

5-2014

Mental Health Case Management: The Perspective of Nursing Home Social Service Personnel

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Recommended Citation

Schmitz, Mary K., "Mental Health Case Management: The Perspective of Nursing Home Social Service Personnel" (2014). *Master of Social Work Clinical Research Papers*. Paper 385.
http://sophia.stkate.edu/msw_papers/385

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Mental Health Case Management:
The Perspective of Nursing Home Social Service Personnel

by

Mary K. Schmitz. BSW

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members:

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the University Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Many clients who suffer from serious and persistent mental illness (SPMI) are admitted to long-term residential facilities, like nursing homes, and often end up staying for years. Many studies have shown that case management helps them to achieve and maintain their highest level of independence however, clients often become ineligible to receive these services when they reside in nursing homes. This mixed methods study was able to get the perspective of nursing home social service personnel, who are often put in the primary role of assisting client's discharge to more independent settings when case management is not available. The goal of the study was to find out if continued case management helps client's discharge to more independent settings. The quantitative data showed a statistically significant relationship between case management greater than 90 days, and clients who had discharged, however it was a weak correlation showing that case management does not appear to have a strong impact on client discharge. The qualitative data showed how important case managers are to clients and social workers. The study showed that case managers who work in collaboration with nursing home social workers offer clients the best chance to successfully return to more independent settings.

Keywords: mixed, mental health, nursing home, social service, case management

Acknowledgements

First and foremost, I would like to acknowledge that my main source of strength to persevere during this study was my Lord and Savior, Jesus Christ in whom I can do all things. I would also like to thank my co-workers, especially Lori who has filled in a big gap at work to ensure our clients were taken care of in my absence, as well as Toni who edited this paper as well as other papers over the past three years. I also would like to acknowledge my children, Sarah & Josh, David, and Albert & Sara Beth who have not seen much of me these past 9 months, as well as my first granddaughter Marissa who was born in the middle of it all and is my newest love. Thank you also to my internship supervisor Arielah who has been a source of strength because she knows just how tough this is as she graduated from St. Kate/St. Thomas several years ago. Thank you also to numerous classmates who encouraged me, and last but not least thank you to my wonderful committee, Sharon and Deb and my chair Dr. Vang.

Table of Contents

ABSTRACT 2

ACKNOWLEDGEMENTS.....	2
INTRODUCTION.....	5
LITERATURE REVIEW	9
HISTORY.....	9
DISCHARGING FROM NURSING HOME TO MORE INDEPENDENT SETTING.....	11
EFFECTIVENESS OF CASE MANAGEMENT	12
CASE MANAGEMENT IN THE NURSING HOME	14
RESEARCH QUESTION	16
CONCEPTUAL FRAMEWORK.....	17
DEINSTITUTIONALIZATION	17
INSTITUTIONALIZATION	17
METHODS	19
RESEARCH DESIGN.....	19
SAMPLE POPULATION.....	19
SAMPLING METHOD AND DATA COLLECTION PROCESS.....	20
MEASURE FOR PROTECTION OF HUMAN SUBJECTS.....	21
DATA ANALYSIS.....	21
STRENGTHS AND LIMITATIONS	22
RESULTS.....	22
DEMOGRAPHICS	22
QUANTITATIVE.....	24
QUALITATIVE.....	26
TYPES OF ASSISTANCE CASE MANAGERS PROVIDED	27
WOULD CLIENTS HAVE BEEN DISCHARGED WITHOUT CASE MANAGEMENT?	29
CAN SOCIAL SERVICE PROVIDE ENOUGH SERVICE TO ENABLE DISCHARGE?.....	30
BENEFITS OF CASE MANAGEMENT WITH THE MENTALLY ILL IN NURSING HOME	32
OTHER COMMENTS.....	34
DISCUSSION	35
MATCHING THE RESEARCH.....	35
FILLING IN THE GAP	37
ANSWERING THE RESEARCH QUESTIONS.....	39
STRENGTHS AND LIMITATIONS	40
IMPLICATIONS FOR SOCIAL WORK PRACTICE.....	41
IMPLICATIONS FOR SOCIAL WORK RESEARCH.....	42
CONCLUSION.....	42
REFERENCES.....	43
APPENDIX A.....	47
APPENDIX B.....	55
APPENDIX C	56
APPENDIX D.....	56

Introduction

Clients who suffer from serious and persistent mental illness (SPMI) began to be admitted more often to long-term care facilities when the federal deinstitutionalization policies of the 1960's and 1970's caused downsizing and closure of state hospitals (Aschbrenner et al., 2011). The Institute of Medicine (1986) (as cited in Aschbrenner et al., 2011) states that at the same time nursing homes had a 100% increase in the number of clients with mental illness. This increase was not the elderly, in fact Andrews, Bartels, Xie, & Peacock (2009) states that Medicaid beneficiaries between the ages of 40 to 64 with a schizophrenia diagnosis are four times more likely to be admitted to a nursing home than people in the same age group without a mental health diagnosis.

In 1987 federal nursing home reform legislation attempted to make it harder to admit SPMI clients to nursing homes. The Omnibus Budget and Reconciliation Act (OBRA) of 1987 mandated the Preadmission Screening and Resident Review (PASRR) program. According to Linkins, Lucca, Housman, and Smith (2006) PASRR requires states to develop and implement a process to screen clients with serious and persistent mental illness to insure that they are not admitted to nursing homes unless it is the most appropriate setting. However, according to Sehrawat (2010) several studies done in recent years have shown that PASRR never hindered admission of SPMI clients to nursing homes.

According to Aschbrenner et al. (2011), many nursing home residents who have a SPMI diagnosis and are not cognitively impaired are considered by consumers and their clinicians to be more appropriate for community based settings. A huge barrier these clients face getting into a community based setting is, according to Aschbrenner et al. (2011), a lack of safe, affordable residential options that have available community

supports to help them maintain their independence. When there is such a lack of community based settings clients do not have the ability, resources or skills to find appropriate placement by themselves. As Ervin (2008) states, “It takes many hours over months for counselors and social workers to assist these people with disabilities in performing painstaking tasks such as finding affordable housing and tapping into new support programs.” (p. 1)

Case management could be considered assistance those clients need to help them discharge to a more independent setting. Mueser, Bond, Drake and Resnick (1998) state that case management began in 1977 to improve the coordination of mental health services in the community. Rapp and Gosha (2004) define case management as a person who coordinates, integrates and allocates care with limited resources. The primary functions of case management are assessment, planning, referral and monitoring, according to Rapp and Gosha (2004). They go on to say that if people receive these services they will be able to live more independently in the community and their quality of life will improve.

The researcher has worked for seven years in a facility that specializes in mental health, it seems case management in a nursing home is limited to clients who are under commitment or are involved in specialized case management programs. Several discussions with case managers over the years have occurred about this subject. During these conversations case managers stated they are required to drop clients because Medical Assistance considers it a doubling of services, as nursing home social workers are said to be able to provide the same service.

After 17 years of being a social service director in two different nursing home settings, the researcher has known the job responsibilities to be very demanding and time consuming. It is a position that involves a wide array of job duties that includes overseeing admissions, dealing with family members, completing regulatory requirements as well as doing behavior management for very large caseloads. It seems like an impossible task to fit time into this busy schedule to appropriately assist clients with discharge planning. If social service personnel do not have the time to help assist clients in this area, there really is no one left to help them in the discharge planning process. Residents then become victims of institutionalization and seldom transition into a more independent setting, even when staff believes they are able. If case management could be continued after admission, it is possible more people could transition into more independent settings when their mental and physical health has stabilized. Case managers could provide assistance to clients by finding appropriate placements as well as help clients locate and apply for the required funding to pay for the services they need to maintain their independence.

Literature Review

History

Fakhoury and Priebe (2007) states that in the 1950's and early 1960's there began a movement to take the mentally ill out of state hospitals. Deinstitutionalization was a major progression of events that led to dramatic changes in the way the seriously mentally ill were cared for. According to Fakhoury and Priebe (2007) before deinstitutionalization started, the mentally ill were being hospitalized in asylums where there was significant overcrowding and minimal treatment. People were malnourished, abused and left un-treated psychologically. The process favored the least restrictive treatment for the mentally ill, yet Fakhoury and Priebe (2007) states patients were often discharged into communities that were unprepared, with little or no support or coordinated care available to them. Many people who suffered from serious and persistent mental illness (SPMI) ended up homeless, in prison or in nursing homes. While there was accelerated downsizing and closure of state hospitals the nursing home population of SPMI clients increased by 100% in the 1960's and 1970's, according to Aschbrenner et al. (2011) .

Aschbrenner et al. (2011) states that currently there are more than 500,000 people with a diagnosed mental illness (excluding dementia) that live in nursing homes across the United States. Simonson, Lipson, and Stone (2011) state that nationally 16% of nursing home residents under the age of 65 have a primary or secondary mental health diagnosis. Minnesota is the state in which this study was completed and according to Simonson et al. (2011) it ranks among one of the three highest states involved, with a 24.4% of nursing home clients who have a diagnosed mental illness. Simonson et al.

(2011) also states that nationally the number of people who live in nursing homes that have a primary or secondary mental health diagnosis far exceeds all other health care institutions combined. There are many of these clients that are elderly, however recent studies show that there is an alarming increase in middle-aged people with a diagnosed mental illness being admitted to nursing homes. Aschbrenner et al. (2011) states that people on Medicaid who are between the ages of 40-64 and have a schizophrenia diagnosis are four times more likely to be admitted to nursing homes than Medicaid clients who don't have a mental illness.

This current trend is alarming given that there was a nursing reform law passed in 1987 that tried to prevent the use of nursing homes to replace state hospitals. Aschbrenner et al. (2011) states that the Omnibus Budget and Reconciliation Act of 1987 (OBRA) included Preadmission Screening and Resident Review (PASRR). This regulation requires states to develop and implement a process to screen all people being admitted to a Medicaid certified facility for a mental illness. If a client has a serious mental illness the state determines whether the client meets the criteria for skilled nursing care. Linkens et al. (2006) states that while PASRR helped to identify the mentally ill, it did not prevent them from being admitted to nursing homes due to tremendous variations between states on the implementation of the PASRR process. Street, Molinari and Cohen (2013) stated these variances allowed states to use creative ways to comply with the regulations in ways that kept nursing homes eligible for Medicaid reimbursement.

Street et al. (2013) found four different ways the states complied with the regulation. There were six states that had very specific PASRR regulations for SPMI clients; including licensure, physical plant and other regulations. Minnesota was one of

the six who were in this category. Nine states made a passing mention of mental illness in the regulation. The rest of the states had specific regulations for dementia related diagnosis, or no diagnosis at all.

Nursing home proponents state in Levin-Epstien (2006) that inappropriate placements to nursing homes occur when community based services might be more appropriate. This happens because community based services are not available and the nursing home is accessible and capable of providing the necessary care. The fact is that many of these clients are capable of living more independent lives. According to Aschbrenner et al. (2011) 40-51% of nursing home residents with a mental illness that are not cognitively impaired are considered by consumers and their clinicians to be more appropriate for community based settings.

Discharging From Nursing Home to More Independent Setting

According to O'Hara (2007) one of the main reasons that people with serious and persistent mental illness (SPMI) are unable to find housing and end up in institutions, "The lack of affordable housing and accompanying support services often causes people with serious mental illness to cycle between jails, institutions, shelters, and the streets; to remain unnecessarily in institutions; or live in large segregated facilities..." (p. 908). According to Carling (1990) not only is there a shortage of affordable housing, but people with SPMI are competing with other low income groups who are seen as more suitable tenants. On top of this, according to O'Hara (2007), Federal Housing legislation enacted in the 1990's prevent people with mental illness and people with other disabilities under the age of 62 from accessing many federal subsidized rental properties.

So how can nursing home residents who have serious mental health issues manage to maneuver the system to find affordable, supportive housing given all of these obstacles? The answer is ... they cannot. According to Ervin (2008), nursing home residents need help transitioning into community living support situations. He goes on to state, "...it takes many hours over months for counselors to assist these clients with disabilities in performing the painstaking tasks of finding affordable housing and tapping into new support programs." (Ervin 2008, p. 1).

So who is going to help the mentally ill transition into more independent living settings? For the past seven years this researcher has worked at a board and care facility that specializes in mental health. What is seen over and over again is clients who have received continued case management after admission, have a much higher success rate of moving back into a more independent setting.

Effectiveness of Case Management

Mueser, Bond, Drake and Resnick (1998) state that case management began in 1977 to improve the coordination of mental health services in the community. Deinstitutionalization caused the mental health system to become complex and SPMI clients found it difficult to navigate.

Case management as defined by Ziguras, Stuart, and Jackson (2002) is:

... the coordination, integration and allocation of individualized care within limited resources... Case management includes the functions of psychosocial needs assessment; individual care planning; referral and linking to appropriate services or supports; ongoing monitoring of the care plan; advocacy; monitoring

the clients mental status; compliance with medication and possible side effects; the establishment and maintenance of a therapeutic relationship; and supportive counseling (p. 17).

There are many different case management models. Hangen (2006), states that most research has shown that it is best to determine which case management model suits the client. A meta analysis study of existing research on effective case management was done by Rapp and Goscha (2004). This study identified several key elements in case management that led to better outcomes for clients. Some of these include:

1. The case manager delivers the majority of help and work with community resources around the client
2. Case management is done in the clients environment
3. Case management involves a multi-disciplinary approach with other professionals to coordinate services.
4. Case mangers have caseloads that are between ten to twenty, but no more than twenty.
5. Case management is time un-limited
6. Clients have 24-hour access to a case manager or someone on the team, or at least have a crisis plan.
7. Case managers foster client choice and goal setting

Three of the case management models listed in Mueser et al. (1998) have most of these elements:

Intensive Case Management was developed to meet the needs of high end users. It employs a low patient to staff ratio and provides outreach to clients in their own environment and provides assistance in teaching daily living skills.

Assertive Community Treatment is a model delivered by a multi-disciplinary team consisting of a doctor, nurse and at least two case managers. They have low patient to staff ratios. Services are provided in the community and caseloads are carried across clinicians. There is 24-hour coverage and the service is time unlimited.

Strengths Based Case Management harnesses the person's personal assets and utilizes them in achieving the client's personal goals. Interventions are based on patient self-determination and contact takes place in the community.

Brokered case management is a fourth type listed in Mueser et al. (1998). It is the primary type used with clients who get case management from the county. It contains the fewest elements of effective case management that were identified in Rapp and Goscha (2004).

Brokered Case Management connects clients with services to coordinate between different assistance populations.

Case Management in The Nursing Home

No matter what type of case management is used, the problem that remains is that

most clients lose the support of the case manager when they are admitted to a nursing home. Case management seems to be limited to clients who are under commitment or are involved in a specialized case management program.

It was difficult to obtain any information on case management in nursing homes. Due to a gap in the research this study is vitally important to gain valuable data in this area.

An early part of this research began with an interview of a veteran county case manager. She stated that clients who are not court committed can only get case management services when they are working on a goal such as housing, employment, disability etc. A greater portion of the time after their goal is achieved the services are discontinued. At that point each individual case manager decides whether to drop a case or keep them on. She stated that when a case manager assists a client with admission into a nursing home, the housing goal had been achieved and it was likely the services were discontinued. She stated it was her preference to stay with SPMI clients longer because she knew that without her services the client often ended up being re-hospitalized in a short period of time. However, she stated that if she did not drop some of her clients, her caseload might get higher than she could reasonably manage because she had to continue to take on new cases. (personal communication, March 23, 2012).

One example of how continued case management is effective towards discharge: The same case manager referred a client to the researchers facility. The client was not court committed, suffered from schizophrenia and had problems with chemical dependency. The client did not have any outside personal support system in place. This

case manager chose to continue services with the client after admission. The client had her ups and downs, but after about 18 months she stabilized. The case manager then helped her find placement in an assisted living facility. The researcher believes that this client would not have moved to a more independent living situation, if her case manager had not continued her services and support.

Ervin (2008) stated it best when he wrote about a Medicaid funding cut that dropped the amount of days for targeted case management from 160 to 60 days to help nursing home clients transition into community living. “People with disabilities need a lot of help navigating through the bureaucratic morass when they want to exit nursing homes and live independently. This takes a lot more than 60 days. Many will be stuck in institutions because of these restrictions” (Ervin, 2008, p. 1).

Research Question

The primary research question for this study is, “*Does continued case management with nursing home residents that suffer from serious and persistent mental illness (SPMI) have an impact on the client being able to discharge to more independent settings?*” Through this study the researcher would also like to get information that could not be obtained in the literature review; these include: “*Does case management with SPMI clients stop at or shortly after admission to a nursing home? Do nursing home social workers/social service designees have the time to provide the amount of case management needed to assist clients to discharge to a more independent setting?*”

Conceptual Framework

Deinstitutionalization

The driving force of this study comes from deinstitutionalization. It is the very reason that people with SPMI were admitted to nursing homes. According to Grob (1995) psychiatric patients in the 1970's were discharged from hospitals due to a philosophical shift to a belief that mental hospitals had lost their usefulness because professionals believed that the mentally ill could live successfully in the community, with the right supports. According to Fakhoury and Priebe (2007) these supports were never put into place. Patients were often discharged into communities that were unprepared with little or no support or coordinated care. Many people who suffered from serious and persistent mental illness ended up homeless, in prison or in nursing homes. Grob (1995) states that two decades later the very term deinstitutionalization suggests a picture of the homeless mentally ill roaming the streets of every urban community. As there was accelerated downsizing and closure of the state hospitals, the nursing home population of SPMI clients increased by 100% between the 1960's and 1970's, according to Aschbrenner et al. (2011). This prevalence continues, as there are currently more than 500,000 people with a diagnosed mental illness (excluding dementia) living in nursing homes across the United States (Aschbrenner et al., 2011).

Institutionalization

Nursing homes have become the new form of institutionalization for mental health care. Townley, Kloos and Wright (2009) states that institutionalization is a process of taking symptomatic mentally ill clients out of the community and placing them in institutions and residential settings with the aim of rehabilitating them and eventually

readmitting them into the community. Chow and Priebe (2013) state the institutionalization model began in 19th and 20th centuries with asylums being the main form of care for clients with serious and persistent mental illness. This model began with a concept called “total institution”, which envisioned life for clients with SPMI always being in an institution. According to Chow and Priebe (2013) clients received total custodial care and had very limited access to the outside world. Their days were completely planned, activities were scheduled and their lives revolved around an institutional routine. Chow and Priebe (2013) state that clients underwent a mortification of self, as they lost all of their previous roles in the community and took on the role of an institutionalized person.

An attempt to change this model occurred with deinstitutionalization when professionals tried to integrate SPMI clients into the community. Integration did not happen because patients had adapted to institutionalized care. This adaptation, is defined by Chow and Priebe (2013) as, “...symptoms exhibited by patients in response to being treated in an institution...” (p. 9). Chow and Priebe (2013) state that people with SPMI who live in an institutional setting often lose their independence and sense of responsibility to the point that they are never able to return to community settings because they are not able to manage the everyday demands of life. It is a disability in social and life skills that Chow and Priebe (2013) term as “institutionalism”, which is an impoverishment of feelings thoughts and initiative. Chow and Priebe (2013) state this phenomenon is found in board and care homes and often is associated with low intelligence, poor education and physical disabilities. Chow and Priebe (2013) state that people become dependent on receiving cares from the setting and often lose confidence

to make decisions which leads, them to remain institutionalized.

Methods

Research Design

The research design that was used is a mixed methods approach. To collect the data a survey that included twenty-four quantitative and five qualitative questions was developed by the researcher (See Appendix A).

The quantitative portion of this survey was designed to explore relationships between variables. From the data, a significant correlation between the variables *discharged clients* and the presence of *case management > 90 days* would indicate a strong positive relationship however, it would not indicate causation.

The qualitative portion of this survey is designed to obtain the opinions of social service staff in nursing homes regarding the level of case management involvement and if it has anything to do with clients being able to discharge to more independent living settings. The reason that a qualitative part of the survey was designed is due to the high probability that there may be a lack of enough statistical information from the quantitative data of case management involvement in nursing homes. Another reason for the qualitative portion of the survey is to gather data about the level of case management involvement in nursing homes and what is expected of nursing home social service departments, as this data cannot be found in the literature.

Sample Population

The population that participated in the study was nursing home social service personnel who work in the state of Minnesota. In order to recruit these people the

researcher mailed out a letter to every nursing home social service director in the state of Minnesota (See Appendix B). The letter detailed the study, gave a computer link to the survey as well as the researchers e-mail address to request the link sent via e-mail.

The letter was followed by three mass e-mails one week apart to all nursing homes in the state of Minnesota, in which a valid e-mail address could be found (See Appendix C). The e-mail detailed the study in which it stated the date the letter had been sent out, including a computer link to the survey. The second and third e-mail went out a week apart with a statement thanking those who had already participated. It also stated that if they had, or choose not to participate, they did not need to make contact with the researcher (See Appendix D).

Sampling Method and Data Collection Process

The number of total letters mailed out was 388. The physical addresses to the nursing homes was found on the Minnesota Department of Health website (2014).

The e-mail addresses were found in several different areas. The primary source for e-mails was found in Care Providers Membership Directory (2013). The secondary source was on the Minnesota Help Info website. (2014). Facility e-mail addresses not found in one of these two sites were found by locating the web site for each individual facility. Not all facilities had web addresses, so those facilities did not receive the e-mails. A total of 266 valid email addresses were located.

The researcher originally aimed to have a total of 50 participants. However, the total number of participants surpassed this goal with 83 who answered the consent question, three answered no to the consent and another 16 did not go further than the

consent. This left a total of 62 individuals that completed the survey; this is 15.9% response rate.

Measure for Protection of Human Subjects

A consent letter was made available on the electronic survey. Before a person could participate in the study they had to read and state that they understood, were aware and agreed with the informed consent form. There was no opportunity for them to hand sign the consent form as consent was given when they clicked, to accept the terms. If they choose not to accept the terms the survey ended. Three participants did not accept the terms and the survey ended. Participants were not expected to experience professional discomfort while doing the survey. In the event that it occurred, a list of contacts was available at the end of the survey. A copy of the consent form can be found in Appendix A.

Data Analysis

Participants anonymously answered survey questions via Qualtrics.com. When the survey was closed the collected data was inputted into SPSS data analysis software. The quantitative data was then statistically analyzed to look for data that could be used in the research outcomes. The researcher used frequencies and cross tabulation to determine demographic information.

Content analysis was used to examine responses to open ended survey questions. According to Monnette, Sullivan and DeJong (2011) this is a method of transforming the written data that is unsystematic into a qualitative, systematic form that can be analyzed.

The researcher analyzed answers from each of the five open ended questions and found common words, themes and concepts. Accorded to Berg (2009) words are the

smallest elements that can be counted. A theme, according to Berg (2009) is a simple sentence or string of words that has a subject, while concepts are words that are grouped together into ideas that in some instances form variables. The common words, themes and concepts were named, counted and put into tables. Examples of themes and concepts that were written in the answers were added to the tables.

Strengths and Limitations

By utilizing both a quantitative and qualitative design in this survey a variety of data was obtained. Due to minimal research available regarding the level of case management in nursing homes for SPMI clients, the qualitative data was beneficial and increased this information. Data however, was limited to the state of Minnesota.

Results

Demographics

A total of 62 people completed the survey. As expected respondents were college educated with a bachelor degree or higher ($n= 59$; 95.2%) while 81.1% ($n= 49$) were licensed social workers with at least a LSW licensure. A large proportion of participants ($n= 24$; 38.7%) had more than ten years of nursing home experience. Many had caseloads greater than 60 residents ($n= 20$; 32.3%).

One of the most surprising statistics was that 64.5% ($n= 40$) of participants work in facilities located in rural Minnesota, while only 34.5% ($n= 21$) of the respondents were located in a metro area where the population was greater than 50,000. Some of the respondents from rural areas commented in the qualitative data that their facilities are in a rural area where the demographics of their residents consist of the elderly who are physically disabled, not mentally ill:

At our facility rarely do we have an admission where SPMI is the main reason for admission

...People do not come to our nursing home because of SPMI...Our residents usually have some type of physical condition as their primary diagnosis...

The number of clients who were admitted with a mental health diagnosis was quite high, as Table 1 shows that 19 out of 59 (32.2%) facilities reported that greater than 30% of their clients have a mental health diagnosis. The numbers were identical when asked if it was the primary reason for their admission to the nursing home. The researcher wanted to determine if there were facilities that specialized in mental health and only 4 out of 43 (9.3%) facilities stated that mental health was their specialty. However, there were 19 (30.64%) that did not answer the question. Table 2 also breaks down the difference between rural and metro facilities. It appears that rural facilities definitely have fewer clients with a mental health diagnosis with 27 out of 39 (69.23%) facilities reporting 10% or less of clients with a mental illness diagnosis while in the metro only 7 out of 20 (35%) reported the same numbers.

Table 1

Cross Tab of Rural or Metro with Mental Health Diagnosis

Mental Health Diagnosis	Rural	Metro	Total
Less than 1%	13	2	15
1-10%	14	5	19
11-30%	5	2	7
31-50%	2	3	5
51-70%	0	4	4
71-90%	4	2	6
91-100%	1	2	3
Total	39	20	59

82% (n= 50 out of 61) of facilities reported that case management at admission

was 10% or less. Case management longer than 90 days was reported at 10% or less by 89.3% ($n= 50$ out of 56) of facilities. There were 82.3% ($n= 51$) of participants who reported that 10% or less of their mentally ill clients could discharge to a more independent setting, while 79% ($n= 44$ out of 56) stated that 10% or less of their mentally ill clients had discharged to more independent settings. There were 61.1% ($n= 38$ out of 54) who reported that of clients who had discharged to more independent settings less than 10% had a case manager when they discharged.

Quantitative

My hypothesis states that if mentally ill clients who reside in nursing homes receive case management longer than 90 days after admission they will have a increased chance of discharging to a more independent setting.

According to Kuechler et al. (2014) a test that can determine if there is an association between two nominal and/or ordinal variables is Chi-Square. Kuechler (2014) et al. also states that in order for this test to be valid there has to be at least 5 responses in each variable. In order to have two variables with at least 5 the dependent and independent variables were recoded to less than 30% and greater than 30%. The validity of this test may not be useable because 2 cells (50.0%) have an expected count of less than 5 and the minimum expected count is .58 as shown in Table 4, even though the frequencies for each of the variables had six or more.

The nominal variable in this study measures clients who were discharged to more independent settings while the ordinal variable measures facilities percentage of clients who had case management greater than 90 days. The nominal variable, *Discharged* was operationalized into reported percentages of clients who had discharged to more

independent settings with the responses being re-coded into two groups less than 30% and greater than 30%. The ordinal variable, *Case Management > 90 days* was operationalized with the responses being re-coded into two groups less than 30% and greater than 30%. The hypothesis for this test states that there is an association between clients who have discharged and those that had case management longer than 90 days.

Table 2 shows that of clients discharged to more independent settings at rates less than 30%, 41.6 (93.5%) had case management rates over 90 days at a rate less than 30% and only 4.4 (6.5%) had case management greater than 90 days at rates greater than 30%. Of facilities who had discharged clients to more independent settings at rates greater than 30%, 5.4 (66.7%) had case management rates over 90 days at a rate of less than 30% and .6 or 33.3% had case management greater than 90 days at rates greater than 30%.

The cross tabulation demonstrates that in the sample those facilities who had greater than 30% of clients who discharged to more independent setting also had greater than 30% of clients who had case management longer than 90 days.

Table 2

Cross-tabulation of Case Management > 90 days and Discharged to more Independent Setting

Discharged	Case Management > 90 Days		v ²
	Less than 30%	Greater than 30%	
Less than 30%	n= 41.6 (91.5%)**	n= 5.4 (8.5%)**	.291*
Greater than 30%	n= 4.4 (60%)**	n= .6 (40%)**	

*Significance at 0.05 level

p= .036

** 2 cells (50.0%) have expected count less than 5. The minimum expected count is .58

Table 2 shows that the p-value for the chi-square of the variables *Discharged* and *Case Management > 90 days* is .036. Since the p-value is less than .05 we reject the null hypothesis. Therefore the data supports the research hypothesis that there is an association between clients who were discharged and having case management past 90 days.

Table 2 also shows the inferential statistics of the relationship between the two variables, *Case Management > 90 Days* and *Discharged*. The calculated correlation ($r = .291, p < .05$) indicates a weak positive correlation. Therefore as the percentage of case management increases so do clients who are able to discharge to more independent settings. Since the p-value ($p < .05$) is at .05 we reject the null hypothesis. Therefore the results of the study support the hypothesis that there is a significant relationship between case management past 90 days and clients who discharge to more independent living settings. This however is a weak positive correlation so therefore case management does not appear to have a strong impact on client discharge.

Qualitative

A total of five qualitative questions were asked at the end of the survey. Responses to these open ended questions were utilized for the qualitative portion of the data. For each question the researcher used content analysis for words, themes and concepts (Berg, 2009). For four of the five questions, key themes were pulled from answers and grouped into different categories which were then statistically analyzed. Some answers had more than one category. No common themes were found in the last question. The data as a whole was then looked at and key themes were pulled from all five questions and several themes were found.

Types of Assistance Case Managers Provided

A total of 40 out of 62 (66.7%) people responded to this question. The common types of assistance found were as follows:

1. Locating placement
2. Set-up services and/or equipment
3. Finding and setting up funding
4. Transportation to tours and at discharge
5. Follow-up after discharge
6. Advice to social service personnel and/or client background information
7. Assist during stay
8. Emotional support to the client and not applicable or clients had not discharged.

As you can see in Table 3 finding and setting up funding was the primary type of assistance provided by case managers with 11 respondents. The second was follow-up after discharge with eight responses and third was setting up services and/or equipment with seven responses. Locating placement only had five responses. Table 3 shows what responses led to the various types of assistance

Table 3

Types of assistance case manager gives

Theme	Number	Written Statements
N/A or clients have not discharged.	13	“Resident with case management have not discharged” “...As long as I have worked here we have not discharged anyone to the community who has had a mental illness diagnosis”
Finding and setting up funding	11	“Assist with setting up financial needs”

		<p>“Funding and approving services, doing the screen for waiver”</p> <p>“Helped manage the other services they were eligible for and also provided the client with accountability for follow-through”</p> <p>“...assisted with helping to establish services and needed equipment needed for patient”</p> <p>“Follow up in mental health needs, Follow up services with nursing for medication management, assistance with follow up medical appointments, financial needs, housekeeping services”</p> <p>“I believe they are important to follow-up with the patient when they are home...”</p>
Follow-up after discharge	8	
Set-up services or services	7	<p>“...Assisted with helping establish services and needed equipment, needed for patient”</p> <p>“...They have offered some advice/recommendations about different placement options that might be appropriate...”</p> <p>“Resources, knowledge of clients background Information re: what services they had at home, what the home situation was...”</p>
Advice to Social Service and/or Client Background Information	6	
Locating Placement	5	<p>“Location of placement options...”</p> <p>“Assistance in finding appropriate facilities Locating housing”</p>
Emotional support to client	3	<p>“...provided the client with accountability for followthrough”</p>
Transportation to tours and at discharge	2	<p>“The assist with taking the resident out to tour place, sign paperwork...”</p> <p>“The Mental Health Case Manager attended Care Conferences and stayed in contact with resident and Social Worker throughout residents stay to assist with appropriate discharge planning...”</p>
Assist during stay	1	

40 out of 62 responded

*Some answers included more than one theme

Would Clients Have Been Discharged Without Case Management?

This qualitative question referred to clients who had discharged with case management services and if they would have discharged if they didn't have case management involvement. A total of 39 (62.9%) people responded to this question with the common answers being yes or no. Other answers were maybe or sometimes, not applicable or unsure.

Table 4 shows that of those that responded 16 (41.3%) stated no and 14 (35.9%) responded yes, that they would have discharged. Other responses were equal at three each.

Table 4

Would clients have discharged without case management?

Answers	Number	Percentage
Yes	14	35.90%
No	16	41.03%
Maybe/ Sometimes	3	7.69%
Not Applicable	3	7.69%
Unsure	3	7.69%
Total	39	
Missing	23	

Of those that answered yes several posts stated that even though the clients would have discharged it probably would not have been a successful placement. Three of those comments were:

Yes, as they are motivated to move to a more independent setting. They are less likely to have a successful placement absent case management.

They would have discharged but would be at a higher risk for failure to follow through plan of care and care needs.

Yes, but I believe the success rate is higher when they have case management to follow-up once in a more independent setting.

A couple other interesting comments came from those who were unsure or indicated sometimes.

Many would have, but it is helpful to have that additional service which can coordinate services and clarify what is available to that person.

Hard to say, it would have been a greater challenge to arrange a discharge.

Can Social Service Provide Enough Service to Enable Discharge?

Social service personnel were asked if they are able to provide enough services to enable clients to discharge. A total of 42 of 62 (67.7%) participants responded, the primary answers were yes or no. Other answers were long, detailed qualitative answers (See Table 5)

Of those that answered yes or no the primary response was yes with 23 (54.7%) and no 11 (26.19%).

Table 5

Can social service provide enough assist for clients to discharge?

Answers	Responses	Percentages
Yes	23	54.76%
No	11	26.19%
Qualitative Answer	8	19.05%
Total	42	
Missing	20	

There were some very interesting qualitative answers given. The following were in favor of case management and stated how very important it was:

With my case load and the pace of my job with frequent discharges, I do not think I could do as good of job without a case manager assisting with the community referrals. I think the case managers are vital.

It depends on the particular resident. I feel additional community support services-case managers play a crucial role and identifying needs in order for a successful discharge to an independent living setting.

Yes, but with extra time and a lot of phone calls. I feel that the services for Mental Health are too few and hard to come by/ get in contact with.

No. It is always nice to work with individuals in the community that specialize in such things for residents with mental health needs.

It is always beneficial to have another person help enable clients to return to the community.

yes, but it would be helpful to have case management from county with their extended resources. I am starting from scratch so it takes longer and they know the resources and the financials involved. When I find things then I have to check the county to see if that is acceptable and if it is paid for...kind of back tracking and doing extra work sometimes I f feel like I am doing someone else's job for them; frustrating at times

The researcher identified with a few comments about not having enough time:

I believe that if nursing home social workers were not bombarded with large caseloads they would have more time to commit to locating appropriate housing and setting up all needed services.

No, due to funding and time demands.

No, The case managers have knowledge of the system that Nursing Home social workers do not. The know the resources available.

One comment that the researcher never really thought of points out how he/she can, but that he/she had many years of experience that many long term care social workers do not.

Yes, however, I have multiple years of experience working with this population. Working with many SW in LTC and TCU are often new graduates and/or lack the knowledge/resources to use or seek out.

Benefits of Case Management with the Mentally Ill in Nursing Home

A total of 40 out of 62 (66.7%) participants responded to this question about what benefits they have seen having case management involved with clients who are mentally ill. The common themes were as follows:

1. Continuity of care
2. Emotional support and symptom management,
3. Help with individualized care
4. Coordination for discharge planning
5. Extra support when there are no family or friend involvement
6. Follow-up after discharge
7. Knowledge of the client for staff,
8. The client having an established relationship,
9. Knowing available resources
10. No help
11. Rarely have case management or not applicable.

Continuity of care was the highest with eight responses, followed by emotional support and symptom management with seven and third was coordinated discharge planning with six, there were also six who stated they rarely have case management. Table 6 shows what responses led to the various themes.

Table 6

Benefits of case management with the mentally ill

Theme	Number	Written Statements
Continuity of care	8	<p>“...Continuity of care and medication management and support”</p> <p>“...The connection with other community members as well as continuity of care is important for people with mental illness”</p> <p>“monitoring of the resident, chart review, med review. ...Continuity of care form community to LTC and back to community”</p>
Emotional Support & Symptom Management	7	<p>“...Emotional support and reassurance that someone is still involved with their cares and will assist them with follow through. This benefits the patient by decreasing anxiety.”</p> <p>“...I feel the resident feels that they have not been forgotten.”</p> <p>“...Helps that the resident has someone to talk with to expression their emotions that the are familiar with and that the person is familiar with their situation”</p> <p>“...they give the resident hope that someone is able to work with them and assist them with touring places, helping them arrange furniture and other needs upon discharge”</p>
Coordinated discharge planning	6	<p>“help in determining appropriate placement”</p> <p>“more coordinated discharge planning”</p> <p>“finding appropriate placement in a timely manner”</p>
Rarely Have Case Management or N/A	6	<p>have not had much of an opportunity to work with this type of service</p> <p>none, rarely have case management</p>
Help with individualized care	6	<p>“The nursing home social workers have a large case load and are not able to give many residents the individualized care that they need. Case managers from outside agencies help to fill the gap”</p> <p>“Handling of finances, opportunities for outings, taking residents home to visit spouse etc.”</p> <p>“Help to get medications and services and referrals in a more timely/expedited manner.”</p>
Extra Support ie: No family/friends	5	<p>“Support system as many times family are not as involved due to their inability to cope with the mental health and effect it has had on their relationships with</p>

		the client”
Knowledge of the Client (Staff)	4	<p>“CM are able to help provide additional insight to the resident’s social history, behaviors, support system, and past services provided.”</p> <p>“Another referral source for the staff to visit with about issues for the client. ”</p>
Established Relationship (Client)	3	<p>“They seem to have a good/trust worthy relationship with the residents and are a major support system, and past services provided.”</p> <p>“Advocating for the individual”</p> <p>“They can be more comfortable in taking with them than being followed by a psychiatrist”</p>
Know Available Resources	3	<p>“Assistance with resource and support”</p> <p>“...extra resource”</p>
No Help	2	<p>“Not a great when the person is LTC. Mental Health providers often come to facilities, care managers rarely attend appointments with client and case managers have not been very helpful/knowledgeable in dealing with behaviors/psychosis within the skilled care setting...”</p>

40 out of 62 responded

*Some answers included more than one theme

Other Comments

The last question was geared to allow respondents to post other comments about case management with nursing home clients who are mentally ill. There were no true themes that could be taken out of these comments. Only 16 out of 62 (25.8%) participants posted comments in this question. These comments were looked at with the other four questions and some common themes were found. These common themes were case manager not helpful, lack of mental health services, no case management involvement and clients only admitted because they failed in the community. The results of these themes were put into tables and will be used in the discussion portion.

Discussion

This study explored nursing home social service perspectives about having case management involvement with clients who are mentally ill in relation to the client's ability to discharge to more independent settings. It was a mixed study that gathered both quantitative and qualitative data in an attempt to find out if there was a correlation between client's ability to discharge and having case management involvement.

In doing a study of available literature about case management in nursing homes there was a gap in the data. The hope was to gather data to fill some of this gap.

The sample size ($n = 62$) was a 15.9% response rate out of a possible 388. When looking at the respondents from different Minnesota regions there seems to be about the same response rate based on the number of facilities in each region, even though 64.5% ($n = 40$ or 61) of the responses were from facilities in rural communities where the population of mentally ill clients tends to be low. This was evident in the research as 45.7% ($n = 40$) of rural facilities reported less than 10% of their population consists of clients with a mental illness. While only 11.9% ($n = 20$) of metro facilities reported percentages at lower than 10% of clients with a mental illness. so the data could be analyzed.

Matching the Research

Simonson, Lipson, and Stone (2011) state that nationally 16% of nursing home residents under the age of 65 have a primary or secondary mental health diagnosis. Minnesota ranks among one of the three highest states with 24.4%. The data strongly supports this research as 31.7% of all facilities reported greater than 30% of their clients had a diagnosed mental illness.

Nursing home proponents state in Levin-Epstien (2006) that inappropriate

placements to nursing homes occur when community based services might be more appropriate. Several comments show that Minnesota nursing home social service personnel report that there is a lack of mental health services.

...I have a couple of current residents that would benefit from living in a less restrictive setting but our community cannot or will not provide services to meet their needs

...What I see lacking in the mental health industry is your "hard to place" younger people- 30s and 40s. So many times we see those referrals from the hospitals and we are not set up for that...

It is not all case management fault the system is broken; does not offer payment for more appropriate settings for younger clients who need more supervised setting d/t mental illness...not enough services out there. Most end up in NH due to lack of placement options, payer sources...

...I feel that the services for Mental Health are too few and hard to come by/ get in contact with...

Mental health is one of the biggest unmet needs of residents in nursing homes...

According to Aschbrenner et al. (2011), 40-51% of nursing home residents with a mental illness who are not cognitively impaired, are considered by consumers and their clinicians to be more appropriate for community based settings. This study does not support the research as 82.3% of social service personnel felt that 10% or less of their clients could discharge to more independent living settings. This is hard to generalize though because the research Aschbrenner et al. (2011) was probably not done with social workers.

Nursing home residents, according to Ervin (2008) need help transitioning into community living support situations. He goes on to state, "...it takes many hours over months for counselors to assist these clients with disabilities in performing the painstaking tasks of finding affordable housing and tapping into new support programs." (Ervin 2008, p. 1). Although this question was not specifically asked there are some

qualitative answers that tend to support the research in this study. See Table 11 for some responses related to a lack of services and/or the time to find them. The following comments also talk about how time consuming finding placement really is:

...it would take longer as it s more time consuming to find the appropriate resources and placement options...

...The Case Managers have knowledge of the system that Nursing Home social workers do not. They know the resources available.

...I feel that services for Mental Health are too few and hard to come by/ get in contact with.

This researcher has repetitively seen that clients who have received continued case management after admission have a much higher success rate of moving back into a more independent setting. This study was successful in finding a statistically significant relationship between case management past 90 days and clients who discharge to more independent living settings, even though it cannot prove causation (See Table 5).

No research existed that showed that there was a lack of case management. However this researcher has seen that case management in a nursing home is generally limited to clients who are under commitment or are involved in specialized case management programs. The qualitative data supports that social service personnel believe there is a lack of case management in nursing homes as reflected by these responses.

We rarely here from Case Management once a resident enters the LTC setting

...If they had case management services living in the community the services were discontinued once they were admitted to the nursing home

...Case managers for mental health generally bow out at 90 days – that is time to get settled into new placement and most facilities have psychologists and/or psychiatrists that come to facilities...”

Filling in the Gap

An important part of this research was to gather data not found in the literature about case management with mentally ill clients who reside in nursing homes. The qualitative portion of this survey definitely provided a wide array of information taken directly from nursing home social workers that work in Minnesota. Many answers show that it isn't just about helping them discharge it is about being there for emotional support, like:

Emotional support and reassurance that someone is still involved with their cares and will assist them with follow through. This benefits the patient by decreasing anxiety

I feel the resident feels that they have not been forgotten

they give the resident hope that someone is able to work with them and assist them...

Support system as many times family are not as involved due to their inability to cope with the mental health and effect it has had on their relationships with the client

Another benefit would be that case managers have a close relationship with the resident prior to admission, so they provide much needed information to staff and help the client cope with the day to day challenges of living in a residential facility. These comments show just how important case management is:

Case management services usually can offer more information of the clients as they generally have worked with the client for years

They can be more comfortable in talking with them than being followed by a psychiatrist

They seem to have a good/trust worthy relationship with the residents and are a major support system, and past services provided.

That data also showed that it isn't just help finding resources and placement options, it is the follow up assistance to assure that discharges are successful, as reflected

by these statements:

Yes as they are motivated to move to a more independent setting. They are less likely to have a successful placement absent case management

They would have discharged but would be at a higher risk for failure to follow through plan of care and care needs

Yes, but I believe the success rate is higher when they have case management to follow-up once in a more independent setting

Answering the Research Questions

Table 5 shows that the results of this study support the hypothesis that there is a statistically significant relationship between clients who had case management greater than 90 days and clients who discharged to more independent settings. The calculated correlation of the chi-square test (.291, $p < .05$) indicated a weak positive correlation.

The qualitative data points to case managers being helpful to help clients discharge, and most social service personnel felt that clients would have not discharged without the assistance as shown in Table 9, however there is not enough data to say that continued case management leads to more discharges.

So did case management stop at admission to nursing homes? The quantitative data points to case management dropping off after admission. At admission 5 facilities reported having case management involvement greater than 30%. When asked if there was case management 90 days after admission only 2 facilities reported greater than 30%. The qualitative data also indicated that case management was not involved after admission (see Table 11).

Do nursing home social workers have enough time to provide the assistance

needed for clients to discharge to more independent settings? 23 (54.7%) stated they had enough time and 11 (26.19%) stated they didn't have enough time; many gave comments related to their answers. While some stated they would never have time others stated they did. One response stated that she did have the time, but that she had a lot of experience and often times nursing home social workers are new or lack the experience. Many also said that if they didn't have such high caseloads they would have the time to assist with client discharges. While others stated they didn't really see the case manager as being beneficial to helping clients discharge as can be seen by these comments:

Case management usually just keep them in the NH. I am the one that advocates for them to move to a more independent environment and it usually is a big deal... not very helpful when they are the ones with the resources. Often times once they are in the NH they expect me to do their job for the client.

Not a great deal when the person is in LTC. Mental Health providers often come to facilities, case managers rarely attend appts. With client and case managers have not been very helpful/knowledgeable in dealing with behaviors/psychosis within the skilled care setting...

The only issue I have is knowing when someone is involved. There are many times I do not get contacted by the case manager, and am unaware that there is such a person...

...The facilities do not always receive information about a case manager until it is late in the planning process which makes coordination difficult when trying to make a safe discharge plan for a client

Strengths and Limitations

The study was designed to get the opinions of nursing home social service personnel to find out if continued case management with mentally ill clients leads to them being able to discharge to more independent settings. A strength that emerged from this study was gaining research in relation to mental health case management effectiveness in the nursing home setting, as current research on this subject was lacking. Another strength was that the study could be generalized to the entire state of Minnesota as the

sample population was from every nursing home in the state, and the data shows that the statewide response rate was 15.9%. Another strength was getting both quantitative and qualitative data. This was really important since 64.5% of the respondents were from facilities in rural communities where the population of mentally ill clients in nursing homes is low. Receiving information from both gave a very large amount of data.

The study also had limitations due to the structure of the survey and the capacity to find strong statistically significant correlations in the quantitative data. This was mainly due to high responses of 10% or less at a rate of 70% or greater of respondents. This is possibly due to the majority of facilities in Minnesota residing in small rural communities where the population of mentally ill clients is low as is shown in Table 2. If the study had been done in metropolitan areas perhaps this would have not been an issue. Another limitation was the structure of the questions. Most quantitative responses were in percentages, instead of numbers or scales. This really made a difference in trying to analyze and explain the data.

Implications for Social Work Practice

As the data points out most nursing homes have a social worker at a LSW level or higher, doing social service in the nursing home setting. Finding out data about mental health case management in nursing homes can be beneficial to help social workers that are in this position. It also can be helpful data to take back to administrators who make the hard decisions about social service caseloads, as well as their duties and responsibilities.

The data can also be beneficial to case managers who can look at the data to see just how important they really are to clients who live in nursing homes. When a case

manager understands just how important they are to a client, it would be less likely for them to stop services if they have the option not to.

At the macro level, data of this type can be used to prove that case management funding for mentally ill clients should not be cut off just because a client resides in a nursing facility.

Implications for Social Work Research

The results of this study showed a statistically significant relationship between clients who had case management greater than 90 days and clients who discharged to more independent settings. This however was a weak correlation that showed that case management does not appear to have a strong impact on client discharge. Therefore, future research should continue to explore the relationship between these two variables. Further research to maximize results could be changed to more reflect where the populations of mentally ill nursing home clients reside.

Research should also not be limited to the perception of the social service person. Research done with case managers who work with mentally ill clients who are in nursing homes would gather a vast amount of knowledge that could get a different perspective. Even research done with case managers who are not able to continue to follow clients once they are admitted to nursing homes. Research could also be done with clients who currently reside in facilities and/or have discharged from a facility into more independent settings. This would give a bigger picture of how important case management is to the client.

Conclusion

The findings of this study indicate just how important mental health case managers are to mentally ill clients who reside in nursing homes. Case managers who work in collaboration with nursing home social workers offer clients the best chance to be able to return to more independent settings. Case managers provide social workers with the histories of clients so they can better understand what the clients needs are. Not only are case managers important in helping clients discharge they are also very important to the mentally ill client who is in a nursing home setting. The case manager often ends up being the client's soul support system, as family members are not as involved due to broken relationships resulting from the client's mental health symptoms.

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Appendix A Survey Questions

Q1 You are invited to participate in a research study investigating the impact of case management working with SPMI client who reside in nursing homes on the clients ability to discharge to a more independent setting. The study is being conducted by Mary Schmitz, a graduate student at St. Catherine University under the supervision of Pa Der Vang, Ph.D., a faculty member of the University of St. Thomas/St. Catherine School of Social Work. You are considered a possible participant of the research if you work in a social work capacity in a nursing home in Minnesota. The purpose of this study is to find out if continued case management with SPMI clients who reside in a nursing home results in them being able to discharge to more independent living settings.

Approximately 50 people are expected to participate in this research. If you participate, you will be asked to read and accept the terms discussed within this consent form and then complete an electronic survey that consists of 24 multiple choice, and 5 qualitative questions. Upon completing the survey a message will appear thanking all for survey participation. This study will take approximately 10-15 minutes to complete. The study has minimal risks. If at any point you are uncomfortable with answering a question you will be allowed to skip a question or discontinue your participation in the survey. There are no direct benefits to you for participation in this research. In the event that you experience professional discomfort as a result of taking this survey there is a list of phone numbers that you can access at the end of the survey. All information will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. I will keep the research results saved on my personal computer and only my adviser and I will have access to the records while I work on this project. I will finish analyzing the data by May 19, 2014. I will then destroy all original reports and identifying information that can be linked back to you.

Participation in this research study is voluntary. Your decision whether or not to participate will not affect future relations with the University of St Thomas/St. Catherine University in any way. If you decide to participate, you are free to stop at any time without affecting these relationships. If you have any questions, please feel free to contact me, Mary Schmitz at 612-201-9886 or by e-mail at schm8146@stthomas.edu. You may ask questions now, or if you have additional questions later, the faculty adviser, Pa Der Vang (651) 690-8647. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may contact Dr. John Schmitt, Chair of the St. Catherine University Review Board, at (651) 690-7739. You are making a decision whether or not to participate. By continuing with this survey indicates that you work in a nursing home/board and care facility in a social service role and have read the information. Please know that you may withdraw from the study at any time.

- No, I do not agree with the terms of this survey; I do not work in a nursing home/board and care facility in a social service role. You will be exited from the survey. (1)
- Yes, I agree to the terms of this survey; I work in a nursing home/board and care facility in a social service role (2)

If No, I do not agree with the... Is Selected, Then Skip To End of Survey

Running Head: MENTAL HEALTH CASE MANAGEMENT

Q2 What is your highest education level?

- High School (1)
- Some College (2)
- Bachelors Degree (3)
- Masters Degree or Higher (4)

Q3 What license do you have?

- Licensed Social Worker (LSW) (1)
- Licensed Graduate Social Worker (LGSW) or higher social work license (2)
- Other Licensee (3) _____
- No License (4)

Q4 What Minnesota Region does your facility reside in?

- NORTHWEST: Becker, Beltrami, Cass, Clay, Clearwater, Crow Wing, Hubbard, Kittson, Lake of the Woods, Mahnommen, Norman, Pennington, Polk, Red Lake, Roseau, and Wadena (1)
- NORTHEAST: Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, and St. Louis (2)
- CENTRAL: Benton, Big Stone, Chisago, Douglas, Grant, Isanti, Kanabec, Kandiyohi, Meeker, MilleLacs, Morrison, Otter Tail, Pine, Pope, Stearns, Stevens, Swift, Todd, Traverse, Wilkin, and Wright (3)
- WEST METRO: Anoka, Carver, Hennepin, and Scott (4)
- EAST METRO: Dakota, Ramsey, and Washington (5)
- SOUTH WEST: Blue Earth, Brown, Chippewa, Cottonwood, Faribault, Jackson, Lac Qui Parle, Lincoln, Lyon, Martin, McLeod, Murray, Nicollet, Nobles, Pipestone, Redwood, Renville, Rock, Sibley, Watonwan, and Yellow Medicine (6)
- SOUTH EAST: Dodge, Fillmore, Freeborn, Goodhue, Houston, Le Sueur, Mower, Olmstead, Rice, Steele, Wabasha, Waseca, and Winona (7)

Q5 Is your facility in a rural or metro area? (Metro larger than 50,000 population)

- Rural (1)
- Metro (2)

Q6 What type of facility do you work in? (Choose all that apply)

- Nursing Home (1)
- Board and Care (2)
- Assisted Living (3)
- Rehabilitation Facility or TCU (4)
- Other (5) _____

Q7 What is your primary responsibility at the facility? (Choose as many as apply)

- Long Term Care Services (1)
- Rehabilitative/TCU Services (2)
- Admissions (3)
- Other (4) _____

Q8 How many years of have you worked for this facility and/or a facility like it?

- Less than 1 (1)
- 1-5 (2)
- 6-10 (3)
- 11-15 (4)
- 15 years or greater (5)

Q9 How many clients do you currently have on your case load?

- Under 20 (1)
- 20-39 (2)
- 40-59 (3)
- 60 or more (4)

Q10 What percentage of your current clients have a mental health diagnosis excluding Dementia?

- Less than 1% (1)
- 1-10% (2)
- 11-30% (3)
- 31-50% (4)
- 51-70% (5)
- 71-90% (6)
- 91-100% (7)

Q11 Of these current clients what percentage were admitted with this diagnosis and it played a major role in their need for long term care?

- Less than 1% (1)
- 1-10% (2)
- 11-30% (3)
- 31-50% (4)
- 51-70% (5)
- 71-90% (6)
- 91-100% (7)

Q12 If you answered greater than 50% would you consider your facility to specialize in mental health?

- Yes (1)
- No (2)

The next set of questions are about all clients (present and past) who were admitted with a mental health diagnosis and it was a major reason for their admission?

Q13 What percentage these clients have either a diagnosis of dementia and/or a major health issue that requires 24 hour nursing?

- Less than 1% (1)
- 1-10% (2)
- 11-30% (3)
- 31-50% (4)
- 51-70% (5)
- 71-90% (6)
- 91-100% (7)

Q14 What percentage of these clients are primarily independent with bathing, dressing and grooming?

- Less than 1% (1)
- 1-10% (2)
- 11-30% (3)
- 31-50% (4)
- 51-70% (5)
- 71-90% (6)
- 91-100% (7)

Q15 What percentage of these clients do you feel could live in a more independent living setting?

- Less than 1% (1)
- 1-10% (2)
- 11-30% (3)
- 31-50% (4)
- 51-70% (5)
- 71-90% (6)
- 91-100% (7)

Q16 What percentage of these clients had a mental health case manager at admission?
(Not their Health Plan Coordinator)

- Less than 1% (1)
- 1-10% (2)
- 11-30% (3)
- 31-50% (4)
- 51-70% (5)
- 71-90% (6)
- 91-100% (7)

Q17 What percentage of clients who had a mental health case manager at admission got case management past 90 days? (Not their Health Plan Coordinator)

- Less than 1% (1)
- 1-10% (2)
- 11-30% (3)
- 31-50% (4)
- 51-70% (5)
- 71-90% (6)
- 91-100% (7)

Q18 When case management was discontinued what was the primary reason?

- The case manager stated their agency does not provide services when the client resides in a nursing facility (1)
- The case manager stated the person no longer needs services (2)
- Case management was dropped as soon as the client was admitted with no reason given (3)
- Case manager stated you were expected to provide this service (4)
- Other (5) _____

These next set of questions are in relation to clients with a mental health diagnosis who received case management past 90 days?

Q19 What percentage of these clients had court involvement?

- Less than 1% (1)
- 1-10% (2)
- 11-30% (3)
- 31-50% (4)
- 51-70% (5)
- 71-90% (6)
- 91-100% (7)

Q20 What percentage of these clients were involved in a case management program where there was no time limit?

- Less than 1% (1)
- 1-10% (2)
- 11-30% (3)
- 31-50% (4)
- 51-70% (5)
- 71-90% (6)
- 91-100% (7)

Q21 What percentage of these cases gave the client and/or the case manager the choice to continue or discontinue services?

- Less than 1% (1)
- 1-10% (2)
- 11-30% (3)
- 31-50% (4)
- 51-70% (5)
- 71-90% (6)
- 91-100% (7)

These next set of questions have to do with all discharged clients who were admitted with a mental health diagnosis and it was a major reason for their admission?

Q22 What percentage of these clients were discharged to a more independent living setting?

- Less than 1% (1)
- 1-10% (2)
- 11-30% (3)
- 31-50% (4)
- 51-70% (5)
- 71-90% (6)
- 91-100% (7)

Q23 What percentage of clients who were able to discharge to a more independent living setting had case management services when they discharged? *Case Management in this question is not relocation services and/or services obtained from a Health Plan

Coordinator

- Less than 1% (1)
- 1-10% (2)
- 11-30% (3)
- 31-50% (4)
- 51-70% (5)
- 71-90% (6)
- 91-100% (7)

Q24 How important was the case managers role in determining their ability to discharge to a more independent setting? *Case Management in this question is not relocation services and/or services obtained from a Health Plan Coordinator

- Very Important (1)
- Somewhat Important (2)
- Important (3)
- Not Very Important (4)
- Not Important (5)

Q25 If Case Management Was Important To Help These Clients Discharge, What Types Of Assistance Did They Provide?

Q26 In Your Opinion Would These Clients Have Discharged To More Independent Settings It They Had Not Had Case Management?

Q27 What Other Benefits Have You Seen For Clients Who Receive Case Management Services While In A Nursing Home Setting?

Q28 Do You Feel That You Could Provide Enough Service To Enable Clients To Discharge To More Independent Settings?

Q29 Do You Have Any Other Comments About Case Management with SPMI Clients in Your Facility?

In the event that you experienced professional discomfort as a result of taking this survey you can call:

Researcher: Mary Schmitz at 612-201-9886

Faculty Advisor: Pa Der Vang (651) 690-8647

Inter-professional Center for Counseling and Legal Services ☐

30 S. 10th Street ☐ Minneapolis, MN 55403

Phone: 651-962-4820 ☐ Fax: 651-962-4815

Appendix B
Letter Sent to Social Service Director

Date:

Dear Director of Social Services,

My name is Mary Schmitz. I am a Graduate Social Work student at St. Catherine University & University of St. Thomas. As a requirement of the program I must develop and complete a research project based on the subject of my choice. Working for the past six and half years as a nursing home social worker in a facility that deals primarily with clients who suffer from serious and persistent mental illness has given me a vast amount of knowledge about the difficulties that clients face trying to discharge to a more independent living setting. I would like to invite you to participate in a study about past and present residents who have a serious and persistent mental illness (SPMI) and the role that case managers have played in helping client's discharge to more independent living settings.

Your participation involves completing a 29 question online survey getting demographic information about your facility, past and present clients with SPMI, and their case managers. A small part of the survey is getting your personal input about what the case managers role has or has not been.

There are no direct benefits for this study. You will not be compensated. The survey will take no more than 15 minutes to complete, if at any time you are uncomfortable answering a question you are free to leave it blank. In the event that you experience negative emotions as a result of taking this survey a list of contacts will be available at the end of the survey

The link to the survey is:

http://stthomassocialwork.qualtrics.com/SE/?SID=SV_9NNOE1gM2e8QAwR

You can access the survey by typing this link into you computer browser, or e-mail me at schm8146@stthomas.edu and I will send the link directly to you. The survey will be available from January 6th to February 6th. I will be sending out e-mail to your facility next week detailing the study with a link to the survey as well.

If you would like more information, please contact Mary Schmitz at schm8146@stthomas.edu or call 612-424-2077.

Sincerely,

Mary Schmitz

Appendix C
E-mail to Administrator/Facility Liaison

Date:

Dear Administrator/Facility Liaison,

My name is Mary Schmitz. I am a Graduate Social Work student at St. Catherine University & University of St. Thomas. As a requirement of the program I must develop and complete a research project based on the subject of my choice. Working for the past six and half years as a nursing home social worker in a facility that deals primarily with clients who suffer from serious and persistent mental illness has given me a vast amount of knowledge about the difficulties that clients face trying to discharge to a more independent living setting. I would like to invite your social service personnel to participate in a study about past and present residents who have a serious and persistent mental illness (SPMI) and the role that case managers have played in helping client's discharge to more independent living settings.

Their participation involves completing a 29 question online survey getting demographic information about your facility, past and present clients with SPMI, and their case managers. A small part of the survey is getting their personal input about what the case managers role has or has not been.

There are no direct benefits for this study. Participants will not be compensated. The survey will take no more than 15 minutes to complete, if at any time they are uncomfortable answering a question they are free to leave it blank. In the event that they experience negative emotions as a result of taking this survey a list of contacts will be available at the end of the survey

I have prepared your social service personnel by sending out a letter requesting their assistance on Wednesday January 8th. I am asking that you please forward this e-mail to your Social Service Director

The link to the survey is:

http://stthomassocialwork.qualtrics.com/SE/?SID=SV_9NNOE1gM2e8QAwR

If you would like more information, please contact Mary Schmitz at schm8146@stthomas.edu or call 612-424-2077.

Sincerely,

Mary Schmitz

Appendix D

E-Mail 2 to Nursing Home

Date:

Dear Administrator/Facility Liaison, Social Worker

If your facility has completed this survey, thank you for your participation, please ignore this e-mail. If your facility is choosing not to participate also ignore this e-mail, you do not need to e-mail me for either reason.

My name is Mary Schmitz, a Graduate Social Work student at St. Catherine University & University of St. Thomas. This is a reminder regarding a survey that I developed as part of my research project to complete my masters degree in Social Work. I sent letters out to all Social Service Directors four weeks ago and e-mails last week and two weeks ago to the facility with the survey link. The survey is open until February 6th. Please forward this to your social service department if you choose to participate.

Survey Information:

Working for the past six and half years as a nursing home social worker in a facility that deals primarily with clients who suffer from serious and persistent mental illness has given me a vast amount of knowledge about the difficulties that clients face trying to discharge to a more independent living setting. I would like to invite your social service personnel to participate in a study about past and present residents who have a serious and persistent mental illness (SPMI) and the role that case managers have played in helping client's discharge to more independent living settings.

Their participation involves completing a 29 question online survey getting demographic information about your facility, past and present clients with SPMI, and their case managers. A small part of the survey is getting their personal input about what the case managers role has or has not been.

There are no direct benefits for this study. Participants will not be compensated. The survey will take no more than 15 minutes to complete, if at any time they are uncomfortable answering a question they are free to leave it blank. In the event that they experience negative emotions as a result of taking this survey a list of contacts will be available at the end of the survey

The link to the survey is:

http://stthomassocialwork.qualtrics.com/SE/?SID=SV_9NNOE1gM2e8QAwR

If you would like more information, please contact Mary Schmitz at schm8146@stthomas.edu or call 612-424-2077.

Sincerely, Mary Schmitz