The Problem: The authors identified roadblocks for non-Medicaid nursing home residents seeking to return to or find housing-with-services settings. Consumers and family describe their searches as labor-intensive and stressful. All participants and stakeholders were prone to erroneous beliefs about what is feasible in various housing settings. Information provided by nursing homes to housing providers was often outdated or wrong.

The Resolution: Professionals who assist non-Medicaid seniors with transitions after a nursing home stay need to identify and dispel misconceptions about seniors housing options. Communication between settings in individual cases needs systematic improvement.

Practical Steps: Checklist tips are offered for independent living providers, assisted living providers, nursing home providers, and multilevel providers to examine, refine, and communicate their own practices. Local-level collaboration and dialogue among seniors housing providers and other stakeholders (including transition counselors, senior advocates, and physicians) is encouraged, including developing a shared understanding of practical meanings of safety in seniors housing.

Keywords: housing options, late-life transitions, non-Medicaid population, long-term services and supports, privately paying long-term care consumers.
INTRODUCTION

Seniors may make a variety of residential moves after age 65 for a number of reasons, such as achieving simplicity, finding a setting where aging with disability is feasible, moving closer to family or back to a community of origin, and as a specific response to widowhood (Karpen, 2016). When seniors need to move to accommodate receiving long-term services and supports (LTSS), the move may become more reactive than proactive; those moving may be in a crisis mode. To explore that critical transition period, the authors further analyzed the qualitative data generated in an evaluation of Minnesota’s Return to the Community Initiative (RTCI). This article provides insights into the experiences and challenges regarding residential care for an understudied group: seniors ineligible for Medicaid who were discharged from nursing homes and are considering or choosing community-based seniors housing, including assisted living, for their long-term services and supports.

Background

RTCI is a statewide program initiated by the Minnesota legislature in 2009 to assist non-Medicaid nursing home residents to return to the community. It aims to encourage and support discharge from the nursing home, a goal consistent with consumer choice, independence, and quality of life. It was also expected to reduce state Medicaid expenditures by preventing or delaying long-term nursing home stays and resultant spend-down to Medicaid eligibility; Medicaid savings were intended to more than recover the program costs. RTCI is targeted at nursing home residents in nursing homes with admission characteristics similar to residents who are discharged but still in the nursing home about 60 days after admission.

Implemented statewide in 2010, RTCI is housed in the Senior LinkAge Line® that operates in each of Minnesota’s six Area Agencies on Aging. It is staffed by social workers or nurses called community living specialists (CLSs). CLSs enrolling nursing home residents in RTCI, in conjunction with nursing home social workers, assist consumers and families to arrange community discharge and provide follow-up support to sustain community stays. Typically assigned to multicounty geographic areas, CLSs become knowledgeable about nursing homes and community resources in their areas. The post-discharge protocol requires a personal visit several days after discharge and telephone check-ins 14, 30, 60, and 90 days after discharge. In-person follow-up is at the CLSs discretion based on the consumers’ needs, consumers’ ability to communicate by phone, and the CLSs workflow. By late 2015, RTCI had expanded from its original nine CLSs to 25 CLSs positions, including a few CLS assistants. As the program evolved, the number of CLS-assisted discharges rose from 202 in 2012 to 1,056 in 2015.1 RTCI appears to be the only statewide nursing home transition program geared specifically toward non-Medicaid residents. Medicare or other insurers usually initially financed these stays. If the residents move to nursing home long-stay units, they typically pay privately.

Money Follows the Person (MFP), a federal demonstration designed to help multiple subgroups (including people with developmental disabilities, adults with disabilities, and older adults), in contrast, focuses on Medicaid participants. Details about Minnesota’s MFP demonstration, Moving Home Minnesota, are online.2 Among the many distinctions between MFP and RTCI, the former offers enrollees enhanced long-term services and supports for a year after leaving the institution, whereas the latter provides no services, although CLSs help consumers identify relevant federal, state, or insurance benefits or community long-term services and supports in their locality.

1For more information on RTCI and its work, see http://www.mnaging.org/Advisor/RTCI.aspx, last visited on 5/7/2016. This site provides more program information, including downloadable PDFs and videos highlighting RTCI cases.
Minnesota Context

To further put the authors’ findings in context, Table 1 briefly summarizes the context for long-term services and supports in Minnesota, where housing-with-services settings (called assisted living [AL] in many states) divide housing functions from care functions, the latter of which are provided by state-licensed home care agencies. With legal notice, home care agencies may withdraw services to an assisted living resident, but the latter are free to purchase care from home care agencies or private-duty providers. The registered housing-with-services settings fall under landlord and tenant rules and Fair Housing standards; tenants cannot be evicted because a home care agency withdraws services.

METHOD

Table 2 summarizes the overall design of RTCI’s mixed-method longitudinal, participatory-action research and then describes each qualitative sub-study: RTCI personnel as respondents, including CLSs; nursing home personnel as respondents; and cases of specific discharges. The last row describes how all qualitative analysis was done to extract themes and issues related to assisted living and related seniors housing, the subject of this article. In this paper, the authors did not evaluate RTCI; rather, they used data collected for qualitative evaluation of RTCI data to look at the phenomenon of leaving a nursing home as it related to assisted living and seniors housing.

Key Findings

According to program statistics, only about 20% of CLS-assisted consumers are discharged to housing-with-services settings, including, in Minnesota, purpose-built apartments, residential care homes providing rooms rather than apartments, and small family homes with five or fewer residents, often called adult foster homes. (Unless specified, hereafter the authors use “assisted living” to include all these variations.) The authors describe key housing-related themes by type of sub-study, with an emphasis on insights from the case study component. In case examples, all names are fictional, no localities or providers are identified, and minor case details are altered to protect the anonymity of research informants.


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Perspectives From Community Living Specialists

From their assistance in the nursing homes and their post-discharge assistance, CLSs lend a valuable perspective on the issues facing private-pay consumers in Minnesota, apart from any of their own activities. The themes come from the two series of interviews with CLSs:

Inaccurate beliefs about assisted living capacity. CLSs noted ubiquitous, firmly held but erroneous beliefs about what is possible in assisted living. Professional advisors often believe that living in assisted living is impossible for those needing certain types of long-term services and supports (e.g., wound care, feeding tubes, management of unstable medical conditions) and communicate that misinformation to consumers and families. CLSs identified a need for widespread education of nursing home personnel, community physicians, and the general public to provide facts on assisted living capabilities.

Variation and changeability of assisted living. Although public and professional views of assisted living were often inaccurate, some assisted living facilities do lack the capacities that the uninformed attributed to the entire sector. Assisted living facilities are varied. A challenge to CLSs was identifying and remaining current on assisted living capabilities, admission criteria, environmental features, and prices in the regions they covered. Small family homes were particularly hard to track, but change of policy and personnel occurred in all sectors.

Premature housing plans. By RTCI design, most consumers were in nursing homes for 60 days before enrolling in RTCI. The CLSs offered many examples of consumers who decided on the location and level for assisted living and booked a specific one well before then. Once a plan had been made, it was usually counterproductive to make consumers aware of other options. The authors heard from CLSs that nursing home residents and their agents needed
Table 1. Minnesota Context.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Summary and Implications for Post Nursing Home Discharge Assisted Living and Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing home rate equalization</td>
<td>Under “equalization policies,” nursing homes may not charge more for private-pay residents than the state would pay for the same resident under Medicaid. This may affect how nursing homes view the relative advantages of serving Medicaid versus non-Medicaid clients.</td>
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<tr>
<td>Nursing home characteristics</td>
<td>Minnesota nursing homes are predominately nonprofit, and many providers offer a full array of living options (e.g., independent living, assisted living, memory care assisted living, and nursing home). Compared to other states, Minnesota nursing homes have a high complement of qualified social workers on staff that affects nursing home discharge planning capabilities. Those qualified social workers are dispersed unevenly, however, and nursing homes with many full-time equivalents of social work time tend to deploy the social workers more heavily in post-acute care than long-stay units.</td>
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<tr>
<td>Long-term services and supports in state Medicaid program and state-funded programs</td>
<td>Minnesota’s Medicaid program offers a wide variety of state plan and Medicaid waiver services for all populations needing long-term services and supports. Minnesota has also used state funds to provide alternative services to low-income citizens not yet eligible for Medicaid. Such provisions helped the state earn the highest state rating in the first two AARP state scorecards (Reinhard et al., 2011; Reinhard et al., 2014). Case management, known as long-term care coordination, is provided through county health and county human services departments and is available regardless of payer source. In 2014, Moving Home Minnesota, the state’s MFP demonstration, was launched. The program design and implementation has affinities to RTCI with Senior LinkAge Line involved. While in demonstration status, the transition counselors for MFP are not integrated with the RTCI CLS role.</td>
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<tr>
<td>Vulnerable adults protection</td>
<td>Minnesota has a strong vulnerable adults protection statute, requiring vulnerable adult protection plans for all nursing home residents and reports on vulnerable adults who may be abused or neglected. Such reports are reviewed and investigated when indicated by county Adult Protective Services. The U.S. Department of Veterans Affairs accentuates strong consciousness of safety among nursing home, assisted living, and home care providers.</td>
</tr>
<tr>
<td>Aging and Disability Resource Centers (ADRCs)</td>
<td>Minnesota’s ADRC, the Senior LinkAge Line, staffed by specialists with expertise in insurance, housing, and other senior support services, has developed a robust capability to provide resource information and decision assistance to all seniors (Alecxih &amp; Blakeway, 2012; Kane, Boston, &amp; Chivers, 2007). Before an older person is first admitted to assisted living, regardless of payer, the Senior LinkAge Line needs to approve the application, a policy designed to ensure that the applicant has been informed of home-based services they could receive. Senior LinkAge Line personnel are tasked to perform the follow-up for nursing home residents seeking information about community services, and in 2015 assumed the nursing home preadmission screening function.</td>
</tr>
<tr>
<td>Housing with services</td>
<td>Assisted living settings in Minnesota are registered as “housing with services” settings and are governed by landlord-tenant rules. The providers of services are licensed as home care providers. An assisted living facility may obtain a home care license or contract with a particular provider, but assisted living residents are free to choose any licensed agency or private-duty provider for their care. Home care agencies may, with sufficient notice, withdraw services if they believe they cannot provide the level and quality needed.</td>
</tr>
<tr>
<td>Licensed home care</td>
<td>Minnesota has about 1,400 licensed home care agencies. Under simplified rules, the categories were reduced to two: comprehensive and basic. Assisted living home care providers have a state license, usually comprehensive. Additionally, 200 of those agencies are certified as Medicare providers. Only those agencies can provide Medicare-reimbursed services in assisted living or other congregate housing.</td>
</tr>
<tr>
<td>Fair Housing</td>
<td>After move-in, assisted living residents are protected by Fair Housing rules; they may not be discharged involuntarily unless they fail to pay rent, create a nuisance, or destroy the property.</td>
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</table>

Specific information about their available choices and, if possible, to be encouraged to make these choices slowly. Physical status can change, and a rush to an assisted living decision may close a current housing bridge behind the resident. Rental units may be relinquished and houses put on the market on the basis of attenuated decision-making. **Financial planning amid uncertainty.** Consumers of assisted
Table 2. Overall Method and Qualitative Methods.

<table>
<thead>
<tr>
<th>Overall research</th>
<th>Longitudinal participatory action involving a collaboration of university-based researchers and Minnesota Department of Human Services to examine effects of RTCI and aspects of program implementation.</th>
</tr>
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<tbody>
<tr>
<td>Quantitative aims</td>
<td>Determine the characteristics of RTCI, effects of RTCI on nursing home discharges of private-pay residents, the likelihood of their remaining in the community, and the likelihood of their spending down to Medicaid eligibility.</td>
</tr>
<tr>
<td>Qualitative aims</td>
<td>Help explain fidelity to program protocols, and outcomes from the quantitative findings; describe the experiences of all participants and stakeholders, including consumers, to help understand the challenges and regional variation in nursing home discharge in Minnesota.</td>
</tr>
<tr>
<td>State activity</td>
<td>Refine program components, including developing a system of program performance monitoring, identify and disseminate issues for other adopters, and identify a system quality indicator for nursing home discharge.</td>
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Components and Methods of the Qualitative Research

1. Sub-studies with program personnel, including CLSs.
   - All CLSs and other Area Agencies on Aging personnel were interviewed in person at beginning of study (CLSs \( N=9 \)).
   - CLS supervisors were interviewed in person or by phone in Year 3.
   - All CLSs were interviewed by phone in Year 3 (\( N=22 \)). This series included CLS accounts of one or more cases where they believed RTCI had made a decisive difference, resulting in a series of 30 complex cases described from the CLS perspective. Some of these involved housing and assisted living issues.

2. Sub-studies interviewing nursing home discharge personnel, usually social workers.
   - Phone interviews with discharge personnel from 49 nursing homes, selected in a random stratified sample from nursing homes with one or more CLS-assisted discharges in previous 16 months. Stratification criteria were: volume of CLS activity (1-2, 3-4, or 5+ CLS-assisted discharges); at least four nursing homes from each of six regions with more from populous regions, and mix of nursing home ownership.

3. Case studies on CLS-assisted discharges.
   - Multiple perspectives on CLS-assisted discharges:
     - A total of 24 CLS-assisted discharges to the community after at least 60 days in the nursing home were selected.
     - Sample was drawn to include at least eight discharged consumers who were initially discharged to assisted living, 10 discharged home alone, and eight discharged home with a spouse. Within that scheme, selection was designed to include cases of as many CLSs as possible and to represent some consumers with high activities of daily living and/or high cognitive needs, not the major population served by RTCI. This purposive sampling approach was designed to permit insights into varied experiences in urban, suburban, and rural areas.
     - A total of two to five interviews per case. All cases included interviews with consumer and/or family and CLSs. Some included multiple family, nursing home personnel, or assisted living or community personnel.
     - Program data reviewed for the consumer cases included nursing home admission Minimum Data Set (MDS) data, community planning tools completed by the CLSs in the nursing home, the initial community service plans agreed to before discharge, and online log notes for the particular consumer; the latter allowed the authors to view and abstract from contacts and notes before RTCI service was initiated.
     - A total of 30 memorable cases and success stories were collected from CLSs as part of sub-study one, above. The authors added log notes information for these cases. Although filtered only through the community living specialist perspective, they add to the whole.

Qualitative Analysis Approach

- Qualitative components were each analyzed separately and then considered together. Interviews entailed a series of topics with probes rather than fixed-response items. All interviews were transcribed and content was analyzed by multiple investigators to establish themes and coding, and multiple coders of all interviews.
- For this article, content analysis was redone specifically to find themes and issues related to housing. All content was considered; comments of CLSs on relationships with assisted living, and the case studies of consumers discharged to assisted living were particularly fruitful, as were all references to 24-hour care and safety services, which surfaced various stakeholder preferences for more restricted environments.
living needed to understand prices and pricing structure for any residential care options they were considering, including the rental prices for apartments or rooms, the way meal prices were handled, basics and extras for care prices, and factors that could increase these prices. Such information was far from transparent. Often they had a home to sell and needed to plan the logistics and timing of that activity based on the immediacy of their need for cash and the housing market. Additionally, consumers and families were also often perplexed and sometimes anxious about out-of-pocket costs connected with hospitalization and their nursing home stays. They were uncertain what parts of nursing home bills would be covered by Medicare, their health plan, or supplemental insurance. Nursing home business offices could rarely help, and consumers had to undertake the arduous clarification process, sometimes involving appeals. In one case, a consumer had not been technically admitted to the hospital due to an error in changing her status from “observation status” when she was transferred from the emergency room to a hospital room, making her liable for her entire post-acute stay. (The appeal was in motion, and they expected to prevail, but anxiety was high.) Money mattered to all but the wealthiest consumers, and all consumers had trouble understanding out-of-pocket costs for past services and future options at a time when they needed to act based on a good understanding of assets and future liabilities.

Communication after discharge. CLSs indicated two types of communication problems with immediate effects after move-in to assisted living. First, the discharge plans sometimes were lost in transition, and the expected services, such as medications, were not started. This observation flags that some private-pay residents moving to assisted living from nursing homes needed an advocate who would be attentive to the discharge care plan and intervene if it fell apart. Second, the information the nursing home relayed about the consumer was often incomplete or wrong. For example, consumers were at times discharged with labels of cognitive impairment that were no longer manifested.

Emotional and social aspects of moving to an assisted living facility. Transitions to assisted living were often accompanied by emotional stress and attenuated social ties. Some consumers mourned their former homes, possessions, and community connections. Some CLSs identified a need for such consumers to have help establishing a sense of home in their assisted living, maintain former ties and interests, and develop new ones.

Perspectives From Nursing Home Discharge Personnel

Complexity and acuity in nursing homes. Nursing home respondents emphasized that residents with long rehabilitation stays often had serious systemic disease, difficult wounds, unstable conditions, or numerous fractures. Multiple morbidities were the norm. This reality fueled their perception that many residents should be encouraged to stay in the nursing home and that others bent on discharge should not return to a private dwelling. Some residents were deemed to “need 24-hour care,” a common but vague phrase that was accompanied by urging staying in the nursing homes rather than assisted living or going to assisted living rather than regular housing.

Respect for consumer choice. Despite their safety concerns, nursing home discharge personnel generally were respectful of resident choice and their right to give community care a try, though they were loath to have someone with substantial care needs go home if they lived alone, had dementia, or had unstable medical conditions. Nursing home social workers often commented that respect for self-determination of clients was a bedrock professional principle for them, and they consciously struggled with the dilemma of conflicting goals.

Reassurance in the face of risk. From the perspective of nursing home staff, most found value in the participation of a CLS. They appreciated CLS’ knowledge of local resources where the consumer lived and they appreciated the follow-up built into the program. RTCI provided an outside presence at discharge planning conferences, which reinforced residents’ rights to take risks while challenging assumptions about the impossibility of community care, and gave encouragement to those on the nursing home team who favored residents’ informed risk-taking. CLSs also helped by looking systemically at how to meet the specific needs of consumers in the preferred setting, rather than taking “24-hour care needs” as an indication for nursing home care. Some nursing home personnel described the outside presence of CLSs in nursing homes as a tool to change attitudes and an ally to those most receptive to
community care. Some nursing home informants also said that the CLSs brought news of how consumers were faring, which could also increase confidence in permitting residents to take informed risks.

**Insights From Case Studies**

Case information was derived from 24 case studies with multiple perspectives and from “success cases” described by CLSs as a component of the 2015 interviews. Many of these cases had an assisted living connection (see Table 2). Eight of the 24 cases were purposely drawn to reflect a discharge to assisted living, but other cases had some connection with assisted living because the consumer had previous assisted living stays or had been urged to move to assisted living post-discharge.

*Frequent and unpredictable assisted living transitions.* For some RTCI consumers, the nursing home stay before the CLS-assisted discharge occurred in the middle of a series of hospitalizations, nursing home admissions, and assisted living stays. The authors illustrate this dynamic situation through three diagramed cases:

**Jason.** Figure 1 illustrates Jason’s many moves, including to a townhouse and later assisted living after his wife’s death, and three moves to other assisted living facilities after his nursing home discharge. Among the general issues in the case discussed below in this section: the logistics of search and selection in an urban/suburban region with many choices but no ideal fit; the stress and guilt of a devoted but harried step-daughter who was balancing needs of her young children, her work, and her step-dad; the possible need for more hands-on help in finding assisted living than a CLS or nursing home social worker could reasonably supply (e.g., sorting out availability, arranging and driving the family member [sometimes with the consumer as well] to see possible locations; preparing questions and debriefing after the visits, and helping in successive assisted living crises); and the phrase “unsafe behind closed doors,” which was evoked by two assisted living facilities where Jason’s arrangement failed. Jason’s relative youth, his physical needs, his particular dementia that combined high-level social skills with impulsive actions or paranoia and suspicion, and his dwindling private resources (expected to last just three years) made

**Figure 1. Consumer Case: Jason – Finding an Assisted Living Fit for the Long Haul.**

Source: Besides archival program information, perspectives on this case came from telephone interviews with Carla, the CLS, the nursing home social worker, Aaron (the private case manager), and the administrator of assisted living option number three. Although the authors intended to meet Jason in person at assisted living option number three, he was already gone when they tried to arrange it. All informants thought Jason would be pleased to provide his perspective but that the authors would not be able to learn it by phone, although Jason did use a personal cell phone.
for a difficult search. Assisted living option number four seems unlikely to be his last living situation.

**Jasper and Doris.** The case of Jasper and his wife, Doris, who suddenly became a short-stay nursing home resident herself, is summarized in Figure 2. It illustrates the aforementioned financial anxiety theme as one daughter struggled to get Jasper’s long-term care insurance benefit to kick in. (Ultimately she discovered a windfall when a veteran’s benefit advisor suggested that Jasper’s longstanding hearing loss could be construed as service connected, allowing him a retroactive veteran’s allowance); the strength and resilience of consumers and family; the frustration when marketing promises do not conform with reality; and RTCI consumers as providers as well as recipients of support to family members. Through the turmoil, Jasper and Doris (with family help) created their home in assisted living. The interview with the assisted living option number one’s manager highlights the struggle about the appropriateness of staying there if acuity is too high. A question mark hovers over whether this couple will someday be pressured to move to a more protected setting, or whether the assisted living would be comfortable with Jasper’s level of disability if he were there without Doris.

**Harold.** Harold’s CLS-assisted discharge was to his own home, but he had been in supportive housing and assisted living previously in the course of his declining health (see Figure 3). Unmarried, living alone in a somewhat primitive farmstead, and no longer driving, Harold’s serious chronic illnesses led him to a month in a free residence in an urban area to prepare for surgery; a respite stay in assisted living after nursing home rehabilitation, a setting which he could not tolerate; and a return to the nursing home as a private payer. His case illustrates many themes: an unusual non-relative support system about to end; the struggle for creative ways for him to remain on or near his farm when he no longer had a “tenant” who oversaw his care, living in the newly created duplex; and the strength of personal preference (some consumers want to move to assisted living after a health crisis at home; others, like Harold, cannot envisage an assisted living that would suit them). Harold may yet be able to leverage his property so that he can live there until he dies. Neither Andy, the friend with...
power-of-attorney, nor the CLS, have given up on creative solutions for Harold to remain on his property or to find an assisted living facility he could tolerate in a tiny community nearby so he could visit the farm.

**Finding and Moving to Assisted Living Setting**

Table 3 summarizes the other six consumers who moved to assisted living. Their cases, along with those of Jason and Jasper, help illustrate other themes related to finding assisted living or seniors housing.

- Some communities offer little choice of assisted living facilities. Audrey had the choice of two small settings.
- When the community offered many choices, the difficulties included lack of information (as in Jason's case) and searches by family that minimally involved the consumer. For Lillian, Glenda, and Felicity, busy professional children made the choice for them. They did not take their mothers to visit places but relied on their own impressions.
- Nursing homes tended to steer consumers toward their own affiliated assisted living. This was illustrated by Lillian's situation. Her assisted living quarters, across the rotunda from her nursing home, was not ideal because of its distance from her home, church, and friends. Her son told the authors with satisfaction that he had "discovered one of the unwritten rules: If you're in a system you're better off staying in the system, because you're already a known quantity to them, and they'll give you priority." He thought he had managed a special deal, though, in fact the assisted living facility had many empty apartments, and other alternatives could have been considered had he taken the nursing home's assertion with a grain of salt.
- Consumers and their families were prone to confusing independent seniors housing settings and assisted living. Felicity had moved to a long-stay unit in a nursing home after three months in rehabilitation because her son thought wound care was impossible in assisted living, based on her experience in a previous assisted living facility. But Felicity had not been in assisted living previously but in a freestanding independent living setting. The CLS communicated that wound care was possible in assisted living. The change represented a large financial savings, because Felicity had been paying privately for the nursing home after rehabilitation ended.
- In contrast to Glenda, Felicity, and Lillian, who moved, regretfully, to assisted living, other consumers actively chose assisted living. Simon and Audrey both were frightened by dramatic events—Simon by a fall outdoors in the winter at his home at the end of a rural road, and Audrey by an episode where she almost bled to death. Others may have preferred to stay at home and accept risks, but both Simon and Audrey wholeheartedly chose
Table 3. Decisions Affecting Move to Assisted Living.

<table>
<thead>
<tr>
<th>Consumer Case</th>
<th>Precipitating Factors in Move</th>
<th>Assisted Living Choice and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simon, a wealthy bachelor in his 90s who lived on a lake on the outskirts of a small town.</td>
<td>Simon fell on the ice and fractured his hip. Since he lived on the end of a long, isolated road, the fall scared him. He wanted to be around people and closer to friends. He did not consider staying home and hiring in-home help.</td>
<td>Simon moved into a corner assisted living apartment near the hospital and nursing home where he had stayed. He declined home health services in assisted living, preferring the independence and sociability of going to the nearby hospital for outpatient rehabilitation. As his health declined, he had several additional hospitalizations, some with short nursing home stays. He eventually was readmitted to the nursing home, where he received hospice services and died a few months later.</td>
</tr>
<tr>
<td>Cynthia and her husband, Jim, both in their late 80s, moved from out of state.</td>
<td>The couple moved to a small Minnesota town after Cynthia, suffering from renal disease and other complicating chronic illnesses, had several hospitalizations in a neighboring state. With Cynthia now using a wheelchair and on dialysis, she and Jim wanted to live closer to their adult children and grandchildren. They decided on assisted living rather than independent living because they understood Cynthia’s health trajectory and did not want to be dependent on their children.</td>
<td>The couple chose a large assisted living apartment near the hospital where Cynthia continued to receive outpatient dialysis. Cynthia continued cooking some meals for the couple, and Jim accompanied her to dialysis appointments. The couple made regular social outings in their wheelchair-equipped van and went to restaurants. They considered the assisted living apartment to be their home and when, after a year, Cynthia was hospitalized and sent to a nursing home for rehabilitation, Jim learned and exercised his rights to make sure she could return home despite the assisted living facility’s effort to prevent or at least delay her return (although her Medicare days were used up). Jim became involved in the governance of the assisted living community.</td>
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<tr>
<td>Audrey, in her mid-80s, lived in a small town near her family.</td>
<td>Audrey, a widow, lived in her own home in a town where she and her husband had lived. Two sons lived in town and Audrey hoped one would move in with her. She offered him the house and a budget to renovate. Neither daughter-in-law could imagine that arrangement, though one, a nurse, was her primary supporter. Audrey moved to an independent apartment where she had a health scare, “almost bleeding to death.” After hospitalization and rehabilitation in a nursing home, she was urged to move to assisted living, and she agreed.</td>
<td>There were only two small assisted living facilities in the town because one closed after a fire. Audrey wanted to move into the small, family-style home for eight people located in the center of town. It did not offer the specialized wound care services she needed, but the CLS was able to arrange additional nursing services from a home health agency in the area. Audrey liked the “family-like” atmosphere in assisted living. A former teacher, she knew everyone in town, and her daughter-in-law described her as “the queen bee” in the setting. She was content in a room in a home rather than an assisted living apartment.</td>
</tr>
<tr>
<td>Lillian, in her mid-90s, previously lived in a suburban area in a ranch-style home.</td>
<td>Lillian much preferred staying in her home, with her memories of her husband and her friends nearby. She and her late husband were musicians and she wanted to keep her grand piano but felt she should accede to her son’s view that she should no longer go back home after several hospitalizations and nursing home stays.</td>
<td>Lillian moved into the large, apartment-style assisted living across a rotunda from the nursing home where she had received rehabilitation. Her son confided he chose it because he learned “a little secret” that it was much easier to get priority for assisted living if “you chose the assisted living affiliated with the nursing home.” By the time the CLS was referred the case, the plans had been made and the discharge date was set. The CLS thought Lillian might have been happier in assisted living closer to her suburban home. Lillian had not yet used the piano in the shared space.</td>
</tr>
<tr>
<td>Glenda, in her late 80s, was unable to manage illnesses in her private home.</td>
<td>After the latest episode of a broken hamstring, Glenda allowed her daughter to explore assisted living. Her daughter selected a spacious assisted living apartment that Glenda liked, even though being away from home was an adjustment.</td>
<td>The move-in was made more difficult because the nursing home information labeled Glenda as having substantial cognitive disability based on an admission MDS. On the other hand, she did need more help with meds that she was missing and in working up incontinence issues that she was concealing. The CLS worked with the assisted living nurse to modify the care plans and worked with Glenda on strategies to turn her assisted living apartment into a place she called home.</td>
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<tr>
<td>Felicity, a widow in her 80s, had lived in an independent living setting.</td>
<td>Felicity had a need for wound care upon nursing home discharge. Her son believed that was impossible to have wound care in assisted living—he mistakenly believed her previous setting was assisted living and it had no staff. After rehabilitation, she moved into a long-stay area of a homelike nursing home. She was happy there, although her needs were not enough to trigger her long-term care insurance, a clue to the community living specialist that she could be at a lighter and less costly level of care.</td>
<td>Felicity’s son signed up for RTCI when he was informed that wound care was possible in an assisted living facility. He sought assisted living with a strong Roman Catholic presence, which was important to his mother, and one able to offer wound care. Felicity moved to a rather old assisted living facility without the amenities of more spacious quarters with a full bathroom in the nursing home. But her functioning did improve at the assisted living level, and her son was grateful for both the decreased costs and what he considered a more independent setting.</td>
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assisted living. Cynthia and Jim also chose an assisted living apartment when they moved to Minnesota to be nearer to their children. They thought that the assisted living would offer them more independence and less burden for children as well as more care for Cynthia’s serious health condition.

**Fair Housing in Action**

Fair Housing rights were not clear-cut to exercise. Cynthia and Jim met resistance to Cynthia’s return to assisted living after her post-acute Medicare benefits ran out, but Jim’s advocacy and awareness of their rights prevailed. Jason’s family was urged to terminate his assisted living contract when he entered the hospital (Figure 1). Gertrude (not on Table 3 because she was not discharged to assisted living) had been in assisted living for several weeks (having just moved from the independent living level) when she sustained a fracture. The nursing home social worker who served the whole complex told the family their mother’s substantial dementia and age in the high 90s dictated she not return to assisted living after rehabilitation in the nursing home; she was “unsafe behind closed doors.” Gertrude’s four adult children and their spouses, all living in different towns within an hour or two from their mother, rejected this advice (one said, “I could not stand having Mom in a nursing home.”). Gertrude was discharged to the home of her oldest daughter, with sufficient in-home services so that her daughter continued working part-time and her son-in-law could work in his home office. The other siblings each dedicated a weekend a month to taking care of Gertrude. Technically, Fair Housing prohibited evictions, but several of these cases illustrate that consumers and families often declined to exercise the right to stay in the setting and arrange alternate services against objections of assisted living, on which the consumer would depend.

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**Unsafe Behind Closed Doors**

The phrase “unsafe behind closed doors” was heard in many of the 24 cases, with multiple perspectives and in all the other sources of information. The meaning needs to be further explored. It may refer to the increased privacy in apartment-style assisted living, compared to nursing homes. There is a belief that impulsive individuals, or people with judgment clouded by dementia or extreme frailty, are at risk of harm to themselves unless under visual surveillance. At a time when more privacy is emphasized for nursing home residents and more have private rooms, nursing home doors may also be closed. Sometimes the term was used by assisted living facilities that no longer wanted to care for someone who disturbed other residents and aggravated staff.

**Independent Seniors Housing**

Four case study consumers lived in seniors housing when they entered the nursing home via a hospital. Their experiences suggest issues particular to independent seniors housing communities:

- Many seniors housing programs had some services available for purchase or as part of the rent, including transportation, shopping, cleaning, health checks, and emergency assistance. Lucille, in her 80s, unable to drive and supported by only a younger, retired, out-of-town cousin who visited every few weeks, gratefully availed herself of these services. Lucille’s setting had gradually become a platform for health services, a trend in the last decade (Spillman, Biess, & MacDonald, 2012).
- With a hospital and nursing home stay, some families worried about whether independent housing was enough. Two somewhat younger seniors with lifelong disabilities, both supported by a sister and a brother, illustrated this phenomenon. Deanna, a 70-year-old consumer with mild intellectual disability, was supported by the housing program’s services and an arrangement her siblings arranged for another tenant to share a meal with Deanna in one of their apartments most evenings. Melanie, an independent 66-year-old retiree with cerebral palsy and who was legally deaf, was resourceful, devising systems of telephone and e-mail communication that she used to reassure her siblings.
she was fine. One in each sibling pair thought that his/her sister should consider moving somewhere with more services after their nursing home stays. Neither woman ended up moving, but the conclusion could have been different, especially for Deanna, whose brother was her legal guardian. (The brothers in these cases were older than their sisters with disability, and this may have accentuated their worries about housing-related needs for their sisters if they died first or became disabled and could not actively help.)

- Stigma associated with moves to higher-care levels in multilevel settings is noted in the literature (Shippee, 2009; Zimmerman et al., 2016) and illustrated in the cases. Maryann, a widow in her 90s, enjoyed her apartment in a 10-unit complex in the heart of town. She liked to volunteer and visit the affiliated nursing home around the corner and attended occasional concerts there. But when she sustained a serious fracture and ended up as a resident of the nursing home, she vehemently rejected a strong recommendation to move to the attached assisted living. To Maryann, that would have represented a dramatic change in lifestyle and self-image.

Return to the Community Initiative
Consumers as Caregivers

Leaving aside mutual support between elderly spouses and partners, many consumers were providing support, care, and/or financial resources to members of their family, especially to one or more children, a phenomenon noted by Brody (2013) when she turned her powers of observation to the independent seniors housing setting where she was living. Maryann received visits from her out-of-town daughter for two to three days about every two weeks. The daughter took her on errands that required a car and made food to freeze; Maryann had agreed to try Meals on Wheels, but so far her daughter’s help made them unnecessary. Maryann, in turn, supported her daughter in the latter’s health crisis and treatments. Lucille, also in independent living, provided support for her son, a nursing home resident, and in all likelihood received it as well, even though the living arrangements and inadequate transportation reduced their visit opportunities. Similarly, Jasper and Doris (Figure 2) were engaged in support for their youngest daughter, who had been traumatized during her former marriage, had health issues, and was under-employed. These cases illustrate the reciprocal family caregiving with the senior generation often assisting children or grandchildren with reversals, such as job loss, marriage dissolution, illness, and bereavement. RTCI consumers’ housing-related decisions often took into account the interests of their more vulnerable family members.

DISCUSSION

Housing has been noted as an element of long-term services and supports that, along with services, contributes to long-term services and supports effectiveness (Kane & Cutler, 2015; Kane & Kane, 2016). Consumers tend not to favor nursing homes as housing settings, nor do these settings generally enhance functioning or quality of life. When private-pay nursing home residents enter organized seniors housing settings, the decision may be harried and hurried. What professionals may view as arranging services after a nursing home stay, people living their lives may view as deciding where they will live, selling and buying furniture and cars, and sustaining important relationships. Golant (2015) has suggested “aging in the right place” is a better aspiration than “aging in place,” and it may be more possible to measure. Although the analysis in this article did not focus on RTCI per se, it pointed to problems of private-pay nursing home residents who could benefit from added assistance and advocacy, such as what CLSs provided in many of the cases the authors studied.

Strengths and Limitations

This article provided a glimpse into a group that has had little research attention: persons with financial resources who faced housing issues related to post-nursing home care. The authors’ approach gave them a broad glimpse into the consumer experience, and their sub-studies and sampling frames permitted an appreciation of the experiences of CLS-assisted consumers of different ages, disability types, incomes, and social support.
Table 4. Takeaways for Multiple Stakeholders.

Independent Senior Housing Providers

- Make sure consumers know the difference between organized senior independent living settings and assisted living.
- Develop and disseminate information about community services consumers can purchase to support their continued independent living.
- Consider collaborating with healthcare entities to make housing a platform for primary care, preventive services, and home care assistance.

Assisted Living Providers

- Consider how physicians and other primary care team members (e.g., nurse practitioners and physician assistants) could work more effectively within seniors.
- Consider organizing and joining public-private workgroups to examine how state regulatory and payment policies might better reinforce consumer goals.
- Consider in particular the kinds of approaches that would offer more opportunity to seniors without involved family members.
- Start or participate in the national movement to form “dementia-friendly” communities.
- Try to ensure that amenities on campus (e.g., restaurants, gardens, swimming pools, spas, or libraries) are available to everyone, including those at the nursing home.
- Be aware that few people want to move to higher care levels, which they associate with less personal freedom and fewer amenities.
- Explore how more people can stay in the independent living setting. Consider a business plan that minimizes skilled nursing home supply while improving its function-enhancing features like private rooms.
- Communicate clearly with assisted living staff and providers working in seniors housing settings about consumers referred to them. Make sure the information is accurate, up to date, specific, and comprehensive enough to be helpful. Telephone if a specific need should be discussed.
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Nursing Home Providers

- In a timely way, complete information that helps consumers realize additional benefits, such as providing documentation of their benefit eligibility for long-term care insurance or realizing veteran’s benefits.
- Get to know the new residents—their values and preferences. Realize that the move may evoke sadness, and support consumers during their transition. Be conscious that personalization of their new home and continuity with former friends is important.
- Consider following up with discharged residents, even those who go to assisted living, to find out if all is going well.
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Multilevel Long-Term Care Communities

- Ensure referrals between service levels on your campus (i.e., between nursing home and assisted living, or between independent housing and assisted living) are in the best interest of the consumer. Offer information about other options if they are available.
- Remember that consumer process in getting to rehabilitation does not reflect their geographic or personal preferences for a longer stay.
- Be aware that few people want to move to higher care levels, which they associate with less personal freedom and fewer amenities. Explore how more people can stay in the independent living setting. Consider a business plan that minimizes skilled nursing home supply while improving its function-enhancing features like private rooms.
- Try to ensure that amenities on campus (e.g., restaurants, gardens, swimming pools, spas, or libraries) are available to everyone, including those at the nursing home level, and develop the volunteer and staff capabilities to make that possible.

All Types of Seniors Housing Providers, Along with Other Stakeholders

- Consider organizing or joining a coalition at the local level—county, town, neighborhood—to identify and address unmet community needs that would help all seniors with disability live fuller, more meaningful lives, regardless of their dwelling places. (Transportation, escort services, specialized mental health services, low-cost dental services, and programs for loaning and repair of equipment may be among the needed areas.)
- Start or participate in the national movement to form “dementia-friendly” communities.
- In particular the kinds of approaches that would offer more opportunity to seniors without involved family members.
- Consider organizing and joining public-private workgroups to examine how state regulatory and payment policies might better reinforce consumer goals.
- Consider how physicians and other primary care team members (e.g., nurse practitioners and physician assistants) could work more effectively within seniors housing settings.
- Take every opportunity to participate in discussions about what vulnerable adult protection means operationally, including thinking about what reasonable safety means, what rights individuals should have to take informed safety risks, and what limitations to choice are necessary for the well-being of everyone in a group residential setting.
A limitation is that the authors did not capture any perspectives from or regarding consumer or family in “naturally occurring discharges”; i.e., discharged residents who did not participate in RTCI. The authors also lack a direct consumer or family voice for those who ended up staying in nursing homes, though CLSs and nursing home discharge personnel offered their perspectives on all three groups. Also, the study does not permit statistical distributions on the frequency of the themes the authors identified. Those themes suggest areas that could further be studied with quantitative designs, close-ended questionnaires, and a representative sampling frame.

CONCLUSION

Recommendations

Flowing from the themes found in this research, Table 4 makes recommendations for each of four types of providers: independent seniors housing, assisted living, nursing homes, and multilevel providers. The last row in the table suggests collective problem-solving with coalitions of housing providers plus other stakeholders in a given geographic area, such as municipal or county leaders, religious community leaders, transportation authorities, and physicians who practice in nursing homes and long-term services and supports setting. The authors’ recommendations are colored by the policies, practices, and circumstances of Minnesota, and solutions must take into account Minnesota’s service and labor force, its hot summers and frigid winters, its regulations, and its demographics. Other states and localities will have different starting points and contexts, but the building-blocks will be similar in considering the changes needed to help non-Medicaid seniors navigate better landings in the aftermath of a nursing home stay. The roots of issues raised in the commentary are, in part, systemic; thus, local consortia could identify gaps, consider barriers (including regulations), and seek creative ways to meet needs.

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