

medicaid  
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**Who Stays and Who Goes Home:  
Using National Data on Nursing Home Discharges  
and Long-Stay Residents to Draw Implications for  
Nursing Home Transition Programs**

*Prepared by*

Judy Kasper,  
Johns Hopkins University

**August 2005**

# kaiser commission medicaid and the uninsured

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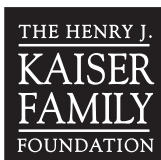
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## **Abstract**

Nursing homes serve a population with substantial medical and long-term care needs. Within this population are individuals who receive rehabilitation services in the aftermath of acute medical events such as stroke, and individuals who need increasing levels of custodial care in response to progressive declines in functioning related to diseases such as Alzheimer's. Over the last several years, some states, have turned their attention to returning nursing home residents to community settings through nursing home transition programs. This paper analyzes data from the most recent National Nursing Home Survey to describe the characteristics of two groups of nursing home residents who are 65 years and older: those who are discharged back to the community over a one year time period and those who remain in nursing homes for 90 days or longer. The study shows that those who were discharged back to the community tended to have shorter lengths of stay, were younger, and had spouses. The prevalence of a major chronic disease was high in both short stay and long-stay residents, but long-stay residents were more than two times as likely to have a cognitive disorder. The findings provide insights on who to target in transition programs and what level and types of community resources are needed.

## **Introduction**

Efforts to prevent unnecessary institutionalization of disabled people have led to growth under the Medicaid program in home and community-based care options. More recently, some states, with federal funding and support, have turned their attention to returning nursing home residents to community settings. A few states have programs of long-standing, but for most states this is a new undertaking.

Nursing home transition programs face challenges in determining whether and how to target candidates for return to community residence, and in meeting the care needs of those who transition. Programs vary as to whether they focus on individuals with certain characteristics (those who are younger or have community supports in place) or are open to referrals for candidates regardless of characteristics and care needs. Information is lacking about characteristics of persons discharged from nursing homes and how they differ from long-stay residents, which could prove useful in decisions about whether and who to target in transition programs. Since transition programs are intended to return individuals to the community who without such assistance would remain in nursing homes, it is also useful to consider the implications for return to community residence of care needs among long-stay residents. The purpose of this paper is to analyze data from the most recent National Nursing Home Survey to fill in some of these information gaps.

**Programs that Promote Nursing Home Transition.** Interest in reducing nursing home placement for persons with long-term care needs is driven by several factors: the high cost of nursing home care to state Medicaid programs that are the primary payers (50% of all nursing home care, O'Brien and Elias, 2004), the strong preferences of disabled individuals and their families for noninstitutional care, and legal pressures on states to provide long-term care in the

least restrictive settings (Olmstead v. L.C., 2004). There has been steady growth in home and community-based LTC service options over the last decade (LeBlanc, Toner and Harrington, 2001) and a variety of government initiatives including Medicaid waiver programs – 1915C, Independence Plus (2002), and Real Choice Systems Change Grants (2004) – have contributed. During the same period nursing home occupancy rates have declined.

The initiation of formal programs to move people out of institutional care settings began with funding from the Centers for Medicare and Medicaid Services and the DHHS Assistant Secretary of Planning and Evaluation in the form of Nursing Home Transition Grants to 12 states from 1998 to 2000. Previously, only a few states, notably Washington and Oregon, were actively involved in identifying individuals already in nursing homes for transition back to the community. Other recent steps to promote state initiatives in nursing home transition include coverage of expenses associated with transition (e.g. moving furniture, utility set-up, purchasing essential household items) under the New Freedom Initiative, and federal support of market-based approaches to financing long-term care that enabled funding to move with individuals from one care setting to another (CMS letters to State Medicaid Directors Aug 17, 2004; Sept. 17 2003 describing state initiatives under Independence Plus and Real Choice Systems Change Grants).

**What is Known About Who Leaves Nursing Homes.** Because state nursing home transition programs are new, the number of individuals who have left nursing homes and returned to community settings as a direct result of these programs is small, and information on characteristics of these individuals is limited (see series of reports funded by Office of Disability, Aging and LTC by the Medstat Group). One study in New Jersey (Howell-White 2003) of all persons discharged from nursing homes in calendar year 2000 provides some descriptive

information on characteristics of individuals who leave nursing home settings, but how many individuals left as a direct result of New Jersey's transition program cannot be determined. Large numbers of individuals enter nursing homes every year – 2.2 million were admitted from hospitals alone under the Medicare SNF benefit in 2002 (Medicare Payment Advisory Commission, 2005)-- and many return home. One study (Mehdizadeh, Applebaum, Straker 2001) of a cohort of newly admitted residents in Ohio found 47% were no longer there after three months, 60% were no longer resident after six months, and 72% were not resident after one year. About one-fifth of those discharged over the one year period were discharged at death, the remainder returned to community residence. An older study using national data on disabled elderly people from the 1980's (Liu, et al. 1988) found that among nursing home users over a 2-year period, 39% had stays of 3 months or less and 23% had stays of 1 year or longer. A better understanding of what distinguishes those who leave nursing homes and return to the community from those who become permanent residents can provide important insights as to who may prove difficult to transition from a nursing home to community care and why.

**Methodology.** The National Nursing Home Survey was last conducted in 1999 (Jones, 2002). This paper examines two populations included in the survey: 1) individuals age 65 or older who were current residents and had a length of stay of 90 days or longer, and 2) individuals age 65 or older who were discharged over a one year period because the resident was stable or recovered, regardless of length of stay.

The current resident sample (n=6,082) is representative of the 1.2 million nursing home residents nationally who were age 65 or older and had stays of 90 days or longer. Residents were sampled from 1,423 nursing homes selected from the universe of all nursing homes in the

U.S. Data were collected through interviews with a nursing staff person familiar with care provided to the resident. Medical records also were consulted for information on diagnoses.

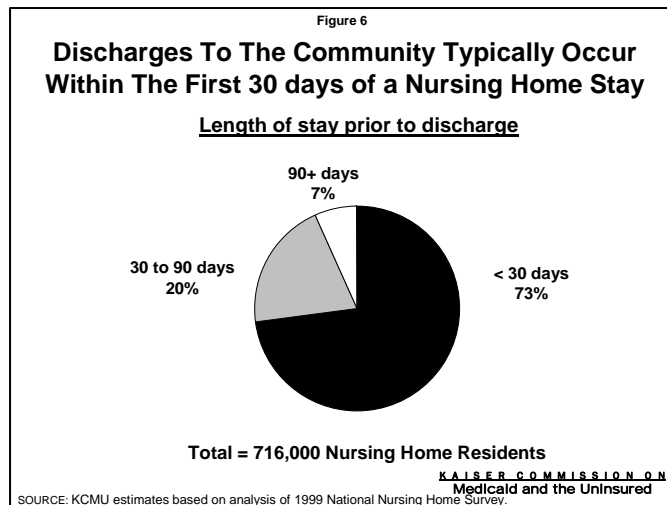
The discharge sample was constructed by collecting information on all discharges in a one month period (selected from October 1998 through September 1999) in the same nursing homes selected for the current resident sample. When weighted to adjust for sample design, estimates from the discharge sample are nationally representative of all nursing home discharges in a one-year period. The total sample of discharges included discharges to another nursing home, to a hospital, because the resident was stable or recovered, due to death, and for a small number of other and unknown reasons. The most common reasons for nursing home discharge among individuals age 65 or older were death (35%) and discharge to a hospital (29%). Discharges to the community (stable or recovered) represented 23% of all discharges in a one-year period (the remaining 13% were discharges to another nursing home, other and unknown). For purposes of this study, only discharges because the resident was stable or recovered were used (n=1,428), since the focus was on discharges to community residence.

Technically the discharge sample represents events (discharges) rather than individuals, but it is rare that an individual would be represented more than once. The likelihood is further reduced in this analysis because only discharges for residents who were stable or recovered were included (for example, someone discharged to the community who returns within the month and is discharged again at death, and for whom both discharges would be included in the total sample, is still only represented once in an analysis restricted to discharges to the community).

Only individuals ages 65 and older are included in this analysis. The proportion of persons under age 65 in nursing homes is small, representing 9.3% of persons with stays of longer than 3 months. These individuals are often the first group targeted for nursing home

transition. Maine’s Home to the Community statewide nursing home transition project, for example, focused exclusively on individuals under 60 years of age (Saucier et al. 2001). It is largely accepted that institutional care for younger people should be avoided whenever possible. The largest segment of the long-stay resident nursing home population, and potentially among the most difficult to transition back to the community, are those over age 65. Information concerning the characteristics of older people who currently return to the community after entering a nursing home in contrast to those who become long-stay residents may be useful in gauging the types and scope of barriers to community return.

**Findings.** Discharges to the community were concentrated among persons with stays of under 30 days (Table 1 and Figure 1). Among all older individuals discharged from nursing homes back to the community, 73% had a length of stay of fewer than 30 days, and another 20% were discharged in under 90 days. Seven percent of discharges were among individuals with stays of longer than 90 days, but only .5% of discharges were among persons with stays of 1 year or longer.



**Table 1. Demographic characteristics of older persons discharged to community and long-stay nursing home residents**

	Discharges to community:				Long-stay residents:			
	Total (in thou)	< 30 days	30 to < 90 days	90+ days	Total (in thou)	90 days to < 1 yr	1 yr to < 3 yrs	3+ yrs
TOTAL	(716)	(72.9%)	(20.4%)	(6.7%)	(1,210)	(30.7%)	(36.9%)	(32.5%)
Age:								
65-74	22.8	23.5	18.5	28.4	12.6	13.3	12.0	12.6
75-84	46.0	47.0	42.3	45.8	34.2	39.1	34.6	29.1
85+	31.2	29.5	39.2	25.8	53.2	47.7	53.4	58.3
Gender:								
Male	37.3	38.2	32.8	40.4	24.7	27.1	25.2	22.0
Female	62.7	61.8	67.2	59.6	75.3	72.9	74.8	78.0
Marital status <sup>1</sup> :								
Married	33.9	36.0	27.3	30.8	16.6	19.8	17.8	12.1
Widowed	49.0	45.8	61.5	46.8	63.0	57.0	63.4	64.2
Never married	1.9	1.3	2.2	8.9	4.8	3.8	3.9	6.8
Single	6.2	7.0	3.8	4.6	7.7	4.3	7.2	9.1
Divorced/Separated	7.3	8.2	4.4	6.3	6.5	6.7	6.5	6.4
Where staying prior to entry <sup>1</sup> :								
Private residence	20.7	21.0	16.8	29.0	31.7	27.1	31.3	36.5
Hospital	72.1	73.1	72.3	62.0	43.7	48.5	44.4	38.5
Nursing home	1.8	1.2	3.5	3.0	11.5	11.9	11.9	10.7
Assisted Living	2.0	1.6	3.4	2.3	5.7	6.6	5.8	4.8
Retirement home	0.9	0.9	0.9	1.2	1.6	1.9	1.4	1.7

*Note:* Discharges classified as stable or recovered were considered discharges to community. These represented 23% of all discharges. The sample of discharges analyzed is representative of all nursing home discharges nationally in a one-year period. Long-stay residents are nationally representative of all current residents who had been in a nursing home 3 months or longer.

<sup>1</sup>Columns do not add to 100% due to unknown marital status or information on where staying prior to nursing home admittance.

*Source:* KCMU estimates based on analysis of the 1999 National Nursing Home Survey.

Individuals discharged to the community were younger than long-stay nursing home residents – those individuals resident for 90 days or longer (Table 1). Among those returning to a community setting, 23% were 65 to 74 years of age, and 31% were 85 and older (30% among those discharged in under 30 days). By contrast 13% of long-stay residents were ages 65 to 74, and 53% were 85 and older. Men comprised a higher percentage of those discharged to a community setting than of long-stay residents. Among those returning to the community within 30 days, 38% were men, but men comprised only 25% of the long-stay population. Married individuals were a higher percentage of those discharged as well, 38% of persons discharged in under 30 days versus 17% of long-stay residents. Only 7% of all discharges occurred after a nursing home stay of 90 days or longer, but persons who were discharged to the community following a stay of this length were twice as likely to be married as long-stay residents, and higher percentages were male and married. Despite much longer stays than most other discharged persons, individuals discharged after a stay of 90 days or more, were closer in age, gender and marital status to other discharged individuals than to individuals with stays of similar length who remained resident.

Individuals admitted to nursing homes were most commonly admitted from hospitals, but 72% of those discharged to the community were admitted from a hospital, in contrast to 44% of long-stay residents (Table 1). About one-third of long-stay residents were admitted from a private residence, and 12% were admitted from another nursing home. Overall, percentages admitted from assisted living were small, but were higher among long-stay residents (6.0% versus 2.0%).

Prevalence of major chronic diseases associated with disability was high in both the discharged and long-stay populations (Table 2). Almost 30% of each group had heart disease.

Overall, over half of each group had one or more of five major physical diagnoses: COPD, stroke, diabetes, heart disease, and hip fracture. Almost twice the percentage of long-stay residents had an admitting or current diagnosis of stroke (22%) as did those discharged in under 30 days (10%). Nonetheless, 20% of individuals discharged after somewhat longer stays (between 30 and 90 days) also had a diagnosis of stroke.

**Table 2. Diagnoses among older persons discharged to community and long stay nursing home residents**

Diagnoses <sup>a</sup>	Discharges to community:				Long-stay residents:			
	Total	< 30 days	30 to < 90 days	90+ days	Total	90 days to < 1 yr	1 yr to < 3 yrs	3+ yrs
<b>Physical:</b>								
COPD	16.2%	16.4%	14.7%	18.6%	11.7%	13.0%	12.4%	9.5%
Stroke	13.0	9.9	20.3	24.8	21.6	20.9	22.0	21.8
Diabetes	19.6	18.5	20.9	27.6	17.6	19.7	17.4	15.8
Heart disease <sup>b</sup>	27.7	27.2	29.3	27.8	29.2	29.0	30.0	28.4
Hip Fracture	2.4	2.6	2.3	1.2	0.7	1.0	0.5	0.8
One or more	56.7	54.2	63.6	62.4	58.1	58.9	59.8	55.3
<b>Mental/Cognitive:</b>								
Dementia	5.3%	4.9%	4.3%	12.9%	24.7%	27.5%	25.8%	25.3%
Depression	7.6	6.2	11.1	11.2	19.4	17.8	19.9	20.3
Schizophrenia	0.3	0.3	0.6	1.2	3.4	2.0	2.7	5.4
Affective and other serious disorders <sup>c</sup>	0.4	0.5	0.2	1.6	2.5	2.4	2.8	2.3
One or more	16.5	15.0	20.2	22.5	48.1	43.0	49.3	51.7
Both Physical and Mental/Cognitive	8.6%	7.3%	11.6%	13.4%	25.0%	22.3%	27.0%	25.2%

*Note:* Discharges classified as stable or recovered were considered discharges to community. These represented 23% of all discharges. The sample of discharges analyzed is representative of all nursing home discharges nationally in a one-year period. Long-stay residents were all current residents, as of a point in time, who had been in a nursing home 3 months or longer

<sup>a</sup>Up to six admitting diagnoses, and for long-stay residents up to 6 current diagnoses, were reviewed. ICD-9 codes were used to create diagnostic categories.

<sup>b</sup>Heart disease includes both congestive heart failure and ischemic heart disease.

<sup>c</sup>Affective disorders includes bipolar and unipolar affective disorders. Other serious mental disorders includes personality disorders, anxiety disorders, other psychotic and other serious mental disorders.

*Source:* KCMU estimates based on the analysis of the 1999 National Nursing Home Survey.

The most striking difference in the diagnostic profile of discharged versus long-stay residents was for mental or cognitive disorders. Almost half (48%) of long stay residents had a mental or cognitive disorder (dementia, schizophrenia, depression, affective or other serious disorder), compared with 15% of residents discharged in under 30 days, and 20% of those discharged after stays of 30 to 90 days. The percentage diagnosed with dementia among long-stay residents was 25%, compared to 5% among those discharged. Schizophrenia, affective disorders, and other serious mental disorders were several-fold higher among long-stay residents. Five percent of persons resident in a nursing home for 3 years or longer were diagnosed with schizophrenia. Depression was an admitting or current diagnosis in 19% of long-stay residents compared to only 8% of those discharged to the community.

The percentage of persons with both physical and mental or cognitive disorders also is substantially higher among long-stay residents (25%) than among persons discharged (7% among discharges in <30 days; 12% for those between 30 and 90 days).

Among individuals discharged to the community, 17% were receiving no ADL assistance at discharge (Table 3), ranging from 20% among those discharged in under 30 days to 7% among those discharged after a stay of at least 90 days. The percentage of long-stay residents receiving no ADL assistance was 4%. At discharge, many of those returning to the community still had substantial ADL needs; 56% of those discharged within 30 days were receiving assistance with 3 or more ADLs. Among long-stay residents, three-quarters received assistance with 3 or more ADLs. These percentages did not vary much between individuals who had been resident for longer than 90 days but less than 1 year, and those resident for 3 years or longer.

**Table 3. Functioning among older persons discharged to community and long-stay nursing home residents**

Functional Status <sup>a</sup>	Discharges to community:				Long-stay residents:			
	Total	< 30 days	30 to < 90 days	90+ days	Total	90 days to < 1 yr	1 yr to < 3 yrs	3+ yrs
Receives assistance with ADLs: <sup>b</sup>								
0	17.2	20.2	10.0	6.6	4.3	4.2	4.1	4.6
1	9.4	7.9	12.6	16.3	6.9	6.7	7.6	6.4
2	15.4	15.6	15.0	13.6	13.9	14.7	13.0	14.0
3 or more	58.0	56.3	62.3	63.5	74.9	74.3	75.2	75.1
Not walking <sup>c</sup>	17.2	14.9	21.9	28.5	46.8	42.6	45.8	52.0
Receives assistance with walking:								
No	23.1	24.8	19.1	17.6	22.0	20.0	23.6	22.3
From another person	41.4	41.9	41.4	36.5	23.0	27.8	22.4	19.1
From equipment only	18.2	18.5	17.6	17.4	8.1	9.6	8.2	6.6
Has ostomy, indwelling catheter or similar device	7.2	7.5	6.6	6.5	6.8	8.1	6.0	6.5
Difficulty with bladder or bowel control <sup>d</sup>	30.1	28.7	32.9	38.2	72.1	68.1	71.4	76.5
Receives personal help or supervision with:								
Care of personal possessions	31.5	26.6	43.4	48.5	75.7	73.7	75.9	77.5
Managing money	27.4	22.8	37.1	47.9	72.3	70.6	72.8	73.5
Securing personal items	40.5	37.5	47.6	52.1	74.0	72.3	74.9	74.6
Using the telephone	25.9	22.8	32.9	38.9	63.1	62.2	64.2	62.8
Any of above	46.7	42.4	56.5	63.2	85.0	83.1	85.0	85.7
Severe vision impairment	3.1	3.0	2.8	5.2	9.0	8.5	8.0	10.6
Severe hearing impairment	3.1	3.4	2.7	2.2	5.7	5.6	5.3	6.1

*Note:* Discharges classified as stable or recovered were considered discharges to community. These represented 23% of all discharges. The sample of discharges analyzed is representative of all nursing home discharges nationally in a one-year period. Long-stay residents are nationally representative of all current residents who had been in a nursing home 3 months or longer

<sup>a</sup> For individuals discharged to community functional status was assessed at/immediately prior to discharge; for current residents at the time of interview.

<sup>b</sup> The ADLs are bathing or showering, dressing, transferring in and out of bed or a chair, using the toilet room, and eating.

<sup>c</sup> Person is bedfast or chairfast.

<sup>d</sup> Includes persons with ostomy, indwelling catheter or other device.

*Source:* KCMU estimates based on the analysis of the 1999 National Nursing Home Survey.

A high percentage of long-stay residents were bedfast or chair-fast and unable to walk (47%), in contrast to only 15% of those discharged within 30 days of being admitted, and 22% of those discharged after somewhat longer stays. Individuals who were discharged to the community were much more likely to be walking with assistance from another person (41%) or from equipment (18%) than were long-stay residents (23% and 8% respectively). As a result, the percentage who received no assistance with walking was similar in the two groups (23% of those discharged and 20% of long-stay residents).

The percentage of individuals with indwelling catheters or similar devices was around 7% among both long-stay residents and those discharged. Difficulty with bladder or bowel control was substantially higher among the long-stay residents, however, at 72% compared with 29% among those discharged to the community in under 30 days.

Receipt of personal help or supervision with various IADL tasks including care of personal possessions, managing money, securing personal items and using the telephone also was much higher among long-stay residents. About 85% of these individuals received assistance or supervision with at least one task, compared to 42% of those returning to the community in under 30 days.

Severe vision and severe hearing impairment affected fewer than 5% of those discharged to the community. Among long-stay residents 9% had severe vision impairment, and 6% had severe hearing impairment.

Individuals with low needs for ADL assistance would appear to be candidates for community-based, as opposed to nursing home, care. Table 4 shows diagnostic and care needs of long-stay residents by levels of ADL assistance. Among the four percent of long-stay residents who received no ADL assistance, 52% had one or more of four physical diagnoses and

37% had dementia or a mental disorder. Two-thirds needed no assistance with walking, but 18% relied on walking assistance from another person or equipment, and 16% did not walk (bed-fast or chair-fast); 13% relied on a wheel-chair for transport. Percentages who received personal help or supervision with IADL tasks ranged from 21% in using the telephone to 41% in managing money. Difficulty with bladder or bowel control occurred in 13% of these individuals.

Individuals who received assistance with only 1 or 2 ADLs (7% and 14% respectively of all long-stay residents) also had substantial health problems. Close to half of each group (50% of those with 1 and 46% of those with 2 ADLS) had a diagnosis of dementia or a mental disorder. A large percentage did not walk or relied on assistance from another person or equipment in walking. Almost half of persons who received assistance with 2 ADLs used a wheelchair for example, 36% of those with 1 ADL used a walker. Difficulty with bladder or bowel control affected 21% of those who received assistance with 1 ADL, and 48% of those who received assistance with 2 ADLs.

**Table 4. Health conditions and care needs of older long-stay nursing home residents by levels of ADL assistance**

Characteristics	No ADL assistance	Assistance with:		
		1 ADL	2 ADLs	3+ ADLs
Total	4.3%	6.9%	13.9%	74.9%
(N in thousands)	(52)	(84)	(168)	(906)
<u>Diagnostic Categories<sup>a</sup></u>	<u>Percentage with:</u>			
Physical:				
Heart Disease <sup>b</sup>	29.3	31.2	30.0	28.8
Diabetes	18.1	18.0	19.0	17.2
COPD	12.2	16.6	14.8	10.6
Stroke	10.8	13.6	17.6	23.7
One or more	52.0	58.5	57.1	58.5
Mental/Cognitive:				
Dementia	10.5	17.3	19.3	27.1
Depression	19.2	23.7	22.7	18.4
Schizophrenia	4.8	6.0	3.8	3.0
Affective and other serious disorders <sup>c</sup>	14.5	18.1	15.6	12.7
One or more	37.0	50.4	46.1	48.9
Both physical and mental/cognitive	16.2	28.3	23.2	25.5
<u>Care Needs</u>				
Not walking <sup>d</sup>	16.0	10.8	36.6	53.8
Walking:				
No assistance needed	66.2	54.9	38.2	13.5
Personal/equipment assistance	17.8	34.3	25.3	32.7
Receives personal help or supervision with:				
Care of personal possessions	26.6	52.4	68.6	82.0
Managing money	41.2	61.8	69.6	75.6
Securing personal items	26.1	53.3	65.4	80.2
Using the telephone	21.3	37.5	55.1	69.4

Table 4. *continued...*

Characteristics	No ADL assistance	Assistance with		
		1 ADL	2 ADLs	3+ ADLs
Has ostomy, indwelling catheter or similar device	0.7	2.5	6.7	7.6
Difficulty with bladder or bowel control <sup>e</sup>	12.6	21.0	48.1	84.7
Severe vision impairment	3.1	3.9	5.4	10.5
Severe hearing impairment	1.9	3.7	5.4	6.1
Uses:				
Wheel chair	13.0	30.9	49.1	71.0
Walker	19.7	36.0	29.3	22.5
Oxygen	2.0	4.8	5.5	5.0

*Notes:* Discharges classified as stable or recovered were considered discharges to community. These represented 23% of all discharges. The sample of discharges analyzed is representative of all nursing home discharges nationally in a one-year period. Long-stay residents were all current residents, as of a point in time, who had been in a nursing home 3 months or longer. A few cells in this table have fewer than 30 cases, thus estimates for these cells are imprecise (relative standard error of greater than 30%). This applies to percentage estimates below 11% among those receiving no ADL assistance, and below 7% among those receiving assistance with 1 ADL.

<sup>a</sup>Up to six admitting diagnoses, and for long-stay residents up to 6 current diagnoses, were reviewed. ICD-9 codes were used to create diagnostic categories. Hip fracture was excluded because prevalence was <1% in the long-stay resident population.

<sup>b</sup>Heart disease includes both congestive heart failure and ischemic heart disease.

<sup>c</sup>Affective disorders includes bipolar and unipolar affective disorders. Other serious mental disorders include personality disorders, anxiety disorders, other psychotic and other serious mental disorders.

<sup>d</sup>Those not walking are bedfast or chairfast.

<sup>e</sup>Persons with ostomy, indwelling catheter or other device are included.

*Source:* KCMU estimates based on the analysis of the 1999 National Nursing Home Survey.

**Implications for Nursing Home Transition Programs.** Nursing homes serve a population with substantial medical and long-term care needs. Within this population are individuals who receive rehabilitation services in the aftermath of acute medical events such as strokes, and individuals who need increasing levels of custodial care in response to progressive declines in functioning related to diseases such as Alzheimer's. Prospects for recovery or continued decline no doubt affect the likelihood of returning to community residence, but other factors are influential as well.

*Differences between those who leave and those who stay.* Almost three-quarters of older people who are discharged to the community leave after a stay of less than 30 days. Leaving a nursing home to return to the community clearly becomes more difficult as a stay lengthens. Given limited resources in most nursing home transition programs, one issue is whether to target individuals at particular points in a stay. If most individuals leave on their own in under 30 days, a program might choose to target for transition those in the one-month to one-year time frame (this of course requires a mechanism for tracking admissions and length of stay).

One-third of Medicare beneficiaries discharged from hospitals go on to use post-acute care -- 39% receive this care in skilled nursing facilities and 33% through home health agencies (Medicare Payment Advisory Commission, 2005). Factors affecting the choice of skilled nursing versus home health for post-acute care include levels of functional limitations, personal or family preferences, supply of providers, and local practice patterns (Medicare Payment Advisory Commission, 2003). While many individuals receiving post-acute care in SNFs are successfully discharged back to the community, a substantial proportion remains resident (44%

of individuals resident for 1 to 3 years and 39% of those resident 3 years or longer were admitted from hospitals). Several states are attempting to prevent post-acute SNF stays from evolving into permanent or long-stays. Approaches include pre-admission assessments to inform individuals about all care options, including those that are community-based, and certifying nursing facility stays for specific periods of time with follow-up from case managers or care planners to facilitate return to the community (Summer, 2005).

Informal support in the community is also likely a key element in leaving a nursing home setting, as suggested by the high percentage of married individuals among those discharged to the community (information on children or other family who also are important sources of support is not available in the National Nursing Home Survey). Among individuals discharged after 90 days, 31% were married, in contrast to 20% of long-stay residents with stays of 90 days to one year. Almost one-third of long-stay residents entered a nursing home from a private residence, however. This pattern may reflect situations in which community sources of support were inadequate or may have been exhausted, another challenge in planning transition back to community residence.

It is unlikely that targeting for nursing home transition would be based primarily on diagnosis. However important differences in the disease profiles of individuals who currently are discharged to community versus long-stay residents have implications for care needs and would be factors in trying to transition more individuals to community care. The most noticeable are the much higher percentage of individuals with dementia or a mental disorder among long-stay residents. These kinds of conditions have different implications for community or home-based care than conditions such as diabetes or heart disease. Compliance with medication

regimens is a significant issue for individuals with mental illness, for example, and leaving persons with dementia unattended may raise safety issues.

*Care needs of persons who receive low levels of ADL assistance.* Extensive needs for assistance in activities of daily living are a major reason for nursing home admission. Yet 4% of nursing home residents required no ADL assistance, and another 20% had relatively low ADL needs (7% received assistance with 1 ADL, 14% with 2 ADLs). These individuals were not without significant medical needs and functional limitations that would have to be addressed in transition to community residence, however. A high percentage had diagnoses of dementia or a serious mental disorder – 37% of those who received no ADL assistance, 50% who received assistance in 1 ADL, and 46% who received assistance in 2 ADLs. Despite low ADL assistance needs, many relied on personal or equipment assistance in walking. Among persons who received assistance with 1 ADL for example, 31% used a wheelchair. Availability of public and private resources to modify a community residence for wheelchair accessibility varies across individuals and communities. Medicaid does not typically cover home modification for wheelchair accessibility. Other conditions with implications for community care needs and living environment include difficulty with bladder or bowel control (12% of those who received no ADL assistance, 19% who received assistance with 1 ADL, 41% who received assistance in 2 ADLs), and severe vision or hearing impairment (although these conditions affected 5% or fewer of persons with low ADL needs).

Individuals with low levels of ADL care needs may be better candidates for transition to community care than other nursing home residents, but they are not without serious health and functional needs for assistance. The availability of community resources, both formal and informal, to address these needs will determine whether they can successfully transition to

community care. Key sources of formal support are the Medicaid Personal Care Option and Home and Community-based Waiver programs (1915C). Whether these programs are currently configured to meet the needs of nursing home residents returning to the community is an important question, and can best be answered by learning from the experience of states that have undertaken programs in nursing home transition.

This paper was prepared by Judy Kasper, Johns Hopkins University, for the Kaiser Commission on Medicaid and the Uninsured.

## References

- Saucier PJ, Bolda EJ, Richards MF, Keith RJ. 2001. Evaluation of Alpha One Independent Living Center's Home to the Community Demonstration Program. [www.rwjf.org/reports](http://www.rwjf.org/reports)
- Howell-White S. 2003. Current Living Situation and Service Needs of Former Nursing Home Residents: An Evaluation of New Jersey's Nursing Home Transition Program.
- Jones A. 2002. The National Nursing Home Survey: 1999 summary. National Center for Health Statistics. Vital Health Stat 13(152). Online at [www.cdc.nchs.gov](http://www.cdc.nchs.gov)
- LeBlanc AJ, Toner MC, Harrington C. 2001. State Medicaid programs offering personal care services. Health Care Financing Review 22(4):155-173.
- Liu K, DeVita C, Manton KG, Coughlin T. 1988. Risks of Entering Nursing Homes for Long and Short Stays. Online at [www.aspe.hhs.gov/daltcp/reports](http://www.aspe.hhs.gov/daltcp/reports)
- Medicare Payment Advisory Commission. 2005. A Data Book: Healthcare spending and the Medicare program. Online at [www.medpac.gov](http://www.medpac.gov)
- Medicare Payment Advisory Commission. 2003. Report to the Congress: Variation and Innovation in Medicare. Chapter 5, Monitoring Post-Acute Care. Online at [www.medpac.gov](http://www.medpac.gov)
- O'Brien E, Elias R. 2004. Medicaid and Long-Term Care. Kaiser Commission on Medicaid and the Uninsured. May. Online at [www.kff.org](http://www.kff.org)
- Olmstead v. L.C.: The Interaction of the Americans with Disabilities Act and Medicaid. 2004. Kaiser Commission on Medicaid and the Uninsured. Policy Brief. May. Online at [www.kff.org](http://www.kff.org)
- Summer, L. 2005. Strategies to Keep Consumers Needing Long-term Care in the Community and Out of Nursing Facilities. Online at [www.kff.org](http://www.kff.org)

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