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Everyone's Talking About It, But Does It Work? Nursing Home Diversion and Transition

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Abstract

In response to increasing Medicaid expenditures and consumer preferences, states are reforming their long-term care systems to provide more community-based services. One popular reform is renewed efforts to prevent unnecessary long-term nursing home placement (diversion) and to provide nursing home residents an opportunity to return to the community (transition). Nearly 3,800 individuals, 60 years old and older, participated in Ohio's statewide nursing home diversion and transition initiative between March 2010 and May 2011. This research tracked outcomes for consumers and evaluated the implementation of the new program. Nearly 80% of diversion and transition participants who were still living at the time of their 6-month follow-up were residing in the community. An agency-level process analysis revealed innovative intervention strategies, promising practices, and barriers. Process results found that Area Agencies on Aging (AAAs) have become more proactive in working with high-risk individuals, with agencies identifying new at-risk consumers through hospital and nursing home interventions.

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Background

With ever-increasing Medicaid nursing home costs and an ongoing consumer preference for receiving long-term services in the community, the United States has dramatically increased funding for home and community-based services (Eiken, Sredl, Burwell, & Gold, 2010; Robison et al., 2011). Initial home and community-based programs, typically funded by state dollars or Medicaid waivers, provided a range of services that would help prevent or delay nursing home placement. Despite the growth of such programs, the system was criticized for continuing to have a large proportion of people in need of long-term services relying on nursing facilities as their primary source of long-term care (Reinhard, 2012). In addition, nursing facility diversion programs only helped to answer one part of the problem—how to keep individuals in their homes as long as possible, but these programs did not address the transition out of nursing homes following placement. In response to this approach, a series of national and state initiatives are now emphasizing efforts to help nursing home residents actually return to the community, and to enhance approaches to prevent very high-risk individuals from becoming long-stay residents (Kitchener, Ng, & Harrington, 2007).

Nursing home transition activities have increased rapidly since the Deficit Reduction Act of 2005 authorized the Money Follows the Person Demonstration that provided states with an incentive to transition long-term nursing home residents back to the community (Wenzlow & Lipson, 2009). The primary purpose of the Money Follows the Person Demonstration is to support state Medicaid programs in creating a greater amount of choice for consumers about where they live and receive services. The demonstration is the largest transition effort to date, as it operates in 43 states plus the District of Columbia (Williams et al., 2012). Since the program's inception, in 2007, nearly 20,000 individuals have transitioned back to the community, with about 8% having been reinstitutionalized within the first year after their transition back to the community (Irvin et al., 2012).

The Money Follows the Person Demonstration has been generally viewed as successful in terms of the number of nursing home residents who have been transitioned back to the community and the typical length of their community tenure (Schurrer & Wenzlow, 2011). The evaluation has the benefit of examining transitions in a large number of states (though the conceptualization of transition has undergone changes over time within the demonstration).

The demonstration first required a nursing home stay of at least 6 months to be eligible for the program, and later reduced the length of stay to 3 months. In general, the demonstration has helped to better define what "transition" means, and represents one of the only systematic studies of nursing home transition to date that also evaluates the effectiveness of such efforts.

A process analysis of the Money Follows the Person initiative determined which transition strategies were the most promising and identified barriers common across participating states. The lack of affordable and accessible housing was by far the greatest and most common barrier, and this was exacerbated by Medicaid policy restrictions (Lipson, Valenzano, & Williams, 2011). For example, current Medicaid policies prohibit home modifications before the consumer returns home, when in many cases the home modification is necessary for the return itself. An additional barrier was the lack of in-home services for individuals with high levels of need or specialized need—such as those with behavioral health issues. Specific strategies, such as employing housing specialists to work with program transition coordinators, and extra incentives and flexibility for program staff were developed in response to these problems (Lipson et al., 2011). These innovative strategies have helped to create a culture among long-term service providers that enables staff to better serve individuals who present a diverse set of needs.

One of the few statewide nursing home diversion programs to be evaluated was the Kansas Diversion Study, which began in 1999 and reported outcomes on a group of 599 individuals 5 years after they were initially diverted (Chapin, Basca, Macmillan, Rachlin, & Zimmerman, 2009; Chapin et al., 2000). This diversion program reported preventing permanent nursing home placement for 57% of the sample over the 5-year study period. Nursing home diversion programs are closely related to transition programs in that they help prevent the potential need to transition nursing residents back to the community later on—by preventing or delaying their nursing home placement in the first place. However, because the vast majority of home and community-based services have diversion as the overall goal, it has been difficult to isolate new diversion interventions.

Thus, although the widespread use of nursing home diversion and transition programs began about a decade ago, there is limited information on the success of such efforts. Evaluation of these programs has been complicated by difficulties in defining diversion and transition. For example, when do routine in-home services become an official "diversion" strategy, and how long does a consumer reside in a nursing home before he or she qualifies as a transition participant? Although the Money Follows the Person Demonstration has helped to establish a clearer definition of what "transition" means and provided comparable data across states, various state transition efforts and

the national demonstration have shifted the definition over time. A comparable systematic evaluation of nursing home diversion efforts does not currently exist.

The Ohio Diversion and Transition Program

This study was designed to evaluate the effectiveness of Ohio's Diversion and Transition Program, which was specifically designated for individuals who were 60 years old or older. The statewide initiative was designed to achieve two distinct goals: to prevent unnecessary long-term nursing facility placement (diversion), and to provide community-based alternatives for long-stay nursing home residents who preferred and were able to live in a community setting (transition). As noted, the concepts of *diversion* and *transition* have not been well defined or clearly differentiated in previous studies. In this study, *diversion* was used to describe community-dwelling individuals who were at high risk of long-term nursing facility placement. *High risk* was measured with the assistance of a risk assessment tool that was designed to target individuals (or caregivers) who seriously considered nursing facility placement and/or showed signs of health deterioration, lack of financial stability, housing problems, or hospitalization. Individuals who experienced a nursing home stay of 3 months or longer, which is a length of stay that is consistent with the Money Follows the Person Demonstration and previous studies (see Arling, Kane, Cooke, & Lewis, 2010), were considered for the transition intervention. Individuals were identified through the use of a community-based alternative assessment tool examining consumer interest in returning home (or caregiver expression of interest) and long-term care ombudsman referrals. Assessors or case managers carried out the baseline assessment, which included the risk assessment tool (diversion), the community-based alternative assessment tool (transition), as well as demographic information and intervention strategies. Those applicants aged 60 and older seeking services and assessed by Area Agency on Aging (AAA) staff to have met the high-risk criteria were included in the study population. Consumers completed a single consent form to receive services and participate in the research study.

The intervention strategies were classified into two categories: identification of consumers who would be good candidates for the program, and specific diversion and transition services. Identification strategies focused on improved effectiveness in locating community-dwelling individuals at risk of nursing home placement and nursing home residents with the potential to return to the community. Service-related strategies are interventions to assist in continued community residence and helping nursing home residents to

return home. The intervention strategies varied based on whether the participant was a diversion or transition consumer (see Table 1).

Diversion interventions varied depending on whether the individual was currently participating in the Medicaid waiver program. For nonwaiver consumers, the identification strategies targeted hospitals with high discharge rates to nursing homes and provided information to caregivers about home care options. Diversion service strategies for nonwaiver consumers were designed to refer consumers to the appropriate services that could meet their unique needs and link consumers to Medicaid waiver programs. Identification strategies for waiver participants were more focused on reemphasizing and restructuring the basic network infrastructure to target current Medicaid waiver consumers with the greatest needs. Service strategies for waiver consumers were developed to provide more intensive services when necessary and to encourage program staff to routinely monitor individuals who were considered most at risk for long-term nursing home placement.

Transition identification strategies were designed to encourage collaboration and cooperation between program staff and nursing homes to more efficiently target individuals who were good candidates for transition back to the community. Database targeting strategies were also developed to assist in the identification process. Transition service strategies focused heavily on enrolling consumers in programs that would provide the services they needed to return to and sustain them in the community. For program staff to better work with transition consumers in nursing homes, AAA staff members were assigned to nursing homes for routine visits (see Table 1).

The Setting—Ohio's Aging Network

The statewide nursing home diversion and transition initiative was carried out by Ohio's 12 AAAs, plus 1 private not-for-profit organization. Ohio's AAAs are independently operated and are overseen by the Ohio Department of Aging (ODA; the cabinet-level state agency that administers services and supports for older adults, their caregivers, and their families). In a collective effort, the AAAs and ODA developed the risk assessment tool (diversion) and the community-based alternative assessment tool (transition), as well as the diversion and transition intervention strategies. The combined target population, both diversions and transitions, was set at 2,300 individuals. Each AAA had the discretion to select which intervention strategies were most appropriate for their respective region. The use of particular intervention strategies varied across AAAs, but their implementation was generally consistent.

Table 1. Diversion and Transition Strategies.

Category	Diversion activity	Transition activity
Identification Innovations to better find community-dwelling consumers at risk of nursing home placement, and nursing home residents with the potential to return to the community.	• Target hospitals with high discharge rates to nursing homes and/or that have heavy rehab caseloads (designed for nonwaiver consumers). • Provide information to caregivers about home care options (for nonwaiver consumers). • Identify current waiver participants who are at high risk of nursing home placement. • Give waiver recipients a Program ID card and a medical information card for use when working with hospitals and doctors.	• Use state and nursing home information systems to identify individuals who could transition from nursing homes. • Partner with LTC Ombudsman to identify nursing home residents appropriate for transition. • Use MDS data to identify nursing homes that serve a high proportion of low casemix residents. • Identify hospitals that include licensed nursing home beds.
Service Interventions that more effectively assist high nursing home-risk consumers to stay or return home	• Provide more intensive services to current waiver recipients: o Increase service plans. o Clinical rounds to improve care. o Caregiver training and support. o Special plan for participants in nursing home. o Target those in need of high-risk case management. • Implement models to work with hospitals to improve discharges and readmissions (waiver and nonwaiver consumers). This could involve colocating case management in the hospital. • Implement models to work with caregivers to assist in supporting family member to remain in community (waiver and nonwaiver consumers). • Refer consumers to levy programs or non-Medicaid services, including mental health, CIL, and housing (nonwaiver consumers). • Link consumers to Medicaid waiver programs (nonwaiver consumers).	• Care managers assigned to nursing homes for routine visits. • Care managers follow up on individuals who might be potential transitions—either referred by ombudsman program or identified in PAR or MDS database review. • Refer potential transition consumers to appropriate program such as Medicaid waiver programs, CIL, or Ohio's MFP program (Home Choice). • Reduce or eliminate the convalescent care exemption.

Note. LTC = long-term care; MDS = Minimum Data Set; CIL = Centers for Independent Living; PAR = pre-admission review; MFP =Money Follows the Person.

Given that Ohio's AAAs are responsible for state Medicaid waiver programs, their work, before this initiative, was generally concerned with nursing home diversion efforts. Thus, the AAA staff were accustomed to working directly with the nursing home eligible population and their families and provided an array of services to prevent nursing home placement and assist consumers and their families with any related concerns or fears. Often, at-risk persons who are not Medicaid eligible require assistance to remain in the community, and it is standard practice to refer these individuals to alternative services, such as county levy programs. In the state of Ohio, these non-Medicaid programs and services are quite common and typically overseen by the AAAs.

However, at the start of this initiative, AAAs were not as involved with nursing home transition efforts. The nursing home transition population included residents who had been institutionalized for at least 3 months in an effort to avoid spending resources on individuals likely to transition without the assistance of the AAA. An important part of transition efforts was to develop a working relationship with nursing homes and their staff. Using Minimum Data Set (MDS) data and past performance information, AAAs identified select nursing homes that appeared to have a high volume of individuals who expressed an interest in returning to the community. AAA staff informed nursing home staff but did not ask for facility permission. The AAAs acknowledged that working with residents who were former Medicaid waiver consumers was generally met with less nursing home resistance than efforts to work with other residents, particularly those who had been residing in the facility for an extended period of time. In addition, the state did not provide extra resources to launch this initiative, and while most AAAs had limited financial resources and staff, 5 of the 13 agencies were able to form specialized units to focus their efforts on nursing home diversion and transition.

Study Methods

The evaluation included a two-pronged approach; an outcomes analysis examined participant status at baseline and 6 months after the intervention, and a process analysis evaluated the initiative's implementation. For the outcomes analysis, baseline measurement included reason(s) for referral to the diversion and transition initiative and the type of intervention(s) used. Follow-up surveys were conducted to track participants 6 months after they were diverted or transitioned. The process analysis consisted of several rounds of interviews with AAA directors and staff, as well as focus groups with case managers, assessors, and supervisors who were responsible for the day-to-day implementation of the intervention. The primary goal of the process analysis was to identify promising practices and challenges related to nursing home diversion and transition work.

Table 2. Baseline Diversion Location, by Waiver Status (n = 2,244).

Location	Diversion waiver (%; n = 771)	Diversion nonwaiver (%; n = 1,473)
Home	56	66
AL	1	5
Hospital	13	10
Nursing facility	30	18
Adult day facility	0	1

Note. AL = assisted living.

The study population consisted of diversion (2,244) and transition (1,555) consumers, of which there were 3,799 individuals who were assessed and considered high risk by AAA staff (e.g., assessors and case managers). The baseline sample includes the complete study population (3,799), and the follow-up sample includes 68% (2,583) of the study population that was eligible for the 6-month follow-up, during the time frame of the project and was based on the participant's initial intervention date. As such, 1,216 participants were not eligible for follow-up because they had been assessed less than 6 months prior to the follow-up date. The eligible follow-up sample included 1,639 diversion and 944 transition participants. Approximately, 11% of the follow-up sample were deceased (197 diversion and 75 transition participants), and 19% were unable to be located 6 months after their intervention (289 diversion and 209 transition participants). Thus, 6-month follow-up data are presented for the remaining 1,153 diversion and 660 transition participants. The diversion group was made up of Medicaid waiver consumers and individuals who were not part of the Medicaid waiver system (see Table 2). Ohio's two most widely used Medicaid waivers for older people are PASSPORT covering an array of community-based services and the Assisted Living Waiver Program. Both waivers are managed regionally by the AAAs and overseen by the ODA. Some waiver consumers experienced a short-term nursing home stay at the time of their intervention but were considered diversions, as their placement (typically less than 90 days) was not long enough to constitute disenrollment from their waiver program. By definition, 100% of the transition participants were located in a nursing facility at baseline (n = 1,555).

Outcomes Analysis

Nursing home diversion and transition initiative participants were identified by AAA staff over a 15-month period. The project timeline allowed us to follow up with approximately 68% of the baseline population within 6 months

of their enrollment in the new program. Baseline data for diversion and transition consumers were collected by AAA staff over the 15-month study period, and demographic information, reasons for referral, and interventions used were recorded. Six-month follow-ups were completed through a short telephone survey and by using the state Medicaid waiver database and the nursing home MDS.

Process Analysis

The first step in the process analysis was to conduct individual telephone interviews with each one of the 13 regional Medicaid waiver program directors. A semistructured interview guide was developed based on preliminary intervention data that identified frequently used strategies. Telephone interviews took place about 6 months after the launch of the diversion and transition initiative and were primarily focused on the strengths and barriers that each AAA encountered in their initial launch of the statewide initiative. A team of three researchers took part in each telephone interview. One researcher conducted the interview, while the other two recorded detailed notes. The notes were compared for discrepancies, and a thematic analysis of these data was used to develop the structure and composition for focus groups. Focus groups with AAA staff were held approximately 9 months after the start of the initiative to provide sufficient time for staff to become familiar with their agency's diversion and transition approach and associated interventions. Two separate focus groups were conducted: one with direct practice staff (care/case managers/assessors) and the other with supervisors. The direct practice staff and supervisor focus groups were recorded and transcribed. The transcriptions were individually coded to identify potential themes and subsequently analyzed in conjunction to identify common themes between the two groups.

As a follow-up to the site director interviews and focus groups, in-depth, semistructured telephone interviews were conducted near the end of the 15-month study period. These in-depth interviews were conducted with three different regional agencies, selected based on their experience with promising practices and common barriers identified in the process analysis. Site directors and at least two staff members from each of the selected AAAs were interviewed separately. The site director in-depth interviews focused on the organizational processes associated with the development and administration of the initiative, and the staff in-depth interviews provided more detail about the diversion and transition processes, promising practices, and barriers. Each interview was approximately 1-hr, and was recorded and transcribed for thematic analysis. In addition, the in-depth interviews were examined to

Table 3. Reasons for Needing the Diversion Program, by Waiver Status.

Reasons	Waiver (%; *n* = 771)	Nonwaiver (%; *n* = 1,473)
Health deterioration	68	76
Nursing facility referral	35	16
Hospitalization	32	14
Caregiver interest	26	11
Financial	3	15
Caregiver change	11	10
Individual interest	11	7
Housing	5	3
Adult protective services	5	3
M (*SD*)	1.9 (0.95)	1.5 (0.79)

reveal additional themes that were not evident in previous data. Initial codes based on previous interviews and focus groups were used for analysis.

Results

Over the 15-month study period, 3,799 individuals participated in Ohio's Diversion and Transition Initiative (2,244 diversions and 1,555 transitions). The greater proportion of diversion consumers likely reflects the fact that nursing home diversion work was already an integral part of the AAA's daily practice; the new initiative might have required that such efforts be reemphasized, more highly targeted, and, in some cases, restructured, but the basic infrastructure was already in place. However, the infrastructure required for helping people transition out of nursing homes and back into the community was just beginning to emerge for most AAAs at the time of this initiative. The number of transition consumers increased progressively over the study period, indicating that AAAs became more familiar with transition interventions over time.

The reasons for referral to the initiative differed greatly between diversions and transitions. For diversion consumers, case managers recorded why the consumer was considered to be at high risk for long-term nursing facility placement, where, for transitions, case managers recorded reasons why the consumer was capable of returning to the community. The most common diversion reasons for referral were health deterioration, occurring in about 7 in 10 cases. Nursing facility referrals and hospital stays were the second and third most prevalent reasons for referral (see Table 3). Finally, caregiver interest in placing the consumer in a nursing facility was recorded for a quarter of waiver and 1 in 10 of the nonwaiver referrals. Caregiver interest in

Table 4. Reasons for Enrolling in the Transition Program (n = 1,555).

Reasons	Transition (%)
Individual interest	93
Caregiver Interest	65
Health care available	52
Housing available	50
Physical improvement	49
Other	6
LTC ombudsman referral	3
M (*SD*)	3.1 (1.37)

Note. LTC = long-term care.

nursing facility placement is an important issue, because when a caregiver expresses concern about whether an individual could continue to be cared for in the home, the consumer is at higher risk for nursing home placement—thus considered a good candidate for the diversion program. For transitions, individual interest in returning to the community was identified by case managers most often (93%), and caregiver interest in transition back home was reported for 65% of the transition participants (see Table 4).

As noted, intervention strategies were specifically designed for diversion waiver consumers and nonwaiver consumers, as well as transition consumers. In addition, care managers could implement one or more of the intervention strategies. The most common intervention strategy for current Medicaid waiver diversion consumers was to increase their care plan to help continue their community tenure (65%). Targeting high-risk waiver consumers with the greatest need was a key component of this initiative, so it is not surprising to see that those with the greatest level of need would require more complex or increased services to remain at home (see Table 5). Other common diversion interventions for current waiver participants involved working with nursing facilities (32%) and hospitals (16%) to help ensure that the consumers could remain in their homes after they left the facility. The most common intervention for nonwaiver diversion consumers was to refer them to one of the two Medicaid waiver programs (73%), which would provide them with access to the type of home care needed to remain in the community (see Table 5). However, some diversion candidates may not financially qualify for Medicaid waiver programs, and the availability of non-Medicaid services may be critical to successful diversion.

Transition interventions were primarily focused on referrals to Medicaid waiver programs (86%) and caregiver education (34%; see Table 6). These

Table 5. Diversion Intervention Strategies, by Waiver Status.

Waiver interventions (n = 771)	%	Nonwaiver interventions (n = 1,473)	%
Increase service	65	Refer to Medicaid waiver	73
Work with NF	32	Refer to other services	28
Work with hospital	16	Caregiver education	26
Clinical rounds	12	Refer to levy programs	5
Health-record tool	10	Care transition hospital	3
Community coach	5		
High-risk case management	4		
Work with AL	3		
M (*SD*)	1.4 (0.78)		1.1 (0.35)

Note. NF = nursing facility; AL = assisted living.

Table 6. Transition Intervention Strategies (n = 1,555).

Strategies	Transition (%)
Refer to Medicaid waiver	86
Caregiver education	34
Refer to Medicare/Medicaid services	11
Refer to MFP	7
Partner with other organizations	5
Refer to OAA or other	4
Utilize LTC ombudsman program	3
Refer to levy programs	1
M (*SD*)	1.6 (0.88)

Note. LTC = long-term care; OAA = Older Americans Act.

interventions occurred both in the nursing home setting and after discharge in the community setting, but no data were collected to specify the location in which these interventions occurred. It is evident from the frequent referral to Medicaid waivers that these programs are used heavily in nursing home diversion and transition efforts and that caregiver education is an important strategy when possible. Caregiver education typically involves the case manager working with the caregiver to provide them information that they may need to aid in a successful transition home and to prevent reinstitutionalization. Such education can range from how to assist with medication to providing contact information and commonly includes information on respite

Table 7. Diversion and Transition 6-Month Status.

	Home/community (%)	Nursing facility (%)
Diversion (*n* = 1,153)	80	20
Transition (*n* = 660)	74	26

Note. 12% of diversion consumers and 8% of transition consumers were deceased 6 months after their intervention. 18% of diversion consumers and 22% of transition consumers were missing at follow-up. Missing consumers were not in Ohio nursing homes.

Table 8. Diversion Program Location at 6 Months, by Baseline Waiver Status.

Location	Waiver (%; *n* = 502)	Nonwaiver (%; *n* = 651)
PASSPORT	69	50
AL waiver	0	8
AL facility	4	3
Home/community	3	22
Nursing facility	24	17

Note. AL = assisted living.

services as well. Partnering with other organizations is a less common strategy (5%) and usually involves AAAs developing a working relationship with nursing homes to help identify individuals who are capable and want to return to the community.

Six-Month Status

The most important question about the effectiveness of this program is whether it succeeded in helping people return to, and remain in, the community. By this measure, the program had a positive impact on the lives of participants. Four in five diversion consumers and three quarters of those who transitioned from nursing homes who were still alive at the time of their 6-month follow-up were residing in the community (see Table 7). Diversion outcomes are presented by baseline waiver status. The majority of diversion consumers (69% waiver and 50% nonwaiver) were enrolled in PASSPORT (see Table 8).

As noted, three quarters of the transition consumers who were still alive at the 6-month follow-up were living in the community, either at home or in an assisted living (AL) facility; 60% were enrolled in either PASSPORT (47%) or the AL waiver program (13%; see Table 9). More than 1 in 10 (12%) were

Table 9. Transition Follow-Up Location (n = 660).

Location	Transition (%)
PASSPORT	47
AL waiver	13
AL facility	2
Home/community	12
Nursing facility	26

Note. AL = assisted living.

living in the community without reliance on one of the waiver programs. Roughly 8% of all transition consumers died within the 6-month time period.

To supplement the diversion and transition consumer tracking outcomes, the study also included a process evaluation, with the goal of learning more about barriers to implementation and about promising intervention strategies. This process analysis included site director interviews that occurred 6 months after the launch of the initiative, focus groups 9 months out, and in-depth interviews with select site directors and staff near the end of the 15-month study period. Common themes were identified at each stage of the process analysis and informed the development and analysis of subsequent interviews and focus groups. The overarching themes included barriers: (a) limited AAA financial and staff resources, (b) internal cultural shifts in AAA practices related to linkages with acute care and hospital work, and (c) external barriers from linked organizations (e.g., hospitals and nursing homes); and promising practices: (a) developing a new organization structure within AAAs to meet the needs of the diversion and transition initiative, (b) colocating AAA staff in hospital settings, and (c) developing working relationships with nursing facilities.

Barriers

One of the most common challenges faced by the aging network is limited resources. Because diversion and transition represent a "new way" of doing business, these innovations often call for the reallocation of current resources, or, sometimes, additional resources. Although states may not have much flexibility in adding new resources, they may have the ability to modify their regulatory structure; for example, changing caseload size or monitoring requirements for individual case managers could help organizations reallocate staff.

An additional barrier involved altering the nature and culture of work traditionally done by area agencies. Case-managed in-home services had originally developed as a nonmedical alternative that relied heavily on a social services

model for providing assistance with the tasks of daily living such as bathing, dressing, and meal preparation. There was a strong emphasis on trying to develop this social model as distinct from the acute care dominated health system. Because this more social model has been a hallmark of home and community-based services for the last three decades, including an acute care and institutional linkage represents a considerable change for the aging network.

> It was the realization that you can't have a strong acute care hospital and divorce it from health and human services in the community. Hospitals save lives, and community services sustain them. (PASSPORT Director)

There are also the external barriers related to establishing new working relationships with hospitals and nursing homes. Some respondents reported that hospital staff described being unaware of the in-home services available in the community, thus adding to the concern of hospital discharge planners that individuals and families could not manage services safely at home. To address this challenge, area agency staff suggested the need for a considerable amount of education about the role of the aging network, across all levels of the hospital, both direct care staff such as discharge planners and hospital administrative staff. We also encountered numerous reports of AAA staff reporting resistance from nursing facilities, such as restricting access and warning their personnel that area agency staff members were in the building.

> Several of the discharge planners and social workers thought we were there to take their jobs. We had to reassure them that is not what we are trying to do at all. (PASSPORT Care Manager/Assessor)

> It doesn't seem to bother them [nursing facility staff] so much when we are working with consumers already in our program. It's the other group of folks that aren't connected with us yet and looking to go home . . . (PASSPORT Supervisor)

A final nursing home transition barrier identified universally by care managers involved housing. Care managers provided countless examples of individuals who had been nursing home residents for months or even years who could now manage at home, if there were housing available. Those individuals with behavioral health limitations requiring housing and supports were a particular challenge.

> Without a doubt, adequate housing is the single biggest barrier we face in being able to transition individuals from nursing home to community . . . And if you have behavioral health needs you can pretty much forget it. (PASSPORT Care Manager)

Promising Practices

The process analysis identified three major areas of promising practices that were developed by the AAAs in the diversion and transition initiative: (a) modifications in organizational structure and culture to support diversion and transition activities, (b) colocation of area agency staff in hospitals, and (c) using innovative techniques to work with nursing homes to identify and transition residents.

Organizational Structure and Culture

Because nursing home diversion and transition usually involve added or enhanced efforts to the day-to-day practice of most home care programs, area agencies reported that it was beneficial to actually create a new organizational structure focusing on diversion and transition. The rationale for developing a new unit or position was that the diversion and transition program was appreciably different from the assessment and case management functions that have been the core of the existing system. In addition to the structural changes implemented, the area agencies also developed and implemented new policies and procedures regarding diversion and transition to help staff learn and understand their new role. This was viewed as an important step in keeping everyone "on the same page," and as an important measure to embed the philosophy and principles of diversion and transition throughout their organization.

> This has required a definite mind-set change. (PASSPORT Director)

> Our staff is really good at doing PASSPORT assessments in the community, but we really had to push them more in the nursing facilities . . . they realized getting people back to the community after being gone for so long is a whole new ballgame. (PASSPORT Supervisor)

> It's all about changing our mind-set. It frustrates me because it's so easy to get wrapped up in "this is how we do things." (PASSPORT Supervisor)

Colocation

Beyond improving the current scope of the state long-term services and supports system, we found that many area agencies are also expanding the breadth of their organization to include partnerships with hospitals and nursing facilities. For some states and/or area agencies, this may mean establishing working relationships with hospitals and nursing facilities for the first time, or, for those with existing relationships, it involves nurturing growth in

those relationships. Many area agencies stated that having a full-time staff member colocated at a hospital was the most promising practice for expanding their diversion program. When there is dedicated staff either assigned or colocated at specific hospitals, they are able to identify individuals at the best point in their trajectory for the possible intervention. Having a consistent staff member assigned to specific hospitals helps hospital staff to attach a face to the agency and better develop a lasting relationship over time.

> We have been in our hospitals for years. Once we proved our value to them and they realized we could actually reduce some of their workload, we were no longer seen as a threat. (PASSPORT Director)

Working With Nursing Facilities

In the recent past, a state's aging network presence in nursing homes was commonly met with tension from the nursing homes themselves, but as nursing home culture is quickly changing to meet the demands of a growing number of Medicare recipients, the nature of this relationship is also changing. It was reported that working with current Medicaid waiver consumers who were placed in a nursing home was typically met with less resistance than working with nonwaiver consumers or long-term residents. To identify potential transition consumers, a number of agencies are now using data from the new MDS that asks the consumer about his or her desire to return to the community. While still a relatively new practice, early reports suggest that it could be a fruitful mechanism to identify potential transition consumers.

> Five years ago, it was almost like we were bothering the nursing home if we walked through the door, and even when a PASSPORT person was admitted we were hesitant.(PASSPORT Supervisor)

> I was contacted by a nursing home about a resident who they thought had dementia and could no longer care for herself, but preferred to stay at home. The woman and her family were unaware that she was eligible for PASSPORT and un-informed on how to maneuver through the medical system. I helped her get to see a doctor. (She had not seen a doctor in over 20 years.) It turned out that she didn't have dementia but only a UTI, which was causing her confusion. I enrolled her in PASSPORT, and she only needed night time care for a little while before she and her family were able to manage on their own. (Transitions Care Manager)

Conclusion

Virtually all states are working to achieve better long-term care system balance, to become more fiscally responsible, and to enhance capacity to

provide services and supports in the setting of the consumer's choice. To this end, special efforts to divert high-risk individuals or to help current residents return to the community are receiving growing attention. Outcome findings from the Ohio study showing that a majority of diversion and transition participants were residing in the community after 6 months are similar to the Money Follows the Person Demonstration results for the transition sample members and similar to the other state evaluation completed in Kansas on diversion participants (Chapin et al., 2009). Our process results, particularly concerns about adequate housing options and difficulties in serving individuals with behavioral health needs, were also consistent with the evaluation results of the Money Follows the Person Demonstration (Lipson et al., 2011). An important lesson learned in the demonstration was that care managers can change practice priorities with the right training and better incentives. For example, prior to this initiative, busy care managers would essentially ignore individuals on their caseload who entered a nursing home, instead allocating limited hours to those remaining in the community. The demonstration resulted in a change in practice and a shifting of efforts to help waiver participants return to the community. The transition efforts particularly routinely sending care managers into nursing homes represented a paradigm shift in how waiver case management was practiced. These experiences indicated that states can reduce the proportion of older people using nursing homes as the venue for long-term care.

Despite the positive findings from this program, there is much work to be done. Efforts to evaluate diversion activities continue to face the definitional problems associated with this goal. Literally, every state in the nation has multiple Medicaid home and community-based waiver programs that are designed to divert individuals with disability from nursing home placement. How do new programs designed for diversion differ from the existing efforts? Can we identify high-risk individuals or special diversion interventions that are somehow different from the current programs? Although transitions are a bit clearer, some of the same issues remain. More and more individuals are going to nursing homes for short-term rehabilitation that could last 100 days under Medicare reimbursement rules. How should these individuals be counted as programs develop transition interventions?

Perhaps the biggest research challenge faced in looking at the diversion and transition interventions being implemented across the nation is that we do not have specific evidence about what works. For example, despite success in moving individuals from nursing homes to the community, about one quarter of our participants either returned to or never left the nursing facility. We need to learn more about the individual, familial, and environmental circumstances of these individuals. Similarly, we do not have good information

about what part of the intervention was the most critical in achieving program success. Was it working with family members, extra resources available prior to nursing home discharge, higher amounts for in-home services, or the combination that is needed? Similar questions can be raised for diversion. A limitation of the study and the field in general is not being able to link specific interventions to outcomes. In addition, the present study only included adults 60 years old or older, and cannot be generalized to the entire long-term services and support population that includes people of all ages. As states continue to develop interventions designed to enhance diversion and transition, having empirically based interventions will be critical. Although a better understanding of the intervention is necessary, what is clear is that as the size of the older population with disability continues to increase, diversion and transition success will be increasingly important.

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