ABSTRACT

“MOVING THE TITANIC WHILE AVOIDING THE ICEBERGS”: A PROGRAM THEORY FOR NURSING HOME TRANSITION PROGRAMS

by Elizabeth Ann Carpio

The purpose of this research is to use existing literature and ongoing evaluation of one state’s initiatives to articulate a program theory of nursing home transition. The resulting model is a testable nursing home transition program model for Ohio, and can guide the development and evaluation of future programs in other locations.
“MOVING THE TITANIC WHILE AVOIDING THE ICEBERGS”:
A PROGRAM THEORY FOR NURSING HOME TRANSITION PROGRAMS

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**Table of Contents**

- Chapter One: Statement of the Problem and Background ........................................... P. 1
- Chapter Two: Research Question and Methodology .................................................. P. 10
- Chapter Three: Results/Findings .............................................................................. P. 14
- Chapter Four: Discussion/Implications/Conclusions ............................................... P. 28
- References ..................................................................................................................... P. 32
- Appendix ....................................................................................................................... P. 35
List of Tables

Table 1: Barriers Encountered by Early Nursing Home Transition Programs  P. 5
List of Figures

Figure 1: Ohio Nursing Home Transition Program Theoretical Framework P. 14
Chapter One: Statement of the Problem and Background

Statement of the Problem

Ohio is faced with the same critical issue as every other state: unsustainable growth in Medicaid budgets (Applebaum, Payne, Straker, 2009). In an effort to respond to this impending crisis the Ohio Legislature passed House Bill One, which requires the implementation and evaluation of programs and strategies focused on institutional care diversion and transition (moving people from an institutional setting back to a community-based setting). These strategies are designed to reduce the Ohio’s long-term care (LTC) Medicaid expenditures on institutional care.

Ohio’s annual LTC Medicaid expenditures total approximately 4.7 billion dollars. Forty-two percent of the LTC Medicaid expenditures are dedicated to the care of adults 65 and older, and about 75% of LTC Medicaid funds are spent on institutional care. Home-and community-based services (HCBS) only represent about 25% of total LTC Medicaid expenditures. The annual costs of institutional care per person are approximately four times greater than the annual per person costs of HCBS (Applebaum, Payne, Straker, 2009). The rising costs of institutional care and the growing census of individuals receiving long-term care services in institutional settings will place an unsustainable burden on the Ohio state budget if alternative care options are not implemented (Applebaum, Payne, Straker, 2009). Effective implementation of a comprehensive nursing home transition program can help alleviate the financial burden on the Ohio state budget while maintaining Ohio’s mission to provide quality services that promote the health and independence of older adults and their caregivers while diverting them from institutional care.

Overall, the growing burden on Medicaid budgets, continuation of unnecessary long-term facility placements, and growing concerns regarding the quality of care provided to older adults and adult with disabilities strengthen the argument for the development of a cohesive nursing home transition program for Ohio that can be implemented and tested for quality and effectiveness. The majority of existing literature regarding nursing home transition strategies and programs is descriptive and anecdotal. The literature lacks concrete theoretical or empirical studies regarding the effectiveness of strategies implemented in nursing home transition programs (Poole, Duvall, & Wofford, 2006). There is even less data regarding how or why any given strategy is selected for a particular program or state. Ultimately, the literature provides piecemeal descriptions about the formulation of nursing home transition programs, and suffers from a lack of a guiding theoretical framework in this area. The purpose of this research is to use existing literature and ongoing evaluation of one state to articulate a program theory of nursing home transition. The resulting model is a testable nursing home transition program model for Ohio, and can guide the development and evaluation of future programs in other locations.

Background

Medicaid is the primary funding mechanism for LTC services in the United States (Wenzlow & Lipson, 2009). In fact, Medicaid accounts for approximately 42% of all LTC spending (Kaiser Commission on Medicaid and the Uninsured, 2006). Until 1981, when the Medicaid HCBS
waiver programs (section 1915c of the Social Security Act) were established by the Omnibus Budget Reconciliation Act (OBRA), most LTC was provided in nursing homes (Miller, Ramsland & Harrington, 1999). The 1915c waiver programs expanded the states and federal government’s ability to provide LTC services in the community (Shirk, 2007). However, the growth of the 1915c waiver programs was stunted by a number of barriers.

First, the OBRA required the cost neutrality of all 1915c waiver programs. Basically, it could not cost more to care for an individual served by a waiver program than it would to care for the individual in a nursing home. The costs of the waiver had to be less than or equal to institutional care (Thompson & Burke, 2008). The “cold bed” rule is an example of a cost neutrality measure imposed on states. It required states to demonstrate the availability of an institutional bed for every individual enrolled in a 1915c LTC waiver program (Shirk, 2007). This rule placed a significant burden on states that had restrictions on building new nursing home beds. Second, there were several federal rules in place that placed significant limitations on the growth of the 1915c waiver programs, including restrictions on the number of individuals that could be served by waiver programs, the types of individuals served and the types of services available (Shirk, 2007).

Several steps taken in the late 1980’s and early1990’s by Congress and the Center for Medicare and Medicaid Services (CMS) relaxed the federal requirements that impeded the growth of 1915c waiver programs (Shirk, 2007). By 1997, all states and District of Columbia had been approved for a 1915c waiver program (Miller, Ramsland & Harrington, 1999). Unfortunately, the demand for HCBS often far exceeded the capacity of waiver programs and long waiting lists became extremely common (Shirk, 2007).

Transition from institutional to community-based care has been a central focus of the long-term care service system for individuals with disabilities for over three decades (http://www.cms.hhs.gov). The Americans with Disabilities Act (ADA) of 1990 laid the foundation for community integration of disabled individuals living in institutions. Title III of the ADA requires the administration of public services such as Medicaid, in the most integrated and least restrictive settings possible while still meeting appropriate level of care needs (Desonia, 2003). States that provided only institutional based LTC services to individuals with disabilities were accused of violating the ADA by advocacy groups. This led to the landmark Olmstead Decision in 1999. The Supreme Court of the United States ruled in Olmstead vs. L.C., that segregating individuals with disabilities in institutions constitutes discriminatory practices by states. In addition, the Supreme Court ruling indicated states could be compelled by the ADA to provide HBCS as an alternative to institutional care for individuals with disabilities (Carbaugh, Elias, and Rowland, 2006). As a result of the 1999 Olmstead Decision, states and the federal government began to develop plans for nursing home transition initiatives that focused resources and efforts toward removing individuals inappropriately institutionalized back to the community, using HCBS waiver programs (Rosenbaum, 2000).

Although the 1999 Olmstead Decision represents the turning of the tide in LTC services, it was only one of several drivers for the movement away from institutional care to HCBS. Consumers, caregivers and advocacy groups increasingly and consistently expressed a preference for HCBS and supports. It was clear that the culture and expectations of LTC services was shifting in the United States (Greene et al., 2005), and that the exponential aging of the nation would require new solutions. Ultimately, state and government officials viewed (and
continue to view) HCBS waiver programs as Medicaid cost-saving measures (Green et al., 2005). The fact that LTC consumers only represent 7% of the Medicaid population, but are responsible for 52% of all Medicaid spending make HCBS cost-savings measures all the more compelling.

To address concerns about our institutional care-orientation infrastructure, the Real Choice Systems Change (RCSC) grant program was enacted by Congress in 2000 in an effort to help states transform their existing LTC service system. The goal was to reduce the reliance of state LTC systems on institutions and increase the use of home and community-based care (Shirk, 2007). The New Freedom Initiative was launched by the Bush Administration in 2001 and awarded over $243 million dollars in grants to all fifty states, Washington, D.C. and four territories between 2001 and 2006 (Shirk, 2007). There were several grant types awarded including Consumer Direction, Adult and Disabled Resource Centers (ADRC), Nursing Facility Diversion and Transition Programs. The grants targeted seniors and people with disabilities, created incentives for community integration to further promote community living, and encouraged the proliferation of HBCS. The grants were intended to instigate the coordination of existing resources that support LTC and help states modify existing policies and create new policies in support of home and community-based care (Shirk, 2007). RCSC also inspired several policy clarifications from the U.S. Department of Health and Human Services. For example, CMS began to allow HCBS waiver programs to cover one-time costs associated with transitioning back to the community from nursing facilities. This included costs such as security deposits for apartments and utility hook-up fees (Shirk, 2007).

In FY 2003, RCSC awarded nine states $6.5 million in grants to improve their nursing home transition efforts by implementing the Money Follows the Person (MFP) initiative (http://www.cms.hhs.gov). The MFP initiative was designed by CMS to improve the balance of Medicaid funding spent on facility placement and home and community-based services (HCBS). MFP is a flexible system of financing LTC services. It allows Medicaid funded LTC services to follow individuals across care settings depending on their transition needs and preferences. This initiative is composed of two primary components including a funding mechanism allowing Medicaid funds earmarked for institutional care to be used for HCBS; and the implementation of nursing home transition programs. The purpose of nursing home transition programs is to facilitate the medically appropriate identification and transition of individuals currently in LTC facilities back to a community setting with the support of HCBS (http://www.cms.hhs.gov). The nine states implemented a variety of MFP strategies. The service-based strategies used by the state programs included case management, information facilitation, and the use of assessments. The CMS demonstration projects found that nursing home transition programs are labor intensive and successful implementation depends on administrative commitment, but that they have the potential to reduce Medicaid expenditures and improve the satisfaction of LTC service recipients. Unfortunately, the authorizing legislation for RCSC grants did not require national evaluation of LTC service recipients. Unfortunately, the authorizing legislation for RCSC grants did not require national evaluation of grant activities until 2005 and 2006 (Shirk, 2007). Although states consistently reported the cost-effectiveness of their nursing home transition programs, the programs were unable to demonstrate this empirically (Hendrickson & Reinhard, 2006). Volumes have been written about RCSC initiatives but there is little evaluative data to empirically establish the impact of MFP projects on state rebalancing efforts (Shirk, 2007). Again, the RCSC grant evaluation reports are primarily descriptive accounts of grant activities and anecdotal data at
best. Empirical analyses to explore the success of specific strategies used in the different MFP initiatives and the overall impact of nursing home transition programs are necessary but scarce (Kane et al., 2006). There are even fewer data regarding the experiences of individuals enrolled in nursing home transition programs, and those who have been “successfully” transitioned from institutional facilities. The final report on MFP explored consumer satisfaction regarding transition experiences. The report suggests consumers’ satisfaction is linked to adequate housing and community services being in place at the time of transition. Specifically, if these are not in place at a level that adequately meets need the consumer’s satisfaction in the community may not be any higher than the satisfaction experienced in a facility (Greene et al., 2005).

In general, nursing home transition programs were believed to be important innovations to rebalance LTC systems in the United States, but demonstration projects faced numerous challenges related to the existence of multiple incentives for consumers to remain in institutions (http://www.cms.hhs.gov). The major barriers impeding the success of early nursing home transition programs are identified in Table 1. Early demonstration projects had little trouble articulating the barriers that impeded their success, but were unable to clearly delineate what constitutes a successful program. The clear articulation of barriers provides a valuable, albeit unconventional insight into nursing home transition program theory. Identifying what doesn’t work and why it doesn’t work helps inform what will or can work. It also allows strategies and processes designed to overcome or avoid the barriers to be built into programs from the very beginning.

Housing represented a significant barrier for low-income older adults and the disabled particularly, since Medicaid does not pay housing costs (Shirk, 2007). A lack of service coordination, shortage of providers and direct service workers made it challenging to successfully transition individuals back to the community. Low consumer awareness of available options and the limitations of HCBS due to state budgetary constraints experiences by states also created barriers for demonstration projects (Shirk, 2007). The major challenge faced by demonstration project participants was their existing HCBS infrastructures. Once the demonstration project funds were exhausted, states were unable to support nursing home transition individuals with their existing HCBS infrastructures (Carbaugh, 2006). The barriers encountered by the demonstration projects are not only major lessons learned; again, they are ways nursing home transition program theory is being articulated. Essentially, the demonstration projects identified what should have worked, what could have worked, but did not work because of the barriers that blocked their success.
Table 1. Barriers Encountered by Early Nursing Home Transition Programs

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Description</th>
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<tbody>
<tr>
<td>Housing</td>
<td>• Lack of adequate and affordable housing for low income older adults and individuals with a disability</td>
</tr>
<tr>
<td></td>
<td>• Lack of resources to pay housing costs</td>
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<td></td>
<td>• Lack of resources to pay for necessary home modifications</td>
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<tr>
<td>Service Coordination</td>
<td>• Services delivered in silos, i.e. medical, housing, social and supportive services.</td>
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<td></td>
<td>• Paradigmatic differences in service delivery systems.</td>
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<tr>
<td>Infrastructure/System Issues</td>
<td>• States unable to support transition efforts once grant funds were no longer allocated due to state budget shortfalls.</td>
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<td></td>
<td>• States’ HCBS systems not designed to support individuals leaving institutions</td>
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<td></td>
<td>• Emphasis of institutional care in State Medicaid programs</td>
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<tr>
<td></td>
<td>• Shortage of providers and direct care workers to care for individuals once transitioned to the community</td>
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<td></td>
<td>• Insufficient resources to create staffing patterns dedicated to administering and implementing transition efforts</td>
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<tr>
<td>Outreach and Education</td>
<td>• Lack of consumer and caregiver awareness regarding available LTC service options</td>
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<td></td>
<td>• Hospital and institutional facility discharge planners unaware of HCBS resources</td>
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<tr>
<td>Eligibility</td>
<td>• Lack of a clear and uniform definition regarding who should be considered a transition client, i.e. short-stay or long-stay clients</td>
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Sources: [http://www.cms.hhs.gov](http://www.cms.hhs.gov); Shirk, 2007; Carbaugh, 2006; and Wenzlow & Lipson, 2009

The barriers identified from the RCSC programs laid the foundation for the Money Follows the Person Rebalancing Demonstration authorized by Congress as part of the 2005 Deficit Reduction Act (Shirk, 2007; Wenzlow & Lipson, 2009). The legislation allocated 1.75 billion in federal funds to assist state Medicaid programs in transitioning individuals from institutions to community setting, and changing states policies that created transitioning blockades over a period of five years (2007-2011) (Wenzlow & Lipson, 2009). Thirty states and the District of Columbia were participating in the MFP initiative as of June 2008. This two-fold effort built upon the lessons learned from previous demonstration projects, acknowledging the need to integrate transition programs with other rebalancing initiatives in order to truly make an impactful change at the system level. The MFP Rebalancing Demonstration initiative also established concrete length-of-stay criteria regarding who could be considered a transition. MFP transition programs can only target Medicaid enrollees who have been in a LTC placement for
six months or more (Wenzlow & Lipson, 2009). This is a critical step toward effective program and impact evaluation. The results from studies conducted on previous transition programs were often inconclusive. It was impossible to determine if the individuals transitioned were short stay LTC residents slated for return back to the community with or without the transition program intervention. The criterion established by MFP will guard against this in future studies. In addition, MFP provides states with enhanced matching Medicaid funds in support of HCBS waiver program services for one year after an MFP enrollee transitions back to a community setting (Wenzlow & Lipson, 2009). The enhanced resource support significantly expands the scope of the MFP initiative when compared to previous CMS rebalancing initiatives.

CMS administered Nursing Facility Transition grants between 1998 and 2000 that targeted individuals under the age of sixty-five. CMS allocated 4.7 million to twelve grant states to transition 1,900 Medicaid enrollees to transition from institutional care to a community setting (Eiken, 2003). Although the RCSC initiative offered several grant types, most state grantees used the funds to support nursing home transition and diversion programs. The RCSC grants have operated since 2001 and have only transitioned approximately 3,600 Medicaid enrollees back to a community setting (Gillespie, 2005). This number represents more than half of the fifty states and four territories that actually reported data on their programs (Gillespie, 2005). The thirty-one MFP grantees plan to exhaust the 1.75 billion in federal funds allocated to this initiative, transitioning approximately 36,000 Medicaid enrollees to community settings between 2007 and 2011 (Wenzlow & Lipson, 2009).

The MFP initiative used data collected in 2004 (most recent year data are available) regarding the Medicaid population in long-term institutional care as baseline data for the grantees. In 2004, 75% of the Medicaid enrollees who received care in institutional care settings were in placement for more than six months and would have been eligible for MFP had it been in existence (Wenzlow & Lipson, 2009). The majority (77%) of MFP eligibles in 2004 were age 65 or older living in nursing homes 63% were age 75 or older and approximately 34% were age 85 and older. Although older adults represented the largest population in institutional care in 2004, they also represented the least expensive when compared to other populations in institutional care (Wenzlow & Lipson, 2009). For example, on average the per–member-per-month cost for an older adult in institutional care was $3,736; the per member per month cost for the ICFs-MR population was $11,291—nearly three times more expensive. This may be why fewer than half of the thirty-one MFP grantees targeted their transition strategies toward the 65 and older population and focused strategies on populations with the potential of achieving the greatest degree of cost-savings in the Medicaid budget (Wenzlow & Lipson, 2009). The data from 2004 shows that 64% of MFP eligibles were institutionalized for twelve months or more, 11% for six to eleven months and 24% reach the six month mark required for eligibility (Wenzlow & Lipson, 2009).

The percent of individuals eligible for MFP who left institutional care and returned to the community were between 2.2 and 5.9 percent in 2004. Older adults (65 and older) represented the largest population of those who transitioned (Wenzlow & Lipson, 2009). It is unclear how or why these individuals returned to the community. It is possible RCSC grant efforts account for some of the returns to the community in 2004, but it is more likely the individuals were simply short stay–LTC residents going back to the community after rehab, respite, etc. Finally, in 2004,
18% of MFP eligible’s died; of those that died 22.3% were 65 and older (Wenzlow & Lipson, 2009).

Current MFP grantees used this information to establish goals and targets for their transition programs. The first year of the five year project period, 2007, was designated a start-up year by nearly all of the grantees. Therefore, a very small goal of seventy transitions across all thirty-one grantees was set and was projected to increase appreciably over the remaining four years of the initiative (Wenzlow & Lipson, 2009). It is anticipated that the largest number of transitions will occur with the 65 and older population (48%), and few individuals with mental illness or a dual diagnosis will be transitioned. Housing and community supports that can meet the unique needs of this population are often difficult to find (Wenzlow & Lipson, 2009). Collectively, the thirty-one grantees have more than one million institutionalized Medicaid enrollees who may be eligible for MFP, but have established goals to transition only about 35% of enrollees during the life of the grant (Wenzlow & Lipson, 2009). If the grantees meet their established goals they will be able to increase the 2.2%-5.9% of the eligible population that transitions without intervention to 15%-40%. This percentage increase assumes targeted individuals would remain institutionalized without the MFP interventions.

Although the MFP Demonstration Grant attempted to create uniformity in eligibility criteria, there is still tremendous variation in the thirty-one state programs. Grantees are able to select the number of proposed strategies they will use in their transition programs, the populations they will target, and the distribution of transitions across targeted subgroups (Wenzlow & Lipson, 2009). For example, although twenty-nine states have targeted the 65 and older population collectively, they propose to transition less than 1% of the eligible population. It appears that MFP grantees are disproportionately targeting the younger disabled population. It is possible grantees are targeting this subgroup because they have more system resources to support their return to a community setting making transitioning them easier (Wenzlow & Lipson, 2009). However, CMS has received several requests from states to approve smaller transition goals than originally indicated by the approved MFP operational protocols. This could be due to the fact that some of the targeted populations have complicated medical needs or high level of functional dependence. Such individuals require a greater degree of assistance finding suitable housing and community supports to meet their complex (Wenzlow & Lipson, 2009). The variation may once again create a challenge for an empirical analysis of program impact. Future evaluations of the MFP initiative intend to focus on the rate of transitions back to the community, strategies used to transition individuals, the functional status of individuals transitioned compared to institutionalized individuals, and MFP program design and implementation (Wenzlow & Lipson, 2009).

The state of Ohio has been working toward LTC system reform for more than two decades. The reform is necessary, as it is a state facing enormous LTC challenges. Although the changes in Ohio have been incremental, they have been steady. In a 2006 Kaiser Commission Report, an Ohio Medicaid official was quoted as saying, “Ohio’s approach to LTC reform is evolution not revolution” (p.10). Ohio has a tremendous dependence on the nursing home industry, and simply closing beds does not appear to be an option given the political influence of the industry. The state’s efforts at controlling nursing home bed usage have taken many forms, but the latest effort is the House Bill One (HB1) initiative passed by the Ohio legislature. HB1 represents a renewed focus on transitioning and diverting individuals from institutions back to community-setting.
The Ohio Department of Aging (ODA) was charged with the task of designing a program with the capability of transitioning or diverting 2,100 individuals in a two-year period. ODA partnered with the state’s thirteen Area Agencies on Aging (AAA) and the Scripps Gerontology Center to develop, implement and evaluate diversion and transition strategies. It took the HB1 committee six month to create and agree on a menu of thirty-six strategies organized into five categories. The categories include retention of ODA waiver consumers, hospital diversion work; nursing facility transitions work; pre-admission screening (PAR) work; and community collaborations. One challenge was developing strategies above and beyond the day-to-day services already provided to clients of the AAAs. Another challenge was developing an approach that distinguished waiver clients from non-waiver clients. Once the strategies were finalized the AAAs were able to select from the menu of thirty-six strategies to tailor the HB1 initiative to the needs and capacity of their particular organization. The AAAs were also asked to indicate if the strategies they selected were already implemented in their organization, or would be implemented within three months or six months. There is significant variation among the AAAs and the strategies selected. There were some strategies selected by every AAA, some AAAs that selected nearly every strategy, and some AAAs that selected to implement only diversion or transition strategies. Although the 60 and older population is the primary target for the HB1 initiative individuals under the age of 60, particularly those with mental health needs, are also targeted.

The evaluation for the HB1 initiative is two-pronged. First, a process analysis will be conducted regarding how the AAAs implemented the various diversion and transition strategies. The goal of this phase of the evaluation is to provide a clear description of the intervention strategies used, number and profile of individuals receiving the intervention. Second, an impact evaluation will be conducted to determine the impact of the intervention strategies on participants and their nursing home usage. Ultimately, the goal is to systematically link the intervention strategies used with the outcomes of participants.

This goal can best be achieved with a well-developed and clearly articulated program theory; without a sound program theory, it is difficult to know why a program did or did not achieve its intended results (Rossi, Lipsey & Freeman, 2004), nor can the model be replicated and sustained. The existing literature suggests that a well articulated program theory is missing in most nursing home transition programs, adding significantly to the struggle to clearly identify what caused program outcomes (whether positive or negative). Evaluation of a program without an articulated program theory is known as black box evaluation (Rossi, Lipsey & Freeman, 2004). Evaluators are unable to adequately assess what caused specific outcomes or properly describe the nature of the program (Rossi, Lipsey & Freeman, 2004).

A program theory describes what the program is intended to do and the rationale used to develop its specific components in a clear and explicit manner that resonates with program stakeholders (Rossi, Lipsey & Freeman, 2004). Typically, a well-articulated program theory includes three key components. First, a program theory describes the intended outcome of the program/intervention; this is also known as the program impact theory (Rossi, Lipsey & Freeman, 2004). The intervention strategies used in the HB1 initiative are the operationalized means by which individuals are transitioned away from institutional care back to the community-the intended program outcome. The intervention strategies represent the essence of the entire program. It is vital that the assumptions that exist within the impact theory are valid and properly
operationalized or the program will fail to reach its intended goal(s). Second, a program theory articulates the program’s service utilization plan. The expectations and assumptions regarding target populations, service frequency and intensity, and appropriate exit strategies at the end of a program are the key components of a service utilization plan (Rossi, Lipsey & Freeman, 2004). This particular component of a program theory can help address the definitional issues regarding what constitutes a “transition” that exists within the HB1 initiative and that is described in existing literature - who is eligible, what combination of strategies should be used, and what criteria are used to determine a successful transition. Lastly, a program theory describes a program’s operational plan, including program resources, personnel, administration and general organization devoted to the intervention (Rossi, Lipsey & Freeman, 2004). This component addresses the infrastructure issues identified in existing literature in relation to nursing home transition programs; preliminary findings also indicate infrastructure as a major consideration within the HB1 initiative. In initial federal initiatives, states were provided with a temporary infrastructure to support nursing home transition efforts. Once the grants were over, many of the transition programs became unsustainable due to inadequate infrastructures. Organizations must have adequate resources, appropriate personnel, invested leadership, and supportive administrative practices for functional service delivery systems to successfully flourish (Rossi, Lipsey & Freeman, 2004). Otherwise, the program will falter and intended outcomes will not be realized. The service delivery system and the overall organization of a program are referred to as the program process. The basis of the program process, including the assumptions and expectations of the process, is known as the program process theory (Rossi, Lipsey & Freeman, 2004).

Program theory assumptions and expectations may be explicitly articulated or implicitly understood. The HB1 program theory appears to be implicit rather than explicit. The theory will must be extracted from stakeholder and key informant interviews, program documents and observations of program activities (Rossi, Lipsey & Freeman, 2004). Specifically, it is important to determine how the intervention strategies chosen for the HB1 initiative are intended to addresses the goal of transitioning individuals from institutional care to community-based care. This study used a complementary approach to articulating the HB1 initiative program theory, including the use of stakeholders and key informants along with existing literature regarding nursing home transition programs. When all of the information collected is synthesized and an explicit program theory for the HB1 initiative is articulated, it must be corroborated by stakeholders to ensure the description accurately reflects the intention of the program in a meaningful way (Rossi, Lipsey & Freeman, 2004). An appropriately articulated program theory can act as a blueprint for effective program management, implementation and evaluation. A well articulated program theory for the HB1 nursing home transition initiative may begin to close the gap in existing literature regarding what constitutes a successful transition program.
Chapter Two: Research Question and Methodology

Research Question(s)/Purpose

**Purpose:** The purpose of this research is to develop a grounded program theory that articulates explicit and underlying assumptions about how and why the program is intended to work. An effective program theory would guide program design and implementation, and can be used to develop a testable nursing home transition program model for Ohio (Rogers, Petrosino, Huebner, Hacsi, 2000). The framework is developed from an analysis of existing literature on nursing home transition strategies and outcomes, and process evaluation data related to the design and implementation of interventions based on the Ohio Department of Aging House Bill One initiative.

**Guiding Questions:**
1.) What is the program theory (i.e. what is the program intended to do and what is the rationale used to develop specific components of the program) that underlies the nursing home transition program in Ohio?
2.) How is the program theory operationalized? Are there any gaps between what is articulated and what is implemented, and if so, what are they?

**Sub-Questions-Eliciting Program Theory:**
1.) How do organizations make decisions about what intervention strategies to use in Ohio’s House Bill One nursing home transition programs?
2.) What are some indicators used in the decision-making process?
3.) What makes a strategy a “good” strategy?
4.) How are transition clients identified/defined?
5.) How are transition strategies operationalized?
6.) What does the existing literature say regarding what does and doesn’t work?
7.) What nursing home transition strategy themes and clusters can be identified in the current literature?
8.) What similarities/differences exist between existing literature and the data collected in the Ohio House Bill One nursing home transition initiative?

Methodology

**Research Design**

The topic under exploration is best addressed using qualitative research methods, specifically a constructivist grounded theory approach. The goal of a constructivist grounded theory study is to co-construct a theoretical framework regarding a social process with research participants (Chamaz, 2002; Chamaz, 2006). The theoretical framework is grounded in the data collected throughout the course of the study (Charmaz, 2002; Chamaz, 2006). It is an inductive approach that is regarded as the most systematic of all qualitative methods. Variables are identified and then linked to an integrated set of conceptual categories that are built into theoretical frameworks. At the same time, the guidelines for collecting and analyzing data are flexible, which is consistent with an emergent design (Charmaz, 2006).
An emergent design allows the data to lead the researchers to the most appropriate ongoing sampling strategy, the literature necessary to expand a sensitizing framework in a manner that helps build toward a theoretical framework, and simultaneous data collection and analysis (Charmaz, 2002; Charmaz, 2006). An emergent constructivist grounded theory research design for this study helped us explore nursing home transition programs in a comprehensive manner resulting in a grounded theoretical framework for an Ohio nursing home transition program model.

Provisions for Trustworthiness

The trustworthiness of the research was established by the various mechanisms that were built into the research design. First, several methods of data collection were employed utilizing multiple sources of information. This includes one-on-one interviews, group interviews (Group interviews), program document and other extant text reviews, and an exhaustive use of existing literature. Second, the data were collected and analyzed over a period of five months. This was done in a three-person team for data collection and a two-person team for data analysis minimizing the potential of researcher bias (Maykut & Morehouse, 1994). The data analysis was conducted using constant comparative methods so the data may be compared at each analytical level through established analytical distinctions (Charmaz, 2006). Finally, the data were compared to existing literature to identify similarities, differences and gaps needing further exploration.

Sampling

We built a purposive (i.e. deliberate and non-random) sample using maximum variation. This was the most appropriate sampling strategy due to the nature of the project. It was important to include representation from each of the organizations responsible for implementation of the HB1 initiative across the state of Ohio. In addition, it was important to include the various staff positions/levels of authority responsible for implementation of the HB1 initiative to ensure all perspectives of the initiative were adequately represented. The HB1 initiative is a mandate from the Ohio Legislature. Therefore, the professionals included as research participants were required to participate. First, telephone interviews were conducted with the Pre-Admission Screening System Providing Options and Resources Today (PASSPORT) Directors from each of the thirteen Area Agencies on Aging (AAA) in Ohio. PASSPORT is Ohio’s Medicaid Waiver program. This sampling strategy allowed us to understand the HB1 initiative from a statewide perspective including rural and urban areas, various socioeconomic status and level of care populations. It also helped us explore the HB1 initiative in diverse organizational settings. Next, a referral sampling method was used by asking the Directors to identify one Care Manager/Assessor and one Supervisor with direct oversight of the HB1 initiative to participate in the two group interviews. Again, each of the thirteen AAAs were represented during the group interviews.

Methods of Data Collection

Several methods of data collection were employed by a three-person team utilizing multiple sources of information to more fully understand the HB1 initiative in Ohio. This multi-faceted approach lent itself to establishing a greater degree of credibility for our research findings. As
previously mentioned, an emergent research design was utilized; ongoing analysis informed design decisions in the several stages of sampling and data gathering.

**Semi-Structured Telephone Interviews:** A telephone interview was conducted with each of the AAA thirteen PASSPORT Directors in Ohio. The interviews were used to collect the “big picture” perspective of the HB1 initiative, including a general description of how the intervention strategies are being implemented at each AAA. We attended the statewide PASSPORT Director’s meeting at the beginning of October 2010 in Columbus, Ohio to distribute letters to the directors regarding the interviews. These letters included the specific intervention strategies that each AAA indicated they would implement and a list of sample questions that were asked during the interview (please see appendix). The directors were informed that we anticipated each interview would take forty-five minutes. A sign-up sheet with possible dates and times was distributed. If the suggested dates and times did not fit the directors’ schedules, we contacted them to find a more convenient date/time for the interview. The interviews were conducted in October 2010. Detailed notes were taken during and after the interviews; the notes were the data for analysis. The notes included not only what was said but observations/reactions of the researcher(s).

**Semi-Structured Group Interviews:** Two group interviews were conducted on December 14, 2010. The first group interview collected data about transition strategies from care managers/assessors (direct line staff) and the second group interview collected data about transition strategies from supervisors responsible for direct oversight of the HB1 initiative. The rationale behind structuring the group interviews in this manner was to explore the perspectives of the various levels of management and decision-making authority involved in the implementation of the HB1 initiative. Interviewing the directors, care manager supervisors, and care managers separately helped to reduce issues of power differential, allowing participants to speak more freely about their perspectives. The group interviews were held at the Ohio Department of Aging, a central location for the various AAAs to travel. Initial contact regarding the group interview schedule was made in November 2010 and a follow-up e-mail finalizing the details of the group interviews was sent to participants and their leadership on December 3, 2010. Detailed notes were taken during and after the interviews by three different note takers. Field notes and transcriptions were used for data analysis.

**Document Review:** Program documents helped us gain an understanding of how the HB1 initiative is operationalized and implemented in the AAA’s. The documents reviewed included any policies/procedures created as a result of the initiative, forms used to record program activities, documents distributed to staff detailing the definition of a transition client and meeting minutes regarding the initiative. Document inquiries were made during each telephone interview with the PASSPORT directors. We also reviewed the documentation created/provided by ODA staff regarding the intervention strategy development/selection. Document review was an ongoing data collection and analysis task.
Confidentiality

All field notes and transcriptions were de-identified however; the type of staff position was recorded such as Director, Care Manager Supervisor, and Care Manager. All contact information for research participants will be destroyed once interviews and final reports are completed. In addition, discussions regarding data collection and data analysis only occurred between members of the research team.

Data Analysis

The transcripts and field notes collected during interviews and document reviews were sorted and organized into units of meaning by AAA. Basically, patterns identified within the data, including the existing literature, were placed into categories. The categories were then synthesized and conceptualized to establish any links between the categories in an effort to identify overarching themes that emerged from the data and existing literature (Maykut & Morehouse, 1994). Once the themes were identified the information was compiled into word tables. This organizational approach allowed the data to be analyzed and reported collectively or by AAA depending on how ODA requests the data. The data analysis was conducted using constant comparative methods so the data could be compared at each analytical level through established analytical distinctions (Charmaz, 2006). This method helps identify themes and patterns in qualitative data without the use of mathematical operations. The data were also compared to existing literature through an analytical literature review to identify similarities, differences and gaps needing further exploration. The themes and patterns were identified within the AAAs and/or across the various AAAs, building toward an overarching theoretical framework for the HB1 initiative.
Chapter Three: Results/Findings

Results/Findings

Results from the exploratory study to identify and articulate the Ohio HB1’s initiative’s program theory are presented in this section and outlined in Figure 1. The program theory is represented in a three part framework: infrastructure, operational activities, and outcomes. This framework provides a helpful guide outlining what the HB1 program is intended to do and the rationale used to develop specific intervention strategies. The framework emerged from concrete, simultaneously collected and analyzed data using grounded theory strategies including individual and group interviews, document review, program observations, and constant comparative methods. This approach allowed the theoretical relationship between the implicit and explicit assumptions of the HB1 initiative to emerge, be identified, organized, and ultimately articulated. In addition, the framework integrates findings from existing literature to explain and support the rationale used in the HB1 initiative as well as bridging gaps identified in program development efforts such as post transition follow-up care.

Infrastructure development represents the foundation of this framework. Significant consideration and planning is required in each of the areas included in this component of the framework to overcome the barriers discussed in Table 1 in Chapter One. Addressing infrastructure needs and barriers allows programs/organizations to development functional intervention strategies capable of producing intended outcomes. The operational strategies are the actual interventions received by the consumer and their family and they are tied directly to the proximal, intermediate and distal program outcomes. Impact and process outcome measures can be developed within and across each component of the framework to ensure that the program is operating as intended and that outcomes achieved can be attributed to the program intervention.

Figure 1: Ohio Nursing Home Transition Program Theoretical Framework

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<tr>
<th>Infrastructure Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS Structure</td>
</tr>
<tr>
<td>• Housing</td>
</tr>
<tr>
<td>Definition of Target Population</td>
</tr>
<tr>
<td>Partnerships and Collaborations</td>
</tr>
<tr>
<td>• Housing</td>
</tr>
<tr>
<td>Organizational Structure and Culture</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operational Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach/Education</td>
</tr>
<tr>
<td>Consumer Choice Facilitation</td>
</tr>
<tr>
<td>Comprehensive Needs Assessment</td>
</tr>
<tr>
<td>Intensive Case Management</td>
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<tr>
<td>Natural Supports Activation</td>
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<tr>
<td>Post Transition Follow-Up</td>
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<tr>
<th>Outcomes</th>
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<tr>
<td>Consumer Transitions from Institution to the Community</td>
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<td>Consumer Avoids Re-institutionalization and Remains in the Community</td>
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<tr>
<td>Cost Savings in Medicaid Budget</td>
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Infrastructure Development:

Infrastructure refers to the macro-system level and mezzo-organizational level needs and barriers that must be considered and addressed by nursing home transition initiatives.

Structure of HCBS Waiver Program(s): The limited capacity of Medicaid HCBS Waiver programs must be factored into program development efforts. For example, in Ohio and several other states, the HCBS waiver does not pay for 24/7 care (Kasper & O’Malley, 2006). Individuals who require 24/7 care would not be appropriate candidates for the HB1 initiative unless they had natural supports and caregivers actively engaged and willing to provide care the HCBS waiver is unable to provide. There are additional limits in terms of per-person spending, eligibility and/or hours of care that must also be considered. Several Ohio PASSPORT Directors discussed the ability to approve client service plans that exceed the per-person cost cap, “We re-emphasize with care managers the ability to waive people over the cost cap up to 100% of their nursing facility costs (Supervisor).” Although this strategy existed prior to the HB1 initiative, it has received a great deal of emphasis as a result of the HB1 initiative, “We remind staff that increasing the care plan and going above the cost cap is always a way to go. It’s a way to keep them from going into facilities in the first place (Director).” However, it appears this strategy only benefits diversion clients before they are admitted to institutional care. ODA rules prohibit exceeding the cost cap for institutionalized clients transitioning back to the community. This is viewed as a major barrier:

“You have people who are used to 24/7 level of care. They often need to be frontloaded with services to get them back in the community, but the ODA rules prevent us from going above cost cap to get them out of nursing facilities. They have to be transferred to case management before an above cost cap care plan can be approved (Care Manager/Assessor).”

This barrier once again highlights the importance of caregivers and natural supports to provide necessary care not covered by the waiver program.

Eligibility for waiver services is another major consideration when developing transition programs. Income eligibility criteria are more restrictive and individuals are allowed to retain fewer assets when applying for HCBS waiver programs (Kasper & O’Malley, 2006; Nishita, Wilber, Matsumoto & Schnelle, 2008; Shirk, 2007; Wenzlow & Lipson. 2009). It is clear the Medicaid asset liquidation requirements were designed with a bias toward institutional care. A Louisiana Medicaid official illustrates this point: “You have to have a waiver to live in the community, but you can go right into a nursing home” (Kasper & O’Malley, 2006 p.12). The requirement for individuals to sell their home after a year of institutionalization unless a spouse is occupying the residence is in clear conflict with the objective of returning to the community, as it has the potential to prevent the retention of community housing (Kasper & O’Malley, 2006; Shirk, 2007; Wenzlow & Lipson. 2009). Asset liquidation and “estate recovery” were identified as major barriers by several care managers:

“Estate recovery scares a lot of people who think they are going to lose their homes (Supervisor).” “They associate state recovery with PASSPORT instead of Medicaid. They don’t realize they are subject to state recovery being in the nursing home anyway….it is not just for Waiver programs (Care Manager/Assessor).”
Care managers emphasized the need for “education” regarding asset liquidation requirements so that individuals are making informed choices and understand all of their options and their consequences.

Although securing housing is an operational activity in nursing home transition programs, it is also a significant infrastructure issue when the rules, regulations and policies that govern the housing system are considered. Community housing options may be limited due to long waiting lists (some longer than a year) for low-income subsidized housing. Individuals requiring home modifications or specialized housing due to disabilities may face additional constraints, and high costs of room and board for non-subsidized housing may be cost prohibitive for Medicaid clients (Kasper & O’Malley, 2006; Nishita, Wilber, Matsumoto & Schnelle, 2008; Shirk, 2007; Wenzlow & Lipson, 2009). Care managers are often limited in their ability to assist with housing, particularly in Ohio, “We refer people to Section 8 housing, but they have to actually do the process themselves” (Kasper & O’Malley, 2006 p.18). Other housing regulations and limitations present barriers for transition efforts as discussed by care managers:

“When we go into the nursing home setting, quite a few folks who want out have mental illness or criminal records. Because of criminal records we can’t get them into subsidized housing (Care Manager/Assessor).” “Getting adequate housing for folks under 60 with criminal backgrounds or mental health issues is impossible. There is no place for them [consumers] to go (Supervisor).” “Prisons dump people into nursing homes and we are called for level of care. When we go out we have to figure out what to do with them...we have two full nursing homes for sex offenders with no place to transition them to (Care Manager/Assessor).”

There are also barriers associated with using Medicaid funds for housing expenses. CMS began to address this in 2002 when they issued a policy clarification indicating that Medicaid could pay for certain one-time expenses including security deposits and essential household furnishings (Kasper & O’Malley, 2006). In Ohio, clients may be eligible for up to $2,000 under MFP, but this may not cover all transition expenses.

“A person may have $2,000 to help but may owe $1,400 in past utility bills that has to be paid before the utilities will be connected, on top of first month’s rent, deposits, groceries, a couch, etc. (Care Manager/Assessor).”

The only way an individual can leave an institution and transition back to a community-setting is if he or she has a safe and appropriate physical environment. This makes housing a central feature of transition programs requiring careful consideration when designing such programs. According to participants, it is a critical central issue in the Ohio HB1 initiative.

Unfortunately, the sense of security that nursing home residents may feel regarding the level of care they receive in an institutional setting is not guaranteed when transitioning back to the community. They may be faced with a number of uncertainties regarding the level of services they are eligible for in the Medicaid waiver program. They are also faced with the challenge of having to re-establish and maintain eligibility (Kasper & O’Malley, 2006; Nishita, Wilber, Matsumoto & Schnelle, 2008; Shirk, 2007; Wenzlow & Lipson. 2009). Medicaid rules state a care plan defining the level and number of HCBS hours a client is eligible for cannot be
determined until a client is evaluated/assessed. Care managers must bridge the gap between the assessment process and the delivery of the first service when individuals return to the community even when eligibility is assured. This gap could be days, weeks or even months if there is a waiting list for HCBS-raising a number of client safety concerns (Kasper & O’Malley, 2006; Nishita, Wilber, Matsumoto & Schnelle, 2008; Shirk, 2007; Wenzlow & Lipson. 2009). Ohio was faced with this barrier until March 2010 when the governor eliminated the PASSPORT waiting list and opened enrollment. PASSPORT program supervisors identified this as pivotal to the success of the HB1 initiative:

“It is challenging to transition or divert people from nursing facilities when they can get services immediately in the facility and have to wait one to three months to get services in the community (Director).”

It is clear that the availability of system level resources is an important consideration for organizations when establishing goals for transition initiatives.

Other eligibility issues are related to the fit between care needs and services offered in the HCBS Waiver. A number of HCBS programs are designed to provide assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). They are not designed to provide assistance with cognitive or mental impairment. Therefore, it is difficult to establish eligibility for individuals who need less assistance with ADLs or IADLs and need significant assistance with supervision or cuing due to cognitive impairment (Kasper & O’Malley, 2006). For example, in Ohio, “An individual sixty or older with schizophrenia and diabetes residing in a nursing home could meet the criteria for unstable medical conditions, but not for serious disabilities and as a result could not qualify for the waiver program that offered the most extensive range of services including skilled care for diabetes management” (Kasper & O’Malley, 2006, p. 22). Additionally, the mental health system may view the individual as a low service priority because his care is being managed by the nursing facility (Kasper & O’Malley, 2006). Eligibility criteria within existing HBCS waiver programs are crucial issues to consider when defining the target population for transition initiatives.

**Definition of Target Population:** The Ohio HB1 initiative saw tremendous difficulty in the beginning of implementation due to an unclear definition of the program’s target population. As a result, the first month of data reported was markedly skewed because some organizations were counting every client they came into contact with as a transition or diversion. They were operating under the assumption that every waiver client was, by definition, eligible for either the nursing home diversion or transition program. Ultimately, the state unit on aging issued clarification regarding target population definitions at the end of March 2010:

“Transition is the process of assisting an individual who is a resident of a nursing facility, regardless of the length of residency, to have long term care services and supports delivered in a community setting of the individual’s choice through the use of one or more designated transition interventions. Currently enrolled waiver consumers who experiencing a temporary nursing facility placement are NOT included in this category.”
When PASSPORT directors were asked to comment on the definition issue they unanimously agreed that the original definitions were confusing and impacted the initial implementation of the HB1 initiative.

“When clarification came out from ODA, we had to sit back down with folks and retrain them: both assessors and case managers. It was unfortunate the way it got going because people were really confused. Once the clarification piece came out and staff were retrained it was sort of this aha moment (Director).” “There was a lot of confusion early on. We were very hazy on the definition so we counted everyone...because we didn’t understand it; but we have a better handle on it now since the clarification was provided by ODA (Director).”

I identify the definitional issue as an infrastructure issue because a clearly defined target population is the foundation for nursing home transition programs, particularly when seeking to measure outcomes and impacts of intervention strategies. A program’s target population can either reflect an agency’s existing infrastructure, or it can serve as a catalyst for the development and change within an agency’s infrastructure.

Unfortunately, the HB1 initiative definition of the transition program’s target population is still vague and subjective even after the clarification provided by ODA. For example, nursing home lengths of stay are not clearly defined and seem to conflict. This represents the same evaluation challenges experienced by previous transition programs. Drawing from existing literature (Kasper & O’Malley, 2006; Nishita, Wilber, Matsumoto & Schnelle, 2008; Shirk, 2007; Wenzlow & Lipson, 2009; James, Wiley, & Fries, 2007), individual and group interviews, the HB1 definition would greatly benefit from more clearly defined parameters including:

- Defined population (i.e. 18+ with a disability, 60+, etc.)
- Individual’s medical/service needs can be met in the community
- A safe and appropriate physical environment can be provided
- The individual doesn’t require 24/7 professional care
- Adequate natural supports are available
- Individual was institutionalized for a minimum of six months to be enrolled in the transition program.

**Partnerships and Collaborations:** Partnerships and collaborations with nursing facilities, hospitals, community providers and stakeholders, and the Ombudsman program have been identified by individuals implementing the HB1 initiative as cornerstones of a successful nursing home transition program. Partnerships and collaborations can result in referral sources, a network of service providers, and the minimization or elimination of potential barriers. PASSPORT directors, supervisors and care managers could not overemphasize the importance of collaborating with local nursing facilities and hospitals. Several reported having great success in this area while several others reported being met with great resistance.

“Ohio has a powerful nursing home lobby and facilities are concerned this program will reduce occupancy levels (Supervisor).” “Several of the discharge plannlers 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 (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. Type of war is still there, it’s always going to be there until we right side the nursing home industry in Ohio (Supervisor).”

The concern expressed by the nursing home industry in Ohio regarding transition programs may be the result of a 2004 letter sent by CMS to state Medicaid directors. The letter encouraged states to reduce nursing home beds as part of their LTC system rebalancing efforts. In response to the letter, the Ohio Medicaid director said, “We don’t see closing nursing home beds” (Kasper & O’Malley, 2006, p.10), nor was closing nursing home beds and reducing institutional care capacity included in the HB1 initiative.

Organizations reporting successful collaborations with hospitals and nursing homes also acknowledged the barriers they had to overcome to be successful:

“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 (Director).” “….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 (Director).”

Nursing homes represent a quick and safe discharge for hospital social workers (Kasper & O’Malley, 2006). HCBS may take longer to coordinate because providers and resources may not be as readily available as institutional beds. Many of the organizations reported that the strategy of developing partnerships and collaborations with hospitals and nursing facilities holds the most promise for the future success of their transition program. It was clear from the individual and group interviews that some agencies were very successful in this area and some were experiencing terrific challenges. When asked what they felt was the best strategy/approach to use when trying to establish or maintain a partnership/collaboration with hospitals and nursing homes, the consistent response was having dedicated staff present in the facilities.

“It’s important the facilities see the same people so relationships can be developed and they know who to call (Care Manager/Assessor).” “We have found that having full time staff members at the hospital and some other part time staff members dedicated to nursing facilities works best. It takes time to build relationships…need consistency (Supervisor).”

When there is dedicated staff either assigned or co-located at specific facilities/hospitals they are able to identify individuals at the soonest point possible for intervention. Staff can follow consumers from the hospital to nursing facilities or identify them as soon as they arrive at the nursing facility, emphasizing a short stay rather than a long term placement. They are able to educate and remind consumers and their families about their options and that “The nursing home doesn’t have to be the end all (Care Manager/Assessor).”

There were other important partnerships and collaborations identified that included ombudsman programs, housing authorities, and the mental health system. The Ombudsman program was identified as an excellent source of referrals for the HB1 initiative. “They [Ombudsman] know and see us as a resource in helping folks transition back into the community
The Ombudsman program has a constant presence in nursing facilities monitoring and advocating for patient’s LTC rights as required by the Older American’s Act (Holt, Jones, Petty, Roth & Christensen, 2006). They know the staff in the facility, the consumers, and their families. The Ombudsman staff and volunteers were identified as excellent gatekeepers as well as referral sources. “Ombudsmen are great to work with, we get cases from them for transition. They help us get into the facilities (Director).” Organizations where the Ombudsman program is an in house program reported better partnerships and working relationships than organizations where the Ombudsman program is an external entity. In general, the HB1 initiative was credited for providing the organizations with the opportunity to have a renewed focus/attention on the importance of their relationships with the Ombudsman program.

As previously discussed, housing and consumers with mental health issues were identified as overwhelming barriers for the HB1 initiative. A number of case managers discussed the limited resources that exist for individuals that have been institutionalized for long periods of time and for individuals with mental health issues. A case manager discussed the lack of supportive housing for this population as a major barrier stating, “If I had the money I would build an assisted living facility for people with mental illness because that is what we really need.” As noted in the literature, the success of an individual with co-occurring mental health issues to remain in the community and out of a nursing facility is often determined by the availability of group residential options (Kasper & O’Malley, 2006; Wenzlow & Lipson, 2009). Some of the organizations were working on housing vouchers for the clients they serve, some organizations reported forming work groups addressing housing and mental health needs, and some reported joining or being part of coalitions that included representatives from the housing and mental health system.

Organizational Structure and Culture: The HB1 initiative’s focus on nursing home transition represented a significant paradigm shift for many of the organizations and staff members.

“This has required a definite mindset change. We have a lot of employees that have been there a long time and it’s hard to shake them up (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 ball game (Supervisor).” “It’s all about changing our mindset. It frustrations me because it’s so easy to get wrapped up in, This is how we do things (Supervisor).”

Organizations developed and implemented new policies and procedures regarding the HB1 initiative to help staff learn and understand their new role. “Keep policies very simple and unintimidating to encourage people to follow the new ideas and new way (Supervisor).” This was viewed as important step in keeping everyone “on the same page”. It was also viewed as an important measure that helped embed the HB1 initiative’s philosophies and principles throughout their organizations. PASSPORT directors and supervisors also reported the need to re-purpose staff, create new positions or conduct some organizational restructuring in response to the HB1 initiative. In some cases the initiative supported changes in the organization that were already in process and in other cases the initiative motivated the changes.
Operational Strategies:

Operational strategies refer to the actual services and intervention strategies delivered to consumers and their families.

Outreach and Education: Outreach and education is identified as an essential component of the HB1 initiative and includes client identification, options counseling, and resource and referral development. Although dedicated/co-located staff and partnerships with Ombudsman programs were identified as effective strategies in client identification and outreach, the use of existing information was also discussed as an effective strategy. In both the individual and group interviews, participants discussed using data from the Pre-Admission Review (PAR) database to identify clients that could potentially be enrolled in the transition program. The PAR database flags individuals in nursing facilities that were on Medicare or private pay who switched to Medicaid. In fact, a number of the organization either re-purposed staff or hired new staff specifically dedicated to monitoring the PAR system and generating referrals for transition program assessments. Participants also discussed the importance of targeting doctors, nurses, social workers and discharge planners at both the hospitals and nursing facilities for outreach and education activities.

“It is surprising how many people [including professionals] don’t know about PASSPORT or the AAA’s. We need to do a better job letting the community know who we are and what we can do (Care Manager/Assessor).” “We are finding that a lot of consumers and their families don’t know they have options, or what their options may be (Care Manager/Assessor).”

The overall lack of consumer awareness regarding HCBS actually incentivizes institutionalization (Shirk, 2007) and as the literature demonstrates it is a common issue experienced by other transition programs. Educating consumers and their families regarding the HCBS options available to them through the Waiver program, educating providers and professionals regarding the range of community-based resources and support available through the AAA’s, and educating staff regarding the HB1 initiative’s paradigm were reported as important implementation strategies in the HB1 initiative.

Consumer Choice: Consumers’ desire to be home/in the community as opposed to an institution is well documented in the literature and the primary reason cited for enrollment in the HB1 transition program (Kasper & O’Malley, 2006; Nishita, Wilber, Matsumoto & Schnelle, 2008; Shirk, 2007; Wenzlow & Lipson. 2009; James, Wiley, & Fries, 2007; Holt, Jones, Petty, Roth & Christensen, 2006; Green et al., 2005). The motivation of consumers and their families to return to the community is viewed as a key factor determining who is able to successfully return to the community (Kasper & O’Malley, 2006).

“People are happier at home. It is where they want to be (Care Manager/Assessor).” “It is all about choices and the least restrictive environment possible (Supervisor).”

The concept of “choices” and an individual’s ability to exercise self-determination are guiding principles in the HB1 initiative. The program allows consumers and their family to make choices regarding their LTC from various options that are not made available or encouraged in
institutional settings. For example, consumers are able to make decisions about daily activities, services and supports, personal grooming and meal times (Holt, Jones, Petty, Roth & Christensen, 2006). The ability to make choices and exercise self-determination also has implications for an individual’s quality of life. In a study conducted on the New Jersey nursing home transition program, New Jersey Senior Initiatives Community Choice Counseling Program, individuals who were transitioned back to the community reported an enhanced quality of life (i.e. the ability to do things that make life more enjoyable) when compared to their institutionalized counterparts (Howell-White, 2003). Individuals indicated that the ability to make choices and engage in activities they were unable to engage in while in the nursing home due to the restrictiveness of the facility were key components of their enhanced quality of life (Howell-White, 2003).

Group interview participants were given the opportunity to make a final statement about the HB1 initiative and a participant responded [with agreement from other participants], “It’s really about the quality of life of the consumer, meeting the least restrictive environment (Supervisor).” Again, this highlights the significance of the quality of life issue.

The literature discusses the importance of supporting consumers and their families in the process of re-establishing choice. Safety and protection are paramount in institutional settings and individuals are taking a number of “risks” by transitioning back to the community (Holt, Jones, Petty, Roth & Christensen, 2006; Nishita, Wilber, Matsumoto & Schnelle, 2008). As previously mentioned, eligibility for HCBS must be re-established, there may be a delay in the start of services and there is no longer the availability of 24/7 care. This is particularly important for long-stay residents who may have developed an unquestioning acceptance of institutional life (Nishita, Wilber, Matsumoto & Schnelle, 2008).

The education strategies employed in the HB1 initiative coupled with the person-centered assessment and case management processes discussed later promote and support the concept of consumer choice. Consumers and their families are informed of their rights, educated regarding all of their options, and encouraged to assert themselves throughout the transition process (Poole et al., 2006).

**Comprehensive Needs Assessment:** Prior to the HB1 initiative PASSPORT needs assessments were conducted after the individual returned to the community, but assessments are now also taking place in nursing facilities. A number of participants identified this as a “new practice” for their agency requiring new policies, procedures and staff training/education.

“From an assessor’s point of view, the first two weeks are the most vulnerable. [so we] need to plan right away.” “The biggest bang for our buck is case managers actually going ahead and making visits in the nursing home. Making those visits is what it is going to take to get the person back home (Supervisor).” “Gives us a lot more presence in the nursing home and with the client and family make sure emphasizing the goal is to get them back home (Director).”

The assessment process allows staff to get to know a consumer’s strengths, abilities, needs and wishes. It also allows staff to identify potential roadblocks for the transition process such as; mental health issues, criminal records, and a loss of natural supports. As a PASSPORT director noted, “Literature shows once people are in a facility for three plus months, all social and community supports start to trickle away so it becomes more and more difficult to transition back to the community.” Participants reported that they frequently engaged natural supports identified by the consumer as well as professionals in the assessment process including family,
friends and providers. Participants also reported that they ensure the consumer’s voice and choice was properly represented. “We are focused on person-centered care. We make sure we advocate for what the consumer wants (Care Manager/Assessor).” It appears staff in the HB1 initiative approach the needs assessment process as a tool to identify areas of need and support that need to be built up, such as natural supports, so people can transition back to the community, not as an exclusionary tool used to weed out enrollment. Another example of how the assessment is used as a tool to build supports/resources is in the area of housing. Staff must first identify housing resources for transition consumers and then conduct an environmental assessment to ensure the space is appropriate, accessible, and safe and can meet the needs of the consumer. This often results in two separate assessments, “The problem with the assessment in the nursing facility is we need to see the consumer in their home environment...so it requires two visits (Director).” The environmental assessments often identify the need for various home modifications such as, ramps, shower/toilet rails, widening of doorways etc. Unfortunately, according to the HCBS waiver rules, PASSPORT dollars can’t be authorized to pay for such modifications until the client is discharged from the nursing facility. A number of group interview participants identified this as a significant barrier they have learned to “work around” in order to get people home safely. Additional components of the needs assessment included, medical/health services needs, transportation, HCBS (i.e. personal assistance, durable medical equipment (DME), financial resources, and client demographic information- this is not a comprehensive listing of all areas covered. The needs assessment is the foundation in the development of the transition/service plan.

**Intensive Case/Care Management:** The complexities of the HCBS waiver program, housing authority, and other systems of care have been identified as significant limitations for consumers and their families requiring the assistance of a case/care manager to help them navigate their options (Kasper & O’Malley, 2006). In fact, nearly every nursing home transition program discussed in the literature includes some form of case management services (Kasper & O’Malley, 2006; Nishita, Wilber, Matsumoto & Schnelle, 2008; Shirk, 2007; Wenzlow & Lipson. 2009; James, Wiley, & Fries, 2007; Holt, Jones, Petty, Roth & Christensen, 2006; Bahr, Kuchibhatla, Maragath, 2006; Newcomer, Taewoon, & Graham, 2006; [http://www.cms.hhs.gov](http://www.cms.hhs.gov)). For the purposes of this study, the term “intensive case/care management” refers to the multiple needs and complexities requiring assistance for transition consumers. The literature suggests that intensive case/care management services for transition clients should last between 90 and 120 days in an effort to minimize the creation of additional dependencies on artificial supports by the consumer and their families (James, Wiley, & Fries, 2007; Holt, Jones, Petty, Roth & Christensen, 2006; Bahr, Kuchibhatla, Maragath, 2006; Newcomer, Taewoon, & Graham, 2006).

Case/care management is a central strategy within the HB1 initiative however; specific parameters defining the length of service were not defined. There are AAA’s that developed intensive case management teams for transition consumers that transfer the transition case to a PASSPORT care manager once the client is “stable” in the community. There are AAA’s that have assessors complete the assessments for transition consumers then transfer the case to a case/care manager once the assessment is complete and services are in place. Finally, there are AAA’s that have such limited staff that the case/care managers are responsible for the entire process and consumers remain on their caseload as long as they are receiving PASSPORT services. The only AAA’s that had defined timeframes for case/care management services were
those implementing evidence-based transition programs such as the Coleman Model. It is important to note these are hospital transition programs used as nursing home diversion measures as opposed to nursing home transition. Regardless of how case/care management services are approached in the HB1 initiative, the case/care managers are responsible for executing the transition/service plan developed as a result of the needs assessment. This is done in partnership with the consumer and their family. As previously mentioned, a number of the AAA’s incorporated a person-centered model in their care/case management services. Consumers are encouraged to take a “leading” role in their care planning and to regain control of their own lives.

Individual and group interview participants identified large caseloads, sometimes between 69-75 individuals, and/or 20-50 facilities across multiple counties, and a lack of adequate staff to address the significant needs of transition clients as major challenges within the HB1 initiative. “You can only pull our staff in so many different directions and still be successful (Supervisor).” Intensive case/care management requires a great deal of time and attention from staff as clients and families members need a tremendous amount of education and support throughout the process. In addition, case/care managers are often navigating multiple systems on one case.

“On any given day you may have to talk to a provider about a ramp, doctors about medications, while trying to find a place for this person to live….when you are done talking to all of those people you have to go back and explain it all to the consumer (Case Manager/Assessor).”

The literature suggests the use of multi-disciplinary planning teams as a promising strategy for case/care management teams due to the complex nature of nursing home transition cases (Holt, Jones, Petty, Roth & Christensen, 2006). For example, the inclusion of natural supports, housing professionals, a nurse/medical professional, mental health professional (if needed) etc. in the transition planning process to help alleviate some of the barriers already discussed (Holt, Jones, Petty, Roth & Christensen, 2006). Although some care/case managers indicated “this is just what we do”, there is no indication the strategy of using multi-disciplinary teams was formalized as part of the HB1 initiative. Again, the only exceptions are the AAA’s that are implementing formal evidence-based transition models. In those cases, individuals discussed having two person Transition Specialist teams comprised of nurses and social workers. However, at the time of the interview/group interview the teams were not fully formed as the organization was experiencing challenges in hiring nurses for the transition teams.

Natural Supports: The literature cannot over-emphasize the importance of natural supports enough, particularly caregivers, in relation to successfully transitioning an individual back to the community and avoiding re-institutionalization (Holt, Jones, Petty, Roth & Christensen, 2006; Bahr, Kuchibhatla, Maragath, 2006; Newcomer, Taewoon, & Graham, 2006). Formal services alone are not enough to bridge service gaps, guard against potential isolation, or assist with community integration efforts. The literature also speaks to the importance of identifying and activating natural supports early in the transition process these can include family, friends, neighbors, and church members (Holt, Jones, Petty, Roth & Christensen, 2006; Bahr, Kuchibhatla, Maragath, 2006; Newcomer, Taewoon, & Graham, 2006). Basically, anyone the consumer identifies as a potential resource for support once they return to the community.
The HB1 initiative includes one strategy specifically targeting caregivers for the purposes post-discharge support to avoid re-admission to a nursing facility once the consumer is transitioned back to the community, “Caregiver education/training (post discharge to prevent re-institutionalization).” Although there were very few AAA’s that specifically detailed the activities associated with this strategy, nearly every “successful” transition story shared during the group interviews involved the activation of natural supports and/or caregivers in some way. The range of natural supports/caregivers involvement included but was not limited to initiating transition efforts, participating in the needs assessment/transition care plan process, providing care, housing and support for the consumer so they could return to the community. The participants that did speak directly to the above mentioned strategy discussed the challenges they encounter with nursing facilities regarding caregiver education:

“Education and training before they go home doesn’t take place in the nursing facilities, which becomes a barrier when they go home. Nursing homes need to teach family members how to take care of the consumer so they don’t end up back in the facility (Case Manager/Assessor).”

“Nursing homes are not providing education to consumers and their family to go home….places think, will work on educating the day they’re going home…can’t do that to get them home safely and get their needs met (Case Manager/Assessor).”

Although nursing facilities are required to include PASSPORT case/care managers in the discharge planning process due to a 2006 change in Medicaid rules, participants indicated this doesn’t happen.

“If you don’t call to get a discharge planning meeting, they just call you to let you know they are leaving today.” Everybody waits until the last minute (Care Manager/Assessor).”

The literature identifies the strategy to educate doctors, other health care professionals, and providers regarding home and community-based LTC options/alternatives as an effort to activate caregiver/natural supports (Bahr, Kuchibhatla, Maragath, 2006; Ryan & Scullion, 2000). There are both quantitative and qualitative studies showing that a caregiver’s decision to place and/or leave a loved one in a nursing facility is heavily influenced by doctors or other healthcare professionals (Bahr, Kuchibhatla, Maragath, 2006; Ryan & Scullion, 2000). It appears the HB1 initiative both directly and indirectly engages in caregiver/natural support activation efforts. However, they are not always explicitly discussed. The tasks associated with caregiver/natural support involvement, training and education are implicit within the HB1 initiative and appear to fall into the category of, “This is just what we do.”

Post-Transition Follow-Up: Post-transition follow-up is a transition program strategy explicitly discussed in the literature, but not clearly defined within the HB1 initiative. This appears to be another implicitly understood function of the organizations within the HB1 initiative. This may be due in part to the structure of the PASSPORT program-every consumer who is enrolled in the PASSPORT program is assigned a case/care manager. The consumer receives care/case management services as long as they receive PASSPORT services including, periodic program eligibility assessments and service plan updates. It is unclear within the HB1 initiative when a consumer stops being a “nursing home transition” client and becomes a “nursing home diversion”. It is easier to identify this change in status in organizations where there is a clear
division of labor between transition and diversion efforts, but much more ambiguous in the organizations where staff is responsible for executing both functions.

The literature indicates post-transition follow-up is a major factor in consumer stabilization and permanency within a community setting. There are several proposed post-transition strategies including, case/care management services for 90 days post transition, evaluation of the transition/service plan to ensure proper implementation, on-going caregiver/natural support education, training, and emotional support for the enrolled transition program consumer (Holt, Jones, Petty, Roth & Christensen, 2006; Bahr, Kuchibhatla, Maragath, 2006; Newcomer, Taewoon, & Graham, 2006). It is suggested the consumer receive frequent contact and/or visits in the first few weeks after their transition back to the community. The frequency of contact and/or visits should be gradually decreased over time depending on the level of support required by the individual (Holt, Jones, Petty, Roth & Christensen, 2006). Although transition program consumers are clearly receive the services described above, the HB1 initiative would benefit from more clear and explicitly defined post-transition strategies.

**Outcomes:**

Outcomes refer to the specific state of the consumer and/or social condition the program is intended to change (Rossi, Lipsey & Freeman, 2004).

The HB1 initiative is designed to achieve three major types of outcomes: proximal, intermediate, and distal. The initial program outcome the HB1 initiative is designed to achieve is to transition identified consumers from institutional settings back to a community setting. The first step in this process is the identification of a transition program target population. There are a number of infrastructure resource and development issues that need to be consider throughout this process including; the capacity of the HCBS waiver program, capacity of the organization, and the capacity and role of partnerships/collaborations. Clients then have to be identified and agree to participate in the program. Once consent is achieved multiple operational strategies are employed including, conducting a comprehensive needs assessment, intensive case management services, and the activation of natural supports.

Once the proximal outcome is reached, the intermediate outcome is to have the consumer remain in the community and avoid re-institutionalization. The strategies used in the HB1 initiative to achieve this outcome are not as explicitly defined as the strategies used to achieve the initial outcome. The activation of caregivers/natural supports, the successful implementation of the transition/service plan, and post-transition follow-up are strategies that are clearly designed to maintain the consumer in a community setting. The HB1 initiative also has a number of nursing home diversion strategies that could be employed once a consumer is transitioned back to the community including, going over the service plan cost cap, evidence-based hospital diversion models, on-going care/case management and on-going caregiver support. Although I do not specifically discuss the nursing home diversion arm of the HB1 initiative, it is important to note that nursing home diversion is the basic service delivery model/philosophy of the organizations implementing the HB1 initiative, “This is what we do.” Although strategies regarding the avoidance of re-institutionalization are not as explicit within the transition paradigm they are implicitly understood and extremely explicit in the diversion paradigm.
Finally, the overall intended outcome of the HB1 initiative is to achieve a cost savings in Ohio’s Medicaid budget. However, this distal outcome cannot be determined within the HB1 initiative at this time. It is an outcome requiring a cost-benefit analysis of a well established program. The HB1 initiative is a start-up project in the infancy of development and implementation. It is also important to acknowledge that there are several factors contributing to the high levels of Medicaid spending on nursing home care. Nursing home transition programs are just one strategy to help reduce this spending (Kasper & O’Malley, 2006).
Chapter Four: Discussion

Discussion/Implications/Conclusions

The importance of a well-articulated program theory cannot be overemphasized. It is the foundation of an effective program. Equally importantly, it is the key to a successful evaluation of a program’s processes and the impact the program is attempting to make on an individual or social condition. Programs designed predominantly on implicit assumptions are impossible to evaluate, and create replication barriers as a result of the limited empirical data such programs are capable of producing (Hendricks, Applebaum, & Kunkel, 2010). An explicit theoretical framework guides the development of process and impact measures, identifies the interconnectedness of program structure and implementation and ties program action to intended outcomes. A clearly defined, well articulated, and explicitly understood program theory is the only way program results can be accurately interpreted because without it there is no way to explain how or why a program did or did not work (Hendricks, Applebaum, & Kunkel, 2010).

This study explored the explicit and implicit assumptions underlying Ohio’s HB1 nursing home transition program. A critical analysis of existing literature in tandem with semi-structured individual and group interviews, document reviews, and observations enabled the development of a clearly articulated three part theoretical framework for the HB1 nursing home transition program. The framework includes a discussion about infrastructure development, operational strategies, and intended program outcomes. The presence of barriers emerged as a key element of the theoretical framework as barriers were used as one mean of program theory articulation. This unique method demonstrates what could have worked, should have worked, but didn’t work because of the barriers; in contrast to what did work, how is worked and why it worked.

The structure of HCBS waiver programs was identified as a primary consideration of nursing home transition programs. Ultimately, the goal of nursing home transition programs is to reduce the Medicaid LTC expenditures, and waiver programs are key strategies in this effort. It is this fact that makes waiver programs so central to the discussion. Nursing home transition programs must be extremely aware of their waiver program’s rules and regulations during program development and implementation to avoid potential barriers and maximize potential successes. There is a great deal of variation in eligibility requirements, income mandates, and services offered within waiver programs. This variation makes the systematic evaluation of transition programs challenging and can create tremendous implementation barriers. For example, the Ohio waiver program, like several other waiver programs, will not pay for 24/7 (Kasper & O’Malley, 2006). Individuals that require 24/7 care require dedicated natural supports to bridge professional services gaps or will have to remain in an institution. In addition, there are significant limits placed on the per-member per-month amount that can be spent on a service plan. Again, this requires a tremendous amount of natural supports to make up the service deficit created by the limits imposed by waiver programs. The activation of natural supports must be a strategy of the HB1 initiative to avoid the pitfalls and overcome the barriers created by the Ohio waiver program. The structure of Medicaid waiver programs should serve as at least one guide for the definition of the program’s target population, intervention strategies development, and program implementation efforts.
Housing was identified as one of the most significant challenges faced by individuals transitioning back to the community. This represented both an infrastructure/systems issue as well as an operational issue. Individuals cannot leave institutions if they have no safe place to go. There is a lack of adequate and affordable housing for low income older adults and adults with disabilities, and there is often a waiting list of more than a year limiting an individual’s options (Kasper & O’Malley, 2006). There are also limited resources that cover housing expenses especially since Medicaid doesn’t cover ongoing housing costs (Shirk, 2007, Wenzlow & Lipson, 2009). Study participants cited regulations and policies governing housing practices as major challenges. Specifically, for individuals with a criminal background, mental health issues, or complex cognitive needs. When developing a transition program it is essential for housing to be a central focus of program planning efforts. Housing influences decisions regarding the target population, partnerships/collaborations, and intended outcomes.

A clear definition of the program’s target population emerged as a critical tenet of program theory. The obstacles associated with an inconsistent or unclear definition of the target population were also discussed as barriers to the success of transition programs, or more specifically, the successful evaluation of transition programs. Nursing home lengths of stay for individuals to be eligible for transition programs was highlighted. There is little empirical data regarding the impact of transition programs because evaluators were unable to determine if individuals returned to the community due to the interventions they received or if they were going to return regardless (Wenzlow & Lipson, 2009). This was a particular challenge for programs, like HB1, that enrolled short stay residents as well as long stay residents. It is also important to mention that institutional care is the most appropriate setting for some individuals with severe/complex medical and cognitive issues. Criteria regarding the ability of an individual’s medical needs to be met in a community setting are an important part of the target population definition. Other factors to consider are age, level of disability, and availability of natural supports. These factors influence what resources will be available, what partnership/collaborations need to be formed or maintained, and the development of program intervention strategies.

The motivation of consumers and their families was identified as a key factor in who is able to successfully return to a community setting (Kasper & O’Malley, 2006). The desire of the consumer to return to the community was the primary reason cited for enrollment in the HB1 transition program. It was found that an alarming number of individuals living in institutions are completely unaware of their LTC options, and they have developed an unquestioning acceptance of institutional life (Nishita, Wilber, Matsumoto & Schnelle, 2008). The ability of consumers and their families to have the tools necessary to actively make choices about their care was identified a quality of life issue as well. A number of study participants discussed a consumers desire to be happily at home and in the community, and how this honored the mandate and mission of providing LTC in the least restrictive environment possible.

Operational strategies designed to get people out of institutions and back in a community setting were discussed a great deal by study participants in relation to the HB1 transition initiative. Specifically, importance of outreach/education, case management and natural supports was explicitly detailed. Although post-transition follow-up strategies designed to keep people in the community once they were transitioned were not as explicitly discussed by study participant, they were discussed in existing literature. The information gleaned from the literature was
synthesized and included in the theoretical framework developed for the HB1 nursing home transition program initiative. The literature indicates post-transition follow-up is a major factor in consumer stabilization and permanency in a community-setting (Holt, Jones, Petty, Roth & Christensen, 2006). It is important to ensure the service plan developed is meeting the consumer’s needs, and natural supports are getting the support they need to be successful. Transitioning consumers from institutional care back to the community represents a paradigmatic shift for the AAA’s. Diverting individuals from institutional care is the “mission” of every AAA implementing the HB1 initiative. The strategies associated with keeping individuals in the community once they are transitioned out of institutional care appear to be an implicitly understood function. A number of study participants summed up diversion strategies by stating, “This is just what we do.” Currently, it is unclear within the HB1 initiative when a consumer stops being a “nursing home transition” client and becomes a “nursing home diversion” client. The HB1 initiative would benefit from more clearly and explicitly defined post-transition strategies. This would help alleviate some of the evaluation challenges the ambiguity creates such as, measurement development for the program’s intermediate outcome and potential black box issues. The HB1 initiative created different strategies/programs for nursing home transition and diversion efforts. Post-transition follow-up strategies must be clearly defined and measurable for evaluators to determine which strategies/program helped consumers remain in the community.

Limitations

A number of study limitations need to be acknowledged. First, due to geographic challenges semi-structured telephone interviews were conducted with PASSPORT directors as opposed to face-to-face group interviews. The group interview process would have allowed interaction between directors and evaluators. Second, PASSPORT directors were asked to identify/recommend group interview participants. Directors may have selected staff with similar views/understandings of the program to participate in the group interviews. This strategy of referral sampling may have led to a biased group interview sample. Third, two group interviews were scheduled in Columbus, OH on the same day—one for program supervisors and one for case managers/assessors. Unfortunately, some supervisors participated in the care manager/assessor group interview and vice versa. This may have caused participants to censor some of their responses. Finally, due to time constraints and the focus on HB1 professionals in this study, consumers of the HB1 transition program were not interviewed. The consumer’s perspective regarding how the program did or did not meet their needs would have provided another valuable insight into the HB1 program theory.

Implications for Research, Practice and Policy

Identifying a theoretical framework for the HB1 nursing home transition program was only a first step in the evaluation process. It acts as a translator between research and practice. The next step is to empirically assess the framework to determine if it is a good/adequate framework to achieve the outcomes established for the program. This study can inform the development of specific process and impact measures for eliciting data to determine if individuals were successfully transitioned back to and remain in the community as a result of the HB1 nursing
home transition program. The empirical data gathered from HB1 program evaluation activities could then be used to develop an evidence-based nursing home transition model capable of replication. This would make a significant contribution to the literature and policy arena. Policies guiding the implementation of Medicaid rebalancing efforts, specifically nursing home transition initiatives, would be better informed by empirical data rather than anecdotal data. Although the framework may not currently be generalizable, it may be applicable to other transition efforts besides the HB1 initiative as it is steeped in existing literature regarding several other transition programs. Medicaid cost savings is a long range outcome requiring a cost benefit analysis of a well established and documented program. Implementation and evaluation activities should be positioned accordingly.

Nursing home transition programs are intended to transform existing LTC systems originally designed to support institutional care. Ohio is an excellent example of a state with an extremely powerful nursing home industry, resulting in an institutional care bias in the state’s LTC system. Medicaid officials in Ohio indicated they would be taking evolutionary rather than a revolutionary approach to LTC system transformation. The HB1 initiative is taking on an enormous challenge; as one PASSPORT director noted, “We are moving the Titanic while avoiding the icebergs.” However, it is important to acknowledge that what may be evolutionary to some systems may very well be revolutionary to others. It is important to have a clear and concise roadmap to guide the way. A well articulated program theory is the sonar equipment necessary to navigate programs away from the icebergs.
References


Appendix

October 8, 2010

Dear PSA,

We understand how busy you are and we appreciate your willingness to speak with us via telephone regarding the Nursing Home Transition and Diversion Project. For your reference, we have listed the strategies you indicated your organization would implement for both transition and diversion efforts, as well as, the questions we intend to ask below. We will address the diversion strategies and transition strategies separately using the same set of questions. We anticipate the phone call to take approximately 45 minutes of your time.

PSA 1 Diversion Intervention Strategies

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<td>2. Hospital Diversion Work</td>
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PSA 1 Transition Intervention Strategies

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<td>1. Nursing Facility Work</td>
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<td>2. Community Collaboration</td>
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Questions:

1. Can you please provide me a general description of each intervention strategy indicated above?
2. How is the intervention strategies implemented in your organization?
3. Which of the intervention strategies do you believe holds the most promise for the future? Why?
4. If we wanted to talk to someone about the diversion strategies and the transition strategies, would it be the same person of different people?
5. Can you please identify the most appropriate person(s) from your organization to participate in future focus groups regarding the HBI program implementation?

Please feel free to contact, Elizabeth Carpio at carpioea@muohio.edu should you have any questions regarding this matter. We look forward to speaking with you.

Sincerely
Scripps Gerontology Center
Project Timeline

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Interview Schedule

1. Can you please provide me a general description of each intervention strategy implemented in the HB1 initiative?
2. How are the intervention strategies operationalized in your organization?
3. How are decision made regarding which intervention strategies to implement?
4. What are some indicators used in the decision-making process?
5. Can you describe what make a “good” intervention strategy?
6. Which of the intervention strategies do you believe holds the most promise for the future? Why?
7. Can you describe any changes in organizational structure made to accommodate the HB1 initiative?
8. Can you describe the process your organization uses to communicate and reinforce the definition of “transition” to staff members?
9. If we wanted to talk to someone about the diversion strategies and the transition strategies, would it be the same person or different people?
10. Can you please identify the most appropriate person(s) from your organization to participate in future Group interviews regarding the HB1 program implementation?
Questions nine and ten were only asked of the PASSPORT directors during the initial telephone interviews. Questions one through eight are examples of questions asked during the initial telephone interviews as well as the group interviews. Additional or different questions regarding intervention strategy descriptions, implementation, and operationalization emerged as the interviews were conducted. Questions related to the impact of the HB1 initiative’s on organizational and system structure also emerged. We did not ask any questions that could be construed as potentially harmful or intrusive.