Determinants of Remaining in the Community Post-Discharge: Results from New Jersey’s Nursing Home Transition Program

Sandra Howell, Ph.D., Mina Silberberg, Ph.D., Winifred V. Quinn, Ph.D., Judith A. Lucas, Ed.D., R.N.

To inform states with nursing home transition programs (NHT), we determine what risk factors are associated with participants’ long-term readmission to a nursing home (NH) within a year after discharge. We examined New Jersey’s NHT program, Community Choice Counseling (CCC) program. Counselors work with the NHs to identify potentially eligible residents.

Model

We used Andersen’s behavioral model to select predictors of long-term NH readmission, and Cox proportional hazards regressions to examine the relative risk of experiencing such readmissions. Andersen’s behavioral model posits that health behaviors (including service use) are a function of predisposing, enabling, and need characteristics.

- Individuals’ predisposing characteristics are the most distal to service use and include demographic (such as age, marital status) and social factors (such as social support and health beliefs and attitudes).
- Enabling resources must be present for service use to take place and include indicators of saliency and community resources (such as eligibility for Medicare).
- Need factors (the most proximate cause) indicate indicators of self-perceived and practitioners’ evaluation of health.

We chose Andersen’s framework since it is a widely employed model and has long been used to explain the use of health services by the elderly and in particular to predict NH admission.

Results

- Although approximately one-third of the sample either experienced a NH readmission or died during the first year post-discharge, it is notable that the predominance of former NH residents (72%) continuously remained in the community.
- Of those who survived, 49% of those receiving a long-term readmission (72%) continuously remained in the community. Only 14% of those receiving a long-term readmission (72%) continuously remained in the community. Only 14% of those receiving a long-term readmission (72%) continuously remained in the community.
- Receipt of any help with ADLs, informal or formal, was significantly associated with dying or having a long-term readmission, perhaps because assistance is an indicator of greater underlying need.
- Notably, having at least one fall had almost twice the relative risk (1.86) of long-term readmission as those who did not.
- Those who remained in the community were also considered censored (not having experienced the event) at the end of 1 year after discharge.

Implications for Policy Makers

- Most of the factors predicting long-term readmission were predisposing, not need factors; this points to the kinds of behavioral approaches to assessing candidates for discharge and the importance of working with clients to understand and address their particular vulnerabilities.
- Unexpectedly, age and OLOS were not significant predictors of long-term readmission as previously reported in the literature. However, the direction of our bivariate findings suggests that OLOS was significant in serving as proxies for other factors such as frailty and social support.
- Since having a fall within 6-10 weeks post-discharge was significant, more resources might need to be directed towards home-based fall risk assessment and services that prevent falls.