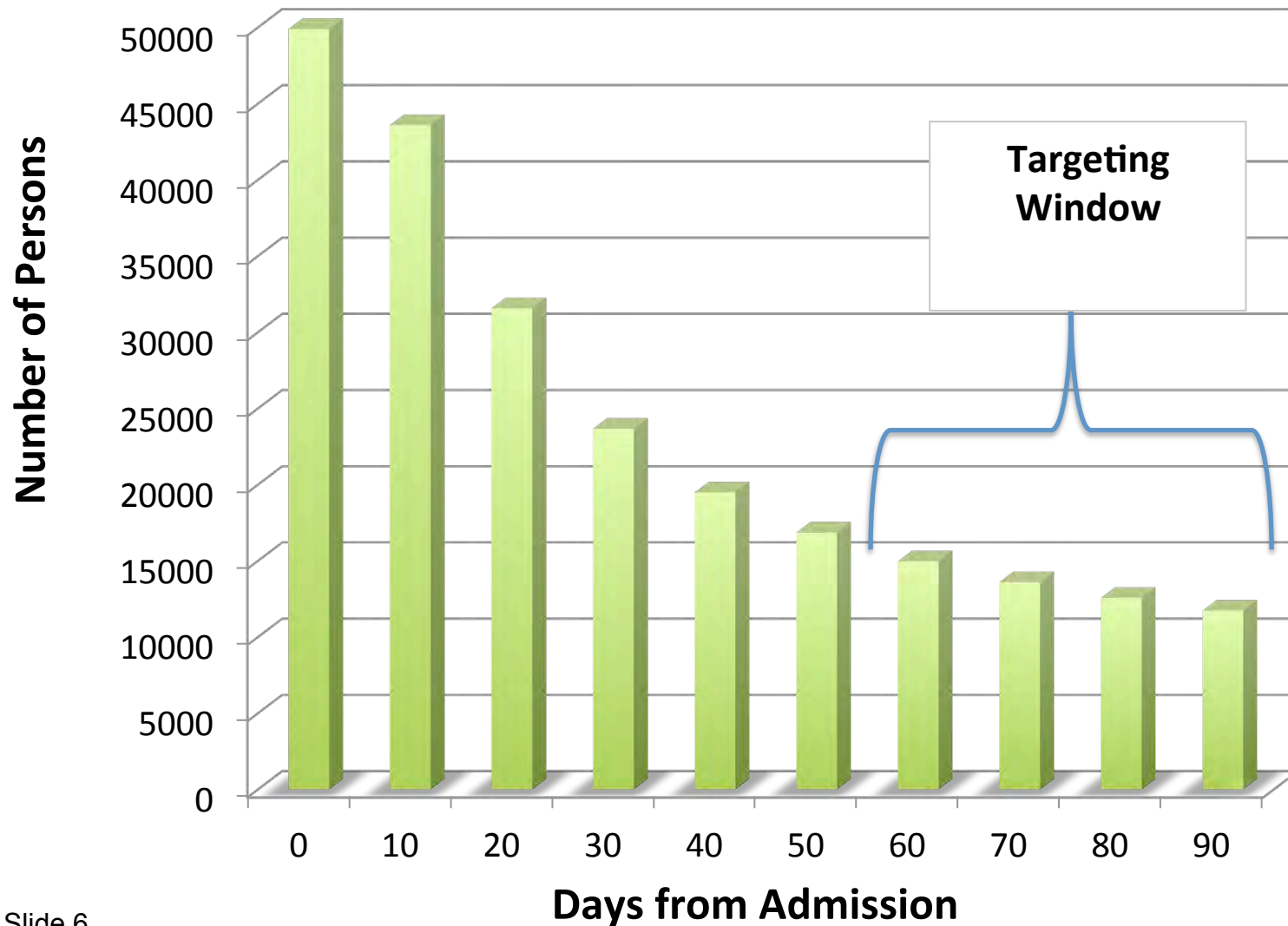# Design, Funding, and Administration of the RTCI

Presenter:
Krista Boston, Director, Consumer Assistance Programs, MN Board on Aging

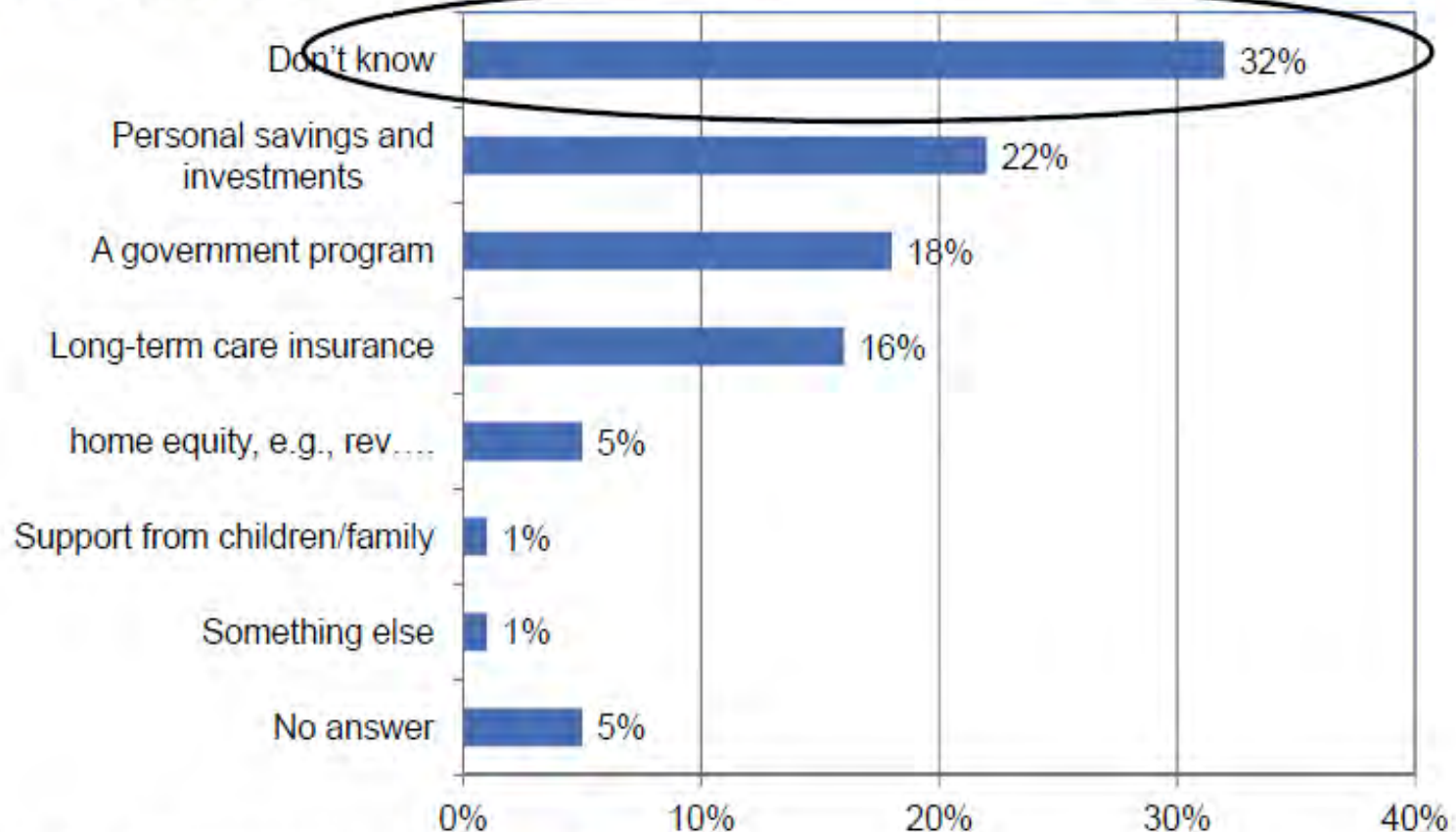# Background - Return To Community Initiative

- The initial research that led to the proposal

- Relationship to the MinnesotaHelp Network™ (ADRC)

- Review of fiscal impact (savings forecasted)

- Implementation strategy

# Target Window: Persons Still in Facility
## (49,895 NH Admissions Jan-Dec 2010)

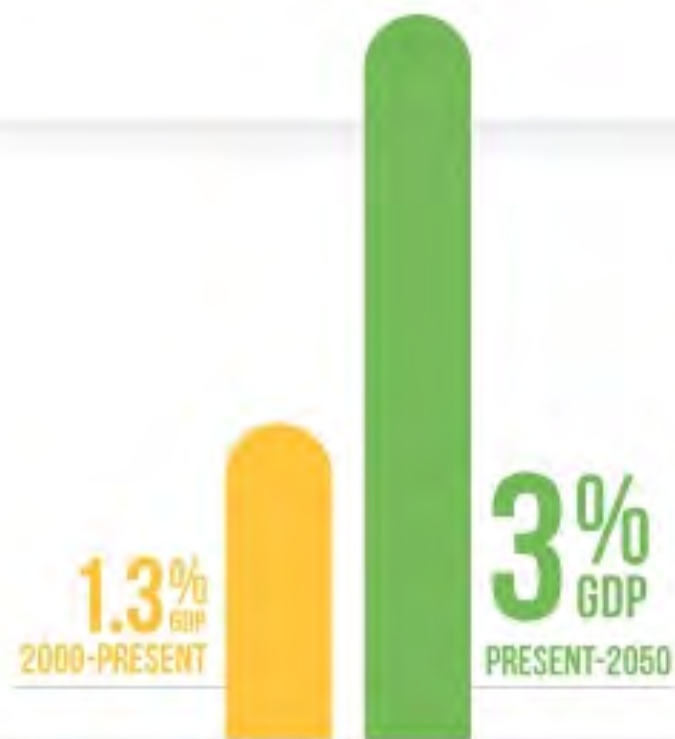# Boomers have no real plans to pay for their long term care

## Boomers' Plans

| Plan | Percentage |
|------|-----------|
| Don't know | 32% |
| Personal savings and investments | 22% |
| A government program | 18% |
| Long-term care insurance | 16% |
| home equity, e.g., rev.... | 5% |
| Support from children/family | 1% |
| Something else | 1% |
| No answer | 5% |

Source: Transform 2010, MN Department of Human Services, 2010

# DEMAND FOR LONG-TERM SERVICES AND SUPPORTS (LTSS) WILL GROW DRAMATICALLY

2010 **12 MILLION**

2050 **27 MILLION**

## LTSS SPENDING WILL DOUBLE AS A SHARE OF THE ECONOMY*

**1.3%** GDP
2000-PRESENT

**3%** GDP
PRESENT-2050

*FOR AGES 65 AND OLDER

http://bipartisanpolicy.org/library/americas-long-term-care-crisis/ April 7, 2014

# The Bottom Line

"Despite this being the most popular care option [home care], nearly one-third of Americans (30 percent) incorrectly believe that costs for these services run under $417 per month[4], when in actuality, the national median rate is **$3,861 per month** for an in-home aide or **$3,813 per month** for homemaker care[5]."

and

"…70 percent of Americans over age 65 will need some form of long term care services and support during their lives," said Tom McInerney, president and chief executive officer at Genworth."

Source: Genworth Financial Cost of Care Survey 2016 and U.S. Department of Health and Human Services National Clearinghouse for Long Term Care Information, 10/22/08.

# Fiscal Impact (forecasted savings)

- Generate state savings by assisting pre-dual eligibles back to community recognizing savings in two areas:
  - More cost effective to be on state waiver vs. nursing home
  - People avoiding spend down to Medicaid
- Base funding in 2010 ramped up to $1,012,000 per year and savings estimated at 9.6 million over four years.
- Beginning in 2014, base funding increased to $3,547,000 and fiscal note estimated to 18 million with the expansion.
  - 23 Community Living Specialists
  - 4 Case Aides
  - 2 Follow Up Specialists
  - 3 State Staff

# How the Money Flows
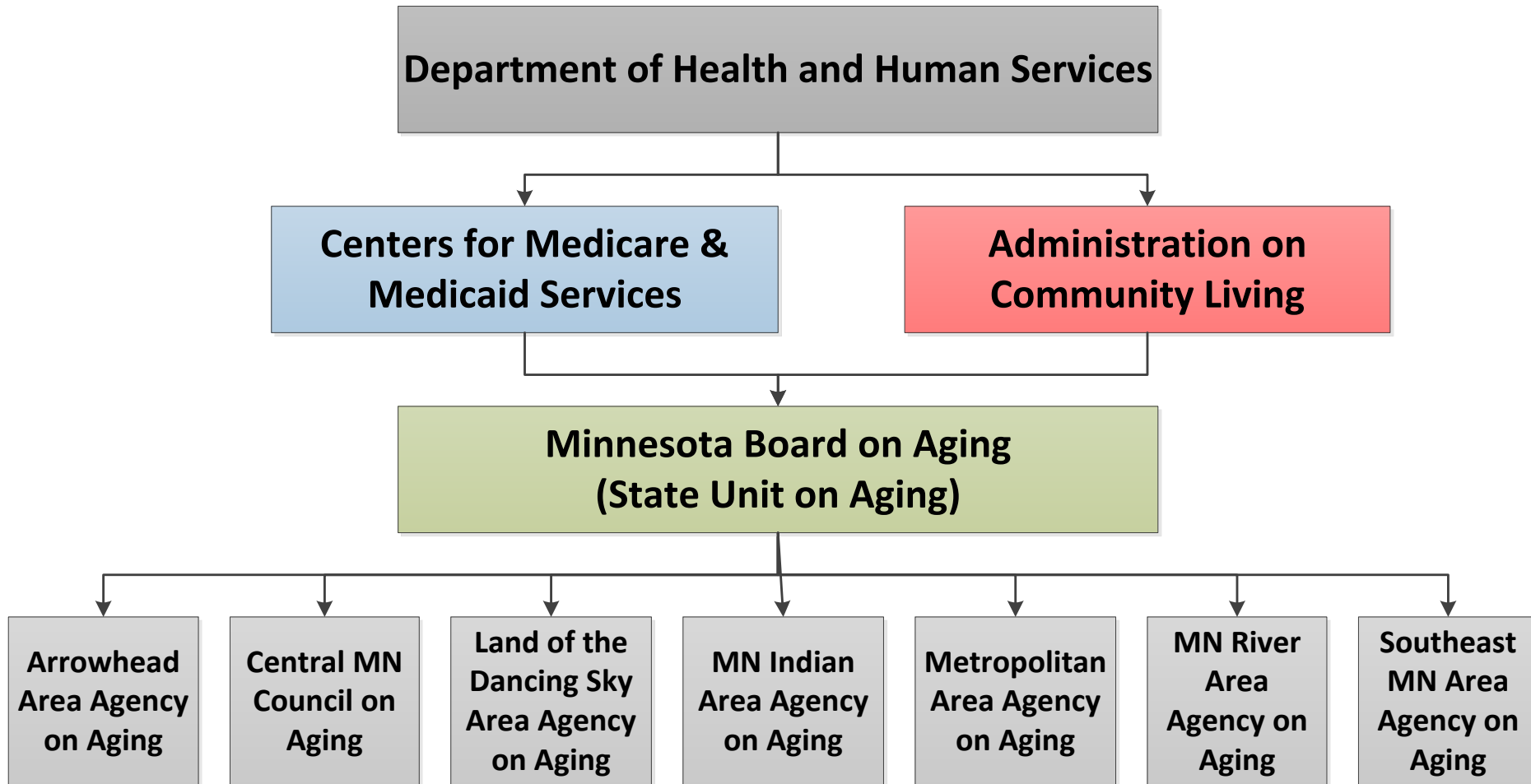
# Building Upon ADRC Framework

- Phone
  - One toll free number – Some need to HEAR it

- In-Person
  - Critical component – Some need to SEE it in person

- Print
  - Many want to study before they ask their questions – Some need to READ IT

- Secure Chat, texting and smartphone use
  - Cognizant of upcoming generations and convenience of real time information

# Implementation Approach

- Business process modeling
- Comprehensive Assessment Process and tools
- Evaluation
- Communications Strategy focused on high level of transparency and stakeholder engagement
  - Road Shows (initial and update)
  - Booklet for consumers
  - Brochures
  - Webinars, booths and conferences presentations at annual industry conferences
  - Dashboards
- Use of Data to complete target profiling

**To solve for complexity and generate consensus the use of standard business planning models is extensive**

- Business process mapping
  - Stakeholders must have "Strategic Relational Engagement"
    - Allows for check in on whether communication is effective
    - Modifying and adapting communications to allow for meaningful input
    - Transparency
    - Modifying Performance in response to inputs
    - Transformative efforts

# Business Process Map
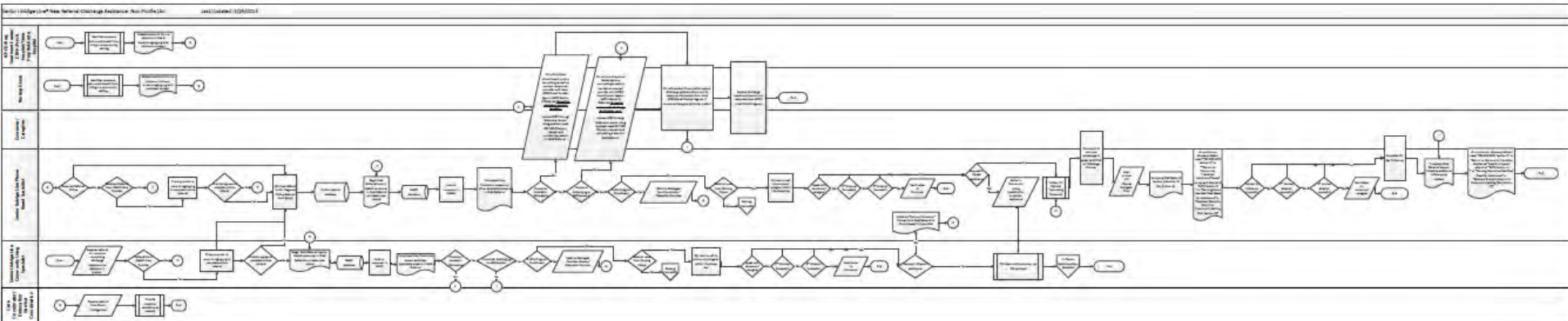
# Clear process allows implementation with simplicity

- Single points of entry when at all possible – we use secure cloud based tools
  - Available 24/7 for providers with asynchronous protocol
- Statewide models
  - Consistency and predictability so providers know what they can get when they need it
- A SINGLE BRAND – This is a must
  - Senior LinkAge Line® - The ADRC is trusted source
  - 20 years of experience in a single brand!
- One telephone number, web site in interactive secure chat
  - Convenience is critical
  - Technology infrastructure is key

# Next, monitor for performance by providing metrics to staff

- Written procedures
  - Hold staff accountable to documented protocols providing for clear expectations

- Thorough training
  - Site visits

- Monitor for quality assurance
  - Individual and agency level dashboards

# Expanding The Reach of RTCI

- ADRC becomes local contact agency for MDS Section Q

- MDS screen is done for people of all ages in the target population beginning 45 days regardless of payor status

- MFP- Return to Community protocol becomes basis for follow up strategy for all populations.

- Online referral site for nursing home

**Senior LinkAge Line®**
1-800-333-2433
LINK TO A LOCAL AGING EXPERT

**Referral Sources for CLS Assisted Consumers**

- NH Referral 14%
- SLL Referral 15%
- MDS Section Q 2%
- MDS Profile List 69%
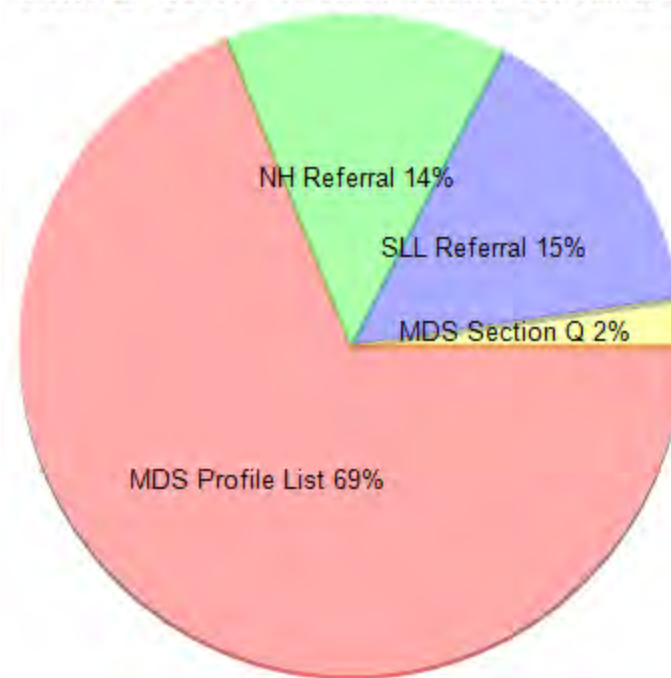
# Program for Continuous Quality Improvement

- Regular conference calls with State staff
- Initial site visits with observation and evaluation
- Statewide trainings and discussions
- Ongoing discussions with Dr. Arling's team
- Dashboards generated and sent out monthly
- Tracked at department level as part of DHS Dashboard

# Facilitating Transitions to the Community

Presenter:
Darci Buttke, Care Transitions Policy Analyst, MN Board on Aging

# Return to Community Implementation

- Training procedures

- Service delivery model and statewide protocol

- Technology used to ensure efficiency and privacy of client data

- Performance metrics for protocol adherence

# Training Protocol

- Internal procedures by Local Area Agency on Aging (AAA)
  - Their employer
  - Title: Senior LinkAge Line® Community Living Specialists
- 8 in-person hours with State staff
  - 50,000 feet down to 50 feet
- Shadow staff in another AAA region as well as their own

- After three months:
  - Two day site visit with state staff to observe protocol adherence
  - Formal write up to AAA Director within 30 days
- Ongoing review in quarterly dashboards

# Training Requirements

- Community Living Specialist protocol
- Resource House Referral (CLS and SLL roles)
- Revation LinkLive™
- MMIS
- Extranet
- DHS Protecting Data and Information Privacy course
- Vulnerable Adult Mandated Reporting training
- Core Body of Knowledge
- Boston University Aging Certificate
- Other trainings (either online or in person) identified by the Minnesota Board on Aging and announced in the weekly email

# Community Living Specialist Minimum Standards

- Education:
  - Minimum of a bachelor's degree or a master's degree from an accredited college or university in registered nursing, social work, gerontology or related human services field

- Experience:
  - *Care coordination and case management is essential AND previous employment at a long-term care facility.*
  - The staff should have a demonstrated interest in the elderly and disabled or in long-term care.

How many in-person staff are dedicated to this work?

How much do they travel?

3

3

3

3

8

3

**Area Agencies on Aging**
- Land of the Dancing Sky AAA
- Arrowhead AAA
- Central AAA
- Minnesota River AAA
- Southeastern AAA
- Metropolitan AAA

It all starts here…

NH collects MDS data

MDS data is sent to MDH

Client enters NH

MDH sends MDS data to DHS

CLS performs 10, 30, 60, 90 day follow-ups

CLS conducts in-person visit in client's home (within 72 hours)

Client Service Center conducts 180 day plus phone follow-ups for up to 5 years

MDS Data Profile List Sent to Community Living Specialist (CLS)

Client leaves NH

CLS completes Community Planning Tool with client and support person

CLS visits consumer face to face and obtains consent

CLS contacts NH, determines client discharge status

# Providing the Information



**Start planning now to return and remain at home successfully**

There are experts that can assist you in returning home.
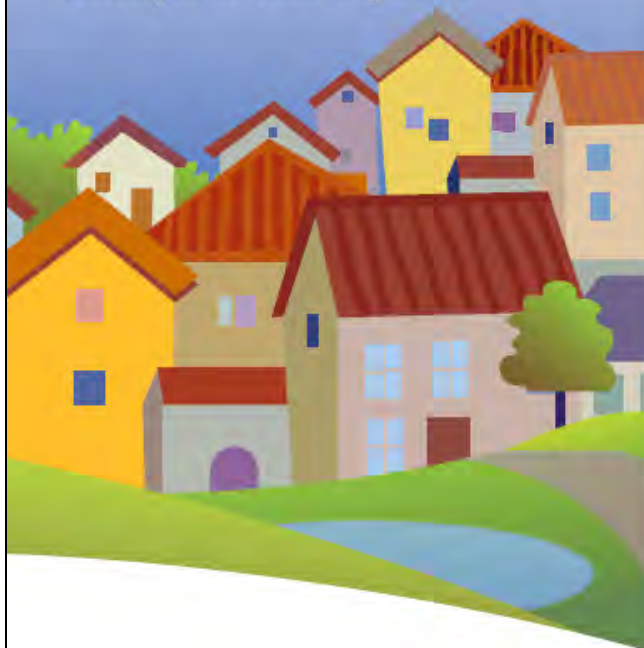
Link to an expert by calling the **Senior LinkAge Line®** today to talk about your long-term care options.

**1-800-333-2433**

# Sharing the Names

# ADRC Secure Client Tracking Tool

# Names are Provided Securely every Tuesday at 6pm

# Revation LinkLive™-Secure Chat and Messaging

# Next Steps

- Every consumer receives face to face visit
- Consent obtained, if applicable
- Returning Home booklet
- Complete Community Planning Tool
    - Care planning tool
- Meet with nursing home staff about discharge plans
    - Divvy up tasks based on consumer request and needs

**Minnesota Board on Aging**
P.O. Box 64976
St. Paul, MN 55164-0976
Phone: 1-800-882-6262
Fax: 651-431-7453

## Consent for Release of Records—5-Year Expiration

I, _____ give permission to the _____
  Consumer Name                                            AAA Name

on Aging (AAA) who employs _____, whose office
                            Senior LinkAge Line® Specialist

_____
AAA Address

_____ has my permission to do the following a
Senior LinkAge Line® Specialist

- Review and receive copies of my medical chart at _____
                                                    Nursing Home Nam

- Communicate with the nursing home staff regarding my medical ca

- Communicate with family members/friends whom I authorize

- Consult with me or my family members on developing a support

# Returning Home

Making a successful move
to your home and community

MinnesotaHelpNetwork™
A network of aging and disability resource centers

# Community Planning Tool

# Developing the Community Living Support Plan

- Person Centered
- Summary of service options and choices
- Typically 3 agencies for each type of assistance requested or required
  - Home Health
  - Transportation
  - Med Management
- Cost information for comparison
- Consumer and Community Living Specialist signatures once finalized

# Community Living Support Plan

## Personal Information

Support Plan Start Date:  02/02/2015

Name: Jane Doe

Address in Community:  Cornerstone Assisted Living of Plymouth
3750 Lawndale Lane N. Plymouth MN 55446
*(Include facility name if applicable)*

Phone Number in Community:  763-550-0333

## Consumer's Strength's and Desired Outcomes:

Jane wishes to get out of the nursing home and receive the minimal services needed. She wants to be located at a place that is convenient for her son and a few friends from church to visit. She is hoping to be in the Plymouth area or a very nearby community.  Returning home is not a comfortable place for Jane to return as she is nervous about being secluded which was a factor with her initial injury. Jane is interested in emergency response systems but she doesn't feel that it would be enough support for her to return home comfortably. Jane is looking for a place where she has her own space but also has the opportunity for socialization. She loves to watch movies on Friday nights with a bowl of popcorn and her dog Bridget.  Jane also wants to be with seniors at a comparable functional level to herself. Jane has a good relationship with her son who assists with driving. Jane needs to be provided with all options so that she can feel she is making an informed decision. Jane knows what is important and she is very realistic about her needs as well as her feelings. One great strength is that Jane is willing to look at different options in order to find a setting that is satisfactory.

## Important Contacts

| Contacts | Name | Phone Number | Address | Notes/Other |
|---|---|---|---|---|
| Community Living Specialist | Jane Smith | 1-800-333-2433 Ext. 12345 | 123 Elm Street Rochester, MN 55442 | Home visit Monday 2/2/2015 at 10:30am |
| Prior Nursing Home | Happy Hills | 763-559-5585 | 432 Spruce Ave N Amora, MN 55448 | Discharging at 10am with your son driving. |
| Emergency Contact | Patrick Doe | 765-555-5656 | 987 Apple Lane, Mankato MN 55448 | |
| Primary Caregiver | Patrick Doe | 765-555-5656 | 987 Apple Lane, Mankato MN 55448 | Son |
| Primary Care Doctor | Patricia Johnson | 432-559-8878 | Health Partners, 543 Oak Lane, Carlton MN 55444 | Follow Up Appointment: 5/11/2014 at 2:15pm |
| Pharmacy | Walgreens | 756-884-7777 | 99888 Evergreen Road, New Ulm MN 44888 | Medications will be ready 3/1/14 at 9:00am |
| Other | None | | | |

# Community Living Support Plan

## Summary of Support Plan:

Based on the review of the support plan, you have chosen to move to Cornerstone Commons 3750 Lawndale Lane N, Plymouth. The phone number is 763-550-0333. This facility allows pets as well as Elderly Waiver in case you ever need to apply for Medical Assistance. You have chosen an apartment that will cost around $3650 a month including rent, laundry services and transportation to medical appointments as needed. Meals and housekeeping are included in the rent. If you need additional care while you are residing at Cornerstone Commons, you can add more services. There will be an additional cost. Your dog Bridget is welcome at the facility. You have chosen to use Fairview Lifeline Services which costs $30/month after a $45 set up fee. You have chosen to use United Way if you ever want a volunteer to come to your apartment and visit you or watch a movie on a Friday night - this was important to you. Your son is part of your emergency backup plan as well as your Personal Emergency Response System.

## Your Selected Providers

| Provider Info | Service | Monthly Cost |
|---|---|---|
| Cornerstone Assisted Living 763-550-03333 | Housing, laundry, transportation to medical appointments, housekeeping, and 3 meals per day. | $3600.00 |
| Fairview Lifeline Services 763-544-8848 | Emergency response system triggered by pressing button on pendant that you can wear around your neck. | $30.00 |
| United Way Volunteer 651-224-1141 | Volunteer can come for a visit and keep you company. Volunteer will come 3/15 at 7:00pm. You will need to call and set up a schedule for ongoing visitors. | $0.00 |
| | | |
| | | |
| | | |
| **TOTAL MONTHLY COST** | | **$3630.00** |

| Consumer (or Representative) Signature: | | Date: 02/02/2015 |
|---|---|---|
| Community Living Specialist Signature: | | Date: 02/02/2015 |

# What happens after discharge?

- Phone call or visit within 72 hours
- Required in-person visit with-in 10 days
    - Depends on consumer situation
    - Based on consumer need and request when it occurs

- Continued follow-up over phone or in-person; based on consumer preference
    - 30 days
    - 60 days
    - Every 90 days for 5 years

# What happens during the in-person visit?

- Consumer demonstrates understanding of medications
- Emergency plan reviewed
- Ensure prescribed meds are filled and available
- Medication reconciliation
- Ensure primary care physician appt scheduled
- Ensure services have arrived as applicable
- Additional caregiver and consumer referrals as needed

# Ongoing Follow Up Calls

- Hospital, emergency room and nursing home stays
- Falls
- Memory concerns
- Current services in community
- Updated Medicare Part D coverage, if applicable
  - Special enrollment period after nursing home stay
- Caregiver supports
  - New referrals if necessary
- ADL/IADL status
  - Used for evaluation purposes

# Monitoring and Compliance

- Dashboards produced quarterly

- Manual audits by State staff

- Majority of reports available on Extranet for staff access

## Metrics and Goals

- Most metrics require 85% compliance

- Release of Information=100%

- Discharges=6/month

# Four Categories to Measure

- Comprehensive Data Collection: Support Planning

- Comprehensive Data Collection: Evaluation

- Successful Discharges: Consumer/Family Rapport

- Maintaining Senior LinkAge Line® Image: Customer Satisfaction



Successful Discharges Consumer/Family Rapport
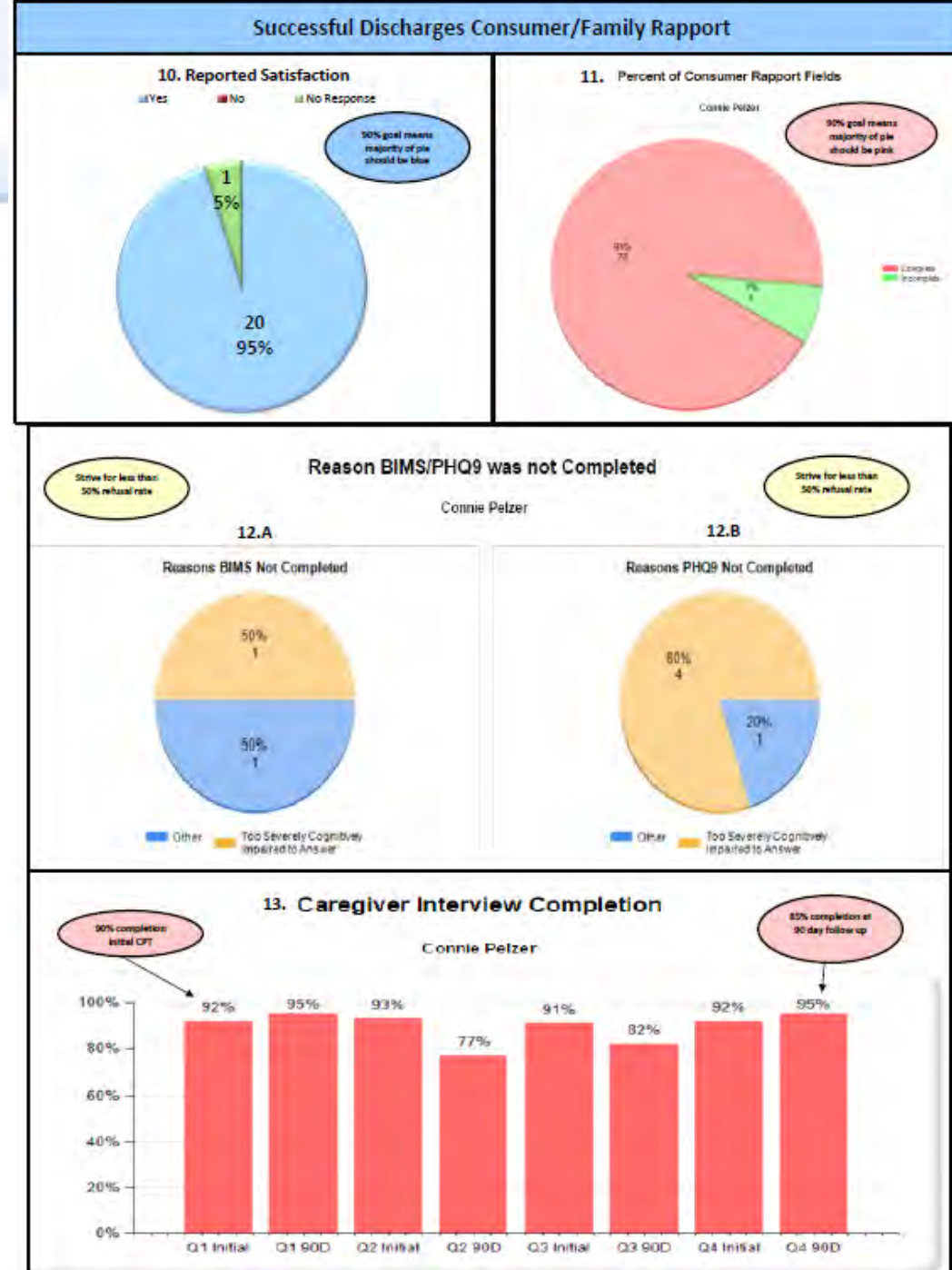
# Monitoring from Statewide and AAA Level

## Community Living Specialist Assisted Consumers

Total Discharges Since April 2010: 3885
Total Discharges in Report Period: 928

Monthly values: Jan 18: 112, Feb: 102, Mar: 120, Apr: 113, May: 99, Jun: 96, Jul: 83, Aug: 105, Sep: 98
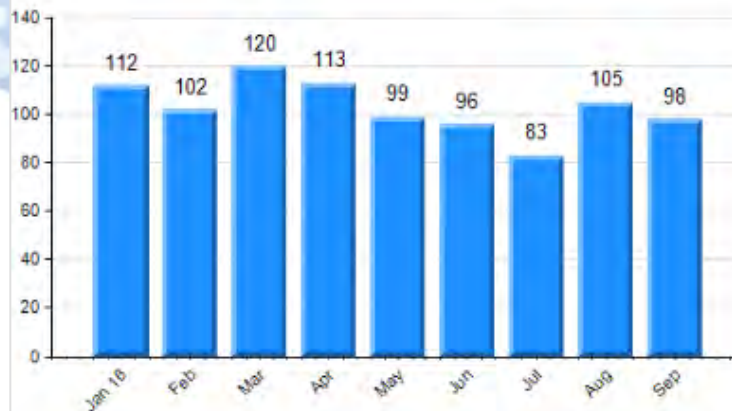
## Location After Discharge-CLS Assisted

- Own home-alone 29%
- Own home-with caregiver 11%
- Own home with spouse/partner 33%
- Assisted living 22%

Less than 3%
- Adult child's home 2.37%
- Adult foster home 0.54%
- Another nursing home 0.22%
- Group home 0.22%
- Other relative/friend's home 1.08%
- Subsidized housing 0.54%
- Temporary housing 0.43%

## Referral Sources for CLS Assisted Consumers

- NH Referral 16%
- SLL Referral 20%
- MDS Section Q 2%
- MDS Profile List 61%
- Ombudsman Referral 0.11%
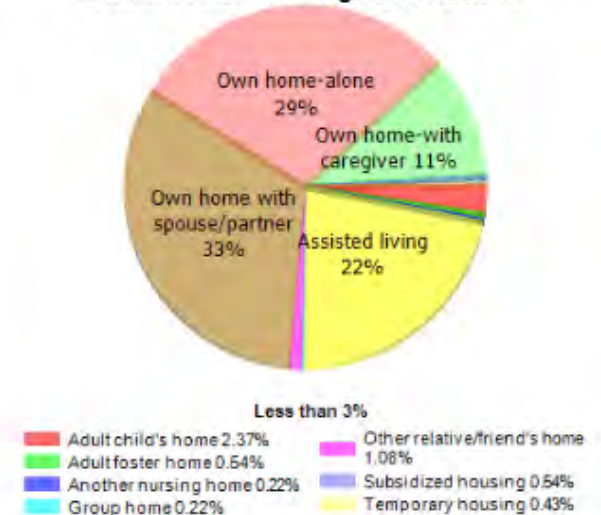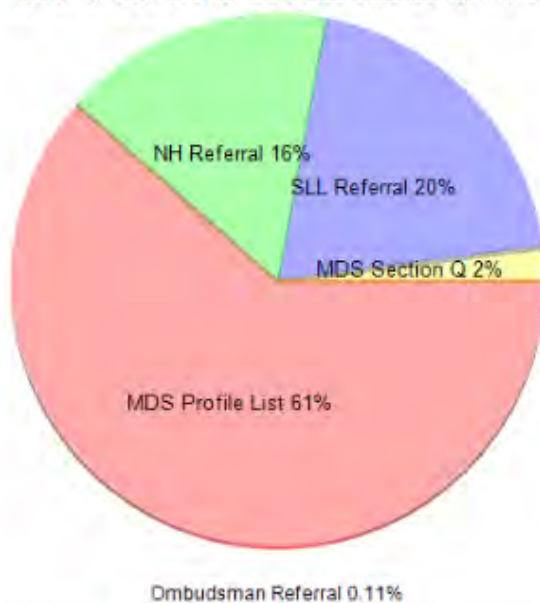
## Reasons Consumer Staying in Nursing Home

Consumers No Longer Planning to Discharge

Values: 4%, 2%, 4%, 0%, 4%, 6%, 1%, 1%, 5%, 13%, 15%, 1%, 1%, 17%, 15%, 4%, 1%, 1%, 4%

Categories: Actively dying-hospice care, Caregiver exhaustion, Caregiver no longer available, Caregiver temporarily unavailable, Doctor recommended, Family refused/acted as decision m..., Health status declined-cardiac event, Health status declined-CVA, Health status declined-injurious fall, Health status declined-other, Health status declined-requires 24..., Lack of housing, Mental health/psych-unstable to lea..., Personal choice: access to health c..., Personal choice-safety, Personal choice-socialization, Personal choice-spouse lives in fac..., Services not available, Vulnerable situation

Total Consumers Being Served Through Return to Community Follow-Up: 901

# RTCI CONSUMER CHARACTERISTICS AND OUTCOMES

Greg Arling, Kathleen Abrahamson, Zachary Hass, Marwa Noureldin, Yun Cai, and Putu Ayu Sudyanti

Purdue University

# No disclosures

# Acknowledgement/Disclosure

# Outline

- Methods
- RTCI resident targeting
- Growth in RTCI
- Characteristics of RTCI transitioned residents and caregivers
- Outcomes for targeted residents at 30, 90 and 365 days

# Methods - Project Data

| Time Point | Data Source | Number |
|---|---|---|
| NH Admission | MDS | 998 |
| Community Discharge | RTCI Community Planning Tool (RTCI staff) | 998 |
| 30 days after discharge | RTCI 30-day Check-in (RTCI staff) | 971 |
| 90 days after discharge | RTCI 90-day Follow-up (RTCI staff) | 971 |
| 365 Days after discharge | MDS, Vital Statistics, Medicad Claims | 751/511 |

# Targeting Residents for RTCI Assistance

Residents are scored at admission according to items on the MDS that are predictive of community discharge within 90 days.

## Community Discharge Profile Points

| Factor | Points | Factor | Points |
|---|---|---|---|
| Preference for Discharge | 22 | NOT Daily Behavior Problems | 4 |
| Rehabilitation (RUG IV) | 10 | Age 75 - 84 | 4 |
| Admission from Acute Care | 9 | Age 65 - 74 | 3 |
| Hip Fracture | 7 | Age 85+ | 0 |
| NOT End Stage Disease | 7 | Female | 3 |
| NOT Moderate/Severe Cog Imp | 6 | Unmarried | 3 |
| NOT Incontinent | 6 | NOT Alzheimer Diagnosis | 3 |
| NOT Cancer Dx | 6 | New Admission | 1 |
| ADL 1 -4 (RUG IV) | 6 | Age < 65 | 1 |
| ADL 5 - 8 (RUG IV) | 6 | NOT Diabetes Dx | 1 |
| ADL 9 - 12 (RUG IV) | 4 | | |
| ADL 13 - 16 (RUG IV) | 0 | | |

Profile Score Range 0-98

# Rate of actual community discharge drops dramatically with longer length of stay



Community Discharge within 120 days based on how long the resident is in the nursing facility by PROB COMM v1 Range

| | Admission | Day 31 | Day 61 | Day 91 |
|---|---|---|---|---|
| 0-40 | 7% | 5% | 3% | 1% |
| 40-55 | 25% | 16% | 9% | 3% |
| 55-70 | 54% | 39% | 20% | 9% |
| 70-80 | 74% | 58% | 37% | 18% |
| 80-100 | 88% | 73% | 49% | 24% |
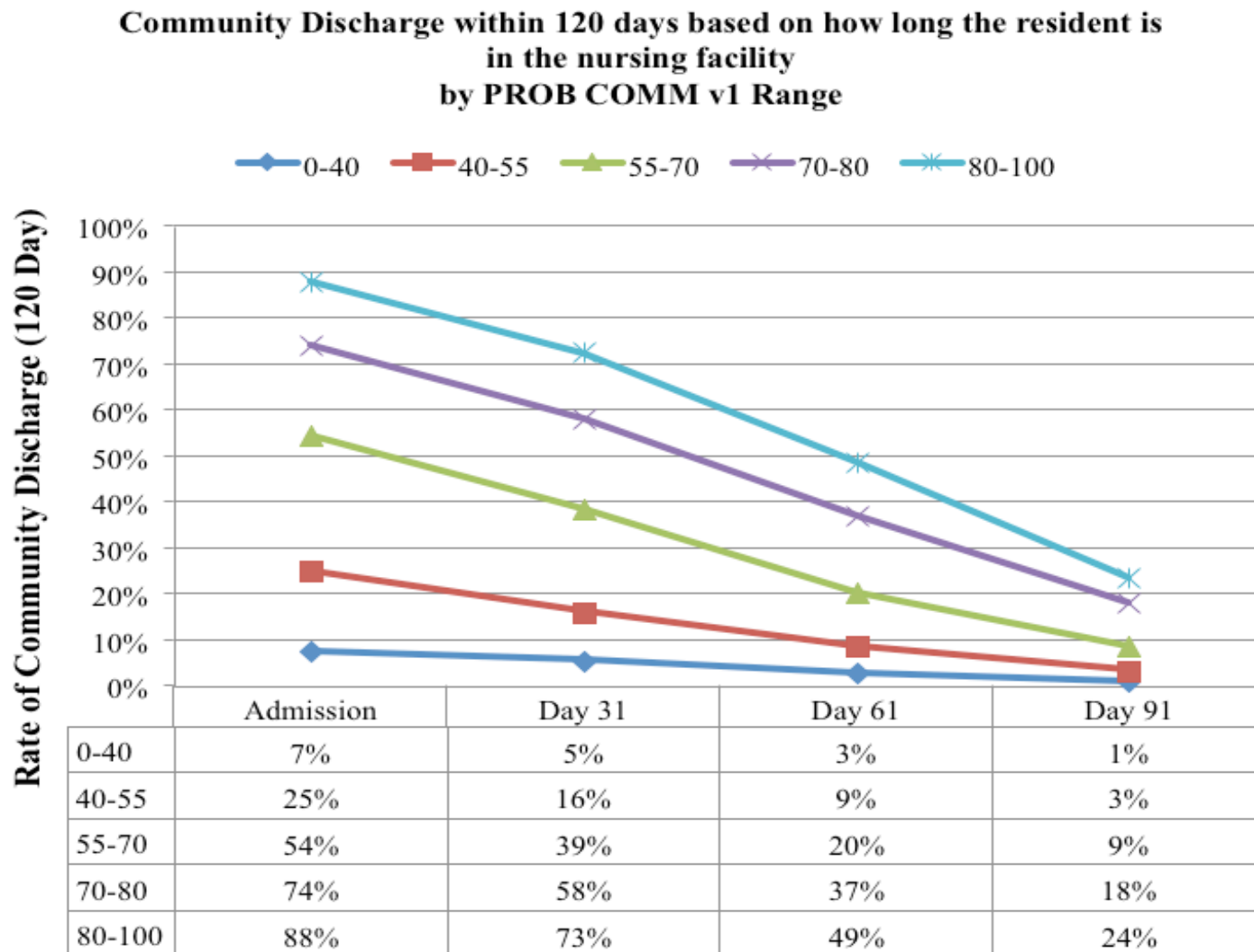
Residents assigned to the target list:
- Not Medicaid at nursing facility;
- Top two quintiles on Community Discharge Profile Score;
- Remain in the nursing facility for at least 60 days

**Persons Still in Facility at Targeting Window**
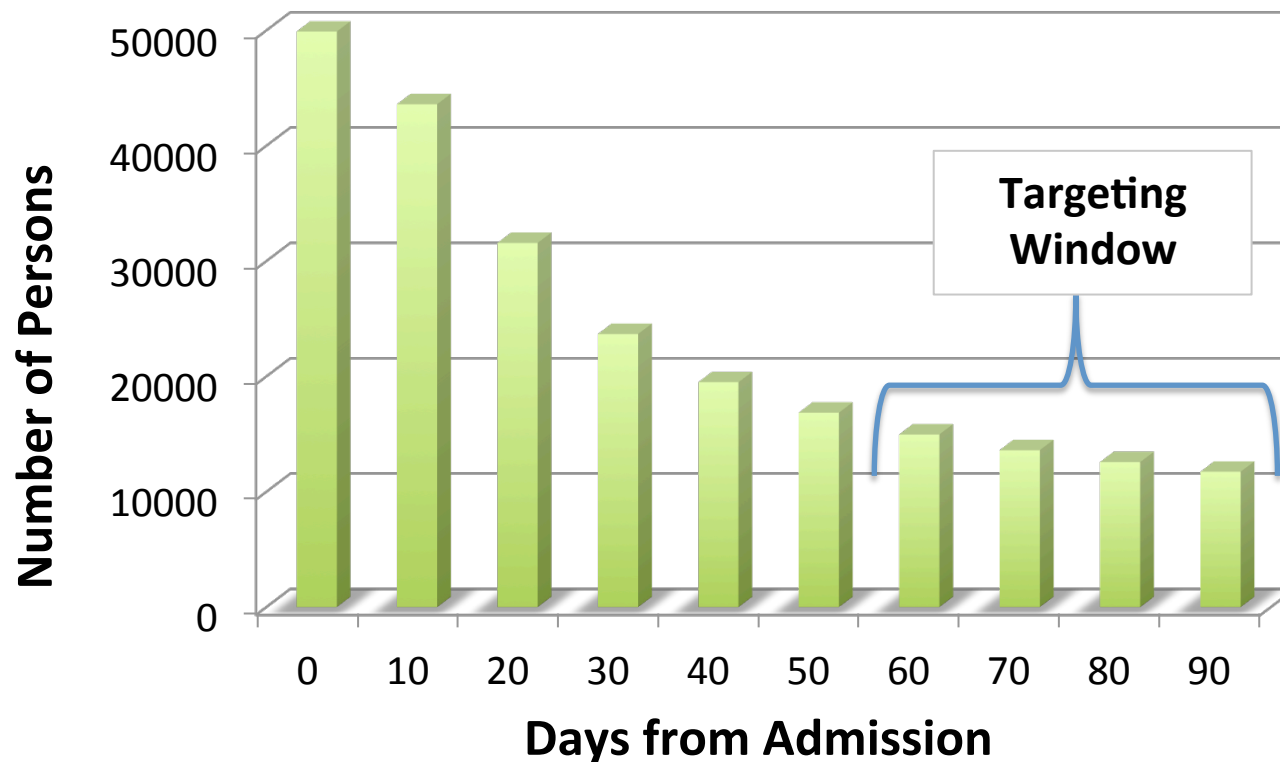
# Patterns in RTCI Growth

# The RTCI has had steady growth in CLS assisted transitions, particularly from the target list



**Target and Non-Target Transitions by Calendar Quarter**
■ Referral or Section Q   ■ Target List
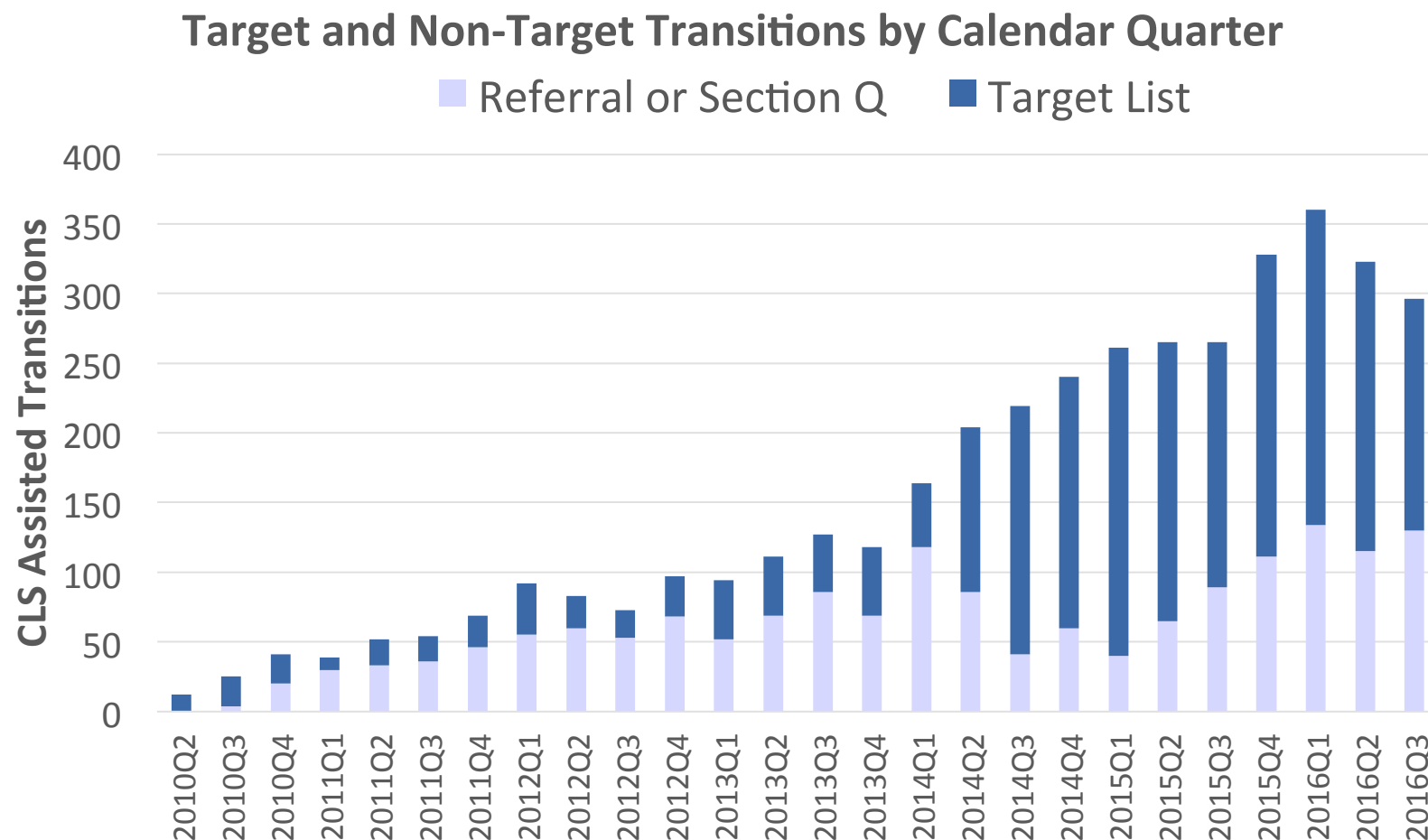
The majority of facilities had one or more residents with CLS assisted transitions – 55% (196) had 1-5, and 23% (81) had 5 or more.

### Number of Facilities by CLS Assisted Transitions
### October 2015 - September 2016



Chart: # of Facilities (y-axis) by CLS Assisted Transitions from Facility (998 Transitions) (x-axis)

- 0: 81
- 1: 85
- 2: 54
- 3: 37
- 4: 20
- 5+: 81
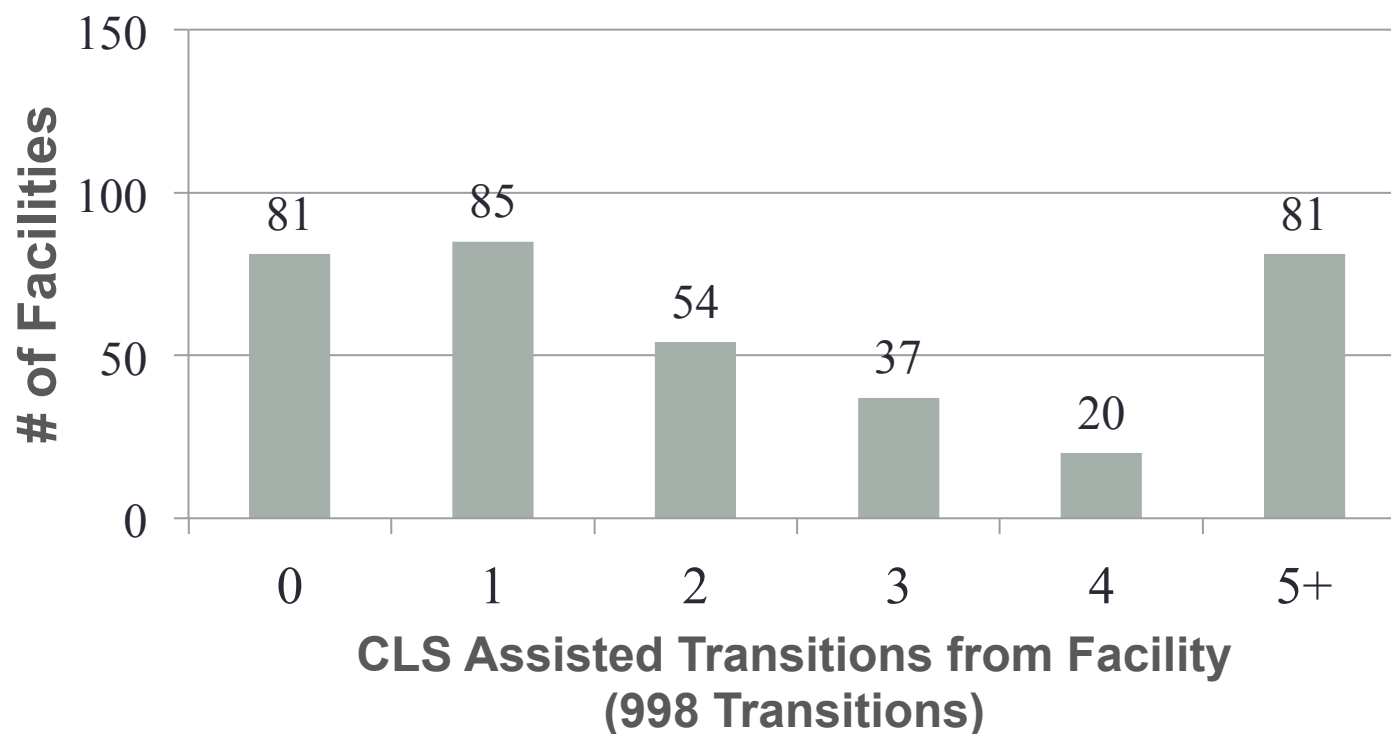
There was wide variation among facilities in the proportion of target list residents with CLS assisted transitions.



Number of Facilities by CLS Assisted Transitions as
a Percentage of Facility Target List
October 2015 - September 2016
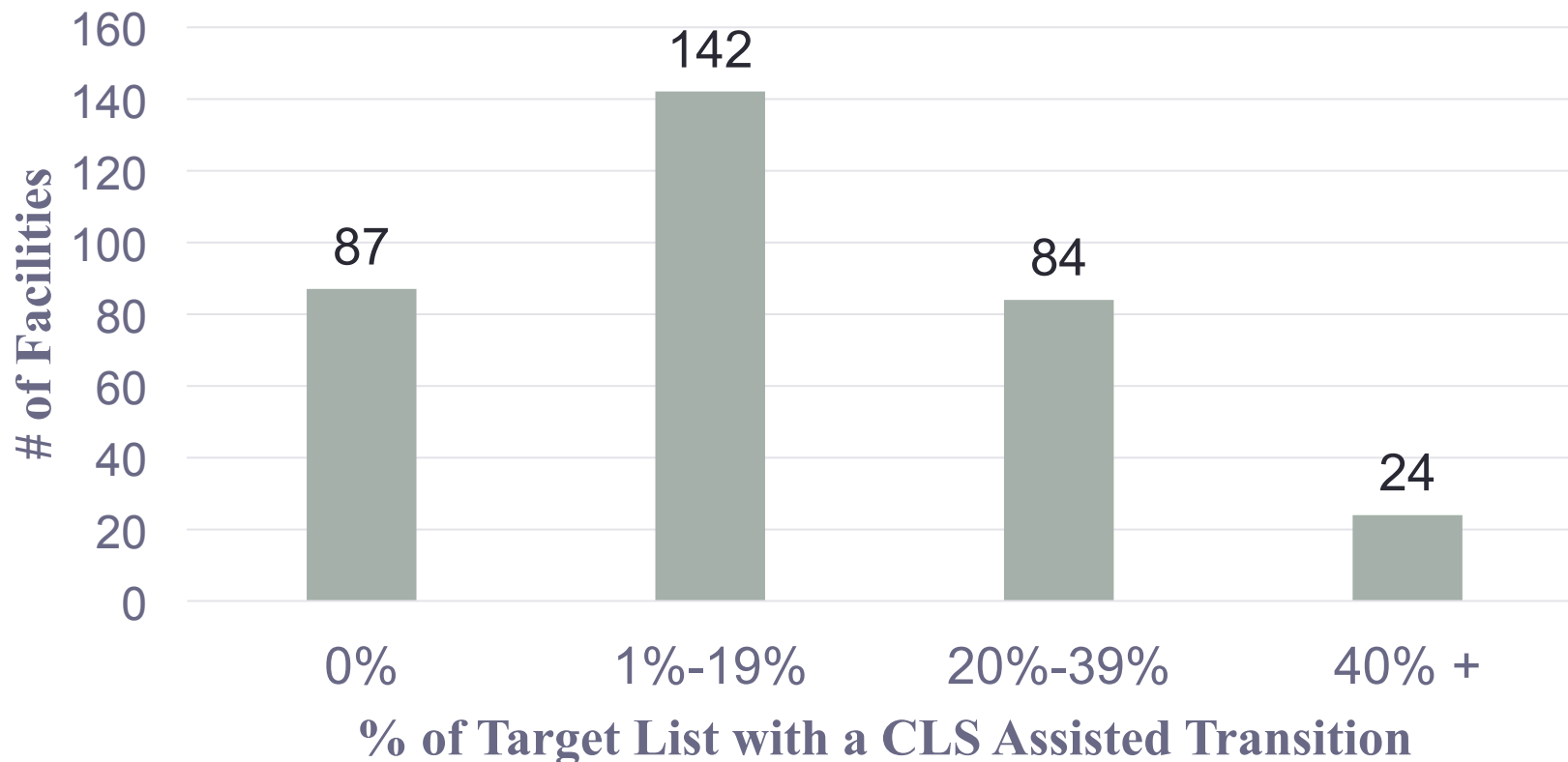
# RTCI Consumer Characteristics

Almost all transitioned residents preferred community discharge. Most residents were continent, without cognitive impairment or behavioral problems, and moderately ADL dependent.



**CLS Transitioned Residents by Profile Variables**
**October 2015 - September 2016 (998 transitions)**
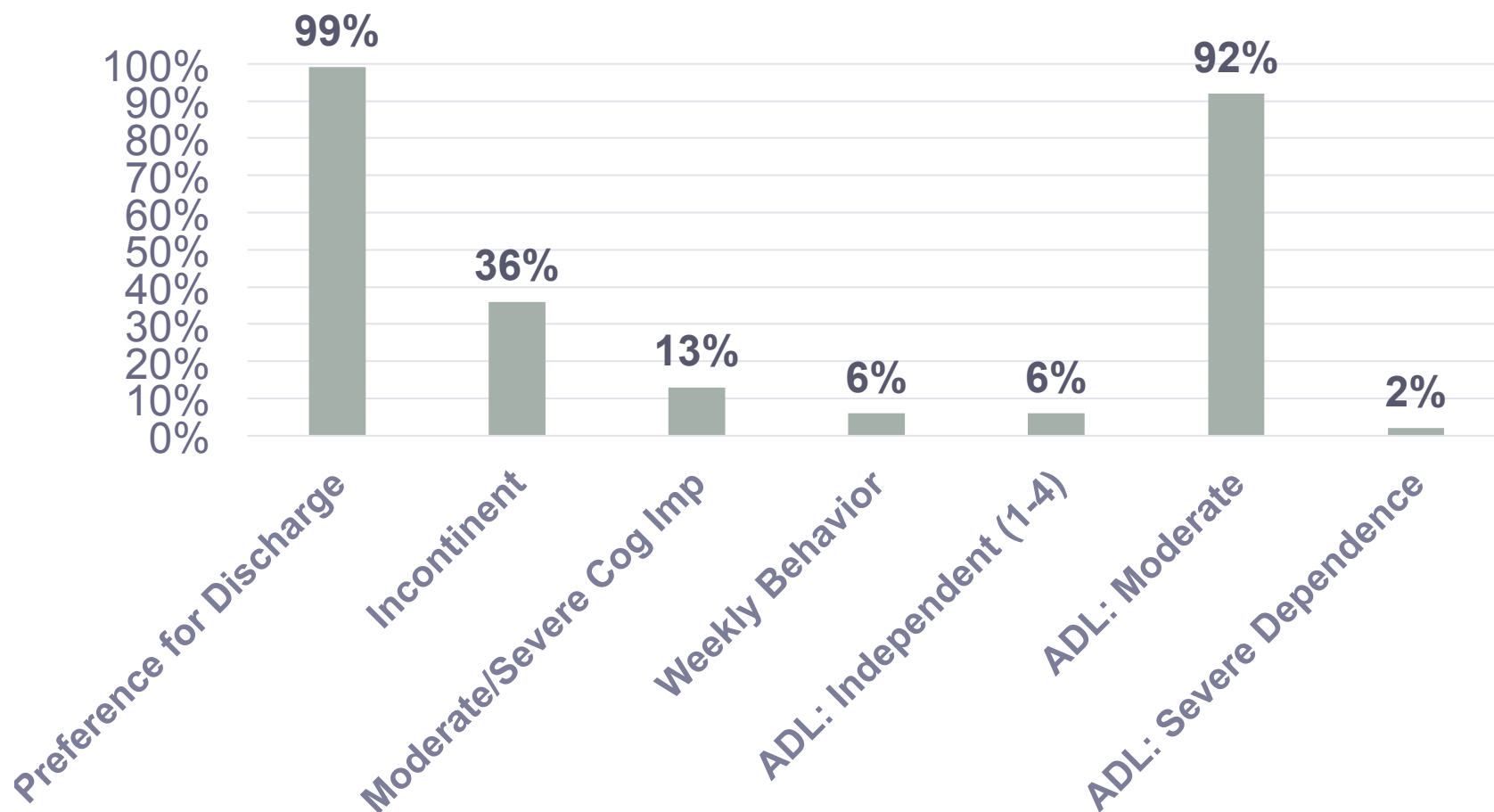
Most CLS transitioned residents went to a private residence, living alone or with a spouse.  One-fifth went to assisted living.

**Discharge Location for CLS Transitioned Residents**
**(October 2015 – September 2016, 998 transitions)**
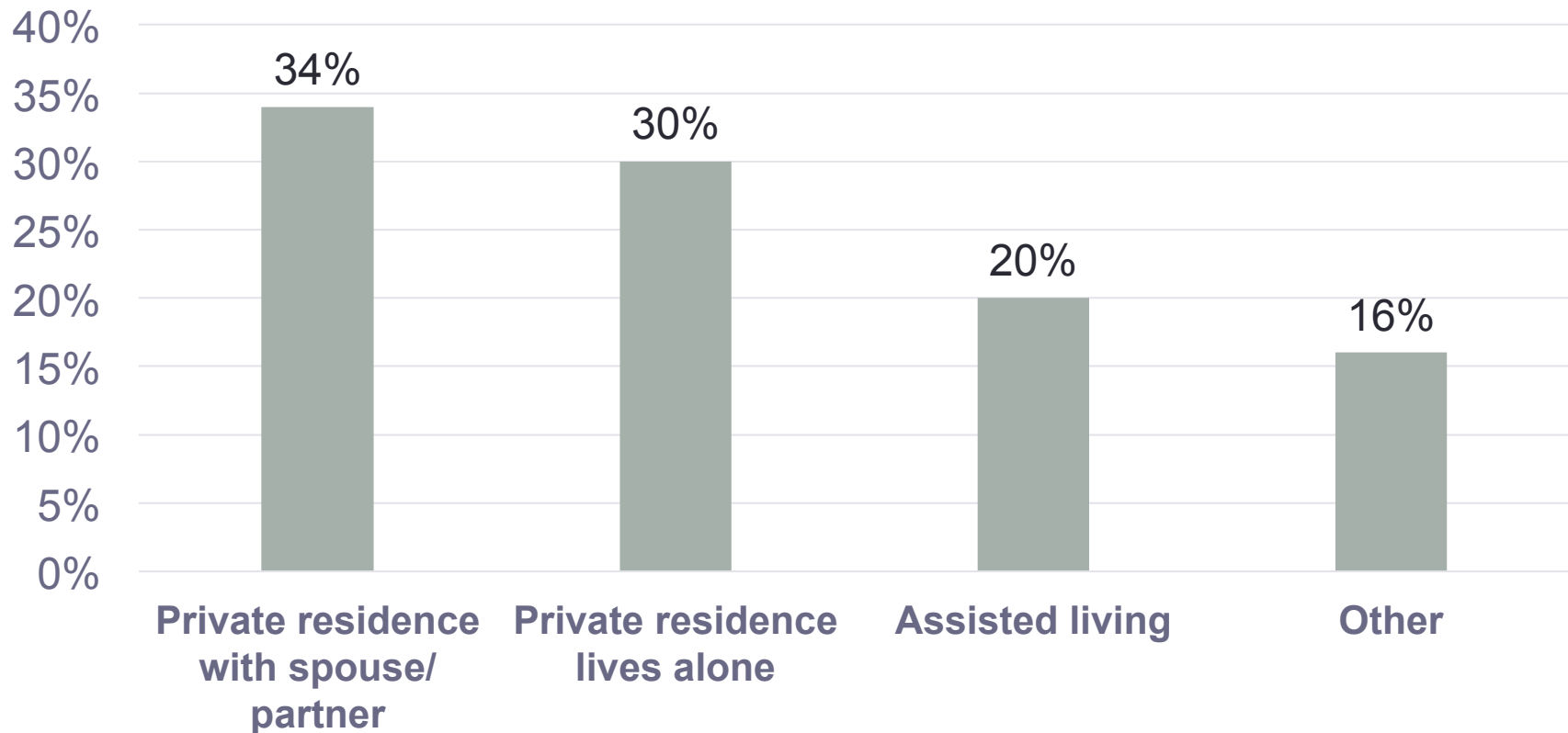
An adult child or spouse was the primary caregiver for most CLS transitioned residents. Only 12% had no primary caregiver.



**Primary Care Givers for CLS Transitioned Residents (October 2015 - September 2016, 998 transitions)**
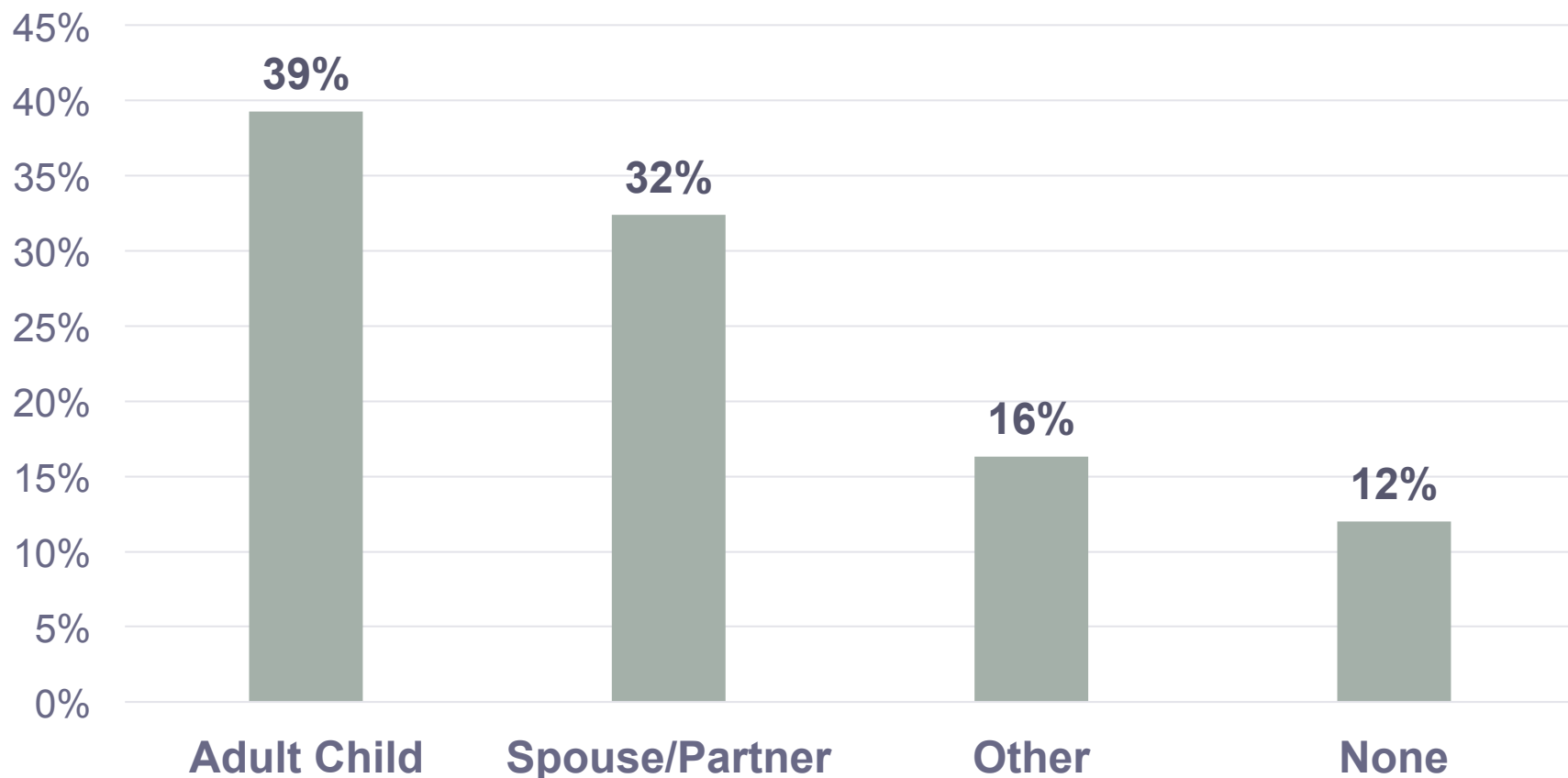
Nearly all spouse caregivers provided care daily. Over one-third of adult children provided care daily, while another half of adult children provided care at least once a week.

## Caregiving Frequency by Caregiver
## (October 2015- September 2016, 787 caregivers)
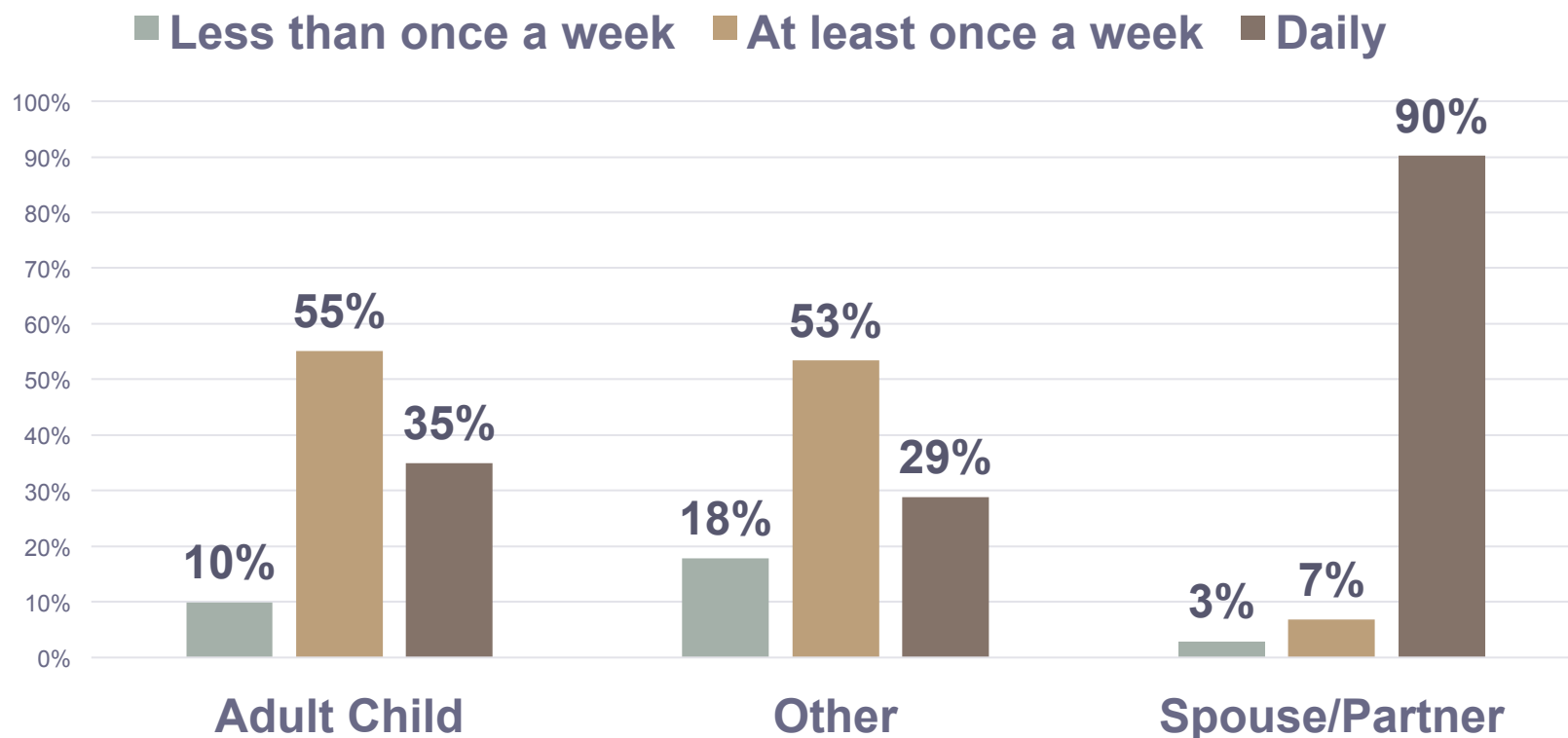
Just under half of primary caregivers anticipated no difficulties in caregiving.  Job and money limitations (adult children) and poor health (spouses) were the most frequent difficulties.

Difficulties Expected by Primary Caregivers
(October 2015 – September 2016, 787 caregivers)
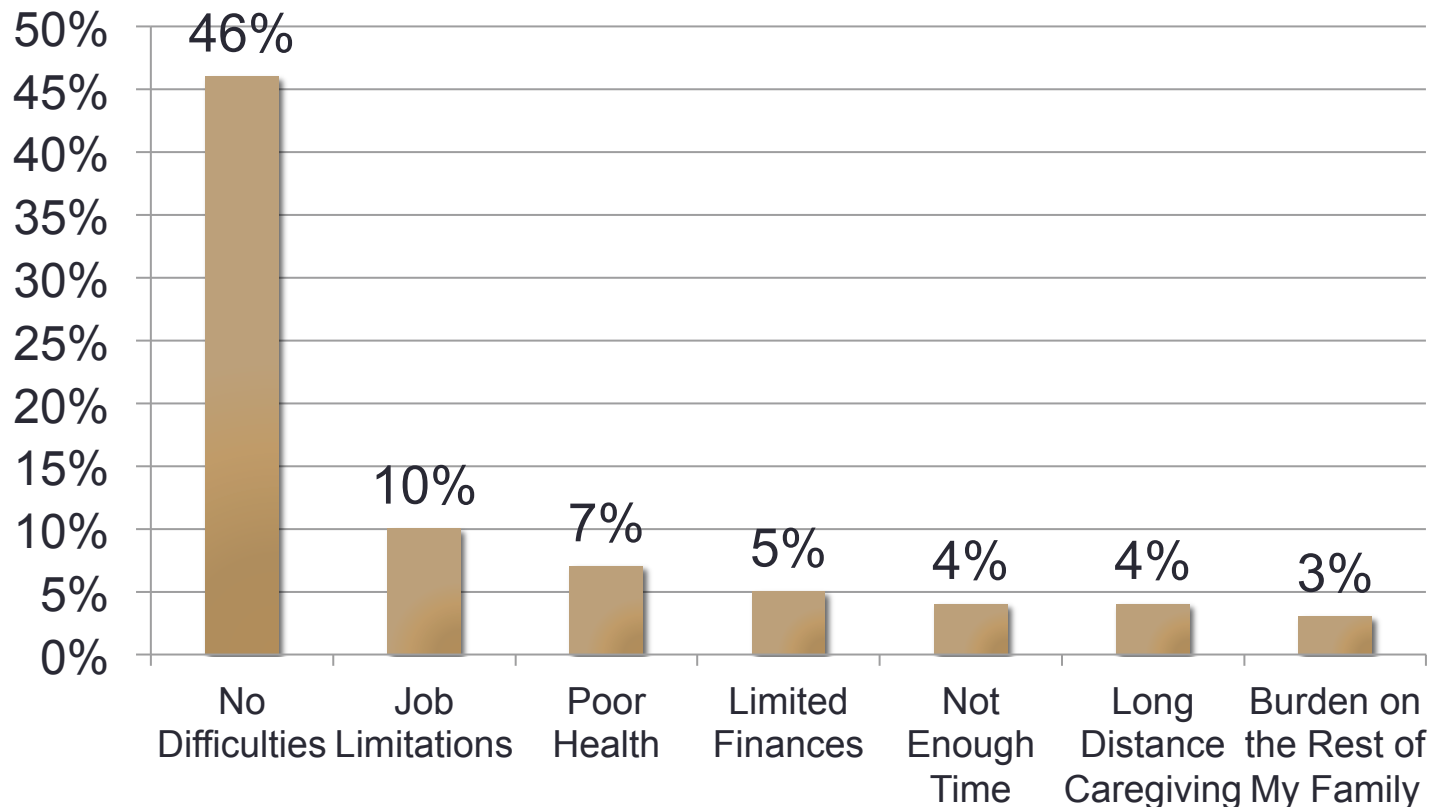
85% of CLS transitioned residents had a home health service, 55% received alarms/technology (alarms), one-third received home care services or meals, and one-fifth had transportation.

Services Received by Transitioned Residents
(October 2015 - September 2016, 998 Transitions)
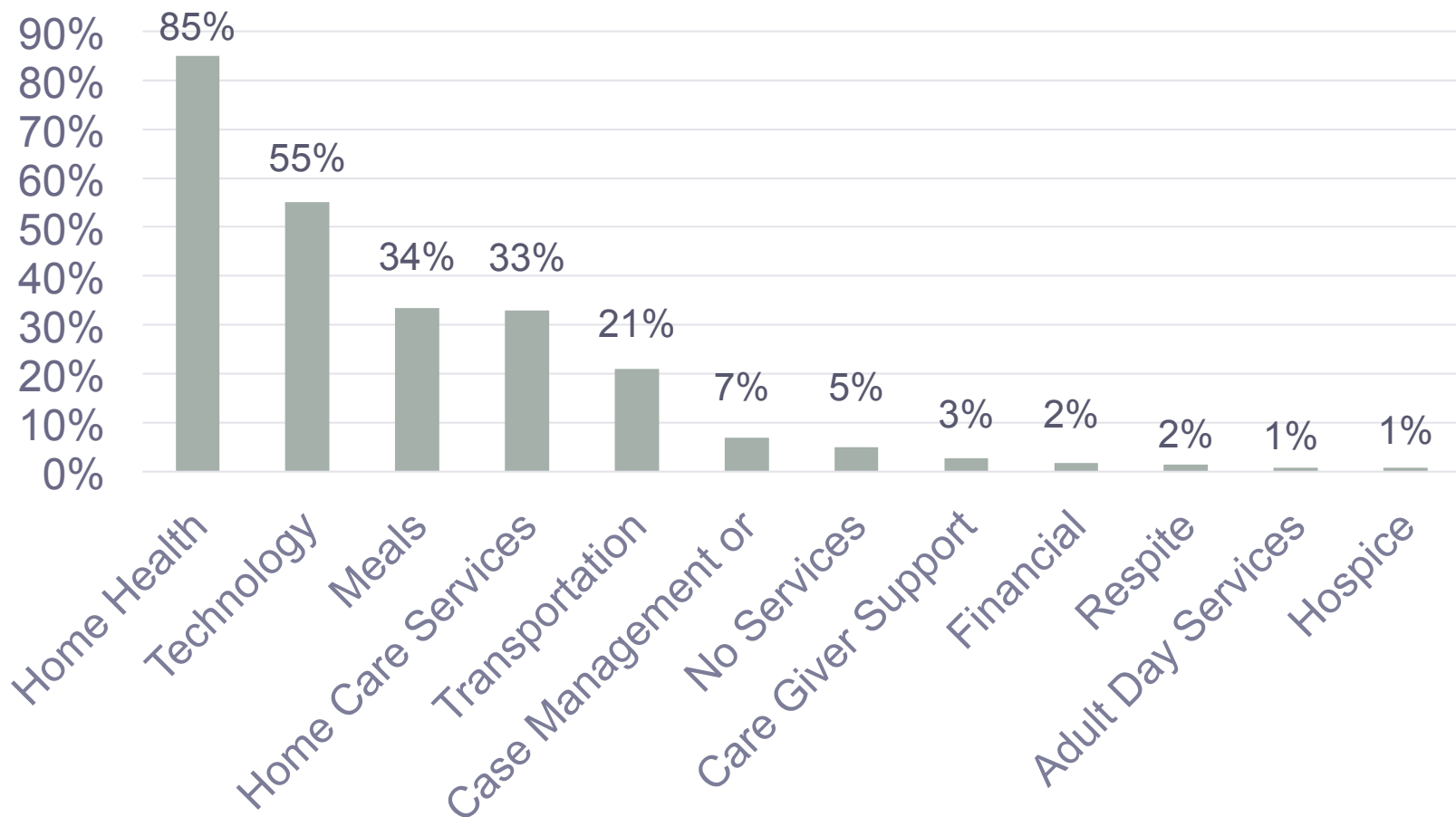
Over half of CLS transitioned residents had a fear of falling and many had risk factors for falls.



Fall Risk by Transitioned Residents
(October 2015 - September 2016, 998 Transitions)
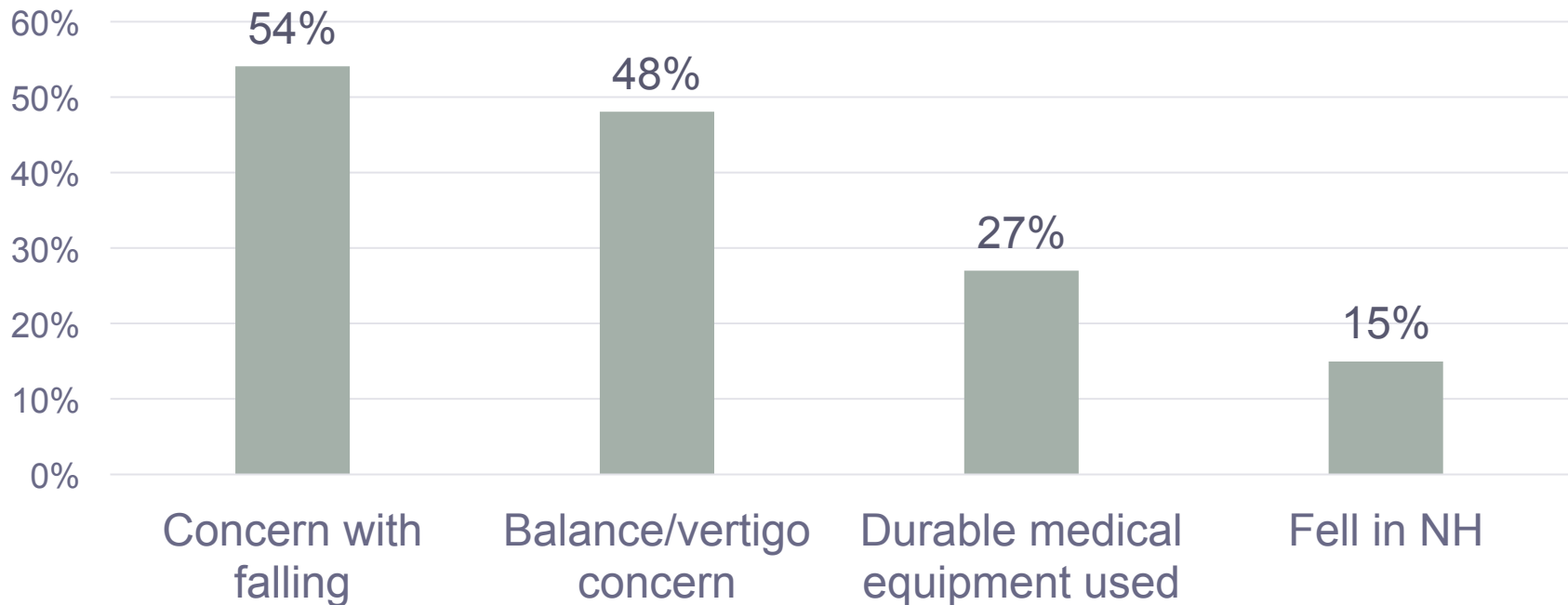
# Psychotropic, anti-coagulant/platelet, and analgesic medications were the most common high risk medications

High Risk Medications by Transitioned Residents
(October 2015 - September 2016, 998 Transitions)
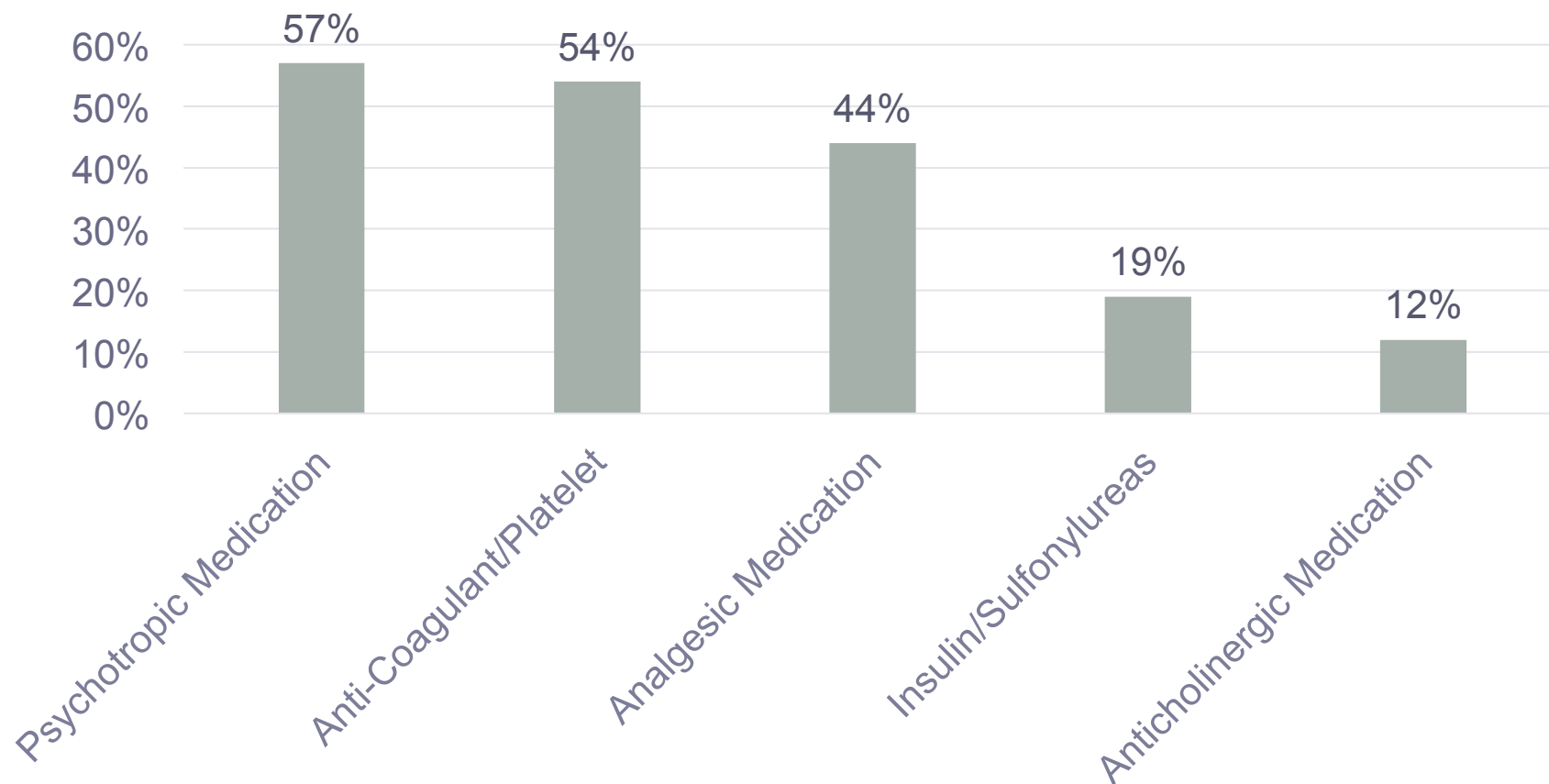
# OUTCOMES AT 30, 90, AND 365 DAYS AFTER COMMUNITY DISCHARGE

## Falls and Hospitalization/ER Visits within 30 and 90 days for CLS Assisted Discharges
### (October 2014 – September 2015 Admissions, N = 971)

|  | 30 Day Follow Up | 90 Day Follow Up |
|---|---|---|
| Hospitalization/ER Visit | 6.35% | 18.11% |
| Fall at Home | 10.42% | 18.85% |

Half of CLS transitioned residents were alive and living in the community at one year after the leaving the facility. 36% had a readmission to the NH.



**CLS Assisted Transitions Deceased or Readmitted to a Nursing Facility within 365 Days (Community Discharges April 2014-March 2015, N=751)**
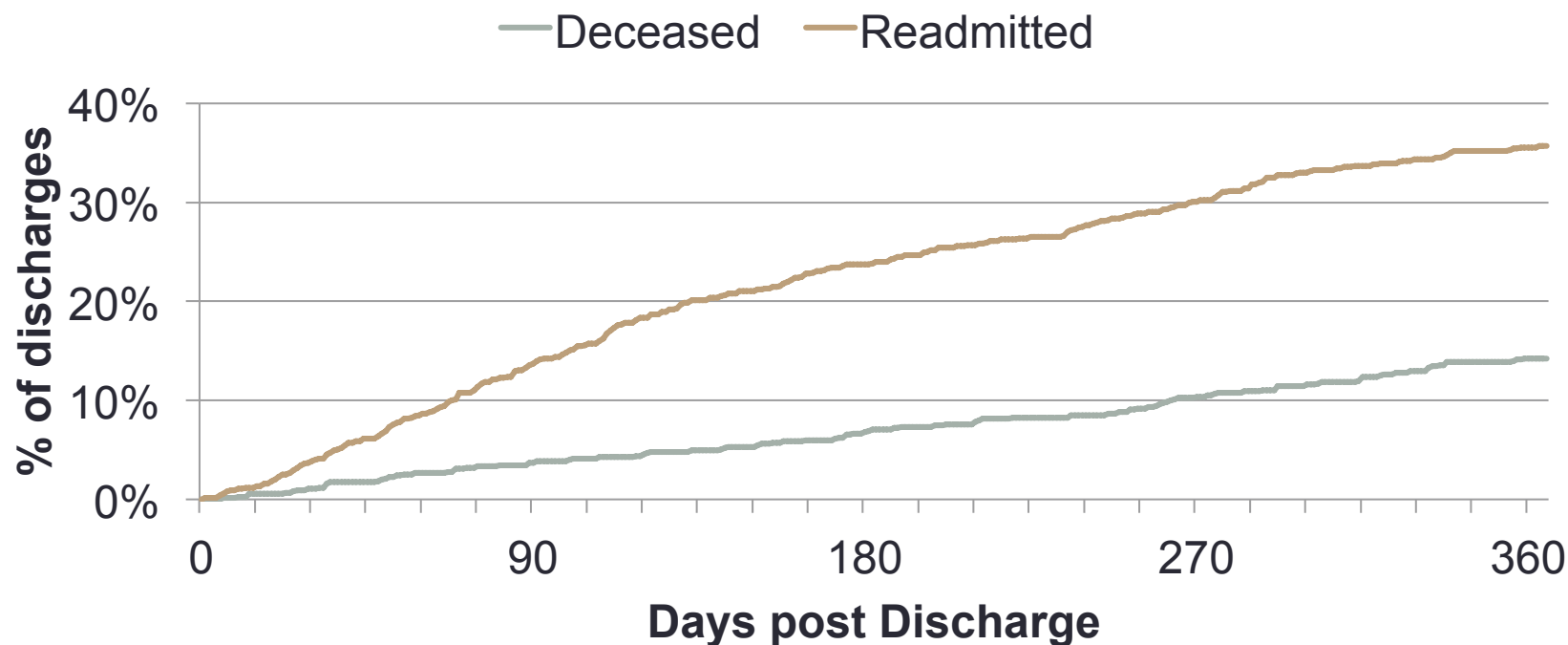
# 11% of CLS-assisted residents converted to Medicaid in one year.



**Medicaid Conversion for CLS Assisted Discharges (January 2014-December 2014, 511 CLS transitions)**
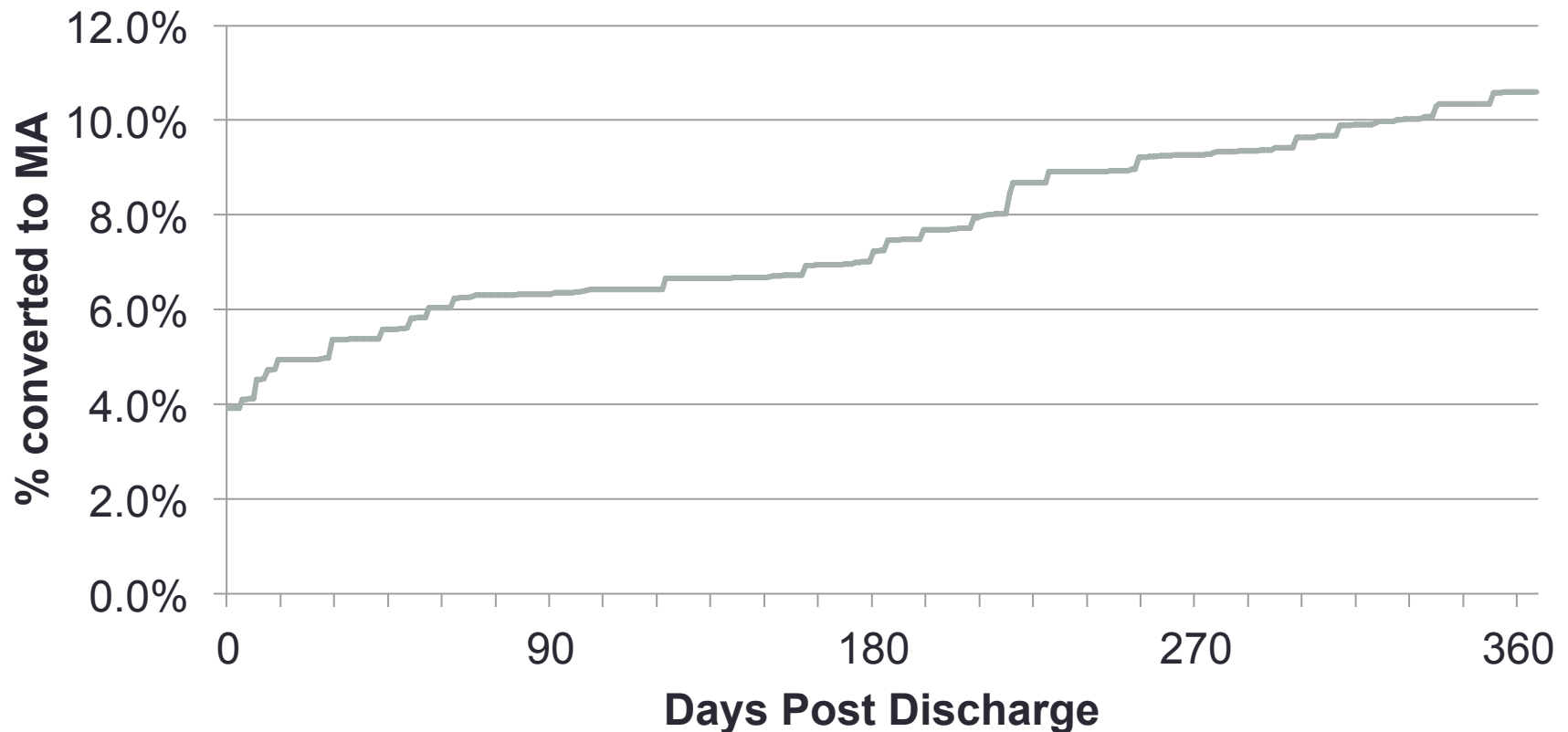
# Conclusions

- The RTCI has had steady program growth with 390 CLS-assisted transitions per year and 4012 total transitions (September 2016)

- The majority of nursing facilities had CLS-transitioned residents, although most facilities had 5 or fewer

- Consistent with the targeting approach, most residents were:
  - A post-acute admission in a RUG rehabilitation category
  - Preferred community discharge
  - Relatively independent in ADLs and IADLs
  - Not impaired or only mildly cognitively impaired
  - Continent

# Conclusions (cont.)

- Most CLS-assisted residents lived alone or with a spouse, yet nearly all had an available family caregiver.

- A substantial proportion of residents had a risk for falls and/or were taking high risk medications

- Within 90 days after discharge, 18% of residents reported falling and 19% reported an emergency department visit or hospital admission

- At 12 months after community discharge
  - 50% of CLS assisted residents remained alive in the community
  - 36% were readmitted to a nursing facility
  - 14% died
  - 11% had converted to Medicaid

# Insights from Qualitative Research on RTCI

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# Disclosure

I have no conflicts to disclose

# Qualitative Research

## Aims

- Shed light on quantitative findings.

- Drill down on nature of RTCI benefits.

- Describe experiences of participants in RTCI over time.

- Provide window on a little studied phenomenon: non-Medicaid residents discharged from NHs
  - Looking at phenomenon regardless or RTCI/CLS inputs.

## Methods

- Semi-structured interviews, dealing with specified topics;

- Non-leading probes for more detail.

- Content analysis and identification of themes by multiple coders

# Qualitative Research Approach: 3 foci

- RTCI program participants
  - interviews with all CLSs in 2012 and in 2015
  - interviews with local RTCI supervisors in Area Agencies on Aging
- Nursing Homes
  - 2 series of interviews with NH discharge managers, usually social workers.
- Consumer Cases
  - 24 in-depth case studies of CLS-assisted consumers discharged to community
    - Consumers in NH 60 days or more and assisted by CLS in discharge.
    - Informants included consumers, family members, the CLS's and others as relevant
    - 3-5 interviews per case + archival information
  - 30 cases described by CLS's in 2015 interviews
    - their most memorable discharges or success stories

# From Cases a Construct of Vulnerability Emerged

- Physical vulnerability of consumers.
  - Complex and unstable medical conditions,
    - E.g., need for prolonged wound care, frequent falls.
- Social vulnerability
  - Spousal pairs, both 80+ and with health vulnerability
  - Living alone, especially in isolated rural areas
  - Consumers with no living children & no nearby relatives.
  - Signs of disagreement within support system.
  - Consumers likely to spend-down to Medicaid soon
    - Vulnerability to getting lost in transition to Medicaid
- Protracted stays in NHs exacerbated consumer deficits and anxieties
  - Assessed cognitive impairment looked worse in NH.
  - Vulnerability to being prematurely defined as unable to leave.

# Consumer Strengths & Ingenuity

- Creativity, resilience and strength shown by consumers.
  - A daughter and son worked with the consumer to sell her home and rebuild a one-story home on a new lot within length of NH stay.
  - Four siblings worked out an arrangement for their mother to live with one daughter and son-in-law while the others rotated to take over on weekend by bringing their mom to their homes or staying with mom in their sister's home.
  - A daughter worked with a VA official to establish a claim for a service-connected disability and a pension for her father.
  - Many consumers developed ways to further the needs of the more vulnerable in their family including adult children with special needs.
- CLS's sometimes accentuated that strength
  - CLS helped a consumer find an AL that accepted a feeding tube—and helped consumer move from that same AL to independent housing w/o feeding tube.

# Possible Missed Opportunities?
## (hints from case studies)

- Consumers with unmet needs
  - Several mentioned current unmet needs they did not disclose to the CLS's on follow-up.

- Consumers cases closed before 60 days for inability of CLS to contact,.
  - We easily contact them for the case study, directly or through a family member.
  - Some of these consumers were known to be depressed, withdrawn, and prone to ignoring their phones.

- Consumers with possible unexplored support
  - —e.g. late husband's family for widows.

- Seniors who had aged with a disability (either developmental or acquired as adults).
  - Some were alienated by the CLS working with their families as a matter of protocol
  - Yes they may have welcomed some long-term planning for and/or referral to CILs

- Consumers who temporarily left Minnesota (e.g. to stay with family on discharge).

- Consumers who might have benefitted by changing physician.

ISSUE: How far to explore? How much to intervene? How involved to get?

# Added Benefit of CLS

- Direct effect of RTCI on NH discharge.
  - Finding resources.
  - Advocating for the right to go home.
- Indirect effect of RTCI on NH discharge
  - Presence of RTCI in NH—education, demonstrating possibilities, adding to sense of security for NH social workers; suggesting a "new normal"
- Direct effect of RTCI after NH discharge.
  - Rescues at early visit to consumers;
    - Plans not always implemented, including for consumers who moved to AL
  - Early intervention for new problems involving consumer or his/her spouse
  - Identification of those needing added support or resources.
  - Some examples of helping a consumer discharged to AL to move to less restrictive setting.
- Indirect effect of RTCI after NH discharge.
  - To be determined with more time.

# 10 Challenges for Private-Pay Consumers

1. Understanding prices and out-of-pocket costs
   - Expenses already incurred in NHs and costs of discharge options.

2. Property decisions--what and when to sell.

3. Understanding LTSS options in housing and group residential settings.

4. Understanding the maze of in-home assistance.

5. Finding transportation assistance—especially in rural areas.

6. Finding mental health resources.

7. Working out roles and responsibilities within families.

8. Finding and building on local non-traditional resources, paid and volunteer.

9. Maintaining stability of informal support.

10. Countering professionals urging that consumers need NHs.

# 10 Issues in Refining CLS Practice

1. Whether and how to individualize needs within a minimum protocol
   - Who needs more frequent and intensive help? who needs less follow-up?
2. Communicating with consumers who cannot easily use telephones.
3. Helping consumers adjust to or modify plans when they had little initial input.
4. Juggling a counseling function—when to do it.
5. Juggling a case management function
   - Continuity of relationship and making handoffs work.
6. Avoiding duplication or exploitation in NHs that embrace RTCI.
7. Getting a start in NHs that do <u>not</u> embrace RTCI.
8. Bringing physicians on board—at discharge and in community.
9. Avoiding over-reliance on group residential settings.
10. Sharing practice ideas—and developing one's own confident style.

# 10 CLS-Expressed Training Interests

1. Alzheimer's disease and other dementia.
2. Specific complex medical conditions
   - Need to know basis when a consumer has that condition.
3. Medications in widespread use.
4. Financial issues and benefits, and legal rsources.
5. Local care resources and resource development.
6. Arranging and conducting family meetings.
7. Continued opportunities to brainstorm with other CLS's.
8. Accepting but mitigating risks.
9. Knowing/building on CLS success stories.
10. Knowing/building on examples of consumer problem-solving.

# Moving from Research Constraints to Operations

- RTCI is innovative—inventing structures and roles as it evolves.
- CLS's reflect variation in approach and style within a standardized minimum protocol.
- Operational issues highlighted from qualitative research.
  - Not everyone targeted will have equal need of RTCI at discharge. Should contact be maintained preventively?  How to prioritize?
  - Some persons are in no danger of spending down to Medicaid because of wealth or poor prognosis—should RTCI help anyway?
  - Help sometimes needed in transition to Medicaid—what is RTCI role?
  - How much variation will RTCI have across AAA regions and across communities within AAA regions.  Should local variation be encouraged?

# Summary

- Qualitative research had ability to suggest issues facing non-Medicaid seniors regardless of RTCI activities.

- Qualitative work supported quantitative on added value of RTCI.

- Qualitative research highlighted emerging CLS roles.

- Possible newer ways of thinking about vulnerability suggested.

- Possible missed opportunities either for CLS or for emerging community coalitions identified through case studies.