FINDING A FINAL HOME:

A NEEDS AND GAPS ANALYSIS OF THE REFERRAL PROCESS INTO LONG-TERM CARE FOR AGING VETERANS WITH A MENTAL HEALTH DIAGNOSIS

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Abstract

Introduction/Background: This study aimed to improve the referral process for Veterans with mental health who are seeking long-term care support through the VA with a needs and gaps analysis. Hackman and Oldham's theoretical framework served as a lens to gain insight into stakeholders of the process and explore the need for stakeholders to know the whole process to yield the most effective outcome.

Methods: Survey, 9 structured interviews, Mental Health admission data collection

Results: More than 45% of all clinical staff at Manchester Veterans Affairs Medical Center reported not feeling confident or only slightly confident on their knowledge of the Long-Term Care Referral Process while 71% reported not feeling confident or slightly confident on their knowledge of the PASRR as part of the referral process. Data Collection from Geriatric programs found all four programs had 35% or more Veterans e nrolled with a Mental Health diagnosis. There were five central themes found from interviews in data analysis; a lack of knowledge of the referral process, an increase in aging mental health Veterans, needed resources, COVID Impact and a need for more training.

Discussion: A discovered lack of knowledge of the whole referral process amongst stakeholders is negatively impacting nursing home placements with an inconsistency in completing the PASRR which supports existing literature on a need for a standardization of the PASRR and an Interdisciplinary approach. This study introduced an approach to standardize the PASRR implementation and improve the effectiveness of the LTC referral process through Oldham & Hackman's theoretical framework. While this was applied to the LTC referral process this approach can be generalized to other areas

working to breakdown the compartmentalization of workflows. Manchester is one VA of 171 facilities. This study was limited to VA stakeholders and future research would benefit from community stakeholder insight.

Keywords: *Long-Term Care, Mental Health, Veterans*

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Introduction

Above the tree line, an American C-7's engine shakes the early orange dawn of 1969 Vietnam. For one 19-year-old, it's time to face another day in a hostile place. As he opens his eyes, he realizes he is not sleeping in a military issued cot but in his hospital bed. That amber hue was simply the glow of his bedside call light. At the age of 65, this Veteran finds himself struggling to manage late symptoms of Parkinson's Disease attributed to Agent Orange exposure. He is in an overcrowded hospital room with a team of providers referencing his nightly nightmares as a symptom of Post-Traumatic Stress. He has nowhere to go because nursing homes will not admit him as a "behavioral admission." Weeks have passed and he is still looking out that same hospital window wondering if there is a place out there for him to call home.

(Fictional case example based on Vietnam Veteran)

Summary of the Background

While this Vietnam Veteran, living with progressive Parkinson's, Post Traumatic Stress and Bi-Bolar is a fictional case, sadly there are many real cases like him that exist in hospitals through-out the country. Older adult mental health patients are waiting longer in hospitals, which not only adversely impacts the individual's referral to another facility and right to equal access to long-term care but places an overall strain on the healthcare system with patients inappropriately taking beds in hospitals who should be in another setting (Aminzadeh & Dalziel, 2002). By the year 2030, 1 out of every 6 people living in the United States is anticipated to be over the age of 65 (Hudson et al., 2013). Veterans of all ages spanning from WWII to the most recent conflicts of Iraq and Afghanistan are getting older and need long-term care. Between 1998 and 2003 the number of Veterans aged 85 and older seeking long-term care nearly doubled (Miller and Rosenheck, 2006). Aging Veterans with both health and mental health needs are challenging the current infrastructure of long-term care. Social work has an opportunity to explore this social justice issue from a systems approach.

Problem Statement

Providers serving aging Veterans with a mental health diagnosis need a standardized referral process that can support Veterans in their application to long-term care. There is a need for more research to be done

on a local level at the New Hampshire VA Medical Center to learn of how the documented research on a national level of inconsistencies and lack of training may be present in the local system. Veterans with a serious mental health diagnosis deserve to be able to access long-term care facilities to meet their needs just like any other aging older adults in the community.

Description of the Problem

Nursing Home Care as an intervention to support older adult Veterans who are at risk in their home communities relies on a referral process from the VA, but there are challenges and flaws in this process that need to be addressed. Currently there are 5 steps of the Referral Process into Long-Term Care for the Manchester VA Medical Center. Providers only know their step in this process and are working in silos with a lack of understanding of how their role contributes to the greater process. Required documentation and screening for the long-term care referral process is being improperly completed resulting in long wait times for placements and inappropriate placements. This study consisted of 3 evaluation components; an original survey informed by the perceived competence scale, data collection from four geriatric extended care programs at the Manchester VAMC, and 9 qualitative interviews with key stakeholders. The survey was aimed at establishing a baseline of where staff is currently with their knowledge base. Geriatric program data was collected on mental health admissions from the past 3 years to explore any possible trends. Interviews with stakeholders were completed on the referral process to gain a deeper understanding of how they see the process and their role in that process. At the end the data collected from all 3 of these evaluations resulted in the development of a visual support tool for stakeholders to use as a resource when making future referrals.

Review of the Literature

By the year 2039 Veterans enrolled in VHA who are age 85 and older is projected to increase by 38% (HQAFSA). As part of that aging population, there are 6.25 million Vietnam Era Veterans living in the United States, most of whom are 65 or older and in growing need of a higher level of care (National Center

for Veterans Analysis and Statistics (NCVAS, 2022). In taking a deeper look into VHA enrollees in fiscal year 2019, 48% were ages 65 or over and 59% of VA expenditures in 2019 were spent to meet the needs of those enrollees (HQAFSA). As Vietnam era Veterans are aging their complex needs of both mental and health are challenging the current infrastructure of long-term care. Vietnam Veterans who are now in their 60s and 70s and with a prevalence of a mental health diagnosis are requiring a greater focus from providers in triaging appropriate level of care (Moye, 2019). Sorrell (2011) in his review of the literature found that 1/3 of all Veterans enrolled in the Veteran Health Administration (VHA) have engaged in mental health services for the treatment of a diagnosed mental disorder.

Aminzadeh and Dalziel found that older adults are more likely to be admitted to an emergency room (ER), have a prolonged stay and a repeated stay, as well as adverse outcomes (2002). From this study it was learned from the negative impact on individuals seeking higher levels of care from the ER that there is a great need for better geriatric screening tools and for interdisciplinary team coordination (Aminzadeh & Dalziel, 2002). This breakdown in the referral system is having a devastating impact on aging Veterans in the United States where instead of living in an appropriate clinical long-term care setting, they are living in crisis where they are presenting to emergency rooms (Larkin et al., 2005) and are at higher risk for homelessness and suicide (Larkin et al., 2005, Schinka et al., 2011). Social work has an opportunity to explore this as a social justice issue from a systems approach in exploring the scope of the problem through a thorough review of existing research.

Emergency Room Use

Between 1991 and 2001 there were 52 million visits to the emergency room for mental health in the United States with an identified risk of older adults presenting over the age of 70 (Larkin et al., 2005). In looking deeper into prolonged emergency room stays for older adults with mental health, Rhodes found that for every 10 additional hours spent in the ER the possibility of an adverse event increases by 20% (2015).

Individual patients are the face of the issue; however emergency room crowding is a biproduct of a dysfunctional health care system and solutions to address this system issue require a comprehensive approach of the system as a whole (Kelen et al., 2021).

Homelessness

On any given night 75, 000 Veterans are homeless, and more than 20% of them are age 50 or older, that is 1 out of every 7 homeless adults (Schinka et al., 2011). Despite Military representing only 7% of the general population, Vietnam Veterans are the largest demographic of homeless adults in the United States (National Coalition for Homeless Veterans, 2022). There are 6.2 million Vietnam Era Veterans living in the United States, most of whom are 65 or older (National Center for Veterans Analysis and Statistics (NCVAS), 2022). As one of the biggest Veteran populations, thirty percent of Vietnam Veterans have a diagnosis of Post-Traumatic Stress Disorder (PTSD)(National Center for PTSD, 2018). Through a study of structured interviews amongst staff working with homeless older adults similar to challenges experienced in the ER, there was a theme of a need for better coordination of services (Molinari et al, 2013).

As Vietnam era Veterans are aging their complex needs of both mental and health are challenging the current infrastructure of long-term care. Providers who are engaging in the long-term care referral process are now having to reflect on current practice and further explore why these individuals might be experiencing such a difficult time when they are waiting for a facility bed from home or like the Veteran in the story, waiting longer in a local community hospital. With increased rates of homelessness, mental health and emergency room use; Veterans are also at risk for suicide; where across all ages Veterans enrolled in the Veterans Health Administration have been observed to have 66% higher rates of suicide than the general population (Schinka et al., 2011).

A Need for Equal Access to Care

While these numbers seem high, these discussed identified areas of concern; prolonged ER visits,

homelessness and suicide risk make aging Veterans a vulnerable minority that are suffering from the systemic social injustices against individuals living with a mental illness who need nursing home placement. Veterans are aging and due to their physical dependency needs are in need of long-term care; however as a population that has a high comorbidity with mental health, the mental health diagnoses are keeping them from being able to access this level of care. These individuals should be able to have an equal opportunity to explore nursing home care and make an informed decision to transition from home based on their own care needs rather than systemic challenges which is a social justice concern and deserves attention for advocacy.

While aging Veterans are in need of a nursing home because they are no longer physically safe at home, the referral system to support them is broken in being ill-prepared for proper screening and care coordination for these individuals. While there are home services like home maker home health-aid in the community, there is a critical shortage of staffing and family members are experiencing caregiver burn-out in trying to make up for this which puts themselves at risk for harm (DHHS, 2011). Nursing homes provide a facility that is built to support higher level of care needs with licensed nursing staff and depending on the diagnosis, a building that is built for a safer environment. An example of this might be a circle unit for dementia patients so that they can walk without getting frustrated that they are being blocked by a wall, an environment that might not be possible at home. When fully staffed, a nursing home can provide support with a 2 person assist versus one spouse or individual as well as an interdisciplinary team to take a whole health approach like nutrition, physical therapy, occupational therapy, mental health, recreation therapy and a primary care doctor (Barooah et al., 2019).

As a healthcare system we need to do better in creating and implementing equal access to care. Before possible improvement can be made there must be an understanding of the scope of the problem for older adult Veterans with a mental health diagnosis seeking nursing home care. These 3 elements are equally important when considering the scope and should be discussed separately to be able to comprehensively capture the

existing literature. The evolution of this scope will start from an exploration on the growing aging population followed by a demonstration of the prevalence of a mental health diagnosis of older adults and then focus on Veterans as a vulnerable minority as a subset population. Together these elements will inform why nursing home care is an important resource for this population and serve as a baseline knowledge in the review of nursing home policies from the public and VA which have dramatically impacted the current referral process.

Growth Aging Population

Since 1900 the percentage of Americans who are over the age of 65 has quadrupled and in 2019 totaled 54.1 million (Administration of Community Living (ACL), 2022). By 2040, that total is projected to increase to 80.8 million (ACL, 2022). Communities are doing their best to support older adults, but the complexities that make up care can be overwhelming and sometimes require nursing home placements to keep both the individual in need and the caregiver safe. According to data from the Centers for Disease Control (CDC) and Prevention, there are 15,600 Nursing Homes in the country with 1.7 million beds to meet the needs of aging communities (CDC, 2022).

Prevalence of Mental Health in Older Adults

1 in 5 U.S. Adults reported experiencing a mental illness in 2020 and 1 in 20 were found to be living with a serious mental illness (Nami, 2020). The evolution of what level of support is appropriate to address the needs of older adults with mental illness has evolved greatly over time. Care in the United States for aging individuals has struggled as an existing dichotomy between community-based services and nursing facility placement, putting a strain on the system when discerning what level of care is going to be the best fit (Hudson et al, 2013). People are living longer, including individuals with mental health where historically someone diagnosed with a mental illness died 25 years before a person without a diagnosis (Kaldy, 2018). As individuals with mental health are living longer, their needs for higher level of care are increasing where in a study completed on nursing home admissions and the admission process found that 17.8% of admissions had

a mental health diagnosis (Miller & Rosenheck, 2006).

Prevalence of Mental Health in Older Adult Veterans

As the largest integrated healthcare system in the United States, the Veterans Health Administration (VHA) is the primary provider to serve Veterans across the country and needs to be prepared to serve Veterans' rising needs (Veterans Affairs, 2019). VHA is comprised of 1,255 facilities with 322,030 employees serving a patient population of 9 million Veterans (U.S. Department Veterans Affairs (VHA), 2022). As one of the biggest Veteran populations, thirty percent of Vietnam Veterans have a diagnosis of Post-Traumatic Stress Disorder (PTSD) with Veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) being diagnosed at a rate of 20% who will be coming of age in the next few years for needing higher levels of care (National Center for PTSD, 2018).

New Hampshire Older Adult Veterans with Mental Health

With a demonstrated prevalence of mental health in aging Veterans, New Hampshire (NH) Veterans are at risk as having one of the states with the highest admissions rates to a nursing home with a mental health diagnosis (Grabowski, Aschenbrenner & Feng, 2009). On a local level, the National Institutes of Public Health found that New Hampshire had one of the highest nursing home admission rates with a mental health diagnosis at 20.6% as defined by having either bipolar, schizophrenia, major depression, or an anxiety disorder which would include PTSD (Grabowski, Aschenbrenner & Feng, 2009). In 2015, there were 101,593 Veterans living in New Hampshire with 38% having served during the Vietnam Era (New Hampshire Employment Security (NHES, 2008). 27% served during peace time and 23% served during the Gulf War (NHES, 2008). New Hampshire's population is growing, and this population increase is significant because it means there will be more people in need of psychiatric care (NHES, 2008). Despite the population changing Medicaid funding has been more restricted and the cost of providing services has gone up, which may lead to more hospitalizations (DHHS), 2008). Options for inpatient and residential group home beds have also

decreased, where over the last 15 years, 3 psychiatric units have closed (DHHS, 2008). The population growth rate is quickly exceeding the demand for services.

Currently there are 2 local primary inpatient facilities for older adults with mental health; the New Hampshire State Hospital which is designed to be short-term and Glencliff Home for the Elderly, a state-owned facility that specializes in providing nursing home level of care for older adults with mental health or developmental disabilities (DHHS, 2008). Hospitals have started to re-design some of their units in response to the bed crisis creating geropsychiatric units (DHHS, 2008). Looking across the state, there are 72 Nursing homes in New Hampshire (University of New Hampshire, 2018). The number of group home beds are at 203 to serve the 7,000 adults with serious mental illness in NH (DHHS, 2008). Along with a strain on available appropriate housing there is a shortage of treatment providers where over one third of NH is designated as a mental health professional shortage area by the Health Resources Services Administration (DHHS, 2008).

New Hampshire has had a long journey in establishing mental health supports for aging individuals and Veterans are a part of that story. As WWI came to an end New Hampshire citizens voiced a need for a hospital to support and serve Veterans (VA Manchester, 2021). Governor Francis P.Murphy and John Sullivan led the charge in 1938 and took the fight to Congress where it would eventually be victorious in getting the needed for approval on March 10, 1945 (VA Manchester, 2021). Construction broke ground in 1948 and the Manchester Veterans Affairs Medical Facility opened its doors on July 2, 1950 (VA Manchester, 2021). Since opening in 1950 the Manchester VA Medical Center has grown, where the hospital now has 4 smaller clinics in Tilton, Conway, Somersworth and Portsmouth (VA Manchester, 2021). The Medical Center has an inpatient unit which is referred to as the Community Living Center as well as has dedicated Geriatric Extended Care Services to include programs for Adult Day, Veteran Directed Care and the Nursing Home program which partners with community nursing homes through-out the state to place Veterans within their home communities (VA Manchester, 2021).

When looking at the Mental Health services at the Manchester VA Medical Center there is a diverse offering of programs and services to include a focus on; Homeless, Individual and Group Therapy, Peer Support, Veteran Justice Outreach (VJO) and Suicide Prevention (VA Manchester, 2021). In the past two years an E-Range program has been developed at the facility that provides case management for Veterans diagnosed with a serious mental illness (VA Manchester, 2021). In addition, imbedded into the Primary Care team is a Primary Care Mental Health Integration (PCMHI) Social Worker who provides short-term case management for Veterans with a mental health need that is related to their health (VA Manchester, 2021).

These VA Mental Health services came out of legislation from congress where in 2007 the VA Mental Health Initiative was introduced in recognizing the value of the Integrated Primary Care model which provided funding for Primary Care Mental Health Integration (PCMHI) Programs through-out the country (Possis, 2016). Karlin (2010) found that the PCMHI model strengthened treatment compliance and helped to reduce stigma that can stem from seeking care for a mental health issue versus a physiological health concern. Possis (2016) later learned that 70% of patients followed through on referrals that were provided by primary care when he conducted his study on the effectiveness of the PCMHI model. As referring providers for Veterans seeking long-term care qualitative research interviews from Primary Care Aligned Teams (PACT) showed that while staff wanted to be able to engage in mental health needs they were undertrained and limited on time (Edwards et. al, 2018).

Legislation and Policy

Two critical legislative policies helped to shape the current climate of long- term supports to include the Community Mental Health Act of 1963 and the Nursing Home Reform Act of 1987 (NHRA) as part of the Omnibus Budget Reconciliation Act (OBRA-87). In 1963 the Community Mental Health Act aimed to dismantle state psychiatric facilities with the hope of providing individuals with serious mental illness a better quality of life in the community so that they could have the opportunity to live more independently however

the community was not ready (Hudson et al, 2013). Many residents did not have a family or home to go to and ended up being placed in nursing home care (Hudson et al. 2013). The quality of care was not equal amongst nursing home care facilities (Hudson et al., 2013). The mistreatment of these individual nursing home patients was deemed a public health crisis by the federal government.

Nursing Home Reform Act of 1987

In 1986 the Institute of Medicine, now the National Academy of Medicine, launched a project to evaluate the state of nursing homes in the United States (Legal Information Institute, 1992). Across the country violations were found in the form of neglect and abuse (Legal Information Institute, 1992). The findings of neglect and abuse in nursing home facilities across the country during the Institute of Medicine's project in 1986 created the framework for future advocacy legislation. In 1987, the Nursing Home Reform Act of 1987 was introduced and passed as part of a larger piece of legislation, the Omnibus Budget Reconciliation Act (OBRA-97) which documented recommendations. The Nursing Home Reform Act called for a closer look at who was in nursing home care and what types of services were being received (Post et. al, 2010). As part of this act, nursing homes would need to provide social services as well as a full-time social worker if their facility was over 120 beds (Nursing Home Abuse Center, 2022). Residents of nursing homes were also given a greater voice in requiring a patients bill of rights (Nursing Home Abuse Center, 2022).

As part of this act the admissions process was heavily scrutinized in developing a more systematic process for determining if Nursing home level of care is appropriate for an individual. This section can be found at 42 CFR Part 483: Requirements for States and Long-Term Care Facilities (Legal Information Institute, 1992). Sub part C to this section is the Pre-Admission Screening and Annual Review of Mentally Ill and Mentally Retarded, which is commonly referred to as the PASRR (Legal Information Institute, 1992). The section that defines the Evaluation Criteria is 483.128 as part a of level 1 calling for the evaluator to identify if the individual has a mental illness or IDD (Legal Information Institute, 1992). Part b of this section

acknowledges the importance of the evaluator to consider the culture, language and ethnic origin and part c requires the participation of the individual and family as part of the screening process (Legal Information Institute, 1992). To ensure that these actions are carried out properly section d requires that all evaluators, as an interdisciplinary team, coordinate with each other (Legal Information Institute, 1992). Outlined in 483.130 is the determination criteria and 483.132 further explains how to evaluate the need for nursing home level of care and nursing home services to ensure if the referral is an appropriate placement (Legal Information Institute, 1992).

Preadmission Screening Resident Review (PASRR)

Since being first introduced in the Nursing Home Reform Act, The Pre-Admission Screening Resident Review (PASRR) has become the standard screening tool for identifying individuals with a mental health diagnosis (Post et al., 2010). The goal is to screen for appropriate level of care and serve as a layer of protection for an at-risk population (Post et al., 2010). Under the Nursing Home Reform Act all 50 states were required to implement this screening; however, the legislation did not specify how and provided no funding for execution, leaving individual states to interpret the mandate themselves (Linkins et al., 2006). Limited funding impacted individual states' ability to provide adequate training and coupled with the broad language led to varied results across the country (O'Connor, 2018).

Building on O'Connor's work in 2018, Barooah learned that while the assessment was an improvement, there was a lack of training on how to accurately complete the PASRR, leading to a disparity in quality across states (Barooah et al., 2019). In 1998 Congress passed the Nursing Home Initiative to help with the enforcement of the regulations that were established in the Nursing Home Reform Act of 1987, but it was still up to each state on what this enforcement process looked like (nursing home abuse center, 2022). Nursing home funding is largely reliant on Medicare and Medicaid money as federal funds; however, the monitoring is done by the state and while this act helped states with their follow through there is still a long journey to go,

"improvements have been made but the system still needs improvement" (nursing home abuse center, 2022).

Attempts to address the challenges of creating quality care in nursing homes and nursing home admissions will continue to fail until it is understood as a systems problem. There is a need on a national level to standardize the implementation of the PASRR (Barooah et al., 2019). When completed correctly the PASRR was able to effectively identify individuals with serious mental illness seeking nursing home level of care (Barooah et al., 2019). In looking at Veterans as a specific cohort of aging individuals with mental health, psychosocial issues were also managed more on a VA Geri Primary Care Aligned Team (PACT) that had an identified mental health provider (Moye et al., 2019). Offering PASRR training to increase the mental health competency of VA Geri PACT teams could improve the number of appropriate referrals.

A Growing Need for Nursing Home Care for Older Adult Veterans with Mental Health

Veterans of all ages spanning from WWII to the most recent conflicts of Iraq and Afghanistan are getting older and need long-term care. In response to this growth the Veterans Millennium Health Care and Benefits Act increased nursing home care (Library of Congress, 2020). Title 1: Access to Care, subtitle A: Long-Term Care as part of the Veterans Millennium Health Care Act directed the Secretary of Veterans Affairs to provide nursing home care to any Veteran who needs a nursing home for a service-connected disability or who is 70% or more service connected (Library of Congress, 2020). Service Connection can be defined as a rating of how disabling an injury either mental or physical is that was incurred during their time of Military Service (VBA, 2022). The percentage of their disability equates to a monetary compensation to help support the Veteran as a result of their life being changed from the disability and is a part of the promise of the VA to continue to care for all those who have served (VBA, 2022).

The Veterans Millennium Health Care Act called for the ongoing maintenance of geriatric evaluation, nursing home care, domiciliary services, adult day, non-institutional alternatives to nursing homes and respite care (Library of Congress, 2020). Funding for this comes from the Treasury of Veterans Affairs Extended

Care Fund and the Secretary is required to report to the congressional veterans committee on the outcomes (Library of Congress, 2020). Subtitle B: Section 116: Access to Care Matters of this same act, directs the Secretary to develop a program to bolster the provision of specialized mental health services to Veterans (Library of Congress, 2020).

A Call to Action

The older adult and Veteran aging population is growing thereby increasing the need for nursing home level of care. Vietnam Veterans are the next era veteran to come of age for nursing home care and with 30% diagnosed with Post-Traumatic Stress Disorder (national center for PTSD, 2018) there is an onus on mental health providers as well as primary care providers to learn of how to best support these individuals. While the demand is high across the United States, New Hampshire ranks as one of the top states for long-term care admissions for residents with a mental health diagnosis (Grabowski, et al. 2009). Despite an established need for long-term care services, referrals are taking longer because staff are inconsistent in completing the referrals for individuals who are seeking nursing home placement and have a mental health diagnosis. Additionally, staffing shortages and a lack of training was found to be an ongoing challenge in New Hampshire as found by the Behavior of Health (SAMSA New Hampshire, 2015). On a national level the PASARR, as a screening tool that is required for nursing home admission, calls for interdisciplinary teams to coordinate with each other as evaluators. These providers need to work together to help each other to understand their role and their colleagues to best facilitate effective and appropriate long-term care referrals.

Providers serving aging Veterans with a mental health diagnosis need a standardized referral process that can support Veterans in their application to long-term care. There is a need for more research to be done on a local level at the New Hampshire VA Medical Center to learn of how the documented research on a national level of inconsistencies and lack of training may be present in the local system. This Capstone research has the potential to not only benefit the New Hampshire VA Medical Facility, but VA facilities

across the country who are serving this same population. This could impact millions of Veterans throughout the country, in over 170 VA Medical Facilities.

Methodology

Evidenced-Based Social Work Intervention

This study was a mixed-methods design with both a quantitative and qualitative approach which examined the referral process to long term care through a needs and gaps analysis of the referral process steps and in-depth discussion with stakeholders with the goal that once this process is better understood that it can be improved. Staff Stakeholders are Primary Care, Community-Based Outpatient Clinics, Mental Health, Specialty Clinics, and the Geriatrics Extended Care Team.

Study Hypothesis.

1. In-efficiency in the long-term care referral process for Veterans with a mental health diagnosis at Manchester VA is a result of lack of training of providers on their role in the process and how their role fits into the entire process.

   Null: Inefficiency is not the result of lack of training

2. In-efficiency in the long-term care referral process for Veterans with a mental health diagnosis at Manchester VA is a result of lack of training on the PASSR, a screening tool needed as part of every long-term care referral

   Null: Inefficiency is not the result of lack of training.

Study Components

Original Survey informed by the Perceived Competence Scale (PCS).

The Perceived Competence Scale (PCS) is a 4-Item questionnaire that assesses participants feelings of competence in their abilities to perform in a particular domain (Williams et al., 1998). The PCS scale was originally used with children to measure perceived self-competence in their abilities and skills in 4 domains;

cognitive, social, physical and general self- worth (Harter, 1982), however over the past few decades since its inception the Perceived Competence Scale (Harter, 1982) as a tested measure has been adapted to a multitude of disciplines and areas not only across the United States but around the world and has been demonstrated to have both high face validity and reliability (Harter, 1982, Williams et al, 1998, Gillespie et al., 2011). Nursing was able to successfully use the PCS to measure competence level in an operating room, helping to establish a precedent for the scale to be used in a health care setting (Gillespie et al., 2010). This scale is typically written to the specific domain or pertinent behavior that is being studied (Center for Self-Determination Theory (CSDT), 2022).

The PCS as a scale is grounded in Self-Determination Theory where competence is a fundamental psychological need and thus an individual's perception of competence is critical when considering the potential impact on goal attainment and satisfaction in one's work (CSDT, 2022). Feeling satisfied with one's ability to do the work can change how they engage in the work activities and influence how effective that effort is (Deci & Ryan, 2012). Hackman and Oldham's model identified job satisfaction as well in having a critical role in work efficiency and effectiveness (1976).

An original five-item survey was developed based on the established importance of measuring perceived competency from the PCS scale. The five-item survey was completed with all clinical staff to establish a base line understanding of their perceived competence in their knowledge of the long-term care referral process through- the VA. The survey was completed electronically and submitted anonymously to provide the best opportunity for authentic and accurate self-reporting.

Qualitative Interviews with Referral Process Stakeholders.

The referral process is intricate and complex with many different stakeholders that play their own role in the overall picture. Together these stakeholders make up a story and it is up to the researcher to ask the right questions with the aim to discover the full breath of that story. This approach in research is known as

qualitative with one of the most common approaches being interviews. Interviews provide in-depth information on people's personal experience and viewpoint on a particular topic (Turner, 2010). Qualitative interviews are frequently compiled with other data collection to be most well-rounded for analysis (Turner, 2010). It was the intent of this study to create a robust analysis in taking this approach with having both the survey and qualitative Interviews.

Turner outlines three types of interview designs to inform the selection process to be most effective: informal, general and a standardized-open ended interview (Turner, 2010). Informal questions come from being present in the moment and are aimed at exploring more about the social environment without having a prescribed list of questions (Turner, 2010). In this type of design, a researcher relies on the participants to navigate the conversation, however, a critique is that it can result in too much variation from one interview to the next (Turner, 2010. In the case of a general interview, questions depend on the researcher who is conducting the interview (McNamara, 2009). A challenge that can arise from using this approach is in the way that questions are posed which can differ depending on the researcher and might lead to an inconsistency in answers (McNamara, 2009). This approach does however allow for rapport building with participants and is flexible where the researcher can ask follow-up questions or adapt questions based on how participants respond (McNamara, 2009). The strength in this approach can also be its greatest risk, where it relies on the ability of the researcher who is asking the questions and their skill in being able to gather generally the same information from each interview (McNamara, 2009).

Strikingly different from the Informal or General Interview Design, the Standard Open-Ended Interview is very structured, particularly when it comes to the wording of the questions, where the same questions are asked with each participant (Turner, 2010). Being open-ended gives participants the opportunity to contribute as detailed as they feel comfortable providing and can result in a substantial amount of data (Turner, 2010). Despite being structured, this approach does allow for follow up questions for clarification

(Turner, 2010). This is the most popular form of interviewing because of the openness of the responses and how much information can be gathered from participants (Turner, 2010). Having a large amount of data to analyze can serve as a challenge for researchers in being able to accurately identify themes amongst each other in agreeing on codes (Turner, 2010). It is important to note that this approach helps to reduce research bias, especially when there are many participants in the study (Turner, 2010).

In working within the strict guidelines for research at the VA and the interview process with VA employees' questions must be pre-approved by the union representative. Based on this requirement, a Standard Open-Ended Interview design was implemented with structured questions that have been reviewed and approved ahead of time. Creswell (2007), an esteemed qualitative researcher, provides a guide for suggestions on how this approach can best be implemented as an evidenced-based qualitative approach. This approach is organized into 3 areas: prepare, create effective research questions and be thoughtful about the implementation process (Turner, 2010). McNamara's research further supports the need for preparation, arguing that preparation can hurt or help an interview the most (2009). McNamara emphasizes the importance of choosing a setting with minimal distraction for the interview and asks that the researcher provide an explanation of the purpose of the interview (2009). Researchers should address terms of confidentiality, review the format of the interview with participants which includes a discussion of how long the interview will take (McNamara, 2009). Feedback and a transparent communication process to access the researcher is important, researchers need to tell participants how to get in touch with them later if they want to and ask them if they have any questions before getting started with the interview (McNamara, 2009). All of the aforementioned components can be compiled into a well- articulated informed consent form that can be reviewed with the participant and signed at the start of the study.

One of the most paramount elements to interview design is crafting effective research questions (McNamara, 2009). The wording should be open-ended, questions should be as neutral as possible to avoid

influencing answers and asked one at a time (McNamara, 2009). It is also important that questions are clearly worded and include appropriate vocabulary of the program of the participant (McNamara, 2009). Why questions should only be used after much deliberation as to the purpose of including the questions and even then proceed with caution (McNamara, 2009). While questions can be calculated and clear, the researcher must still be prepared to ask follow-up questions to be able to ensure that the optimal responses are given from participants and to keep the interview on track (Turner, 2010). It is also important to note that sometimes participants will not answer a question directly or will answer a previous question in another question later on in the interview (Turner, 2010).

To facilitate a fluid interview, researchers should provide transitions between key topics (McNamara, 2009). Additional recommendations for effective implementation are to routinely check the recording to ensure that it is still on and to be aware of body language as the researcher doing the interview in responding to answers so that the researcher remains neutral (McNamara, 2009). Finally, the researcher who is conducting the interview needs to be supporting the pace and flow in keeping the interview on track, actively mitigating the risk of losing control over the interview (McNamara, 2009).

Theoretical Framework

When thinking about the gaps and breakdowns in the referral process for Veterans with a mental health diagnosis to long-term care,Hackman and Oldman'sCharacteristic Model serve as an appropriate lens. This theory is grounded in the idea that employees are motivated by purpose (Hackman & Oldman, 1976). Without the ability to know the whole picture and how staff are actively contributing to that picture their efficiency and work productivity is negatively impacted (Hackman & Oldham, 1976). The goal in using this model is to advocate for the need for better interdepartmental communication and collaboration. Currently at VA Manchester one referral passes through many departments. Stakeholders, however, are all selectively focused on their step in that process. If asked about the steps needed to be completed as part of the referral

process before or after their particular step in the process individual providers are often times unsure, unclear of how their work is contributing to the whole picture. This is not to say that providers should know everything and reach beyond their expertise but should be aware of the complete picture when performing their tasks in the referral process. If providers knew the whole process, the assessment experience would improve. According to Hackman and Oldham's theory, those providing the assessments would be more invested because they would know how their role fits into the larger system and impacts the rest of the referral process.

The final intervention for this study was the provision of a visual support tool that was given to staff following the commencement of the survey and stakeholder interviews. This visual tool captures all the steps and stakeholder roles of the referral process for aging Veterans with a mental health diagnosis who are seeking long-term care services and serves as a tool that is informed from the data of the other two other interventions of the survey and the Stakeholder Interviews. The idea of mapping all of the components together of the referral process for stakeholders to use in one place is rooted in Hackman and Oldham's Characteristic Model from leadership theory which articulates the need for staff to be aware of the entire process so that in turn that knowledge can positively increase their efficiency, effectiveness, satisfaction and motivation (Hackman and Oldham, 1976). Precedence for utilizing this model as a tool to strengthen job identity and clarify job role as a method for inspiring motivation was established in a health care setting by Gahr and Mohamed in 2012 as part of their study with redesigning nursing care in general surgical units.

Hackman and Oldham's Model is comprised of three components: (list those components here.) Core Dimensions, which are job functions that either foster or worsen an employee's Critical Psychological States which result in the work outcomes of motivation, performance, job satisfaction and rates of turnover (Hackman & Oldham, 1976). There are five characteristics in Core Dimensions; skill variety, task identity, task significance, autonomy and feedback that together form the Motivating Potential Score (MPS) as an

index for how likely a job will affect the attitudes and behaviors of staff (Rungtusantham & Anderson, 1996). If these core dimensions are addressed in the job functions by leadership, staff will see meaning in their work, feel responsible for the outcomes of the work and demonstrate knowledge of the overall goals of the organization (Hackman & Oldham, 1976).

Hackman and Oldham's Model identify three Critical Psychological states; meaningfulness in the work, responsibility for work outcomes and knowledge of the results of the work (Rungtusanatham & Anderson, 1996).). It is important to note that all 3 are required to produce the desired outcomes for the model (Rungtusanatham & Anderson, 1996). To achieve the best outcomes Hackman's model argues that job enrichment and job rotation help to introduce skill variety and challenge staff in a productive way (Hackman & Oldham, 1976). Open and continuous feedback as part of the core dimensions are paramount to this model to gage progress (Hackman & Oldham, 1976). In 1980 Hackman and Oldham built upon their original proposed model introducing the role of moderators for both Core Job Characteristics and Outcomes; knowledge and skill, growth need strength and context satisfactions (Hackman & Oldham, 1976). Hackman and Oldman's Job Characteristics Model has been tested and found to be a valid measurement in over 200 relevant studies (Fried and Ferris, 1987).

Project Rationale and Aims

The purpose of the study was to learn of possible gaps and needs with the aim to inform improvement of the referral process. The current referral process for long-term care at the Manchester VA is experiencing challenges with providers working in silos and completing inconsistent and incomplete documentation needed to support facility placement.

Impact of Silo Work on Referrals

Currently there are 6 steps of the Referral Process into Long-Term Care for the Manchester VA Medical Center. Providers only know their step in this process and are working in silos with a lack of

understanding of how their role contributes to the greater process.

Lack of Training and Incomplete Documentation

One evidence-based assessment that is being utilized for long-term care placement is the Pre-Admission Screening Resident Review (PASRR) (Carpenter, 2018). There is a lack of training however on how to accurately complete the PASRR which has led to a disparity in quality of completed assessments across states (Barooah et al., 2019). When completed correctly the PASRR was able to effectively identify individuals with serious mental illness seeking nursing home level of care (Barooah et al., 2019). The PASRR is a screening tool that was designed to protect individuals with a mental illness from being placed prematurely or inappropriately into a nursing home (Carpenter, 2018). The screening asks providers to consider all possible solutions of support for this individual to include nursing home care in concluding that home or community resources have all been exhausted first before taking the next step in level of care to seek facility placement (Carpenter, 2018). There is a need on a national level to standardize the implementation of the PASRR (Barooah et al., 2019), but first focusing on New Hampshire as one state, as part of that larger discussion, is a start to the much-needed gaps analysis of this referral process. While the PASSR assessment itself is the same, individuals who are completing the assessment vary. This also means that the level of competence and confidence in navigating the long-term care referral process varies amongst those completing the assessment. A comprehensive study aimed at exploring the referral process through the lens of the stakeholders was needed so that future improvements can be made to produce better outcomes for Veterans and their families.

Project Design

This study was a mixed-methods design with both a quantitative and qualitative approach. There were 3 components; a survey of clinical staff, 9 structured interviews and a data collection of mental health admissions from the 4 Geriatric Services Programs to include community living center, adult day, community nursing home and veteran directed care.

Project Site and Population

Manchester Veterans Affairs Medical Center. This is a health care facility that provides primary care and other specialty services to Veterans in New Hampshire and surrounding New England states. For the purposes of this study, the survey was completed by clinical staff which is comprised of a multitude of disciplines. Clinical staff were selected because as providers can come across needing to know about the long-term care process ton best facilitate continuity of care. For the interviews, the identified population was staff who were identified to be stakeholders in the referral process for long-term care placements in helping aging Veterans with accessing nursing home care. Inclusion criteria was based on social workers being identified as the stakeholders for the interview because as a facility social workers serve as care coordinators in facilitating continuity of care for Veterans. Other disciplines were excluded from discussion because this study was meant to gain insight into the needs and gaps that social work is experiencing as part of the referral process. Future work might call for further interviews with a wider scope of other disciplines in the facility and possibly community stakeholders outside of the medical center like community nursing home admissions.

Data Collection Procedures:

Survey

An original 5 question Qualtrics survey informed from the perceived competence scale was sent out through email with a link to all clinical staff for the Manchester VA Medical Center which is a total of 534 people. Surveys were able to be completed anonymously after reviewing and agreeing to the informed consent that was approved by both VA and University of Alabama IRB. The Survey was open for three weeks for clinical staff to complete.

Structured Interviews

All interviews were conducted through Microsoft Teams over a two-month period. Interviews were recorded with transcripts automatically generated. To ensure accuracy of the content provided in the interview

the audio recording was also listened to correct any words that might have been incorrect or missed from the transcripts. 3 cycles of coding were implemented over a period of 2 months. The first cycle reviewed the transcripts with 3 umbrella codes; Strengths, Gaps and Needs. The second cycle was done after all of the 9 interviews were coded in cycle 1. The second cycle introduced subcodes of the larger categories based on noted themes that were a part of many of the interviews. A third cycle grouped the subcodes into 5 themes.

Mental Health Admission Data Collection

Mental Health (MH) admission data was reviewed from each of the four Geriatrics Extended Care programs with a look back of 3 years to help to inform the study of possible trends in new admissions, 2019, 2020 and 2021. Currently enrolled Veterans were also reviewed to determine the percentage of Veterans enrolled with a MH diagnosis.

Ethical Considerations/Protection of Human Subjects

This study was reviewed and approved by both the Manchester Veterans Affairs Institutional Review Board (IRB) and the University of Alabama IRB. Informed Consent was provided for the clinical survey before participants completed it. A separate informed consent was also provided to the staff who were interviewed. All questions for both the survey and the interviews were reviewed by Union Representatives to ensure protection and confidentiality of staff.

Results and Data Analysis

Survey

A total of 84 employees out of 534 completed the survey equating to 15.8% of clinical staff. When reporting on staff's perceived confidence of their knowledge on the eligibility criteria for a community nursing home over 50% shared that they were not confident or only slightly confident. When asked about where to start a referral again 50% reported feeling not confident at all or only slightly confident. When considering their ability to complete a referral nearly half at 49.5% reported not feeling confident at all or

only slightly confident and subsequently 57% shared that they did not feel confident or were only slightly confident in their ability to identify all the steps in the process. Perceived knowledge from clinical staff yielded the largest percentage, where 71% reported not feeling confident or only slightly confident on their knowledge of the PASRR.

It is noteworthy that one staff member reached out to the study to share that they were not completing the survey because in the 10 years that they had worked there that they had not been a part of making long-term care referrals and therefore did not need complete the survey.

Geriatric Extended Care Data Collection

Admission data collected from all Veteran Directed Care and the Adult Day Program showed an increase in admissions with a mental health diagnosis (see Figure 1). When looking at the current enrollment of Veterans across the four programs, each program had over 35% of their enrollees with a mental health diagnosis (see Figure 2). Two of the programs have over half the program of Veterans with a Mental Health diagnosis where the Community Living Center is at 58% and Veteran Directed Care is at 68%. The 2 predominant identified mental health diagnosis from the data across all of 4 programs was depression and PTSD which later matched the most common MH diagnoses from the interviews.

The CLC and CNH program went down in admissions from 2019 to 2021 but then CNH went up again from 2021 to 2022. It is important to note that COVID impacted Adult Day, CNH and CLC heavily as inpatient facilities where admissions were frequently closed due to quarantines or staff shortages which might have influenced the admissions data. As COVID limitation guidelines are lessening the admissions for MH are now increasing.

Figure 1: Admission Data Geriatric Extended Care Programs

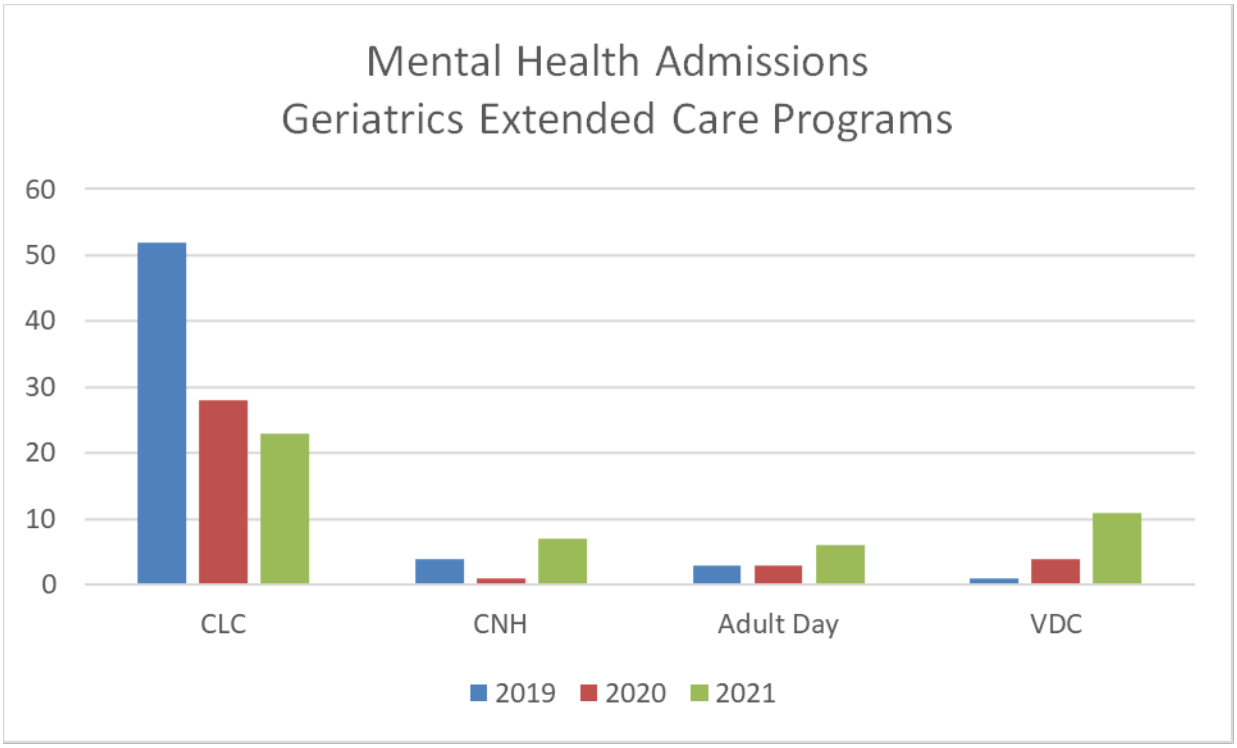
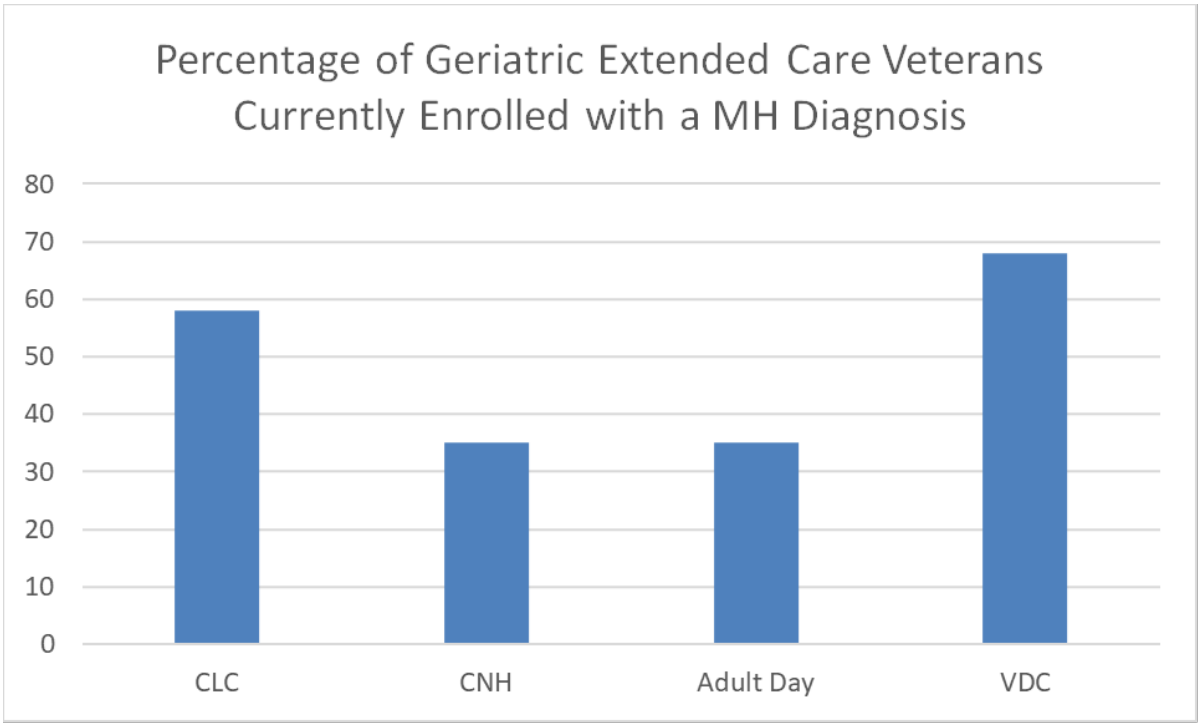


Figure 2: Currently Enrolled Geriatric Extended Care Veterans with MH Diagnosis



Interviews

Following 3 cycles of coding, 5 central themes emerged; A lack of knowledge of the referral process, Increasing Aging Mental Health, COVID Impact, Needed Resources and Needed Training (see Tables 1 and 2).

Table 1. – Interview Codes

PARENT CODES	***INTERVIEW PARENT AND SUBCODES*** **SUBCODES**
STRENGTHS	Resources Process
GAPS	knowing the whole process Communication knowledge of PASRR stakeholders not knowing all stakeholders in the process more comprehensive consult needed mental health and physical health not being able to be addressed together referral process too difficult resistance to change mental health knowledge in primary care
NEEDS	increasing aging population increasing aging mental health more beds COVID impact training/education long-term care planning needed before placement

Strengths

Stakeholders each shared on the current strengths of the VA in identifying the extensive resources that the facility is able to offer Veterans to aid in their goal to age in place. In addition to resources, stakeholders also spoke on the spectrum of geriatric services and social work staffing support to accdess those services as a strength when considering current resources and processes. One stakeholder reviewed that while

interdisciplinary consultation still needs improvement that it has come along way and has significantly increased in recent years.

Strengths: Transcript Quotes from Interviews

"Showers, hospital beds, sometimes we can do home modifications. So I think all of that plays a really important role of our helping our aging population of Veterans"

"I think we have a pretty robust geriatrics extended care team and robust team of social workers"

"VA does a good job at trying to help"

"Nice spectrum to help people as they age so you know, starting with maybe a few home health aid services then increasing to adult day then veteran-directed and you know eventually if the veteran needs it looking at contracted nursing home if they meet eligibility. I think its really nice because the VA offers services to our aging population that I think most people who are non-veteran would not have access to"

Table 2. Interview Themes

INTERVIEW THEMES
Lack of Knowledge of Referral Process
Increasing Aging Mental Health
COVID Impact
Needed Resources
Needed Training

Lack of Knowledge of Referral Process

In all nine interviews stakeholders reported a gap in the knowledge of the whole referral process and further noted that that gap is negatively impacting the care provided. Stakeholders in eight of the nine interviews discussed how not knowing other stakeholders in the referral process prolongs placement and reduces efficiency. Strained communication, an inability for facilities or departments to address both medical mental health needs together and a need for a more comprehensive community nursing home consult were identified in eight of nine interviews. Inconsistency in documentation was also found in seven of the nine

interviews as defined by lack of knowledge of the PASRR as a screening tool for the long-term care referral process.

Lack of Knowledge of Referral Process: Interview Transcript Quotes

”Our staff are more than likely only aware of their piece, they don’t have their finger on the pulse of you know the complexities of a long-term care referral”

“I don’t think that every piece is aware of the other pieces of it, I don’t think everybody is aware of the full process and I do think it causes the problem”

“I don’t think there is an actual identified process for someone with a mental illness”

Increasing Aging Mental Health

Here we learned that Veterans are presenting as more complex with both mental health and physical needs and that they are significantly younger than seen historically when presenting to long-term care. Over half of the interviews mentioned an increasing aging mental health population. Additionally, the presence of mental health stigma as an existing barrier to care for Veterans as part of the referral process was noted in over half of the interviews.

Increasing Aging Mental Health: Interview Transcript Quotes:

“I think you’re starting to see younger folks with some different social needs, you know its not just the elderly veterans anymore. It is the younger, more complex and psychosocial.”

I definitely think that mental health stigma is a contributing factor in all aspects of this work, especially not just on, say, the provider side with our community nursing homes and whether they have ever had training in mental health but also the families of veterans who had mental health concerns whether they have their own stigmas about it and what they have lived through”

“We have had veterans with bi-polar disorder, severe PTSD, or alcohol use disorder, that we’ve really had to advocate for to be placed into long-term care”

"So aging veterans with a mental illness, I think there's a gap because we ae seeing more veterans with a mental health diagnosis now than I think there had been in the past"

COVID Impact

The Covid-19 Pandemic really has put a strain on resources and how referring providers can access those resources. Nursing homes are limited on beds due to staffing and unit closures. Mental health has been exacerbated with increased social isolation.

COVID Impact: Interview Transcript Quotes

Resources are just super limited all nursing home beds are limited right now. They are closed to admissions on and off every day. Seems to be a moving target because of the COVID issue. So, I mean, that impacts the whole entire system, including mental health."

"People in the pandemic have had an increased need for mental health support, but you know you think about specific niche of veterans who have already been predisposed to mental health or other concerns, and then you add on top the multitude of layers of being isolated or having their own combat trauma or what have you, in addition to other societal issues that we have going on that only amplifies"

"I would say its been much more challenging with a pandemic, we've seen reduced bed rates, we've seen staffing issues with the veterans we work with if they are working with outside agencies. We've really struggled with the homeless population, veterans that are needing a higher level of care."

Needed Resources

Resources was highlighted as both a strength by stakeholders and a need. When speaking in strengths all nine interviews reviewed the resources of the VA especially for service-connected Veterans from home services that VA can provide including equipment. Stakeholders also shared the robust geriatics extended care team at the Manchester VA facility and social workers throughout the medical center which has grown over time. The benefits that Veterans have in comparison to non-Veteran older adults was also a theme of strengths

found amongst stakeholders. Stakeholders recognizded the variety of resources of support across the aging spectrum; home health aide services, adult day, veteran directed as a paid caregiver program and community nursing homes where VA contracts with nursing homes through-out the state. When discussing needs, seven of the nine interviews noted a call for more psychiatric beds in not having enough in the state of New Hampshire.

Needed Resources: Interview Quotes

"It can be really difficult at times to find appropriate placements for our aging veterans because of some of those agitated behaviors and flashbacks to war. So that can be a real concern"

" Nursing homes are meant to take care of people's medical needs, so I don't think that there's been a focus of nursing homes to focus on mental health needs as well and that is something that I hope changes"

"there's not a lot of resources for Veterans that aren't service connected, there's a huge gap for Veterans that are not eligible for long term care through VA"

Needed Training

All nine stakeholders reported a need for more training and education and eight of the nine stressed a need for clarity of the referral process itself to better understand it as a referring provider. Results shared that documentation was inconsistent and dependent on the provider showing a need for future training results from the interviews were consistent with existing literature when providers are trained the process becomes easier and more effective.

Needed Training: Interview Transcripts

"I think it depends on the provider I think it depends on their level of experience"

"Little nuggets of information that get passed on rather than a good comprehensive screen"

"I definitely think there are, you know, in terms of the referral system, there is a lot more that we could be doing or asking or preparing our veterans to do in the meantime of trying to figure out what the best

level of care is appropriate"

"Once providers have figured out what to do with it, it gets easier, each provider that I had to ask to do it, didn't know what it was" (when referencing the PASRR screening tool)

" I think that making the process very clear to everybody across the board would be very helpful"

It is noteworthy that although ten stakeholders were identified, only nine were completed because one stakeholder chose not to participate in the study. It was shared that they did not feel they were a part of the long-term care referral process being in mental health and would not have been able to contribute to the study. This highlights a gap in current practicethat excludes potential stakeholders from contributing to the conversation of placement where possible providers that could be engaged do not consider themselves a part of of the process.

Discussion

For over 100 years Veterans Affairs has been serving those who have served in fulfilling President Lincoln's promise, "to care for him who shall have borne the battle" (VA, 2022), but how providers carry out that mission has changed over time. Today, the VA is the largest integrated health care system in the United States and as a large institution it faces many systemic challenges that can lead to having a negative impact on the provision of care. This study which explored the gaps and needs of Veterans with a mental health diagnosis seeking long-term placement through-the VA provides a new level of understanding of these challenges with the aim to inform future improvements to facilitate continuity of care.

Data resulting from the survey and structured interviews confirmed hypothesis 1 and 2 of the study. Over half of clinical staff are unaware of the whole process and the PASRR as a part of that process The themes of Needed Training and Lack of Knowledge of the whole Process confirmed both research questions in demonstrating through the data there a lack of training on the process is directly having a negative impact on care in leading to inefficient referrals. Despite providers not knowing how to complete the PASRR responses from interviews revealed that once training was provided that the outcome in documentation and

the placement improved which is in line with what previous research has found in highlighting the value of training. Interviews also showed that providers are willing to engage in learning if given the opportunity. A lack of knowledge of the whole process and a demonstrated barrier of communication across disciplines is in contradiction to the legislation 42 CFR which is intended to serve as a guideline for best practice in deciding if a nursing home placement is appropriate.

1. In-efficiency in the long-term care referral process for Veterans with a mental health diagnosis at Manchester VA is a result of lack of training of providers on their role in the process and how their role fits into the entire process.

   Null: Inefficiency is not the result of lack of training
2. In-efficiency in the long-term care referral process for Veterans with a mental health diagnosis at Manchester VA is a result of lack of training on the PASSR, a screening tool needed as part of every long-term care referral

   Null: Inefficiency is not the result of lack of training

Micro

In the survey, admissions collection, and structured interviews the data showed that as a health care system we are experiencing an increase in the need for services from aging mental health Veterans. As Veterans are presenting to facilities; however, there exists a mental health stigma both within the facility and in the community, which is prolonging the time for appropriate long-term care placement. Stigma has shown to be rooted in a lack of understanding, which the data supports in revealing that there is an overall lack of knowledge from providers on the referral process, to include the screening tools required to clinically discern if this placement is going to be appropriate for this Veteran with mental health. Despite this gap, the data also showed a willingness on behalf of providers to learn and when provided training they were able to follow-

through in completing documentation to support the process in an effective way to improve the quality of referral outcomes. This is consistent with Oldham and Hackman's theoretical model where when stakeholders are provided with enough knowledge their investment in the process increases and produces a better outcome. This provides evidence for possible future training as an approach to standardize documentation.

On a local level this data can be used to support a need for future staffing and funding to provide training in creating the same standard of care across the facility. As a facility Trainings needed on the referral process and how to properly complete a PASRR to standardize how providers are trained to facilitate consistent documentation. This research is evidence for more opportunities for interdepartmental discussion between primary care and mental health on the aging process with focus on how Dementia is viewed either as medical and mental health and how that impacts our delivery of care, Future strageic planning should include the development of more interdisciplinary team consultations to strengthen the screening process and make it more comprehensive and the cultivation of more community hospital relationships to facilitate continuity of placement process.

Additional training through the VA may also be possible as part of Two already existing initiatives; for the VA to become a High Reliability Organization (HRO) and an Age Friendly institution. HRO is a national initiative of the VA that is focused on the reduction of risk and patient harm through a commitment to process improvement (VA, 2019). Age Friendly is an evidenced based care initiative that is comprised of 4 components that work together to support older adults; what matters, medication, mentation and mobility and is often referred to in the literature as the 4Ms (VA, 2022). If findings from this study are able to be integrated into the goals of HRO and Age Friendly as a facility, there could be potentially an increase in opportunities as well as needed support across disciplines and departments.

Mezzo

On a VISN or regional level this data could show the importance of planning for the development of

more geriatric psych facilities to support the rapidly aging Veteran population with identified mental health needs. The State of New Hampshire Commission on Aging annual report from 2021 identified this same need for the expansion of long-term supports and a statewide effort to bolster behavioral health system of care. Data from this study aids in that mission and can help to further this effort in demonstrating the gaps in services.

Geriatric Research Education and Clinical Centers (GRECCS) are VA centers that are dedicated to supporting aging Veterans with 3 main missions; contribute to geriatric care through research, improve health care for older Veterans through innovation and to provide training and education on best practice (GRECC, 2022). There are 20 GRECCs through-out the country with Bedford VAMC serving as the GRECC for VISN 1 in the New England Region. This study contributes to this VA mission in advocating for best practices of the PASRR and navigating support for aging Veterans with mental health. Research from this study can provide an opportunity for possible future studies on how VA is preparing for older adults with mental health. Results from this capstone revealed the importance of training and increasing awareness for stakeholders and staff, trainings from the GRECC that are already currently being provided could help to fill this gap in adding to the facility's knowledge base.

Macro

Data found from the study aligns with research previously conducted on the challenges of implementation of the PASRR as a screening tool and the call for standardization (Linkens et al., 2006; O'Connor et al., 2011). Stakeholders shared through their experience that due to a lack of training on the PASRR that an inconsistency in completion of documentation as a screening tool exists as a barrier to placement. Stakeholders also revealed that when applied appropriately that the PASRR could be utilized to explore alternative community supports despite Veterans seeking placement so that only Veterans that need to be in a facility are placed and Veterans who are able to age in place can safely remain at home as long as

possible. O'Conner discovered the use of the PASRR in this same way where it can be an opportunity to be used as a diversion tool (2011). The PASRR is a required screening tool for all nursing homes across the United States and therefore knowledge learned from this study can serve as a possible catalyst for change in other VA Medical facilities as well as referring health care providers in communities through-out the country to increase effectiveness and efficiency of the long-term care referral process. Social workers can serve as the conduit for social justice in helping to bring this conversation forward as a discipline that is often in the critical role of bringing stakeholders of a problem together.

On a national VA level, the movement towards more Geri-PACT and the incorporation of primary care mental health integration to VA medical facilities is spreading as research continues to provide evidence for these programs to foster successful outcomes (Moye et al., 2019) and this study highlights the challenges that can come compartmentalization and silo work. To provide comprehensive assessment and screening primary care and mental health as well we subject matter experts who are attuned to geriatric specific needs is critical for future success as a whole system of care.

Findings from this study can also serve as a basis for future advocacy in public policy to voice a need for legislation that requires a standardized training on the PASRR for providers as well as legislation that calls for the provision of mental health training to nursing home staff. Additionally, data on the lack of clinically appropriate facilities suggests that there is an opportunity for state and federal supportive funding to develop more geriatric psych beds.

Limitations and Future Research Opportunities

This Capstone study was only able to interview social workers, future research can be done with other disciplines that are part of the long-term care referral process to gain insight into other perspectives. This Capstone Study did not include interviews from community nursing home admissions or adult day the community which might be useful data for future research in comparison to the VA lens. Data learned from

this study on how different Dementia can be viewed depending on the department or even community provider suggests that hosting panel discussions to foster a better appreciation for Dementia as medical or mental health might aid in the effort to improve patient care. Future qualitative research in interviewing more providers on this topic is warranted.

Conclusion

Findings learned from this study call for future action to meet the social justice need of caring for America's aging Veterans with a mental health diagnosis. With the expectation that 1 out of every 6 people living in the United States is going to be over the age of 65 by 2030 (Hudson et al., 2013) **a**nd the knowledge that 1/3 of all Veterans enrolled in the Veterans Health Administration (VHA) have engaged in mental health services for the treatment of a diagnosed mental disorder (Sorrell, 2011), as the largest health care provider the VA needs be ready to serve those who have served. Required change will need a commitment from medical center staff to use the developed stakeholder support tool, provide future training on the PASRR and the long-term care referral process for medical facility staff and advocate for the creation of a Geri-PACT. The conversation started here should continue to inform social work practice with leadership theory to best improve patient and program outcomes and be applied to combat the challenge of compartmentalizing as a facility. The lessons learned from this study recognize the value of evidence-based practice through application of Hackman and Oldham's theoretical model to other processes. These collected aims together serve as a channel to improve continuity of care across the facility and possibly to the other 170 VA medical facilities. Social workers play a critical role in the referral process for services at the VA, but it is not enough to just know one piece of that process. We have learned through the findings in this study, which are supported by other research, that knowing the whole piece matters and therefore as a facility we need to commit to this cultural shift as part of the medical center's journey to becoming a High Reliability Organization (HRO) with the plan to reduce risk and improve patient care. Veterans seeking support from VA

are inviting us as providers into their story and this helps the VA community to better understand how together we can help them find their final home.

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Appendix A: University of Alabama IRB Approval

THE UNIVERSITY OF ALABAMA® | Research & Economic Development
Office for Research Compliance

April 19, 2022

To: Kristen Lawlor
School of Social Work
Box 870314

From: Carpantato T. Myles, MSM, CIM, CIP
Director & Research Compliance Officer

Re: **Notice of Approval**

IRB Application #:	e-Protocol 22-03-5466
Project Title:	"Finding A Final Home: A Needs and Gaps Analysis of the Referral Process into Long-Term Care for Aging Veterans with a Mental Health Diagnosis"
Submission Type:	New
Approval Date:	April 19, 2022
Expiration Date:	April 18, 2023
Funding Source:	None
Review Category:	Exempt
Approved Documents:	Informed Consent Documents

Dear Ms. Lawlor:

The University of Alabama Institutional Review Board has approved your proposed research. Therefore, your application has been approved according to 45 CFR part 46. Approval has been given under exempt review category 2 as outlined below:

(2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met: (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects.
(4) Secondary research for which consent is not required: Secondary research uses of identifiable private information or identifiable biospecimens, if: (ii) Information, which may include information about biospecimens, is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained directly or through identifiers linked to the subjects, the investigator does not contact the subjects, and the investigator will not re-identify subjects.

The approval for your application will lapse, as noted above. If your research will continue beyond this date, please submit the Continuing Review to the IRB as University policy requires before the lapse. Please note any modifications made in research design, methodology, or procedures must be submitted to and approved by the IRB before implementation. Please submit a final report form when the study is complete.

Please use reproductions of the stamped IRB-approved informed consent form to obtain consent from your participants.

All the best with your research.

166 Rose Administration | Box 870127| Tuscaloosa, AL 35487-0127 | 205-348-8461
Fax 205-348-7189| Toll Free 1-877-820-3066 | rscompliance@research.ua.edu

Appendix B: Manchester VAMC IRB Approval

Manchester VA ACOS/R

Research Determination Individuals conducting non-research operations activities (as well as the relevant program office, network, or facility) have particular obligation to ensure that the safety, rights, and welfare of affected patients and staff are appropriately protected.

Patient Risks and Prevention
Has the safety, rights and welfare of affected patients and staff been thoroughly evaluated?

Response/Comment

Yes ☐No
☒☐

Can it be stated that **NO** potential risks (beyond nominal risks) have been identified? (This includes physical, psychological, social, financial, privacy, confidentiality and other reasonable, foreseeable risks associated with project participation or inclusion).

Yes, Please explain: All patient data gathered from program admissions will be deidentified to protect patient's confidentiality. Names of individuals from the completed Qualitative Interviews will also be deidentified to protect employee confidentiality. Surveys will be able to be completed anonymously and deidentified to protect all participants who have completed the survey.

No, Discuss appropriate protections to mitigate risks:

☒☐☐

Please describe in the space to the right, the data being accessed and how it will be accessed

Determination: Research Non-Research

This project has been reviewed and determined this Operations Activity is RESEARCH. Institutional Review Board (IRB) and Research and Development Committee (RDC) approval is required. This project has been reviewed and it has been determined that
this Operations Activity is NOT RESEARCH. Institutional Review Board (IRB) approval is not required. It has been acknowledged by the submitter (above) that Documentation of non-research status is (i) required prior to peer-reviewed publication, and (ii) encouraged whenever non-research status may be questioned.

☐☒

ACOS, Research:
By signing this document I acknowledge this project has been determined to be ☐Research, Non-Research

_Sherry Thrasher, PsyD_____ Signature: _____ Date:_12/03/2021_____

Appendix C: 5 Question Survey

Survey Questions:
**Likert scale 1-5, 1 not confident at all, 5 completely confident*

1. I believe that I know the eligibility criteria for Nursing Home Placement through the VA
2. I believe that I know where to start a referral for nursing home placement for long-term care
3. I am confident in my ability to complete a referral for nursing home placement for long-term care
4. I am confident in my knowledge of the PASRR as part of the Nursing Home Referral Process
5. I am confident in being able to identify the steps of the nursing home referral process from the start of the process to nursing home placement.

Appendix D: 10 Question Structured Interview

Questions for Interview:

1. Tell me about your experience in working with aging Veterans at the VA?
2. How have the needs of Aging Veterans with Mental Illness changed over the years in working with individuals and their families?
3. What is your understanding of the referral process for Veterans with a Mental Illness?
4. Do you think there are gaps in this referral system and if so what are they?
5. Who are the key stakeholders in this referral process?
6. Do you think Mental Health Stigma has been a contributing factor to the referral process? If so, how?
7. Do you think a lack of understanding of Mental Health has been a contributing factor to the referral process? If so, how?
8. Do you think a lack of knowledge of clinical staff of the entire referral process is a contributing factor to the referral process? If so, how?
9. What do you think could be done differently to best improve this referral process?
10. Is there something that you wished I had asked and did not that you would like included in the discussion?

Appendix E: Long-Term Care Referral Support Tool

Developed following the Interviews to be used as a future tool for Stakeholders in the Long-Term Care Referral Process in seeing all required steps in one place

Step 1:
Veteran is identified as needing Long-Term Care Placement
Stakeholder: Veteran, Primary Care Team

Consulted Stakeholders If MH or Enrolled In Specialty Care:
Mental Health
Specialty Clinics – Spinal-Cord Injury, Traumatic Brain Injury, Pain
Stakeholder: Veteran**,** Mental Health and Specialty Clinics

Step 2:
Primary Care places CLC-Admission Consult if Veteran is 70%SC or More if not Refer to PACT SW to support Veteran family with applying for Medicaid
Stakeholder: Veteran**,** Primary Care SW, State Medicaid Office

Step 3:
Geriatrics Extended Care receives the consult reviews it for clinical eligibility and approves
Stakeholder – Veteran, Geriatrics Extended Care Team (GEC)

Step 4:
PASRR is completed and H&P within last 30 days is confirmed
PASRR needs to be signed by the Primary Care PCP
Stakeholder: *Veteran, Primary Care, Mental Health, Specialty Clinics, GEC Team*

Step 5:
Veteran is referred to all CNH facilities for availability based on clinical appropriateness
Stakeholder: Veteran, GEC Team, Community Nursing Home Admissions

Step 6:
Veteran is placed at CNH facility based on medical and mental health needs
Stakeholder: Veteran, Primary Care, Mental Health, Specialty Clinics, GEC Team, Veteran, Community Nursing Home Admissions

Appendix F: Abbreviations

Veterans Health Administration (VHA)

Veterans Affairs (VA)

Veterans Affairs Medical Center (VAMC)

Veteran Integrated Services Network (VISN)

Community Living Center (CLC)

Community Nursing Home (CNH)

Veteran Directed Care (VDC)

Geri-Primary Aligned Care Team (Geri-PACT)

Geriatrics Extended Care (GEC)

Primary Care Mental Health Integration (PCMHI)

Pre-Admission Resident Review (PASRR)

High Reliability Organization (HRO)