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Assessing the Role of Preference, Ability, and Feasibility in Transition Decisions: Developing and Testing the California Nursing Facility Transition Screen

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Abstract

Purpose: Little is known about the preferred living arrangement of custodial nursing facility residents. This study describes the development and application of an instrument designed to systematically assess preference toward transition and to explore their ability and feasibility of transitioning. *Design and Methods:* We targeted all Medicaid-funded, long-stay residents in eight nursing facilities in southern California (n=218). Of these, 121 (56%) self-consenting residents or their legally designated proxy decision-maker were interviewed using the California Nursing Facility Transition Screen. No presumptions were made as to which residents were good or bad candidates for transition based on their health or functional capacity. *Results:* Results indicated that 46% of those interviewed preferred to transition whereas a smaller proportion believed in his/her own ability to transition (23%) and the feasibility of transitioning after discussing potential living arrangements and services (33%). Most who indicated that transitioning was feasible remained stable in their transition decision (79%). In 46% of cases, the screen found a preference to transition whereas the MDS did not indicate such a preference. A higher proportion of residents who were responsible for their own decision-making (65%) thought it was feasible to relocate than residents with designated proxies (35%). *Implications*: Transition decisions are complex and include preference as well as one's own (resident or his/her proxy) assessment of the resident's ability and feasibility of transitioning. Compared to the MDS, we identified a higher proportion of residents who want to transition, suggesting that a systematic approach to assessing residents' preference is needed.

Key Words: custodial care, nursing facility residents, living arrangements, relocation

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For over two decades, long-term care policy efforts have focused on developing home and community-based alternatives to institutionalization. In 1999, these efforts became a federal imperative with the Olmstead Decision, in which the Supreme Court determined that unnecessary institutionalization violates the ADA [Americans with Disabilities Act of 1990] (Williams, 2000). In response, public entities must administer

programs and activities in the most integrated setting appropriate for persons with disabilities (Rosenbaum, 2000). Some states have responded by using health and social supports to: 1) divert persons at risk of nursing facility placement, 2) delay entry into the nursing facility, and 3) identify and transition nursing facility residents into community settings. Although an extensive body of literature has developed that focuses on strategies to divert and delay nursing facility placement, comparable information about transitioning long-stay residents out of nursing facilities is lacking. The purpose of the present study was to develop and test a comprehensive instrument that identifies nursing facility residents with the potential to transition by assessing their preference and self-reported ability to leave the facility.

Understanding the Preferences of Nursing Facility Residents

Although it is clear that prior to placement the vast majority of older adults wish to remain in their own homes (AARP, 2000), little is known about the extent to which long-stay nursing facility residents of any age prefer to transition to community settings or to remain in an institutional setting. Both the admission and annual assessment of the Minimum Dataset 2.0 (MDS), completed for all residents in state and federally certified nursing facilities, include one question about the resident's preference to return to the community. However, the MDS measure, which is based on a single screening question about the resident's potential interest in returning to the community, may not be uniformly and regularly asked of every resident and does not explore the reasons and circumstances surrounding the preference. Furthermore, the MDS manual instructs assessors to use indirect questions with long-stay residents to avoid creating unrealistic expectations.

The lack of a more direct approach is defensible if those being interviewed are clear and spontaneous in expressing their intent. For example, residents admitted to the nursing facility for rehabilitation and still have housing will likely express a strong preference to return home, even if not asked directly. However, long-stay residents may not make their preference known because they may not consider transition to the community as an option. Barriers, which make transition less likely to be considered, include losing prior housing, unquestioning acceptance of life in the facility, and lack of awareness of home and community-based alternatives.

In addition to the MDS, several states and localities have developed tools to assess preference of residents to transition out of nursing facilities.

The Michigan Department of Community Health developed planning tools, including open-ended interview questions that explore potential barriers, availability of friends and family to provide support, and previous experience with personal care assistants. In some states, questions about preferences are built into uniform assessments as part of an integrated system. For example, Washington's Comprehensive Assessment Reporting Evaluation (CARE) tool has an open-ended, broad assessment of client goals, which can include a nursing facility resident's preference to return to the community. The uniform assessments in both Oregon (Client Assessment and Planning System tool) and Wisconsin (Long-term Care Functional Screen) have a section in the assessment that asks about current and preferred living situations.

Some Independent Living Centers (ILC) have also developed instruments to determine the health and social service needs of persons who want to transition from the nursing facility to the community. Community Resources for Independence in Santa Rosa, California and the Austin Resource Center for Independent Living in Texas have assessments that contain several items that evaluate community living preference. In these localities, however, potential candidates have already been referred to the ILC by family members or health professionals because the resident has indicated a wish to transition home. Therefore, the focus of these assessments is on housing and service needs.

These examples demonstrate that approaches to assessing the preference of nursing facility residents have been developed. However, we are not aware of instruments that systematically assess all nursing facility residents or gather comprehensive information on both preference and self-perceived ability to relocate using standardized protocols. Rather, most measure preference to return home before an individual is admitted to the long-stay portion of the nursing facility or after the resident is identified by caregivers or family members as wanting to transition. Where instructions are included in the protocols (e.g., MDS), they allow interviewers wide flexibility in how or even if preference questions are asked. In addition, few instruments include training for interviewers, which could lead to inconsistency in obtaining responses.

Studies on the nursing facility population must distinguish between residents who enter for long-stay custodial care, many of whom are funded by Medicaid, and those admitted for short-stay Medicare-funded rehabilitation (Keeler, Kane, & Soloman, 1981, Liu & Palesch, 1981). This distinction is important because those most likely to be discharged are short-stay residents receiving Medicare-covered rehabilitation. For

example, one study found that residents with Medicare-covered stays were nearly three times more likely to be discharged than residents not covered by Medicare, whereas those relying on Medicaid were almost four times more likely to remain in the nursing facility than those whose stay was not covered by Medicaid (Chapin, Wilkinson, Rachlin, Levy, & Lindbloom, 1998). Long-stay residents are more likely to utilize Medicaid funding for custodial care and to have higher levels of impairment. Gillen, Spore, More, & Freiberger (1996) found that the longer a resident remained in the facility, the less likely he/she was to be discharged to the community. In addition, older residents and those with high levels of functional and cognitive impairment were least likely to return home.

In addition to assessing preference to leave or to remain in the facility, it is important to help residents weigh the implications of their choice. In this regard, there is some evidence that lack of awareness of what options are available influences residents' statements about preferences. For example, a study of residents in three nursing facilities who were identified by nurses as having light care needs indicated that 70% (n=20) did not want to remain in the facility but all but one believed that they had no other option (Grando, Mehr, Popejoy, Maas, Rantz, Wipketevis, et al., 2002). Lack of resources or inability to identify and access resources may present a significant barrier for long-stay residents to consider returning home (Mehr, Williams, & Fries, 1997). Related factors that may impact preference and residents' perceived ability to transition successfully include: 1) concerns about safety and the perceived risk of living in the community without 24- hour care; 2) lack of affordable and accessible housing, 3) lack of transportation needed to access services; and 4) concerns about retaining the resident's primary care physician.

To comply with the Olmstead Decision, a comprehensive transition screen is needed that can systematically assess the preferences of all long-stay nursing facility residents receiving custodial care. The protocol should tap residents' core preference about remaining or leaving the facility. In addition to soliciting preference, the screen should evaluate the consumers' perceived ability to transition and include information to help the resident and/or the resident's family examine the feasibility of transitioning to the community. To address the lack of systematic research in this area, we report the findings from using the California Nursing Facility Transition Screen in eight nursing facilities to address the following questions: 1) What is the proportion of long-stay residents who indicate a preference and self-perceived ability to transition from the nursing facility to a community-based setting? 2) Do residents believe that transition is

feasible after discussing the available community services and supports? 3) Are residents' transition decisions stable over time? 4) Does interviewing all Medi-Cal-funded (California's Medicaid program), custodial residents within the nursing facility using a comprehensive interview protocol identify a different rate of preference to return home than the MDS?

Design and Methods

The Development of the California Nursing Facility Transition Screen

The screening tool was developed by building on lessons learned from reviewing other instruments such as the MDS and preference instruments from other states and localities. We also sought input from key stakeholder groups who represented those in facility-based care such as consumer groups and groups representing persons with disabilities and older adults. Previous efforts in California to design a transition assessment protocol had been criticized by some of these key stakeholder groups for failing to adequately measure resident preferences, according to initial conversations with the California Department of Rehabilitation and Department of Health Services, who were co-sponsors of the project. Representatives argued that many people with a strong preference to live outside of the nursing facility have the ability to do so despite the presence of objective medical problems that would appear to make community living difficult. Advocates were concerned that residents' medical characteristics were the primary or only factor that influenced transition decisions.

As a result, efforts were made to solicit extensive feedback and to pilot test the instrument. The initial screening protocol was placed on a website and representatives of a variety of stakeholder groups, identified by the California Department of Health Services, provided comments. To further solicit feedback on the instrument, an in-person meeting was held with representatives from advocacy groups, provider groups, and community agencies with interests in transition activities. Preliminary drafts of the interview were revised based on pilot tests in two southern California nursing facilities. Criteria for the screening tool were that it assessed preference from all Medi-Cal residents, included information on community supports to help the resident determine the feasibility of transitioning, was not taxing to complete, and did not create unrealistic expectations about opportunities to live outside the facility. The University of California Los Angeles Insititutional Review Board approved all facets of the project.

The interview, which can be completed in about ten minutes, begins with a brief description of the project and the purpose of the interview. Participants are informed that they will be asked questions about their preferred living arrangements, but there is no guarantee that transition will

result. The interview includes 27 open- and closed-ended questions that examine reasons for entering the nursing facility, preference to transition, and ability to return to the community. Finally, to ensure that respondents are aware of housing and community options before assessing the feasibility of transition, the instrument explores potential living arrangements and services needed.

Sample

The project targeted all English-speaking residents alive and residing in the nursing facility at the time of the interview. These eligible residents were receiving custodial (long-term) nursing facility care covered by Medi-Cal in eight nursing facilities in Southern California (n=178). Residents paying privately and those receiving Medicare-funded rehabilitation were excluded. Non-English speaking residents (n=4) were excluded from this pilot phase but plans are being made to accurately translate the screening tool and the protocol to accommodate other languages.

Seven facilities were affiliated with for-profit nursing facility chains and one was an independent for-profit facility. Facility inclusion criteria were 99 or more beds, freestanding facility, and a high proportion of Medi-Cal residents (75% or more). Exclusion criteria included nursing facilities that were primarily locked psychiatric facilities, those that were exclusively rehabilitation or sub-acute facilities, or facilities that served only the developmentally disabled.

Procedure

With privacy safeguards in place, each nursing facility identified residents whose stay at the nursing facility was funded by Medi-Cal and whose stay at the nursing facility was expected to be long-term. Information from each resident's face sheet was used to indicate those who could provide self-consent and those who required a proxy for health care decisions. For those who could not provide consent due to dementia or other impairments, the face sheet in the resident chart identified the legally designated proxy. It is important to note that because we did not exclude residents based on cognitive status criteria, a significant number of residents had a designated proxy for medical decisions. We were thus required to contact these proxies telephonically since it was not known when or if the proxy would be visiting the facility in person.

Interviewers were graduate students who received four hours of training to administer the interview. Interviewers contacted residents in the facility who had the capacity to provide self-consent (n=44). Using an interview script, they notified residents of the potential option to transition to

a community setting and asked if they were willing to be interviewed about their preferences regarding transition. Thirty-three residents (75.0%) agreed to participate.

For residents who had a legally designated decision-maker and could not consent to the interview themselves (n=174), a total of three attempts were made to contact the proxy via the telephone. Trained researchers used a structured telephone script to leave messages, to introduce the study to the proxies, and to obtain consent to conduct the interview. Seventy seven percent (n=134) of proxies were contacted and eighty-eight proxies (65.7%) agreed to participate. Both nursing facility residents and proxies who consented to the interview were asked to sign a Health Insurance Portability and Accountability Act of 1996 (HIPAA) consent to access the resident's MDS records. Preference information contained in the most recent full MDS (item Q1.a) were compared with the responses to the California Nursing Facility Transition Screen. Residents who preferred to transition to the community were asked to sign a release consent to share their information with the community agencies who would assist them. Twelve inter-rater reliability interviews were conducted, in which two interviewers coded participants' responses. Agreement was 100% on participants' preference to relocate. In addition, to assess stability of the transition decision, all participants who indicated that transition was feasible were re-interviewed approximately three weeks later.

Results

Securing Participation in the Study

Figure 1 illustrates the flow of residents through the study. A total of 218 Medi-Cal residents were eligible for the study in eight nursing facilities, 44 were self-consenting residents and 174 had proxies for health care decisions. Researchers were able to contact 82% of Medi-Cal residents or their proxies (n=178). Forty proxies (18.3%) could not be contacted after three attempts; some did not return researchers' messages and others did not have an answering machine. Sixty eight percent of all those contacted (n=121) consented to the interview, 33 were self-consenting residents (75.0% of all self consenters) and 88 were proxies (50.6% of all eligible proxies). Seventy-two percent of the 57 participants who did not consent to the interview provided explanations. Most cited the resident's excessive health problems as reasons for declining the interview (36.6%, n=15). Twenty nine percent (n=12) were clear that the resident was incapable of leaving the nursing facility. Other participants were not interested in the study (24.4%, n=10), were satisfied with the nursing facility (7.3%, n=3),

and one was unwilling to provide personal information. The final analytic sample consisted of 33 residents and 88 proxies or 56% the original sample.

(PLACE FIGURE 1 ABOUT HERE)

Reasons for Entering the Nursing Facility

Participants were first asked: “What changes occurred in your (your relative’s) life that led you (your relative) to move to the nursing facility?” All provided responses (n=154) were collapsed into categories. Fifty six percent (n=86) cited a change in medical health status as the reason for entering the nursing facility. Another 27% (n=42) indicated a change in physical ability. A smaller number indicated the need for therapy to recover from surgery (n=8) and the need for 24-hour assistance (n=4).

Ability and Preference to Leave the Nursing Facility

Participants were first asked about their *ability* to transition with the question: “Do you think you (your relative) would be able to leave the nursing facility and live somewhere else now?” Twenty three percent (n=28) said that the resident was able to leave the nursing facility, 69% (n=84) indicated the resident was not able, and 7% (n=9) were unsure. Although there were more than two times more proxy interviews than resident interviews, only 25% (n=7) of proxies stated that the resident was able to leave the nursing facility whereas 75% (n=21) of residents responded in the affirmative (χ^2= 8.72, p=.013). Most participants provided a response when asked why the resident was unable to leave the nursing facility (81.0%, n=68). The majority cited the need for a high level of care (50.0%, n=34), the inability to perform basic activities such as walking or eating (33.8%, n=23), and the risk involved with leaving the nursing facility (5.9%, n=4, e.g., risk of falling).

Participants were then asked about the resident’s *preference* to leave the nursing facility with the following question: “Would you (your relative) want to live somewhere other than the nursing facility?” Almost half of the participants (n=56, 46.3%) indicated that the resident wanted to leave the nursing facility. Forty-two participants (34.7%) said the resident did not want to leave the nursing facility, and 19% (n=23) stated that they didn’t know. A greater percentage of proxies (85.7%, n=36) than residents (14.3%, n=6) indicated that the resident did not want to leave the nursing facility (χ^2= 16.09, p<.0001). To determine why participants did not want to transition, they were asked "What are some reasons you/your relative want to continue living in the nursing facility?" Thirty-four of the 42 participants who did not want to leave the nursing facility provided responses that could be easily collapsed into three categories: 1) need for a high level of care

(56%); 2) like nursing facility or staff (29% of comments); and 3) the nursing facility is the most appropriate placement (15% of comments). Twenty percent (n=24) indicated that residents both preferred to leave and were able to transition from the nursing facility.

In the third part of the interview, interviewers briefly described various community-based living arrangements and the types of support that can be provided in each setting. Participants were asked if they thought these housing and services were good options for the resident. Among those who responded “no” or “don’t know”, the interviewer asked a second question in which he/she listed specific Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) and said that assistance with these tasks could be provided to the resident. The interviewer asked if the respondent could get this help, would the respondent change his/her mind about transitioning. If the participant said “yes” or “don’t know”, the interviewer proceeded with the next section of the interview. If the respondent again said “no”, the interview was stopped. If the respondent said “yes” to the former question about living arrangements and types of support, the interviewer again listed the ADLs and IADLs, but asked if this type of assistance sounded important for the resident. The interview was stopped for respondents who said “no”. If the respondent says either “yes” or “don’t know” to this question, the interviewer proceeded with the next section of the interview (n=52).

Living Arrangements and Assistance

In the next section, interviewers further explored potential living arrangements and assistance needed with the 52 participants who indicated an interest in transitioning if needed support were available. Respondents were able to express an interest in more than one living arrangement. Thirty percent of these respondents (n=17) said that the resident had no place to go if he/she left the nursing facility. Another 25% (n=14) said that the resident would live alone in an apartment or home. Twelve respondents said that the resident could live with other family members (21.1%) or with a partner/spouse (5.3%, n= 3). Several respondents said that the resident would be interested in an assisted living facility (7.0%, n=4) or group home (12.3%, n=7). It is important to note that the above data reflects self-reports and may not reflect what happens at the point that relocation is attempted.

To further examine the need for support and the capacity for residents to transition, interviewers asked the respondents to evaluate the resident’s need for assistance with activities of daily living (ADL) and instrumental activities of daily living (IADLs). Residents or proxies reported

a mean of six IADL difficulties (M = 5.6, SD=1.6). Most problematic were housework (96.1%, n=49), cooking or preparing meals (91.8%, n=45), shopping (90.4%, n=47), and transportation (90.4%, n=47). Residents had a mean of three ADLs (M=3.02, SD=1.7), with the majority needing help with bathing or showering (86.3%, n=44). The next most prevalent ADL difficulties were dressing (69.4%, n=34) and toileting (56.0%, n=28).

Feasibility of Transitioning

The interview concluded by asking the question, "If you had help available for any of these services, would you or your relative be able to leave the nursing facility?" This question is identical to the earlier question asking about the ability to transition, but after discussing the preferred living arrangements and services needed, the goal of the question was to assess whether respondents believed transitioning continued to be a *feasible* option.

Seventy-seven percent (n=40) of those who completed the entire interview believed that transitioning was a feasible option, 13% said "no" (n=7), and 10% (n=5) were unsure. Of the 40 respondents who responded that leaving the nursing facility was a feasible option, the majority were self-consenting residents (65%) rather than proxies (35%) (χ^2= 8.72, p=.013). In short, 40 respondents out of the 121 who were initially interviewed (33%) believe that transitioning was a feasible option after hearing about service and community living options.

Clarity and Motivation to Transition

After completing the interview, interviewers rated the resident's or proxy's understanding of the transition process. Among participants who indicated that transitioning was feasible (n=40), the majority of interviewers stated that residents and proxies were very clear in understanding what services were needed (77.5%), 15% were somewhat clear, 5% were neither clear or unclear, 3% were rated as "somewhat unclear", and none of the respondents were "not at all clear". Interviewers also rated the level of motivation that the resident or proxy had toward transition. Most participants (60.0%) were "very motivated" toward the transition process, 23% were "somewhat motivated", but 10% were "neither motivated nor unmotivated", and 8% were "somewhat unmotivated". None of the respondents were "not at all motivated" to transition.

Feasibility of Transitioning: Stability Over Time

Interviewers approached the 40 participants who said that transitioning was feasible approximately three weeks later. Most participants consented to a second interview (85.0%, n=34). Of the 34 who provided consent, 23 were residents and 11 were proxies. Overall, 27

participants (79.4%) responded with a stable response to transition to the community. In comparing residents and proxy responses, 74% (n= 17) of residents demonstrated stability in their transition decision versus 91% (n=10) of proxies. Among these 27 participants, 81% (16 residents, 6 proxies) completed a release form to enable researchers to refer their case to a community-based agency.

Comparison of Preference Findings with MDS Preference Question

Among the 121 residents who consented to the interview, permission was obtained to secure MDS data on 41 residents. The preference data from the California Nursing Facility Transition Screen were compared to MDS question Q1a "Resident expresses or indicates a preference to return to the community." In 46% of cases (n=19), our interview indicated that the resident preferred to move, but the MDS indicated that the resident did not want to leave ($\chi^2 = 4.67$, $p = .097$). In one case, the MDS indicated that the resident had a preference to leave whereas our interview found the opposite. Twelve percent of residents (n=5) were unsure if they wanted to leave according to our interview, but the MDS was recorded as "no". There was agreement in the remaining cases (39.0%, n=16).

Comparing Resident Characteristics

Table 1 illustrates the characteristics of residents who indicated that transitioning was feasible and those who said moving was not feasible. Although the small proportion of the sample who agreed to sign a HIPAA consent reduced the power to identify differences, it is clear that participants who thought that transitioning was feasible were less cognitively impaired and younger.

(PLACE TABLE 1 ABOUT HERE)

Discussion

This article's main research question was: How many long-stay residents express a preference and ability to relocate if attempts are made to interview all Medi-Cal residents or their proxies using no cognitive or physical functioning exclusion criteria? Forty six percent (n=56) of respondents indicated that the resident preferred to return home. However, the question on self-reported ability to move reduced the percentage of affirmative responses by half (23%, n=28). Many respondents may prefer transition, but at the same time, indicate reasons that transition is or may not be possible. Qualitative analyses on the reasons given by participants demonstrate that the need for a high level of care was the most prominent reason for not preferring or not being able to move. These findings suggest

that residents and their proxies are sensitive to what care setting is most appropriate. Transition is a complicated decision in which the individual must weigh both the desire and capacity to relocate. Despite the preference to return to the community, the person may also have concern and anxiety over the transition home, residing in the community, and potential need to return to the nursing facility in the future.

The second research question explored the capacity of residents and proxies to assess the feasibility of transitioning after discussing potential living arrangements and service needs. This section of the interview was designed to encourage residents and proxies to think about the need for assistance with daily tasks. Forty participants stated that transitioning was feasible, a number higher than the 28 who indicated that the resident was able to move. It can be argued that these residents and proxies, who believed that transition was feasible, were most serious about transition. They may be more likely to work closely with community agencies throughout the transition process, which can involve many tasks, including securing housing and arranging for services. Some respondents may want to move and believe that they are able to leave, but a discussion of potential living arrangements and service needs was necessary to determine whether community living was possible. It helped participants to understand what assistance could be available to them before answering the final question about feasibility of transitioning.

The third research question investigated whether the respondent's perception of the feasibility of transitioning was stable over time. The majority of participants who consented to a second interview continued to believe that transition to the community was feasible (79.4%, n=27). The instability of the remaining 20% reflects the gravity of the transition decision. This subset could be targeted for further educational or supportive efforts to understand their fears or concerns. In practice, a secondary interview may be necessary to enable residents and families to reflect on this important decision. Furthermore, the 22 of 27 participants, who completed the release form to be referred to a community agency, took a proactive step that demonstrated their commitment to transition.

The study's fourth goal was to determine whether the California Nursing Facility Transition Screen identified a different proportion of preference to transition than the MDS. The MDS assesses preference with a single item on the admission and annual assessment that is based largely on the assessor's judgment and cautions assessors against creating unrealistic expectations. With the systematic approach of interviewing all custodial residents and proxies regardless of their health

condition, the screen identified a large proportion of residents who wanted to transition even though the MDS indicated a lack of preference to leave (46.3%, n=19). Although only a small proportion of participants allowed access to their medical records, this finding suggests that a direct questioning approach should be employed when ascertaining a custodial resident's preference to return home. Furthermore, it does not appear that the California Nursing Facility Transition Screen created unrealistic expectations. The responses of participants indicated that they were aware that some residents needed a high level of care or that the nursing facility setting was most appropriate.

The conclusions made in this paper are limited in several ways. First, relatively few people who did not want to relocate were willing to allow access to their medical record data. This prevented better comparison of the California Nursing Facility Transition Screen and the MDS approach to assessing preference. Secondly, we did not conduct stability interviews with residents or proxies who said "no" to the move and there is a chance that some of these participants would later believe that transitioning was feasible. We did not repeat interviews with these participants at least partially because many proxies appeared definite in their opinion that the resident could not move and did not want further contact. Thirdly, we do not know how successful the people who were referred to community agencies will be in the transition process or the cost of this process. There is a chance the nursing facility staff are not identifying more people on the MDS for transition because of low expectations about the feasibility of this transition process. Finally, only English-speaking residents were interviewed during this pilot phase.

Despite these limitations, this pilot study represents an important first step in an area with no previous systematic research. We approached and enabled all eligible nursing facility residents to express their preferences and beliefs toward their ability to and feasibility of returning home. In addition, no presumptions were made as to which residents were good or bad candidates for transition based on their health or functional capacity. In supporting the philosophy of consumer direction and choice, the California Nursing Facility Transition Screen presents both the opportunity and means for nursing facility residents to create a different future for themselves and receive the needed resources to meet this goal. The interview identified a significant proportion of people expressing a preference to relocate, an important population according to the Olmstead principles. Despite the instability of some interview responses toward the feasibility of

transitioning, the screen should be conducted with all long-stay residents independent of the MDS.

The fact that residents who were able to self-consent and who were less cognitively impaired were more likely to express a stable belief that they could transition than proxies who were answering for more impaired residents also has important policy implications. Specifically immediate efforts should be made to interview this important but relatively small group of self-consenting residents since they appear to be excellent candidates for transition. MDS item 'A9', which records the legal proxy decision-maker, could potentially be used to identify this group. The number of interviews would be smaller and it is likely that a high number of transition candidates would be identified with this effort.

The next stage of the pilot project in California is to document the transition process and to determine if the resident's or proxies' perceived feasibility of transitioning predicts their success in the community. Further research with the nursing facility MDS may determine whether there are certain conditions or levels of impairment that are more difficult to maintain in a community setting. A profile could be developed of residents who prefer to transition home versus those who do not want to transition. Policy research will determine the extent to which there are barriers that interfere with the ability to honor a resident's preference. For example, long waiting lists for services and a lack of supply make it difficult to secure affordable senior housing units. Future evaluation of processes and outcomes of the transitioning process will guide policy makers and inform advocates as states strive to facilitate consumer direction and comply with the principles of the Olmstead Decision.

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