Going Home: Community Reentry of Light Care Nursing Facility Residents Age 65 and Over

Rosemary Chapin, Deborah Schild Wilkinson, Roxanne Rachlin, Michelle Levy, and Rachel Lindbloom

Issues of consumer choice, and rising public expenditures of nursing facility care for the rapidly increasing elderly population have fueled interest in community reentry of nursing facility residents. The Minimum Data Set Plus (MDS+) contains a wealth of information which can be used to provide a better understanding of nursing facility residents including those who discharge. This study employs the Andersen model of health services utilization and logistical regression on MDS+ data to examine characteristics of higher functioning nursing facility residents age 65 and over related to community reentry in one midwestern state. Findings include having Medicaid as a payer source significantly decreased the likelihood of discharge. In contrast, being younger than 85, retaining decision making responsibilities, and having no cognitive impairments were found to increase the likelihood of discharge. Policy and program implications related to identifying and assisting nursing facility residents in resuming community living are discussed. Key words: *community reentry, light care, MDS+, nursing facility discharge*

The Increasing Need for Community Reentry

The community reentry of nursing facility residents is receiving growing attention from the public, policy makers, and social work practitioners. Four trends are contributing to the increased interest in helping older adults resume community living: (1) the rising costs of long-term care, particularly nursing facility care; (2) the rapidly growing elderly population; (3) issues of consumer preference and choice regarding long-term care settings; and (4) the growing emphasis on reducing unnecessary institutionalization of people with disabilities.

Nursing facility care is a costly method of meeting long-term care needs, particularly for people with light care needs. Both in terms of the total cost ($77.9 billion in 1995) and average per-resident cost (about $3,800 per month in 1995), nursing facility care is more expensive than any other long-term care setting.[1] Public sources, particularly

***Rosemary Chapin, PhD, MSW,** is Associate Professor, University of Kansas, School of Social Welfare, Lawrence, Kansas.*

***Deborah Schild Wilkinson, PhD, MPH, MSW,** is Assistant Professor in the School of Social Welfare, University of Kansas, Lawrence, Kansas.*

***Roxanne Rachlin, MHSA,** is a policy analyst and research coordinator for the Long-Term Care Project at the University of Kansas School of Social Welfare, Lawrence, Kansas.*

***Michelle Levy, MA,** is the Child Welfare Training Project Coordinator at The University of Vermont, Department of Social Work, Burlington, Vermont.*

***Rachel Lindbloom, MA,** is a Health Planning Consultant for the Kansas Department of Health and Environment, Topeka, Kansas.*

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Medicaid, pay for a major share of care received in nursing facilities. Due to the high cost of nursing facility care, there has been a great deal of attention given to reducing unnecessary institutionalization and developing alternatives to nursing facility care. These issues are particularly important for state Medicaid agencies that are attempting to reconfigure their long-term care systems so that people have the option to receive services in the least restrictive environment that is cost effective.

Projected growth in the elderly population adds impetus to the search for more effective methods of helping people resume community living. The number of persons age 65 and over is projected to grow 17.5 percent between the years 1995 and 2010.[2] The rise in the elderly population will likely result in increased use of nursing facility care. The largest population growth is projected for the 85-and-over population, which is the group most likely to need and use long-term services. In 1990, 41.8 percent of the national nursing home population was 85 or older.[3] Elderly population growth is expected to produce a sharp increase in the demand and public costs for long-term care services.

Issues of consumer choice and preference also need to be taken into account when developing policies and programs to serve elderly people. Research as well as practice experience indicates older adults would generally elect to remain in their own homes when possible if given the choice.[4] State efforts to reduce the institutional bias in their long-term care systems build on broader efforts to deinstitutionalize disabled populations.[5] The lack of alternatives to nursing facility care, such as community-based services, often results in older adults inappropriately residing in nursing facilities. In a recent study conducted by the National Academy for State Health Policy, it was estimated that between 20 and 30 percent of the nursing facility residents in the state where our research was completed had one or no impairments in activities of daily living (ADLs), had high levels of cognitive functioning, and could be served cost-effectively in less intensive settings.[6] In a national study of state long-term care systems, it was found that 36 states had average or below-average rankings in terms of the acuity levels of nursing facility residents in the state.[7] The lack of adequate preadmission screening for nursing facility care, the lack of available or accessible community-based services at the time of admission, and an improvement in the resident's condition during a nursing facility stay can all be antecedents to unnecessary institutionalization. These residents may require special assistance to discharge from the nursing facility to their home or to assisted living.

The demographics of an aging society, mounting long-term care expenditures, support for deinstitutionalization, and issues of choice dictate development of practices and policies to reduce the number of older adults with light care needs residing in nursing facilities. Social work professionals in both long-term care facilities and in state Medicaid agencies are charged with the task of helping nursing facility residents resume community living. They know that there are people residing in nursing facilities who are not severely functionally impaired, who would choose to live in the community if they believed sufficient services were available, and who could do so cost-effectively. However, social service professionals are faced

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with real-time constraints and lack research-based information about which resident characteristics are associated with discharge to the community. With such information, they will be better able to allocate their time and to offer appropriate services that will assist individuals to return to the community.

In order to more fully understand factors related to nursing facility discharge to the community, we have analyzed Minimum Data Set Plus (MDS+) assessments of light care nursing facility residents age 65 and older. The Omnibus Budget Reconciliation Act (OBRA) of 1987 required use of the MDS as a standardized assessment instrument to be completed for nursing facility residents of all Medicare and Medicaid nursing homes. It provides a comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status. The MDS+ is an expanded resident assessment instrument being used in the Multistate Nursing Home Case Mix and Quality Demonstration (NHCMQ). An objective of the demonstration is to test a differentiated payment system based on the classification of residents into resource utilization groups. The MDS+ contains the same items as the MDS with the addition of items needed for the NHCMQ.

As databases such as the MDS+ are more widely implemented, they represent an important potential resource for policy makers as well as social service professionals in the field. With funding from the Health Standards Quality Bureau of the Health Care Financing Administration, Hawes et al. conducted a study on the reliability of MDS data.[8] They found that MDS data met a standard for excellent reliability in key areas such as ADLs, continence, and cognitive functioning. The study authors further state that the reliability of MDS data makes them useful for research purposes.

This study used the data from one state's MDS+ data set to determine what resident characteristics influence the likelihood of discharge for nursing facility residents with light care needs. This research will provide information useful in identifying and assisting high-functioning nursing facility residents to resume living in a community setting.

Background

Previous studies of similar light care populations have indicated that certain factors are related to the likelihood of being discharged to the community. The Andersen model of health services utilization has been used to categorize predisposing, need, and enabling factors.[9-11] According to the Andersen model, predisposing factors are an individual's characteristics that act as indicators of a greater propensity toward service use.[12] Preexisting factors that are not subject to change through intervention but are related to the outcome are predisposing factors. Both marital status and age are examples of predisposing factors.[9,13] The relationship between marital status and nursing facility discharge has been clearly documented. Married individuals, due to the presence of a

spouse to provide informal support, have been found more likely to be discharged to the community.[14–17] Age is correlated with physical and mental deterioration.[18] In addition, Becker and Kaufman found that younger nursing facility residents are more likely to have family and friends whom they can depend on for assistance.[19] Because of mortality, older residents often have a smaller number of potential caregivers. Thus, advanced age could be anticipated to decrease the likelihood of discharge.[14,17] Previous stay in a nursing facility was another factor found to predict nursing facility placement and the potential for discharge.[16,20–22] Residents without prior nursing facility stays may be more likely to have a home in the community and established arrangements for formal or informal caregiving, which increases the likelihood of discharge.

Need characteristics, including physical functioning, cognitive impairment, and the burden of care, represent the cause of service use.[12] Residents discharged to the community have been found to have better cognitive functioning and better performance in ADLs.[14,17,20,23] *Need factors* are those specific characteristics of an individual that represent the reason for use of care. Unlike predisposing factors, need factors may be changed through intervention.

Enabling factors are certain conditions that must be met to obtain services, such as family resources. Nursing facility residents who have the resources to pay privately for their care for extended periods or are publicly funded are more likely to remain in the facility than residents with median incomes.[12,15] Chapin and Schwartz found that establishing one's own goals and being legally responsible for one's self are positively associated with discharge.[24] Family support measured in such ways as regular contact with family members has been found to reduce the need for nursing facility care by elderly persons.[25] Findings from these previous studies were used to inform our selection of variables to be examined in the current study.

This study examines characteristics for their association with the likelihood of discharge for residents age 65 and over. The subgroup of the sample who were age 85 and over was also analyzed separately due to the unique challenges facing the 85-and-older age group. Persons age 85 and over are at the greatest risk of nursing facility placement,[26,27] and 24.5 percent of this group reside in nursing facilities.[3] The number of adults age 85 and over is projected to grow 56 percent from 1995 to 2010 and 400 percent by the year 2050.[2] The proportion of those age 85 and over in the population as a whole is also expected to increase dramatically. Because of their advanced age, members of this age segment are less likely to have informal supports available, such as a spouse or a family. The presence of these caregivers can help adults live in the community by meeting some of their long-term care needs.[28,29] Therefore, nursing facility residents age 85 and over face additional obstacles in reentering the community.

The intent of this study was not to replicate earlier studies, but rather to build on what was learned previously. Instead of analyzing the initial MDS+ assessment, the last available assessment was used. An earlier study by Lindbloom and Chapin examined the discharge experience of that group of residents age 85 and over who entered the nursing facility in need of only light care as indicated by the MDS+ assessment.[30] In this study we

examined the functional and Medicaid status of residents as close as possible to the time of discharge determination.

Methods

Sample

Data for this study came from the MDS+ assessments of one state's nursing facility residents for the fiscal year 1995 (July 1, 1994, through June 30, 1995). The populations of interest were (1) all light care residents who were between 65 years and 110 years old during fiscal year 1995; and (2) the subset of that sample who fell between the ages of 85 and 110. Light care residents are those with an MDS+ case mix classification of PA1, PA2, or PB1. Case mix classification groups are composed of residents with similar resource use, based on the Resource Utilization Group RUG-III classification. Based on the MDS+ Reference Manual, the light care case mix groups are defined as follows: Residents ranked as PA1/PA2 should be independent or needing only supervision with bed mobility, transfer, and toileting, however, they may need limited assistance with eating. Classification of PA1 and PA2 is differentiated based on occurrence of nursing rehabilitation activities. Residents ranked as PB1 need limited assistance in not more than two ADLs.[31] Since the MDS+ was designed for use in nursing facilities, certain variables important to discharge, such as the presence of a caregiver at home, are not assessed. Examination of these classifications provides a base for first-pass analysis that can be linked to in-person social work assessment to determine actual discharge potential, as described in the "Implications" section of this article.

To ensure that no case was counted twice and to capture information from the assessment associated with the discharge of those who returned home or to the community, data from the last assessment during the fiscal year were used. In the state studied, a special supplemental form is filled out whenever a resident leaves a nursing facility. The MDS+ Resident Termination Information Form contains information about the reason for the resident discharge.

Certain nursing facility residents were excluded from the analyses. Data from the residents at the 15 nursing facilities for individuals with mental health or developmental disabilities were not included. An additional 233 cases care were excluded based on information recorded on the Resident Termination Information Forms. Those cases were residents who discharged to (1) a mental health/developmental disability nursing facility; (2) an acute hospital; or (3) other, nonspecified care settings.

MDS+ assessment data are collected for all residents, whether they are admitted for respite or longer-term care. However, there is no indication on the MDS+ forms, and thus in the data set, of a respite admission. Because Medicare will pay for respite care for up to 14 days, we decided to consider the light care persons who were discharged during the first 14 days as respite care residents and did not include them in the major sample for analysis.

An examination of the length of stay for residents who were discharged revealed that nearly all who were discharged left nursing facilities during the first two years of residency. The analysis was limited to the subsample of people whose length of stay fell between 15 days and two years in order to

include nearly all residents who were discharged to the community, while excluding those who were likely to have been admitted for respite care. Light care residents in the facility for more than two years could be expected to face significant added difficulties in returning to the community due to the effects of prolonged institutionalization. Our interest in this study was in light care residents with the greatest potential for community reentry.

To take into account the fact that some residents may have discharged after the study period, the length of stay of all residents who were discharged was examined. The median length of stay for those residents was 60 days. All residents ($N = 313$) who were admitted to the study during the final 60 days of the study period (May 1, 1995, through June 30, 1995) and who were not discharged or did not die during that time were excluded from the logistical analyses. The total number of people age 65 to 110 years old in the study sample was 4,407. There were 2,388 adults age 85 to 110 years old in the subset, or 54 percent of the total sample.

Variables

Outcome variable

The outcome of interest in this study was discharge to the community, including a resident's own home or an alternative care setting such as an assisted living facility. A dichotomous variable indicating discharge or not was constructed using data from the Resident Termination Information Forms. Residents who died ($N = 267$) during the study period were included in the data set and coded as not discharged.

Study variables

Variables found in previous studies[12-15,20,24,25] to be related to discharge from nursing facilities were considered for inclusion in the models in this study. The distribution of those variables in both the complete and subset samples using the Andersen model categories of predisposing, need, and enabling factors is shown on Table 1. The question on the MDS+ that corresponds with the variable is included.

Some of the variables are proxy measures for factors that are not measured directly on the MDS+. For example, family participation in assessment may be an indicator of social support. Residents with better health status, as represented by the light care classification, are the focus of this study. A variable indicating the absence of cognitive impairment was constructed using MDS+ measures of memory, cognitive skills for daily decision making, indicators of delirium, and change in cognitive status.

Regardless of age, the distribution of most of the predisposing, need, and enabling characteristics of interest is relatively constant. As can be expected, the rate of those who are married after age 85 (14.4 percent) decreased slightly in comparison to the rate of marriage of the entire sample (16.1 percent). Notably, only 29.9 percent of the older and 31.1 percent of all residents retained responsibility for making health care and treatment decisions, despite the fact that in both groups the majority of residents did not have significant cognitive impairments. As explained in the MDS+ Reference Manual, "in the absence of guardianship, or legal documents indicating that decision-making has been delegated to

Table 1. Distribution of characteristics in study samples

	MDS+ variable	Complete sample ($N = 4,407$)	85 and older ($N = 2,388$)
Percent discharged to home or community		10.9	8.7
Percent who died during study period		6.1	6.5
Mean Age (S.D.)	I-7	84.4 (7.4)	89.9 (3.7)
Predisposing characteristics			
Percent age 65–84	I-7	45.8	NA
Percent married	A-11	16.1	14.4
Percent not in any facility during the past five years	I-10	68.1	68.9
Percent women	I-5	73.2	76.8
Need characteristics			
Percent without cognitive impairment	B-2, 4, 5, 6	57.4	56.7
Percent with bowel continence	I-1a	96.7	96.7
Percent with bladder continence	I-1b	85.9	85.2
Percent who can always communicate clearly	C-4	85.0	85.4
Enabling characteristics			
Percent who retain decision-making responsibilities	A-8a	31.1	29.9
Percent who participated in own assessment	P-1	86.2	85.2
Percent whose family participated in assessment	P-1	31.9	31.9
Percent with Medicaid as payer source	A-7a	39.5	33.8
Percent with Medicare as payer source	A-7b	2.8	2.2

others, assume that the resident is the responsible party if the resident is capable of making decisions."[31(p. 93)]

Other research has shown that nursing facility use patterns differ in rural and urban areas.[32] In this sample, however, rurality did not have an effect on nursing facility utilization. The National Resource and Policy Center on Rural Long-Term Care has developed a system to categorize counties into urban, midsize, and rural based on population.[33] That classification was attached to each resident based on the location of the nursing facility. The distribution of residents in light care case mix classifications and their discharge rates were not found to be statistically different across urban, midsize, and rural regions (Table 2).

Table 2. Discharge to home or community by population density

Nursing facility located in an urban county	9.6%
Nursing facility located in a midsize county	11.4
Nursing facility located in a rural county	11.5
All counties	10.9
$\chi^2_{(df)}$	$2.111_{(2)}$
P value for distribution	$P = 0.348$

Statistical analysis

Crosstabs of each variable and the outcome were examined for their association with discharge. Several variables were found to have chi-square *P* values greater than 0.1 and therefore were not included in the next stages of the analysis. Those variables were: location of nursing facility in rural, midsize, or urban county; being female; being married; not having lived in any facility during the previous five years; being continent of bladder and of bowel; having the ability to communicate one's needs; and participation in one's assessment and having a family member participate in the assessment.

The associations of the remaining variables with discharge to home or community were tested with hierarchical multiple logistical regression models. Enabling characteristic variables were entered, followed by predisposing and then need characteristics. The goodness of fit for each model was tested by examining three statistics: the χ^2 for the change in the −2 log likelihood; the χ^2 for the entire model; and the Hosmer and Lemeshow C-Hat test, a χ^2 statistic that, when not significant, indicates a good fit. The final models for the entire sample and older subsample are presented here.

Findings

Only 10.9 percent of the entire sample of light care residents age 65 and over were discharged during the study period (see Table 1). Within the entire sample, five factors were both significantly and substantially related to discharge to home or the community (Table 3). Three of the factors were enabling characteristics: reliance on Medicaid, reliance on Medicare, and retaining decision-making responsibility. One factor was a predisposing characteristic: the age of the resident. A final factor found to be associated with discharge was a need characteristic: having minimal cognitive impairment. Four factors had a positive relationship, and one had a negative relationship. Odds ratios (ORs) as well as confidence intervals (CIs) are reported on the tables.

Reliance on Medicaid to pay for nursing facility services increased the risk of remaining in the facility by a factor of 3.6 times (OR: 0.28, CI: 0.22, 0.36). The other two enabling characteristics found to be associated with discharge were having Medicare as a payer source and retaining decision-making responsibilities. Reliance on Medicare as the payer source increased the chances of dis-

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Table 3. Odds of discharge to home or community, complete sample (N = 4,094); multiple logistic regression analysis

Factor	OR	(95% CI)	*P*
Younger than 85 years old	1.9	(1.5, 2.3)	< 0.0001
No cognitive impairment	1.8	(1.5, 2.3)	< 0.0001
Retains decision-making responsibility	1.7	(1.3, 2.0)	< 0.0001
Medicaid is payer source	0.28	(0.22, 0.36)	< 0.0001
Medicare is payer source	2.9	(1.9, 4.5)	< 0.0001
Goodness of fit for model			
−2 Log likelihood for model	2614.938		
Model $\chi^2_{(df)}$	$268.503_{(5)}$		< 0.0001
Hosmer and Lemeshow C-hat $\chi^2_{(df)}$	$7.7175_{(8)}$		0.4615

charge by 2.9 times (CI: 1.9, 4.5). The wide confidence interval for the odds ratio on this variable is attributable to the small number of residents who rely solely on Medicare as a payer source. The Medicare limitation on payment for 100 days of nursing facility care most likely contributes to the increased likelihood of discharge for these residents. Retaining responsibility for making one's decisions almost doubles the chance of discharge compared with those who relinquish it (OR: 1.7, CI: 1.3, 2.0).

Residents who were younger than 85 were nearly twice as likely to be discharged home as were older residents (OR: 1.9, CI: 1.5, 2.3). Similarly, having minimal cognitive impairment increased the chances of discharge by almost two times compared with those with greater cognitive difficulties (OR: 1.8; CI: 1.5, 2.3).

Within the subset of residents age 85 and over, 8.7 percent were discharged to the community (see Table 1). As with the entire population, three enabling characteristics and one need characteristic were found to be associated with the likelihood of discharge (Table 4). Residents who relied on Medicaid were three times more likely to remain in the nursing facility (OR: 0.32; CI: 0.21, 0.48), and having Medicare as a payer source increased the chances of discharge by 2.8 times (CI: 1.4, 5.7). Retaining responsibility for making one's own decisions increased the chances of discharge by about 1.5 times (CI: 1.1, 2.1). Again, being free of significant cognitive impairment increased the chance of returning to community living by two times (CI: 1.5, 2.8).

Implications

Enabling characteristics

Findings related to decision making and Medicaid status have important implications for both policy making and direct social work practice. Analysis of these enabling characteristics indicates that residents who retained responsibility for decision making were more likely to be discharged than those resi-

Table 4. Odds of discharge to home or community, 85 and older ($N = 2,224$); multiple logistic regression analysis

Factor	OR	(95% CI)	*P*
No cognitive impairment	2.0	(1.5, 2.8)	< 0.0001
Retains decision-making responsibility	1.5	(1.1, 2.1)	< 0.0001
Medicaid is payer source	0.32	(0.21, 0.48)	< 0.0001
Medicare is payer source	2.8	(1.4, 5.7)	< 0.0001
Goodness of fit for model			
−2 Log likelihood for model	1250.800		
Model $\chi^2_{(df)}$	$76.556_{(3)}$		< 0.0001
Hosmer and Lemeshow C-hat $\chi^2_{(df)}$	$6.3184_{(7)}$		0.5031

dents who shared it with family or relinquished it. This finding underscores the importance of residents being encouraged to retain responsibility for decision making if they are cognitively able. Only 31.1 percent of the sample retained responsibility for decision making. Since the sample was composed of all light care residents and more than half the residents were without cognitive impairment, it is likely that a greater number of residents could have retained responsibility for their decision making. Residents and their families should be educated on the importance of retaining decision-making responsibilities for themselves. By taking an active role in their health care decisions, residents can effectively work toward the outcomes they desire, such as reentering the community.

The finding that residents with Medicaid as a payer source were more than three times less likely to be discharged indicates that these residents need to be worked with more closely to determine the barriers to their discharge. Inequitable access to community-based options for Medicaid residents is one explanation for this finding. These residents have spent down their resources to become Medicaid eligible and as a result lack the financial means to return to the community. It is imperative to help residents discharge while they still may have a home to go to and before they have depleted their assets. This finding points to the need to identify and target these residents as early as possible in order to maximize the chances of discharge success. More professional case management and program initiatives are needed to facilitate the discharge process for these residents and to address issues of inequitable access to home- and community-based options.

From a policy perspective, the finding that Medicaid residents were three times less likely to be discharged also suggests that low levels of community-based services may contribute to increased public costs and greater institutionalization than is necessary. Policies regulating financial and functional eligibility for Medicaid need to be scrutinized to determine how they are contributing to low discharge rates. The combination of the current financial incentives for nursing

facilities to retain light care Medicaid patients, lack of adequate transition funds, and low levels of community-based services all mitigate against social workers successfully helping these residents return to the community.

Need characteristics

Residents analyzed for this study were initially selected based on having only light care needs. The finding that the need characteristic of having minimal cognitive impairment increased the likelihood of discharge for this group highlights the importance of accurately targeting residents with potential to reenter the community. Specific responses to the MDS+ assessment could be used to alert nursing facility social workers and Medicaid case managers to residents with light care needs who are cognitively intact so that discharge planning could begin immediately. As mentioned previously, it is also important that cognitively intact residents be made aware of the importance of retaining decision-making responsibilities for themselves in order to increase their chances of discharge.

Predisposing characteristics

The finding that the predisposing characteristic of being younger than 85 years old increased the likelihood of discharge points to the unique circumstances facing the 85-and-older age group. As indicated earlier, residents of this age are less likely to have informal social support available, because family members and friends may have died.[34] Therefore, residents who are 85 and over face greater obstacles in reentering the community. Alternatives in the community that provide social support need to be developed in order to facilitate nursing facility discharge for light care residents over the age of 85. Expansion of alternatives to nursing facility care, such as assisted living, may be especially useful for this group. It is important to note that people over age 85 can be and are discharged to less restrictive settings. Age alone should not be considered a factor in determining whether a person will remain in a nursing facility, move to assisted living, or be discharged to home.

Discharge rates

It could be argued that the most interesting finding in the examination of light care nursing facility residents is the fact that so few of these individuals are discharged back to a community living setting. Only 10.9 percent of the residents in these light care categories who had been in the facility between 14 days and two years were discharged to the community. Of those who were discharged home, half were discharged within the first two months, and 93 percent did so by the end of the first year. This finding highlights the importance of working with light care residents on discharge before they become institutionalized.

A survey of social service professionals in this state indicated that some of the lightest care residents live in nursing facilities because of nonphysical/medical needs, such as safety, and that some residents are misclassified.[35] Use of the MDS+ for preliminary identification of residents with discharge potential must be coupled with professional case management to more accurately assess the capacity of both residents and community support systems when the goal is to facilitate community reentry of individual residents.

Another explanation for the low rates of nursing facility discharge of light care residents is the lack of community-based services in this state. In a recent comparison of state long-term care systems, this state was ranked 39th in progress toward a home and community-based services system.[7] These services need to be available and accessible for adults if they are to be served in a cost-effective and less restrictive setting. In addition, residents and their families may not be aware of the services available or that community reentry is an option. It is necessary to educate the resident and his or her family as early as possible about available assistance to facilitate discharge and get past the mindset that "once you enter a nursing facility you never leave."

Further research that builds on use of the MDS+ to understand why light care residents are remaining in the facility is needed. This research should include examination of the nonphysical/medical reasons older adults reside in nursing facilities in order to develop preferable alternatives to nursing facility placement for this group. Such research is vital for policy making, effective service delivery, and public expenditure cost containment.

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Ongoing analysis and monitoring of state data sets such as the MDS+ can provide vital information for both policy makers and direct service practitioners. Over the one-year time period considered in this analysis, only 10.9 percent of all light care residents age 65 and over in the sample were discharged to community settings. An even smaller proportion of light care Medicaid residents were discharged to community settings. Since older adults overwhelmingly report a desire to receive long-term care services at home, it is important we learn all we can about the factors related to the outcome of discharge to the community. Doing so can help to ensure that older service users receive cost-effective service in the least restrictive setting of their choice.

This study illustrates how states can use the wealth of information currently available from the MDS+ to understand who is residing in skilled nursing facilities in the state and the factors contributing to resident discharge. Information derived from MDS+ analysis can also help frame thinking about other quantitative and qualitative research needed to more fully understand the nursing facility use pattern of specific age groups. Social workers can help shape this research so that information to enhance effective practice is identified and collected. This information can then form the basis for policy and program development to prevent premature institutionalization, target community reentry efforts, increase community options, and support consumer choice.

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