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# Transitioning Back to the Community: Barriers Experienced by People with Acquired Brain Injury or Physical Disabilities

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Transitioning Back to the Community:  
Barriers Experienced by People with Acquired Brain  
Injury or Physical Disabilities

Deborah M. Pacik

B.A., Boston University, 1990

A Thesis

Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Public Health

At the

University of Connecticut

2018

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# APPROVAL PAGE

Master of Public Health Thesis

## Transitioning Back to the Community: Barriers Experienced by People with Acquired Brain Injury or Physical Disabilities

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2018

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## Introduction

As compared with living in institutions, such as nursing homes, community living is less isolating and improves quality of life. (Hoffman, Kehn, & Lipson, 2017; Robison et al., 2015). Benefits of living in the community include increased autonomy in decision-making, privacy, socialization, and dignity (Winkler, Farnworth, Sloan, & Brown, 2011). There are also significant cost savings when long-term services and supports (LTSS) are provided in the community rather than in an institution (Hoffman et al., 2017). Perhaps most importantly, both community- and institutional-dwelling adults prefer to live in the community when possible (Guo, Konetzka, Magett, & Dale, 2015; Eckert, Morgan, & Swamy, 2004; Nguyen, PrvuBettger, Guerrier, Hirsch, Thomas, Pugh, & Rhoads, 2015).

Community living satisfies the needs of people with disabilities who prefer living in a non-institutional setting and the budgetary needs of the federal and state governments to reduce spending on LTSS. LTSS accounts for a significant proportion of Medicaid spending, \$158 billion in 2015, of which \$87 billion went to HCBS (Eiken, Sredl, Burwell, & Woodward 2017).

The goal of reduced LTSS spending combined with consumer preference has led to changes in federal and state policies over the past few decades (Thomas et al., 2010). These changes have led to slower growth of LTSS spending over the past few years, in part due to a shift from institutional to community living (Eiken, 2017). Increased availability of home- and community-based services (HCBS) gives consumers more options for receiving care and support in the community, such as assistance with personal care and homemaking (Hass et al., 2017). The cost savings associated with HCBS combined with improved quality of life for those who live in a community make it imperative to understand what prevents people from transitioning out of institutions.

This paper will focus on people with an acquired brain injury (ABI) or a physical disability (PD). PD is broadly defined as difficulty with mobility or activities of daily living (ADL), such as bathing, dressing, and eating. In this thesis, PD refers specifically to the inability to perform two or more ADLs due to “chronic, severe, [and] permanent disability” (McEvoy, 2012). In addition to cognitive or behavioral issues, people with an ABI may also have physical disabilities and ADL impairments.

There are significant gaps in the literature regarding the current number of people living with either an ABI or PD in the United States. No official statistics have been published describing the incidence or prevalence of people living with ABI in the United States, however, there are an estimated 3.5 million new cases of ABI each year (Brain Injury Association of America, 2018). Institutional data is lacking but a 2013 report found that mobility (13%) and cognitive (11%) disabilities are the most common type of disabilities among community-dwelling adults (Courtney-Long et al., 2015).

Although transition rates have been identified, there are no previous studies comparing the transition rates of people with an ABI compared to those with a PD. Comparing these two different but overlapping populations will provide insight into transition challenges common to those who need assistance with ADLs and highlight the impact of cognitive and behavioral impairments found in the ABI group.

## Specific Aims and Hypotheses

### Aim 1

Compare community transition rates between the ABI and PD groups.

*Hypothesis:* People in the PD group will transition to the community more frequently than the ABI group.

## Aim 2

Compare challenges to community transition between the ABI and PD groups.

*Hypothesis:* The ABI group will have different challenges than the PD group.

## Aim 3

Identify the role of gender in transitioning back to the community for each group.

*Hypothesis:* Women will transition at greater rates than men in both groups based on previously published studies.

## Aim 4

Identify the role of age in transitioning back to the community for each group.

*Hypothesis:* Increasing age will decrease the likelihood of transitioning to the community.

## Aim 5

Identify the impact of length-of-stay on returning to the community.

*Hypothesis:* Longer length-of-stay decreases the likelihood of returning to the community.

## Aim 6

Identify and compare the subcategories for each challenge for the ABI group.

*Hypothesis:* People who closed prior to transitioning will have different subcategories within each challenge compared to those who transitioned.

## Aim 7

Identify and compare the subcategories for each challenge for the PD group.

*Hypothesis:* People who closed prior to transitioning will have different subcategories within each challenge compared to those who transitioned.

# Background

## ABI

### Defined

An ABI is an injury to the brain that can be traumatic or non-traumatic in origin. Non-traumatic causes include stroke, tumor, alcohol, and hypoxic-ischemic injury (Potter, Sansonetti, D’Cruz, & Lannin, 2017). Traumatic brain injury (TBI), as defined by the Center for Disease Control and Prevention (CDC), is an injury to the brain caused by trauma, such as a blow to the head or rapid acceleration-deceleration from a motor vehicle accident or fall, leading to neurological changes such as “...decreased level of consciousness, amnesia, other neurologic or neuropsychological abnormalities...intracranial lesions, or death” (Corrigan, Selassie, & Orman, 2010). Of note, congenital causes of brain injury are not included in the ABI designation (Potter et al., 2017).

### Cost and Prevalence

ABI is a significant problem in the United States but there is a lack of statistical data on non-traumatic causes. A Canadian study found that over a six-year period of time, there were over 51,000 hospitalizations due to non-traumatic brain injury among older people (Chan, Zagorski, Parsons, & Colantonio, 2013). The vast majority of literature on ABI focuses on TBI. The CDC estimated that in 2013, there were 2.5 million emergency department visits, 282,000 hospitalizations, and 56,000 deaths associated with TBI (CDC, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, 2017). Long-term disability associated with hospitalization for TBI affects over 3.2 million people (Corrigan et al., 2010). There is a significant financial cost to society; the total lifetime costs of all TBI injuries that

occur in one year is \$85.9 billion, when adjusted for inflation from 2000 to 2017. The youngest and oldest people are at greatest risk for a TBI, most often due to a fall. Young, white males tend to have more severe TBI that are caused by vehicular accidents (Cuthbert et al., 2011). People with TBI are younger than those with non-traumatic causes of ABI (Chiavaroli et al., 2016). These reported statistics are likely underestimates since only people treated in civilian hospitals and clinics are included; those treated in military and veterans hospitals are excluded from these statistics (Corrigan et al., 2010).

### Long-term sequelae

ABI affects over 12 million people in the United States (Brain Injury Association of America, 2018). The long-term sequelae affect many aspects of life, including cognition, such as memory and executive function, mood, behavior, and neurological disruption of gait and balance (CDC, 2015). Every aspect of life can be impacted: employment, relationships, life expectancy, and quality of life (Eum et al., 2015). Family and caregivers frequently display depression and experience reduced professional productivity (Corrigan et al., 2010).

## PD

### Defined

The definition of physical disability is somewhat amorphous with different organizations using a variety of different terms and inclusion criteria. One internationally-accepted definition of PD is a limited ability to perform ADLs independently or without an assistive device and self-report of functional limitations (Mahmoudi & Meade, 2015). The PCA waiver included people who required assistance with two or more ADLs. The Medicaid State Plan did not have specific

criteria for eligibility. For purposes of this paper, people who were only in either the PCA waiver group or on the Medicaid State Plan were included in the PD group.

### Cost and Prevalence

The definition of disability varies somewhat by study. That said, there are several relevant epidemiologic studies. A national study of community-living adults ages 24-64 reported that 13.4% of all participants had a physical disability as defined by “difficulties walking, climbing stairs, grasping objects, reaching overhead, lifting, bending or stooping for [a] long period of time” (Mahmoudi & Meade, 2015). This was similar to the 13% of adults living in the community who self-reported a mobility disability in the 2013 Behavioral Risk Factor Surveillance System (Courtney-Long et al., 2015). People with physical disabilities, using the same definition as the Mahmoudi study, had four times the annual medical expenses compared to people without physical disabilities (Reichard, Stolzle, & Fox, 2011).

### Long-term sequelae

People with physical disabilities report more chronic health conditions, such as hypertension and diabetes, as well as self-reported overall poor health, than those without disabilities (Mahmoudi & Meade, 2015). This same study found that prior to implementation of the Affordable Care Act (ACA), people with physical disabilities had less access to medical and dental care and prescription medications.

### Barriers to Transitioning into the Community

There are myriad reasons that make it difficult for people with disabilities to transition from living in an institution to living in the community, such as length-of-stay (LOS), age, affordable housing, and lack of family support (Arling, Kane, Cooke, & Lewis, 2010; Chiavaroli

et al., 2016; DeVivo, 1999; Gassoumis, Fike, Rahman, Enguidanos, & Wilber, 2013; Greene & Ondrich, 1990; Hass et al., 2017; Yoo et al., 2013). The literature is mixed on the role of gender with some studies showing that women are more likely to transition than men and others showing the opposite or no difference (Mudrazija, Thomeer, & Angel, 2016; Gassoumis, Fike, Rahman, Enguidanos, & Wilber, 2013; Mees, 2016). Previous studies have shown that consumer preference and family support play a significant role in successful transitions and a lack of either leads to decreased likelihood of transitioning (Arling et al., 2010; Winkler et al., 2011). Additionally, inadequate affordable housing and housing supports are critical for people with all types of disabilities to move back into the community (Hoffman et al., 2017; Irvin, Denny-Brown, Morris, & Postman, 2016).

Although previous studies have identified barriers that make transitioning back to the community less likely, specific barriers for people eligible for ABI and PD Medicaid waivers have not been identified. Understanding the many obstacles faced by people with an ABI or PD when moving from an institution to the community is a key step in making the process easier and more successful.

## Supports for Transition to the Community

### HCBS

There are many services and supports that facilitate both the transition process and remaining in the community. Home- and community-based services (HCBS) allow people to receive assistance and care while outside of an institution and are fundamental to remaining in the community (Grabowski et al., 2010). LTSS provide “home health care, personal care, homemaker services, adult day care, respite care, and assisted living.” The goal of HCBS is to

keep people living in the community as independently as possible rather than moving into an institution, such as a nursing or a large group home.

### Medicaid waivers

Medicaid waivers provide HCBS care for targeted populations (Shirk, 2006). The waivers give people access to a greater array of services and supports than traditional Medicaid coverage (McEvoy, 2012). They are used by states to provide care and services to their residents who otherwise would require institutional care. Medicaid HCBS costs must be less than institutional costs for each individual in order to reduce or contain costs associated with LTSS (Hargan, 2017; Robison et al., 2015; Shirk, 2006). In 1999, the Supreme Court ruled in *Olmstead v. L.C.* that states must provide care in an integrated setting rather than in an institution (Shirk, 2006). This combined with efforts to reduce LTSS costs have given impetus to expanding Medicaid waivers and increasing the availability and use of HCBS.

### MFP

Consumer use of HCBS and Medicaid waiver programs is facilitated by Money Follows the Person (MFP), a federal demonstration program implemented by the majority of states. Funding for MFP comes from the Centers for Medicare and Medicaid Services (CMS) and provides support for people in some Medicaid waiver programs. MFP utilizes the flexibility of Medicaid HCBS to improve LTSS (Hargan, 2017). There are two goals of MFP: increase the availability and quality of HCBS and to increase the number of people living in the community rather than in an institution (Hass et al., 2017; Leedahl et al., 2015; Robison et al., 2015). These goals must be met while simultaneously reducing costs for LTSS.

The type of supported services and supports vary depending on the specific program, but may include transition costs, such as rental assistance and home modifications, housing

assistance, personal care services, and vocational support (Robison et al., 2015). MFP pays directly for some of these extra demonstration services whereas all regular Medicaid HCBS costs are paid by the Medicaid program but with an increased match from CMS. Instead of the standard 50/50 split, the federal portion is higher for the first 365 days. States use the extra money to improve the HCBS infrastructure thus increasing availability of these services. The combination of HCBS, Medicaid waivers, and MFP provides residents of institutions opportunities and support during their transition back to the community.

## Community Living

Living in the community is not just having a home or apartment outside of an institution. It means living in a home or an apartment with appropriate services and supports and social integration in the community (Freeman et al., 2017; Robison et al., 2015). Community integration improves the quality of life for most people who have transitioned from an institution (Espinosa, 2015; Freeman et al., 2017; Hoffman et al., 2017; Robison, 2015).

Some of the benefits of living in the community are increased choice and dignity, privacy, and decreased isolation due to more socializing. (Winkler et al., 2011). Simple things, such as choosing what time to sleep and eat, are often not possible in an institution (Racino & Williams, 1994). Younger people living in nursing homes have few interactions with their peer group and minimal opportunities to participate in activities such as shopping or community recreation (Winkler et al., 2011).

In addition to improved quality of life, there are significant cost savings compared to institutional care (Espinosa, 2015; Hass et al., 2017; Hoffman et al., 2017; Robison, Shugrue, Porter, Fortinsky, & Curry, 2012). Institutional care is expensive and services and supports in the community cost less. Many residents are able to perform many of their ADLs independently, do

not need intense medical care, and therefore do not require the high level of care found in an institution (Arling, Abrahamson, Cooke, Kane, & Lewis, 2011). Providing HCBS instead of institutional care would both reduce costs and improve their quality of life.

Although there are many benefits to living in the community rather than an institution, there may be difficulties associated with the transition. The funding availability of HCBS is variable between states and communities leading to unmet needs (Robison et al., 2012). Suboptimal levels of services and supports may cause complications, such as increased hospitalizations or nursing home readmissions if the care provided does not meet the needs of the consumer (Konetzka, 2014; Robison et al., 2012). Family members and friends may fill in the gaps of care which can lead to increased stress in relationships and caregiver burnout (Turner, 2007).

## Methods

### Participants

There were 446 people in the ABI program and 2,556 in the PD program enrolled in Connecticut's MFP between December 2008 and November 2017 for a total of 3,002 participants. Those in the ABI waiver program and the Personal Care Attendant (PCA) Medicaid Home and Community Based Services Waiver and the Medicaid Physical Disability State Plan groups were included in the study. The PD group included participants in the PCA and Physical Disability programs. The information was de-identified prior to inclusion in the data set used for analysis.

The Connecticut ABI waiver program was available to adults ages 18 and older with an acquired brain injury that does not include developmental or degenerative disorders who prefer

to live in the community rather than an institution (McEvoy, 2012). Services provided with this waiver included independent living and vocational skills training, housing support, modifications for home and vehicle, home-delivered meals, supported employment, homemaker services, and mental health support.

The PD Medicaid program was available to people with “chronic, severe, permanent disability” but did not include those with mental illness, mental retardation, or dementia (McEvoy, 2012). People in this program were required to self-direct their services (including hiring, training and managing staff), or have a family member to assist them with managing their employees. Adults 18 years and older who needed assistance with two or more ADL were eligible for this program. This waiver provided assistance with ADLs such as feeding, bathing, grooming and dressing, continence, and toileting and emergency response systems. There were separate Medicaid waivers that served older adults or those with development and degenerative diseases. Since the ABI waiver provided more financial assistance than the PD Medicaid programs, people eligible for both were placed in the ABI program. Therefore, people in the ABI group may have had a PD in addition to an ABI, whereas the PD group included those with only physical disabilities.

## Study Procedures

People were eligible for the MFP program after 90 or more days of being in an institution, such as a nursing home, skilled nursing facility, or LTSS hospital. (Hargan, 2017; Leedahl et al., 2015).

There were a number of referral methods (J. Robison et al., 2015). Participants were referred by family members, social workers, or self-referred. The transition team consisted of the resident, family members, case managers and coordinators, a social worker, and other

appropriate health care providers. After obtaining informed consent to participate in the MFP demonstration project, a person-centered transition plan was designed based on the consumer's goals and preferences.

All consumers referred to MFP met with transition coordinators and specialized care managers throughout the transition process (Center on Aging, 2016). Transition coordinators and care managers collected data about transition challenges using a standardized checklist to determine challenges faced by each participant. The challenge checklist was updated monthly until the consumer transitioned or the case was closed. Demographic data was collected at the first meeting with the consumer. The University of Connecticut IRB reviewed and approved the procedures.

## Measures

The primary outcome measure and dependent variable was transition back to the community, a dichotomous variable - transitioned or did not transition. Community living included private homes, individually-leased apartments, and group homes with four or fewer people (Connecticut Department of Social Services, 2011) Cases may have closed prior to transition for many reasons, including lack of signed informed consent, high level of physical or mental health needs that exceeded the programs' ability to provide appropriate services, death prior to transition, return to institution for more than 90 days within first 365 days after transition, and withdrawal of MFP application by the participant or conservator (Ruiz, Shugrue, Kichuk, & Robison, 2014).

The independent variables were participation in either the ABI or PD Medicaid program, the Transition Challenges: physical health, mental health, housing, consumer engagement, services and supports, waiver, MFP, other persons, legal, facility, and financial, see Figure 1 for

the details and subcategories of each challenge. Each transition challenge was categorized as a dichotomous variable, the challenge was present or absent. Other independent variables were gender, age, and LOS. Gender was a dichotomous variable. Age was categorized as a continuous variable. LOS was the difference between the day of admission to an institution and the date of either transition to the community or when the case was closed with no transition and was categorized as a continuous variable. Subcategories of the transition categories were measured as percentages. These were included to better understand the nuances and factors contributing to each challenge.

## Analyses

All data analysis was done with SPSS, version 25. The percentage and significance of ABI and PD cases that transitioned out of the combined ABI and PD cases was calculated. A chi-square test was performed to test the null hypothesis that there was no association between frequency of transitions and inclusion in either the ABI or PD programs. Descriptive statistics were analyzed, including frequencies and cross tabulations, to characterize the groups and subgroups that transitioned and the challenges faced within these groups.

A qualitative cross tabulation analysis was done to assess the independent associations of the barriers faced by each group, ABI and PD, by eleven challenge categories: physical health, mental health, housing, consumer engagement, services and supports, waiver, MFP, other persons, legal, facility, and financial as well as gender. A chi-square test was performed to test the null hypothesis of no association between these independent variables and transition status.

Relationships between transition to the community and the independent variables age and LOS were analyzed using an independent t-test. A correlation matrix of the independent variables was created to determine the relationship and dependence between the variables.

A binary logistic regression was done for each group, ABI and PD, to assess the statistical significance of the model, identify variance of the independent variables, and to control for the independent variables. Adjusted odds ratios were calculated to determine the strength of the contribution to the outcome.

The contribution of each transition challenge subcategory towards the overall challenge was calculated as percentages.

## Results

### Transition Rates: ABI versus PD

There were 3,002 people in the ABI and PD groups. There were 446 (14.9%) people in the ABI group. The PD group had 2556 (85.1%) people. Of the total 3,002, 1,850 (61.6%) transitioned. There were 257 (57.6%) in the ABI group who transitioned to the community and 1,593 (62.3%) in the PD group transitioned. There was no statistically significant difference in transitions between the two groups. No association was found between the type of program and the likelihood of transitioning back to the community, chi-square (df=1, N = 3002) = 3.548, p = 0.060.

### Transition Rates by Challenge Category

Table 1 shows the transition rates for the ABI and PD groups and includes the challenge categories from the transition checklist.

Table 1: Transition Rates for each Challenge Category

	ABI (N = 446)	PD (N = 2556)
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	Transitioned		p-value	Transitioned		p-value
	%	N		%	N	
Has Challenge - Physical	53.2	156	.010**	60.9	1085	.023*
Does not have Challenge - Physical	66.0	101		65.6	508	
Has Challenge - Mental	55.1	124	.279	59.9	668	.027*
Does not have Challenge - Mental	60.2	133		64.2	925	
Has Challenge - Housing	61.5	150	.070	65.0	1135	.000**
Does not have - Housing	53.0	107		56.6	458	
Has Challenge – Consumer Engagement	49.0	100	.001**	53.8	454	.000**
Does not have – Consumer Engagement	64.9	157		66.5	1139	
Has Challenge – Services and Supports	57.9	113	.902	62.5	779	.842
Does not have Challenge – Services and Supports	57.4	144		62.1	814	
Has Challenge - Financial	63.2	72	.166	69.0	755	.000**
Does not have Challenge - Financial	55.7	185		57.3	838	
Has Challenge - Facility	65.3	49	.138	65.7	261	.126
Does not have Challenge - Facility	56.1	208		61.7	1332	
Has Challenge - Legal	54.1	53	.422	61.8	433	.722
Does not have Challenge - Legal	58.6	204		62.5	1160	
Has Challenge – MFP Program	56.3	67	.733	64.2	325	.323
Does not have Challenge – MFP Program	58.1	190		61.9	1268	

Has Challenge - Waiver	48.2	122	.000**	61.9	568	.765
Does not have Challenge - Waiver	69.9	135		62.5	1025	
Has Challenge – Other People	43.9	25	.024*	51.8	171	.000**
Does not have Challenge – Other People	59.6	232		63.9	1422	
Has Challenge - Other	59.3	16	.859	57.0	73	.205
Does not have Challenge - Other	57.5	241		62.6	1520	

In the ABI group, the significant challenges related to transitioning to the community were physical health, consumer engagement, waiver, and other involved people. Those with a physical health challenge were less likely to transition than those without this challenge (53% vs. 66%). People with a consumer engagement challenge were significantly less likely to transition (49% vs. 65%). A waiver challenge decreased transitions compared to those without this challenge (48% vs. 70%). When other involved people were a challenge, the transition rate decreased (44% vs. 60%).

In the PD group, the significant challenges to transition were physical health, mental health, housing, consumer engagement, financial, and other involved people. There was also a significant correlation between gender and transitioning. Those with a physical health challenge were less likely to transition (61% vs. 66%). A mental health challenge decreased transitions compared to those without a mental health challenge (60% vs. 64%). Those with a housing challenge were more likely to transition (65% vs. 57%). Lack of consumer engagement decreased transitions (54% vs. 67%). The presence of a financial challenge increased the rate of transitions (69% vs. 57%). When other involved people were a challenge there were fewer transitions (52% vs. 64%).

Significant challenges common to both groups that decreased transitions were physical health, consumer engagement, and other involved people.

## Transition Rates by Gender

Table 2 shows the transition rates by gender for each group. There was no significant difference in transition rates between men and women in the ABI group. However, in the PD group, men were significantly more likely to transition than women (64% vs. 60%).

Table 2: Transition Rates by Gender

	ABI (N = 446)			PD (N = 2556)		
	Transitioned		p-value	Transitioned		p-value
	%	N		%	N	
Gender - Female	56.3	85	.684	59.9	612	.038*
Gender - Male	58.3	172		64.0	981	

## Age

Table 3 shows the average age of those who transitioned and did not transition in both the ABI and PD groups.

Table 3: Age and transition rates

	ABI (N = 446)				
	Transitioned (mean)	No Transition (mean)	Mean Difference	95% Confidence Interval	p-value
Age (years)	44.6 (sd 12.6)	51.4 (sd 9.3)	6.9	4.7-8.9	.000

	PD (N = 2556)				
	Transitioned (mean)	No Transition (mean)	Mean Difference	95% Confidence Interval	p-value

Age (years)	51.3 (sd 10.2)	53.3 (sd 8.7)	1.9	1.2-2.7	.000
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### Independent T-Test - ABI and Age

In the ABI group, those who transitioned were significantly younger on average than those who did not transition, with a mean difference of 6.9 years of age ( $p = .000$ ). The 95% confidence interval showed the age difference was between 4.7 and 8.9 years. The mean age of those who transitioned was 44.6 (standard deviation 12.6) whereas those who did not transition had a mean age of 51.4 (standard deviation 9.3).

### Independent T-Test - PD and Age

In the PD group, those who transitioned were significantly younger than those who did not transition, with a mean difference of 1.9 years ( $p = .000$ ). The 95% confidence interval showed the age difference was between 1.2 and 2.7 years. The mean age of those who transitioned was 51.3 (standard deviation 10.2) whereas those who did not transition were a mean age of 53.3 (standard deviation 8.7).

### Length-of-Stay (LOS)

Table 3 shows the average LOS of those who transitioned and did not transition in both the ABI and PD groups.

Table 3: LOS and transition rates

	ABI (N = 446)				
	Transitioned (mean)	No Transition (mean)	Mean Difference	95% Confidence Interval	p-value
LOS (days)	824 (sd 703)	989 (sd 619)	165	38-293	.011

	PD (N = 2556)				
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	Transitioned (mean)	No Transition (mean)	Mean Difference	95% Confidence Interval	p-value
LOS (days)	489 (sd 489)	696 (sd 671)	208	162-253	.000

### Independent T-Test - ABI and LOS

People in the ABI group who transitioned had shorter LOS than those whose cases closed without transition. There was a mean difference of 165 days with the independent t-test at  $p = 0.011$  assuming equal variances. The 95% confidence interval showed the difference in LOS was between 38 and 293 days. The mean LOS of those who transitioned was 824 days (standard deviation 703 days) whereas those who did not transition had a mean LOS of 989 days (standard deviation 619 days), before their case was closed.

### Independent T-Test - PD and LOS

People in the PD group who transitioned had shorter LOS than those whose cases closed without transition. There was a mean difference of 208 days using the independent t-test with  $p = 0.000$  assuming equal variances. The 95% confidence interval showed the difference in LOS was between 162 and 253 days. The mean LOS of those who transitioned was 489 days (standard deviation 495 days) whereas those who did not transition had a mean LOS of 696 days (standard deviation 671 days).

### Correlation Matrix

After running the bivariate analyses, a correlation matrix was used to analyze the relationships between the independent variables to identify any issues of multicollinearity. None of the independent variables were correlated more than .321 showing there was no significant dependence between the variables and in fact are independent from one another.

## Logistic Regression

### ABI

Table 4 shows the logistic regression of all the independent variables. The model chi-square was 95.31 ( $p = .000$ ) indicating that the independent variables that contributed to the overall model had a statistically significant impact on the dependent variable, whether a person transitioned back to the community or not. The -2 Log likelihood (-2LL) was 498.9 and the Nagelkerke  $R^2$  was .264 showing that 26% of the variance was explained by the model. The independent variables that made a significant contribution to the model for the ABI group were housing challenges, consumer engagement, facility challenge, waiver or HCBS program, other involved individuals, and age. People with housing challenges were 1.75 times more likely to transition than people with no housing challenges. A facility challenge made a transition 2.28 times more likely. People with consumer engagement challenges were 42% less likely to transition. People with a waiver or HCBS program challenge were 62% less likely to transition. A challenge with other involved individuals made it 57% less likely for transitions to occur. Older people were 6% less likely to transition than younger people.

Table 4: Adjusted odds ratio for effects of challenges, age, LOS, and gender on transition to the community from an institution in ABI group

	<b>B</b>	<b>Adjusted odds ratio</b>	<b>95% CI</b>	<b>P value</b>
<b>Transition Challenges</b>				
Physical health	-.338	.713	.427 – 1.191	.197
Mental health	.129	1.138	.701 – 1.847	.600
Housing	.560	1.751	1.072 – 2.860	.025*
Consumer Engagement	-.539	.583	.350 - .973	.039*
Services and Supports	-.031	.969	.585 – 1.605	.903
Financial	.427	1.533	.905 – 2.597	.112
Facility	.826	2.284	1.231 – 4.241	.009**

Legal	-.230	.795	.457 – 1.383	.416
MFP or Transition Coordinator	-.261	.770	.465 – 1.278	.312
Waiver or HCBS program	-.970	.379	.238 - .604	.000**
Other involved individuals	-.853	.426	.220 - .827	.012*
Demographic factors	<b>B</b>	<b>Adjusted odds ratio</b>	<b>95% CI</b>	<b>P value</b>
LOS	.000	1.000	.999 – 1.000	.148
Age	-.065	.937	.918 - .957	.000**
Gender	.030	1.030	.650 – 1.631	.900
<b>Model Chi-Square</b>	<b>df</b>	<b>P Value</b>	<b>-2LL</b>	<b>Nagelkerke R<sup>2</sup></b>
95.31	14	.000	498.9	.26

## PD

Table 5 shows the logistic regression for the PD group with all of the independent variables. The model chi-square was 176.63 ( $p = .000$ ) indicating that the independent variables that contributed to the overall model had a statistically significant impact on the likelihood that a person transitioned back to the community. The -2LL was 3,152.9 and the Nagelkerke  $R^2$  was .09 showing that 9% of the variance was explained by the model. The independent variables that made a significant contribution to the model for the PD group were housing challenges, consumer engagement challenge, financial challenge, legal issues, other involved individuals, LOS, and age. Those with a housing challenge were 1.35 times more likely to transition than those without this challenge. A financial challenge made it 1.44 times more likely to transition. People with a consumer engagement challenge were 33% less likely to transition than those without the challenge. The presence of a legal challenge made a transition 17% less likely. The challenge of other involved individuals made it 31% less likely that people with this challenge would transition. People with longer LOS were 1% less likely to transition. Older people were 2% less likely than younger people to transition.

Table 5: Adjusted odds ratio for effects of significant challenges and age on transition to the community from an institution in PD group

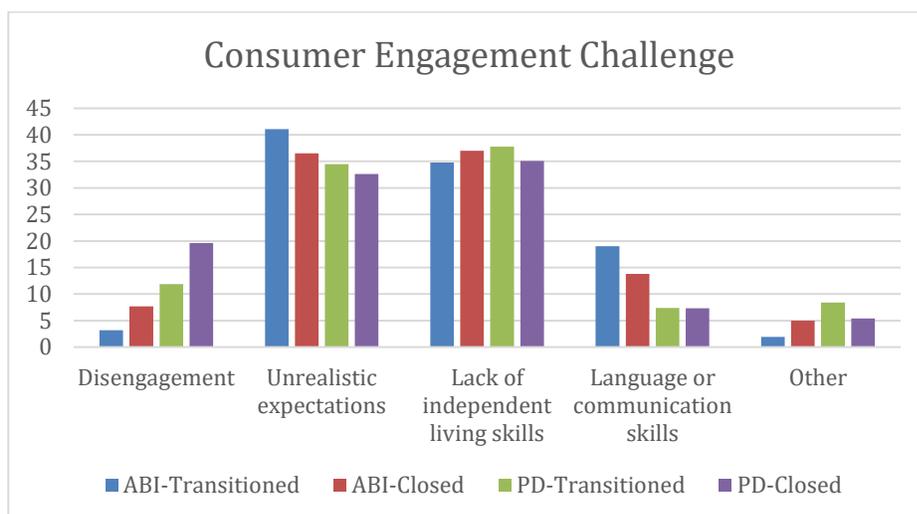
	<b>B</b>	<b>Adjusted odds ratio</b>	<b>95% CI</b>	<b>P value</b>
<b>Transition Challenges</b>				
Physical health	-.171	.843	.690 – 1.030	.094
Mental health	-.104	.901	.749 – 1.083	.267
Housing	.303	1.354	1.114 – 1.646	.002**
Consumer Engagement	-.402	.669	.551 - .812	.000**
Services and Supports	.073	1.076	.894 – 1.294	.438
Financial	.365	1.440	1.196 – 1.733	.000**
Facility	.139	1.149	.899 – 1.469	.266
Legal	-.187	.829	.677 – 1.015	.070*
MFP or Transition Coordinator	.156	1.168	.936 – 1.458	.168
Waiver or HCBS program	.177	1.194	.995 – 1.434	.057
Other involved individuals	-.371	.690	.536 - .890	.004**
<b>Demographic factors</b>	<b>B</b>	<b>Adjusted odds ratio</b>	<b>95% CI</b>	<b>P value</b>
LOS	-.001	.999	.999 – 1.000	.000**
Age	-.021	.979	.970 - .988	.000**
Gender	-.070	.933	.784 – 1.110	.433
<b>Model Chi-Square</b>	<b>df</b>	<b>P Value</b>	<b>-2LL</b>	<b>Nagelkerke R<sup>2</sup></b>
176.63	14	.000	3152.9	.09

## Percentages of Subcategories for each Challenge

Every challenge was comprised of multiple subcategories that provided more detailed information about the reasons that people did not transition back to the community. Identifying the dominant subcategories in each challenge can be used to develop solutions to overcome these obstacles. The following pie graphs show the percentages of each subcategory within each challenge. Comparisons are made between the ABI and PD groups and transitioned versus closed prior to transition.

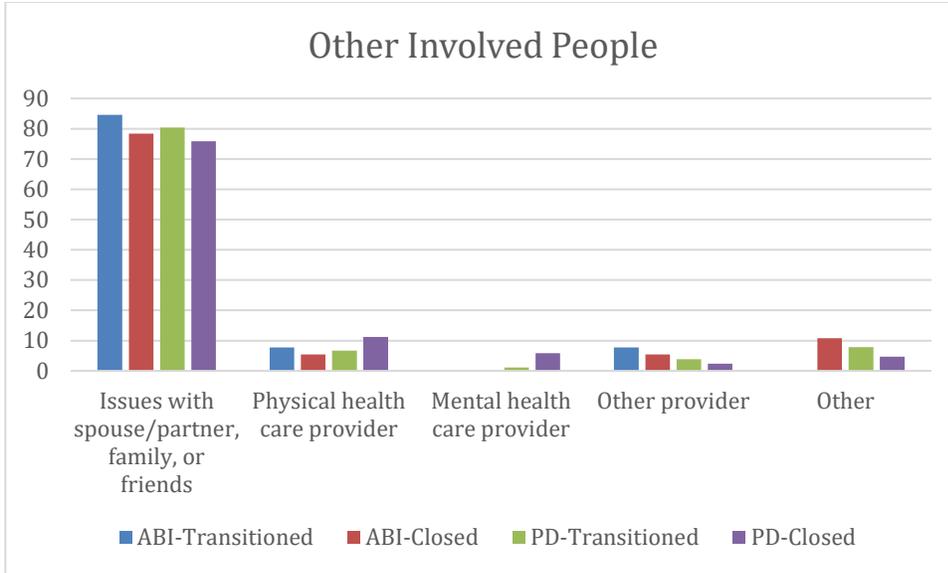
## Chart 1: Consumer Engagement

The two greatest consumer engagement challenges for both groups was a lack of awareness or unrealistic expectations regarding their disability or needed supports and a lack of independent living skills. Language or communication skills was more prevalent in the ABI group versus the PD group. Disengagement or lack of motivation was more common in the PD group.



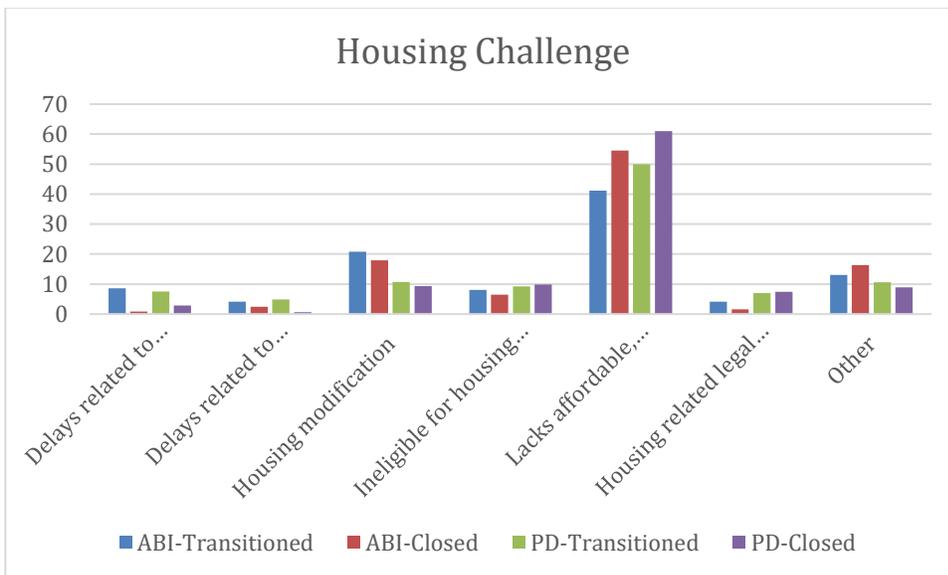
## Chart 2: Other Involved People

The overwhelming cause of other people as a challenge in both groups was issues with spouse or partner, family, or friends. In the PD group, a small percentage of people had a mental health provider who did not support the transition whereas no one in the ABI group reported this challenge.



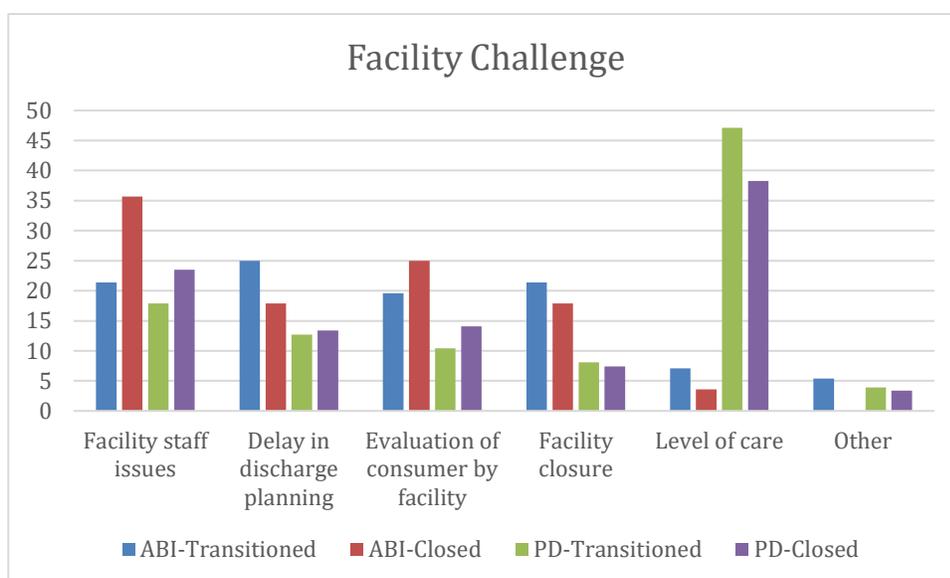
### Chart 3: Housing

The most frequent housing challenge for both groups was the lack of affordable and accessible community housing. A greater percentage of people in the ABI group had a challenge related to housing modification than in the PD group.



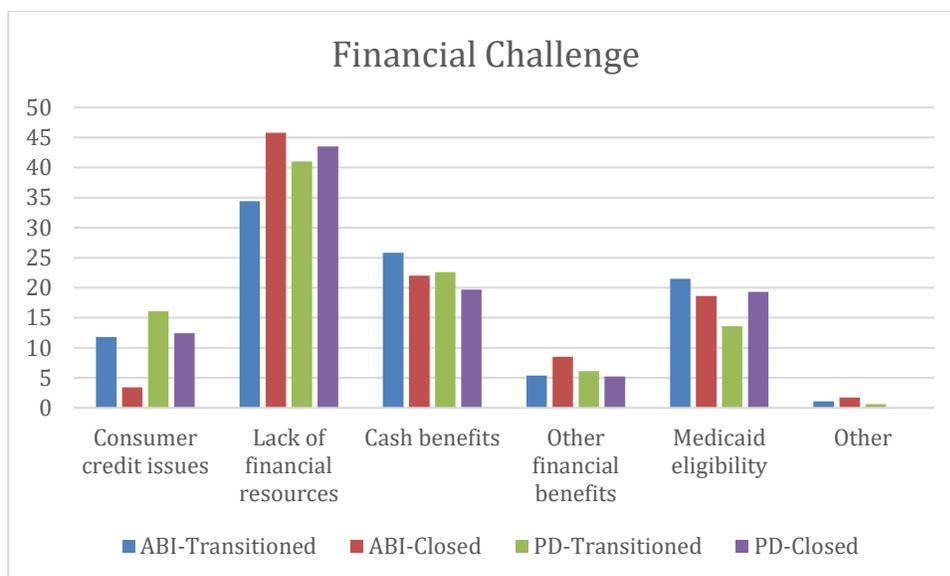
## Chart 4: Facility

Those who did not transition in the ABI group were most likely to have facility staff or administrative issues as a facility challenge. Other prevalent issues in the ABI group were facility closure, evaluation of the consumer, and delay of discharge planning. The PD group's most frequent facility challenge was level of care issues related to behavioral health issue, much more so than those in the ABI group. Facility closure played a much smaller role in the PD group than the ABI group.



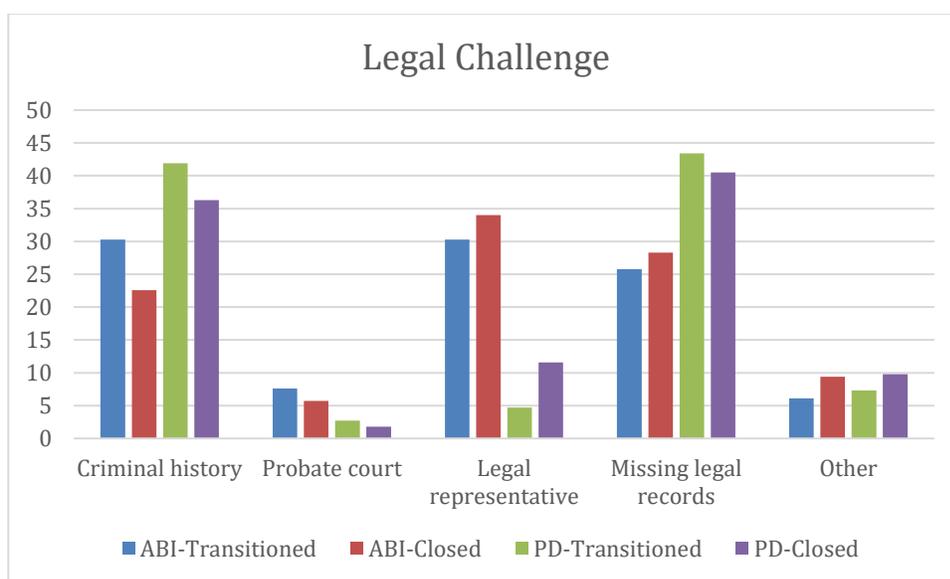
## Chart 5: Financial

Both groups had a lack of or insufficient financial resources as their most frequent financial challenge as well as benefits and Medicaid eligibility or insurance issues.



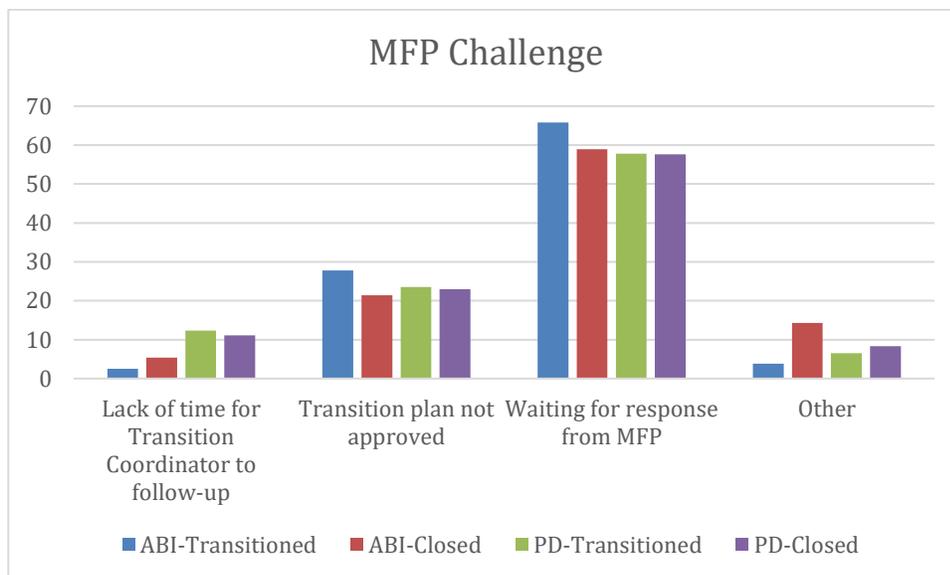
## Chart 6: Legal/Criminal

In the legal/criminal challenge, both the ABI and PD groups had missing birth certificate or related records, and criminal history as the most common causes. The ABI group also had a lack of or unsupportive legal representation.



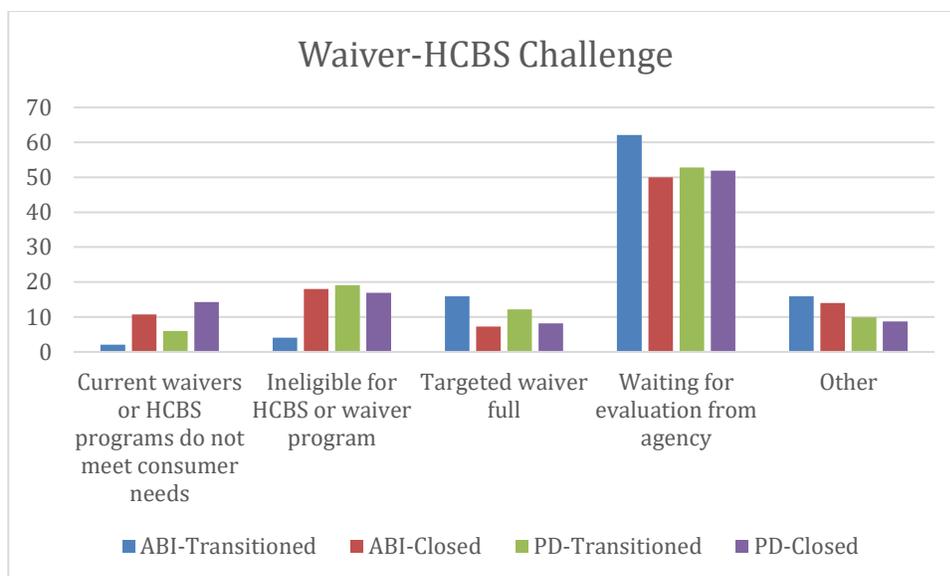
## Chart 7: MFP

The single most frequent cause of an MFP challenge for both groups was waiting for a response or approval from the MFP office. In both the ABI and PD groups, a large percentage of people had a transition plan that was not approved. Compared to the ABI group, lack of time for Transition Coordinator to follow up was more of an issue in the PD group.



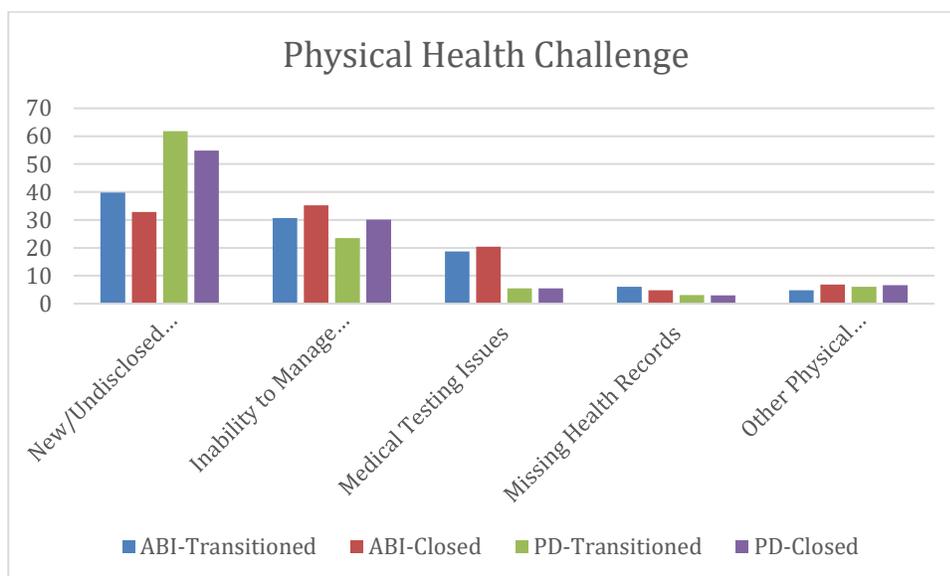
## Chart 8: Waiver

The ABI and PD groups had waiting for evaluation, application review, or a response from waiver or HCBS agency as the most common waiver/HCBS challenge. In both groups, more people who did not transition had waiver or HCBS programs that did not meet their needs.



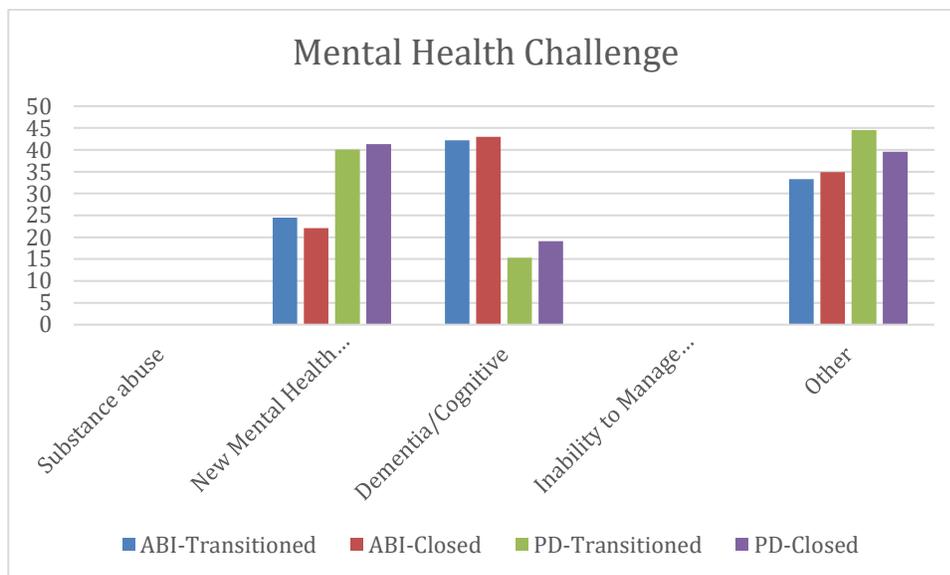
## Chart 9: Physical Health

The most frequent cause of a physical health challenge for both groups was new or undisclosed physical health problems. The second most common cause was the inability of the resident to manage their physical disability or illness in the community. The ABI group had more people with medical testing issues than the PD group.



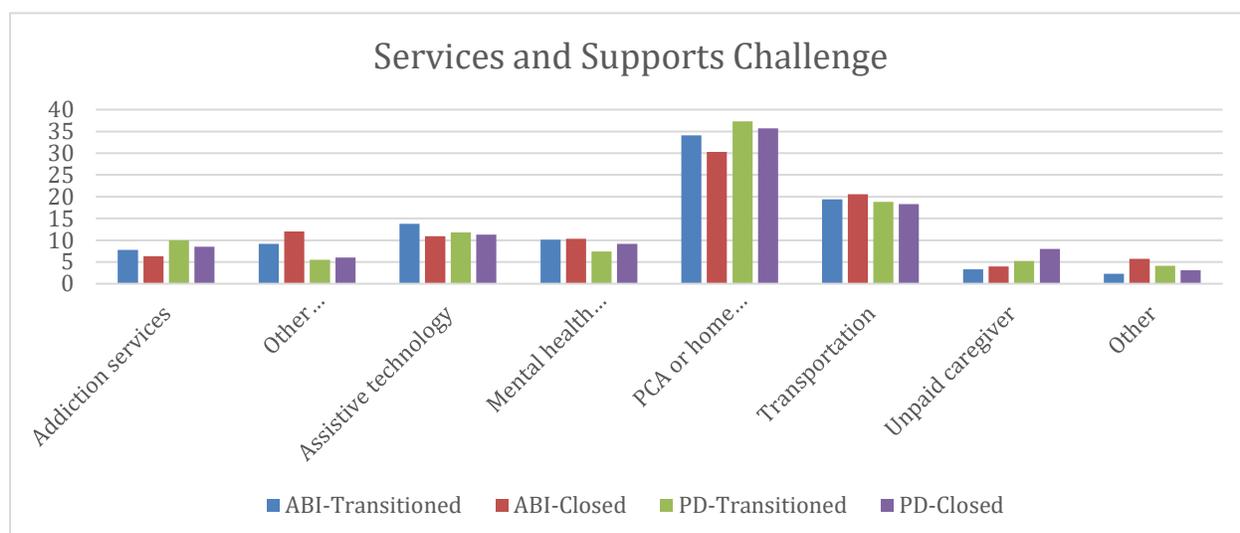
## Chart 10: Mental Health

In the ABI group, the greatest mental health challenge was dementia or cognitive issues. The two most common mental health challenges in the PD group were new or undisclosed mental health issues and other types of mental health issues. Neither group had reported issues with substance abuse or inability to manage mental health.



## Chart 11: Services and Supports

The most common cause of a services and supports challenge in both groups was due to a lack of PCA, home health, or other paid support staff. Lack of transportation was also frequently reported in both groups. Both groups reported similar rates of lack of assistive technology or durable medical equipment and lack of mental health services or supports in the facility or the community.



## Discussion

### The study's major findings

This study found that there was no statistically significant difference between people in the PD group transitioning back to the community compared to people in the ABI group, although the PD groups transitioned at slightly greater rates than the ABI group. Significant barriers to transition in both groups were issues with consumer engagement, other involved individuals, and age. A housing challenge *increased* the likelihood of transitioning in both groups. In the ABI group, a waiver challenge was a significant barrier to transition, whereas a facility challenge *increased* the likelihood of transitioning in this group. In the PD group, legal/criminal challenges and LOS were significant barriers to community transitions, whereas financial challenges increased the likelihood of transitioning.

## Greater percentage of people in PD group transitioned than in ABI group, but no statistically significant difference

Although people in the PD group transitioned at slightly greater rates than those in the ABI group, the results were not statistically significant, which supports the null hypothesis that there is no difference in transition rates between the groups. This was similar to findings by Baker, et al. (2016) where people in the CT MFP program under the age of 65 years with physical disabilities transitioned at greater rates than other target populations, such as older adults (Baker, Porter, Shugrue, & Robison, 2016). The level of support for the ABI waiver is much greater both in types of services and financial support than the PD Medicaid programs, which provides only PCA services, or PD state plan services. As of 2012, ABI monthly coverage was up to \$11,596.00 per month whereas the PD Medicaid program amount was determined by the degree of impairment (McEvoy, 2012). It may be that although people with an ABI may have more types of disabilities, the higher amount of support equalizes the rates of successful transitions between the groups. In this study, only 14.9% of the population studied were in the ABI waiver group; a larger number of subjects may increase the significance of the findings.

## Significant barriers to transition in both groups

### Consumer Engagement

Consumer engagement was a significant barrier to transitions in both the ABI and PD groups. Consumer engagement included disengagement or lack of motivation, unrealistic expectations, lack of skills necessary to live independently or ability to manage support staff, and language or communication skills. The challenge subcategories with the largest role in both groups were lack of awareness or unrealistic expectations and lack of independent living skills.

Previous studies showed that some consumers changed their mind after starting the transition process because they felt their needs were better met in an institution (Baker et al., 2016). Others enjoyed socializing in the institution or preferred the familiarity of the facility (Gassoumis et al., 2013). These consumer engagement obstacles may be overcome with better communication or maintaining community connections while in the institution (Irvin et al., 2016). Other studies have found that consumer engagement and preference for living in the community is one of the most significant factors contributing to successful transitions (Arling et al., 2011, 2010; Nishita, Wilber, Matsumoto, & Schnelle, 2008).

### Other Involved Individuals

Lack of support from other involved individuals was also a significant barrier to transitioning to the community. These individuals may be a spouse or partner, family, friends, or health care provider. The single greatest challenge subcategory was a lack of support from spouse or partner, family, and friends.

Previous studies have shown that family support, not necessarily as informal caregivers, was one of the most important determinants of successful transitions back to the community (Agarwal, McRae, Bhardwaj, & Teasell, 2003; Arling et al., 2010; Lewis et al., 2016; Meador et al., 2011; Winkler et al., 2011). Lack of family support may have been due to a worsening of the resident's condition, 24-hour care requirements, needs that would be better met in an institution, incontinence or memory issues, and lack of interest or ability to manage support staff (Arling et al., 2010; Baker et al., 2016). Engaging family members and friends in the transition process was crucial to increase the likelihood of transitioning. One study discussed peer network facilitated transitions; people who successfully moved back into the community provided support to institutional residents throughout the transition process (Irvin et al., 2016).

## Housing

Interestingly, a housing challenge *increased* the likelihood of a consumer transitioning back to the community in both groups. The housing challenge included a lack of affordable and accessible housing, dissatisfaction with available housing, ineligible or waiting listed for rental assistance programs, pending home modifications, administrative delays, or legal, criminal, and credit issues. The challenge subcategory with the greatest number of participants in both target groups was the lack of appropriate or desirable housing.

One possible explanation for the positive effect found in this study was a recent increase in subsidized housing made available after Connecticut won a funding award in 2013 (Irvin et al., 2016). Another possibility was the relatively younger age of the population studied; younger people are more likely to live in an apartment and thus able to take advantage of housing subsidies. On the other hand, older people may have access to senior housing which is often more prevalent in a community.

Housing issues, especially lack of housing, have a major impact on successful community transitions (Hoffman et al., 2017; Irvin et al., 2016). Adequate housing ensures a person can be “independent, safe, and comfortable” (Agarwal et al., 2003). Finding appropriate living situations can be a complicated process that is best accomplished with the coordinated effort of case managers, social workers, and owners of subsidized housing units (Irvin et al., 2016).

## Age

In both the ABI and PD groups, there was a statistically significant association between younger age and increased likelihood of transitioning back into the community. It is unclear if this finding is clinically relevant since in the ABI group, older people were 6% less likely to transition and in the PD group, older people were 2% less likely to transition.

Older age leading to lower rates of transitioning was consistent with previous studies showing that older people are more likely to remain in an institution (Agarwal et al., 2003; DeVivo, 1999; Eum et al., 2015; Greene & Ondrich, 1990; Irvin et al., 2016). There are likely multiple confounders. Older people may have more complex physical and mental health issues making it more difficult to live in the community (Agarwal et al., 2003). Informal caregivers may be unable to sustain the necessary level of care (Greene & Ondrich, 1990). Finally, younger people may be referred to transition programs more often because they are considered to be better candidates (Irvin et al., 2016).

## Gender

Gender was not a significant barrier to transition in either group although in both groups, more men transitioned than women. The literature is mixed on the role gender plays in community transitions, however, a 2015 study by Mudrazija showed that in the first year of institutional living, more women transitioned than men, but as LOS increases, the difference decreases (Mudrazija, Thomeer, & Angel, 2015). This same study showed that men and women have different post-discharge destinations. Men are more likely to live with their spouses whereas women are more likely to live with their children or other relatives. In this thesis, we did not have access to discharge destination or marital status, therefore it is unclear if either of these factors had an effect on the lack of significance of gender in transition rates.

## Significant challenges in the ABI group

### Waiver program

Difficulty with the waiver program decreased the likelihood of transitioning to the community. The components of this challenge were no openings in the waiver program due to a

cap, ineligibility, inadequate support to meet the consumer's needs, or waiting for administrative processing. The most frequent reason was waiting for administrative processing, such as a neuropsychological evaluation to determine eligibility, review, or response. The short-term cause of this problem specific to Connecticut may have been due to the loss of several critical program staff in a relatively short period of time.

Other studies have shown that funding support for HCBS plays a role in successful community transitions (Arling et al., 2011). Although funding for HCBS has increased over the years, states must maintain cost neutrality in these programs, which often leads to enrollment caps (McEvoy, 2012; Shirk, 2006). As rebalancing of LTSS continues to shift funding away from institutions and into HCBS, states will be able to enroll greater numbers of people without increasing total costs.

## Facility

A facility challenge in the ABI group increased the likelihood of transitioning back to the community. This challenge included problems with facility staff or administration, delay in discharge planning or evaluation of resident, facility closure prior to transition, or level of care issues. Those who did not transition were most likely to have facility staff or administration issues or a delay in evaluation of resident. There were several issues that were comparable in frequency for those who transitioned: facility staff or administration issues, delay in discharge planning or evaluation of resident, and facility closure. The difference between those who transitioned and those who did not may be that people who transitioned had fewer issues with staff and administration and there were fewer delays in discharge planning and evaluation of the residents. Facility closure may be one reason this challenge category increased the likelihood of

transitioning since MFP has a process to assist residents living in closing facilities to move into the community instead of moving to another facility.

Residents in facilities with higher rates of community transitions, more nurses, and higher occupancy levels were more likely to transition to the community (Arling et al., 2011, 2010). One study found that residents in facilities with longer average LOS and a greater dependence on Medicaid were more likely to remain in an institution (Holup, Gassoumis, Wilber, & Hyer, 2016). Facilities in areas with higher levels of HCBS were more likely to discharge residents to the community (Arling et al., 2011).

## Significant challenges in the PD group

### Legal/Criminal

The presence of legal or criminal issues decreased the likelihood of transitions in the PD group. This challenge included criminal history and incarceration, probate court problems, missing records such as birth certificates, and lack of or unsupportive legal representative or conservator. The most frequent problem in the PD group was missing records and the next most frequent problem was consumer criminal history and incarceration. There was no literature found on this topic in any of the literature searches performed during this study.

### Financial

People with financial challenges in the PD group were *more* likely to transition than those without this challenge. This challenge included inadequate financial resources, unpaid bills, lack of or poor credit, rejection or delay in application for financial benefits, and Medicaid eligibility issues. In the PD group, the most frequent problem was lack of financial resources. This finding makes sense given that this study exclusively included people with Medicaid insurance and

Medicaid eligibility depends upon financial need. It may be that people with the greatest need are prioritized when determining level of support. The results of this study differ from previous studies that showed decreased community transitions from facilities with a higher percentage of residents with Medicaid (Arling et al., 2010; Holup et al., 2016).

## LOS

In the PD group, people with shorter LOS were more likely to transition to the community than those with longer LOS. Although the result was statistically significant, it may not be clinically relevant since increased LOS was associated with a less likely transition by 1%.

Several studies found that discharges were less likely after 90 or more days in an institution (Arling et al., 2011, 2010; Gassoumis et al., 2013; Yoo et al., 2013). There were several possibilities proposed such as lack of social support, loss of connection to the community, and increased levels of needed care (Arling et al., 2010; Gassoumis et al., 2013; Lewis et al., 2016). One study showed that increased LOS was associated with any type of physical disability (Chiavaroli et al., 2016). This may be due to increased requirements for services and supports.

## Public Health Implications

In this study, people in the ABI group may have had both physical and cognitive/behavioral disabilities whereas those in the PD group had only physical disabilities. Although we were unable to measure the level of disability in each group, it would seem likely that since those in the ABI group may have had multiple types of disabilities, they would transition less frequently than those in the PD. Given that there was no significant difference in transition rates, one explanation might be the difference in funding available for each of these

groups. People in the PD group received less funding and fewer services than those in the ABI group. Increasing funding for LTSS for the PD group may lead to greater transition rates.

The paradoxical effect of housing and financial challenges, where people with these challenges were more likely to transition, was likely due to providing housing and financial support to those with the greatest need. Increasing these types of supports to those with less dire need may increase transition rates.

One of the significant challenges in this and previous studies is the role of consumer engagement and family support. Providing guidance and information to the resident and family may assist in their decision-making but requires the transition team to have the time and available staff. Funding to increase the number of transition team staff members would lead to more people living in the community.

## Study's Limitations

The study participants were all Connecticut residents with Medicaid insurance. Although the moderate to large number of cases increase the possibility of the study's generalizability, people eligible for the study may have different challenges than people in other parts of the country or with different types of insurance. Everyone in the study had the same insurance which minimized financial disparities between participants. People were assigned to the Medicaid HCBS program for which they meet eligibility criteria. This meant that people in the ABI group may have had a physical disability in addition to the brain injury, but the data did not include this level of detail. In Connecticut, the per capita funding is higher in the ABI program than in the PD Medicaid program which may have made a difference in transition challenges rather than due to type of disability. Comparing functional limitations, such as capacity to perform ADLs, pain levels, subjective health, and quality of life, between those who transitioned and those who did

not would have allowed us to compare rates of transition by degree of disability. At this time, this information was only collected for those who successfully transitioned to the community.

## Future Research

Expanding the population of interest to all of the MFP programs around the country would increase the generalizability of the results. Collecting information about participants' ability to perform ADLs and IADLs, quality of life, pain levels and subjective health would provide richer information about the role these have in community transitions. The paradoxical positive effects of housing and financial challenges need to be addressed in future studies to understand how the presence of these challenges increases the likelihood of transitioning. Research on legal and criminal challenges is warranted since there seems to be a dearth of information on this topic. Finally, evaluating the effect of per capita funding available in different Medicaid waiver programs on transitions may help shape future policy.

## Conclusion

Federal and state programs are in place to support community living both to satisfy consumer preference and reduce the costs of LTSS. This study showed that there was no significant difference in transition rates from an institution to the community between people with an acquired brain injury and physical disabilities. The increased funding available to people in the ABI program may equilibrate their more complex needs and increased service and support requirements allowing them to transition at similar rates to people with physical disabilities alone.

Additional findings in the data analysis show that significant barriers to transition are lack of consumer engagement and personal preference, lack of support from family and friends, increased LOS and age. Novel contributions to the literature are the barriers that impact transitioning back to the community specific to different target populations. The ABI group was less likely to transition with waiver challenges. This was likely due to their reliance on services and supports to live in the community. In contrast to the ABI group, longer LOS, and legal issues were the most significant unique barriers to transition for people with physical disabilities.

This research provides the basis for future analysis that could include data from other states' MFP programs. Including participants from around the United States would increase the generalizability and could inform federal and state policy regarding allocation of funds to specifically address the barriers to community transition.

## Figure 1. Transition Challenges Checklist

- Physical health**
  - Current, new, or undisclosed physical health problem or illness
  - Medical testing issues or delays
  - Inability to manage physical disability or physical illness in community
  - Missing or waiting for physical health related documents or records
  - Other physical health issues (describe) \_\_\_\_\_
- Mental health or mental illness**
  - Current, new, or undisclosed mental health problem or illness
  - Current or history of substance/alcohol abuse with risk of relapse
  - Dementia or cognitive issues
  - Inability to manage mental health/illness in community
  - Other mental health/illness issues (describe) \_\_\_\_\_
- Financial or insurance benefits**
  - Lack of or insufficient financial resources
  - Consumer credit or unpaid bills
  - SSDI, SSI, SAGA, SSA, VA, or other cash benefits
  - Other financial benefits or issues
  - Medicaid eligibility or insurance issues
  - Other financial issues (describe) \_\_\_\_\_
- Consumer engagement, awareness, and skills**
  - Disengagement or lack/loss of motivation
  - Lack of awareness or unrealistic expectations regarding disability or needed supports
  - Lack of independent living skills
  - Language or communication skills
  - Other consumer related issues (describe) \_\_\_\_\_
- Services and supports**
  - Lack of transportation
  - Lack of PCA, home health, or other paid support staff
  - Lack of mental health services or supports (in facility or in community)
  - Lack of alcohol, substance abuse, or addiction services (in facility or in community)
  - Lack of assistive technology or durable medical equipment (excluding home modifications)
  - Lack of any other services or supports
  - Lack of unpaid caregiver (including family or friends) to provide needed care or informal support
  - Other issues related to services or supports (describe) \_\_\_\_\_
- Waiver or state plan home and community-based services (HCBS)**
  - Targeted waiver full
  - Ineligible for or denial of HCBS program or waiver services
  - Current waivers or HCBS programs do not meet consumer needs
  - Waiting for evaluation, application review, or response from waiver or HCBS agency/contact
  - Other HCBS or waiver program issues (describe) \_\_\_\_\_
- Housing**
  - Lacks affordable, accessible community housing
  - Ineligible for or waiting for approval from RAP or other housing programs
  - Needs housing modifications before transition
  - Delays related to housing authority, agency, or housing coordinator
  - Delays related to lease, landlord, apartment manager, etc.
  - Housing related legal, criminal or credit issues, including evictions or unpaid rent
  - Other housing related issues (describe) \_\_\_\_\_
- Legal or criminal (includes conservatorship)**
  - Consumer criminal history
  - Probate court issues
  - Missing or waiting for identity, birth certificate, or other related records
  - Legal representative issues
  - Other court or legal issues (describe) \_\_\_\_\_
- Facility related**
  - Facility staff or administration issues
  - Waiting for, loss of, or absence of discharge planning
  - Evaluation of consumer by facility issues
  - Nursing home or facility closure
  - Level of care (ASCEND) issues
  - Other facility related issues (describe) \_\_\_\_\_
- Other involved individuals**
  - Issues with spouse/partner, family, or friends
  - Physical health provider/doctor opposed, unsupportive, or unresponsive
  - Mental health provider/doctor opposed, unsupportive, or unresponsive
  - Other provider or state agency opposed, unsupportive, or unresponsive
  - Other issues related to involved individuals (describe) \_\_\_\_\_
- MFP Office or Transition coordinator**
  - Transition plan not approved
  - Waiting for response, approval, etc. from MFP Office
  - Lack of time for transition coordinator to follow up
  - Other transition coordinator issues (describe) \_\_\_\_\_
  - Other MFP Office issues (describe) \_\_\_\_\_

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