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Original Study

Care Transitions to the Community From Veterans Affairs Nursing Homes: Experiences of Social Connection and Disconnection



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A B S T R A C T

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Objective: This study aimed to further knowledge of older Veterans' experiences with transitioning to the community from Veterans Affairs nursing homes (Community Living Centers or CLCs) with emphasis on social functioning.

Design: A qualitative study design was used in addition to administration of standardized depression and mental status screens.

Setting and Participants: Veterans ($n = 18$) and caregivers ($n = 14$) were purposively sampled and recruited from 2 rural CLCs in Upstate New York.

Methods: Semistructured interviews were completed with Veterans in the CLC prior to discharge (to explore experiences during the CLC stay and expectations regarding discharge and returning home) and in the home 2–4 weeks postdischarge (to explore daily routines and perceptions of overall health, mental health, and social functioning). Caregivers participated in 1 interview, completed postdischarge. The 9-item Patient Health Questionnaire and the Brief Interview for Mental Status were administered postdischarge.

Results: Thematic analysis of verbatim transcriptions revealed 3 inter-related themes: (1) Veterans may experience improved social connectedness in CLCs by nature of the unique care environment (predominantly male, shared military experience); (2) Experiences of social engagement and connectedness varied after discharge and could be discordant with Veterans' expectations for recovery prior to discharge; and (3) Veterans may or may not describe themselves as "lonely" after discharge, when physically isolated. Veterans lacked moderate to severe cognitive impairment (Brief Interview for Mental Status: range = 14–15); however, they reported a wide range in depressive symptom severity postdischarge (9-item Patient Health Questionnaire: mean = 4.9, SD = 6.1, median/mode = 3, range = 0–23). **Conclusions and Implications:** This study identified a potential for increased social isolation and disengagement after discharge from Veterans Affairs nursing homes. Nursing homes should integrate social functioning assessment for their residents, while extending care planning and transitional care to address patient-centered social functioning goals.

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Poor social functioning and related factors (social isolation, loneliness, and lack of social support) are associated with greater risk for cognitive and functional decline, suicidal thoughts and behavior, and mortality in later life.^{1–3} Interactions with healthcare systems, including skilled nursing facility (SNF) stays, are key periods for intervening in trajectories of declining social health. However, a limited body of intervention research exists for improving social health in older adults⁴ and few studies of this type have been conducted in nursing homes.⁵ Likewise, there is a lack of knowledge regarding the capacity for older adults to maintain social health across transitions in care including during and after stays in SNFs. Such knowledge would inform the development of interventions targeting social connectedness that could be introduced in SNFs and sustained across long-term services and supports environments.⁵ The importance of this work has recently been brought into greater relief as a result of the coronavirus disease 2019 (COVID-19) pandemic, which has isolated older adults in nursing homes and community settings.

During the past 2 decades, policies that have encouraged “rebalancing” of long-term care⁶ and changes to the structure of Medicare payments have resulted in shorter hospital stays and greater use of post-acute stays in SNFs nationwide.⁷ As a result, approximately one-quarter (26.3%) of patients with Medicare reimbursed hospitalizations are discharged to a post-acute care setting, with most patients (60%) subsequently discharging to the community.^{7,8} Likewise, the Veterans Health Administration (VHA) has similarly prioritized rebalancing its long-term services and supports system. Nationally, 74% of short-stay and 60% of long-stay residents of the VHA’s 123 nursing homes (“Community Living Centers” or CLCs) are discharged to the community.⁹

The current cohort of Veterans who receive care from CLCs are a unique patient population: One that is predominantly male and often possessing a complex profile of medical conditions and mental and behavioral health disorders (eg, post-traumatic stress disorder, substance abuse disorders, and serious mental illnesses).^{10–13} CLCs outpace VHA’s hospitals and outpatient clinics in terms of the proportion of older patients receiving care who have a diagnosed mental illness (49% vs 39% and 28%, respectively).¹⁴ Suicide risk is also a concern in this population. For example, Vietnam Veterans have a greater likelihood of lifetime depression and recent emotional distress than their same aged peers who do not have military service.¹⁵ Six percent of older male Veterans (aged 60+ years) experience suicidal ideation; however, the rate is significantly greater in combat (9.2%) vs noncombat (4.0%) Veterans.¹⁶ Suicide rates are elevated in the first 6 months following discharge from CLCs (when compared with rates of suicide among age and sex-matched VHA patients), though are particularly highest in the first 3 weeks.¹⁷

Indicators of poor social functioning (eg, loneliness and social isolation) are known contributors to suicide and mortality risk^{4,18,19} in older adults. Little is known about the home and social environments of older US Veterans. These factors are likely to influence mental health and suicide risk above and beyond physical health and functioning. Likewise, improved understanding of experiences with social functioning during nursing home care transitions (eg, social functioning before and after discharge) may also inform care planning and approaches to community-based services and supports. The objective of the current study was to further knowledge of older Veterans’ experiences with transitioning to the community from CLCs, with emphasis on social functioning.

Methods

Semistructured interviews with Veterans and their caregivers served as primary data sources for this study. Postdischarge depression and mental status screens were also administered. Participants were recruited from 2 CLCs in Upstate New York, located 45 miles

apart in a rural area, that provide short-stay and long-term care to Veterans. The study was approved by a Veterans Affairs (VA) Institutional Review Board, which oversees research at both medical centers.

Sampling and Recruitment Procedure

A purposive sampling strategy was used with study referrals received from CLC interdisciplinary team members, including social workers and nurse managers. Members of the research team also attended weekly interdisciplinary team meetings to learn of newly admitted Veterans who may meet our eligibility criteria. Veterans age 50 years and older with a planned discharge to the community, whose homes were within 90 miles of the primary research site, and who could provide their own informed consent (determined by responses to an informed decision-making capacity screener) were included. Veterans who had planned discharges to other nursing homes and those receiving hospice care were excluded. We recruited from short-stay units and included Veterans primarily admitted for post-acute rehabilitation, though residents admitted for respite stays were also eligible. Caregivers were identified in the Veteran informed consent form as a family member or “support person” that “will spend the most time with you and provide any regular assistance and support once you are discharged.” We excluded paid caregivers. Informed consent for caregivers’ participation was obtained separately and only after the Veteran provided signed consent to the study team for the caregiver to be included.

Semistructured Interviews

Two semistructured interviews were completed with Veteran participants. The first occurred in the CLC 1 to 3 days prior to discharge and a second, more in-depth interview occurred in the home 2 to 4 weeks postdischarge—our primary observation period. Caregivers were interviewed once after discharge with interviews typically taking place in the home immediately following the Veteran interviews. Veterans could choose to have their caregiver present during interviews; however, all but one caregiver was interviewed individually. Interviews were audio recorded and completed by a PhD social worker (first author) or by a study coordinator with a master’s degree in psychology.

The pre-discharge interview guide, the shorter of the 2 interviews, was structured to engage the Veteran in a discussion about his/her experiences during the CLC stay and general thoughts and expectations regarding returning home. Postdischarge interviews were more in-depth and queried about daily routines and activities, perceptions of overall physical health, mental health, and social functioning. Caregiver interviews were intended to supplement the responses provided by Veterans, who were the primary focus of this study; therefore, the caregiver interview guide largely mirrored the questions asked of Veterans. Veteran pre- and postdischarge interviews averaged 15 and 40 minutes in length, respectively. Caregiver interviews averaged 30 minutes. Please See [Table 1](#) for example interview questions and probes.

Postdischarge Assessment of Depression and Mental Status

Depression (9-item Patient Health Questionnaire or PHQ-9^{20,21}) and mental status (Brief Interview for Mental Status or BIMS²²) screens were administered by the interviewers at the postdischarge interview, following completion of the semistructured interview. As the PHQ-9 and BIMS are included in the VHA’s Minimum Data Set (MDS), we sought to extract the MDS PHQ-9 and BIMS discharge scores via electronic health records vs administering these assessments at discharge ourselves. Although electronic extraction was feasible from one site, it could not be completed from the second as

Table 1
Example Veteran Interview Questions and Probes

Topics	Questions [Probing Items]
Predischarge	
Experiences during CLC stay	What can you tell me about your stay here? [Why are you here? What's been good about being here or perhaps not so good about being here?]
Thoughts and expectations for discharge	What are your particular hopes or expectations for the future? [Do you think you will go back to your old routines and activities or maybe start new ones?]
Postdischarge	
Perceptions of overall well-being	So how are you doing now that you are back home or at the new residence? [What's been good about it? Or, what's perhaps been not so good?]
Routines and activities	How do you spend your time these days? [Have you gone back to your old routines and activities or started any new ones? What does a typical day look like?]
Social isolation/loneliness	Do you think you have enough people to talk to? [Do you ever feel lonely? Tell me about that.]

initially anticipated. Therefore, we present descriptive information for all participants at postdischarge only—our main observation period.

PHQ-9

The PHQ-9 is a valid and reliable measure of depression that has been used across health settings, including as part of the nursing home MDS 3.0 instrument, and in many studies.^{20,21} Scores range from 0 to 27 with clinical thresholds as follows: minimal depression (0–4), mild depression (5–9), moderate depression (10–14), moderately severe depression (15–19), and severe depression (20–27).

BIMS

The 7-item BIMS was developed for use in the MDS 3.0 instrument.²² The BIMS assesses attention (“I am going to say three words for you to remember”), temporal orientation (“Please tell me what year it is right now”), and item recall (“What were the three words that I asked you to repeat”).²³ Total scores range from 0 to 15 with scores of ≥ 13 indicating a lack of moderate to severe impairment.

Demographic and Background Questions

Veteran participants were asked to self-report demographic and military service characteristics including age, sex, race, ethnicity, marital status, level of education, service era, length of service, and status as a combat Veteran. We additionally asked with whom they lived, if anyone. Mental and physical diagnoses documented in discharge summaries and notes were captured from medical records for those participants who fully completed the study. A similar set of demographic questions—sex, age, race, ethnicity, and marital status—were asked of caregivers.

Analytic Plan

Univariate, descriptive statistics were performed in StataMP (StataCorp LP, College Station, TX)²⁴ to evaluate the frequency and distribution of the sample demographic characteristics as well as the postdischarge depression and mental status scores. Discharge diagnoses were content coded in Microsoft Excel to identify the most commonly assigned diagnostic categories. A thematic analysis of

verbatim transcripts was also conducted.²⁵ Three analysts, including 2 doctoral level researchers in aging and a doctoral student in psychology, coded the interviews. A preliminary codebook was developed based on key constructs and questions from the interview guide. Each transcript was then open coded by 2 analysts to allow for additions and changes (eg, clearer definitions, deletion/merging of codes). The team met biweekly during the initial rounds of coding to discuss areas of agreement and disagreement, to finalize the codebook, and to develop consensus coded documents. Coded transcripts were entered in NVivo software (QSR International Pty Ltd, Burlington, MA).²⁶ During the final stage of analysis, the lead investigators (first and last authors) reviewed each set of coded extracts (nodes) in NVivo to ensure consistency with the codebook, to define relationships among codes, and to develop overall themes and a coding matrix.

Results

Demographic and Background Characteristics

Twenty-one Veterans took part in predischarge interviews. Three of the Veteran participants either withdrew ($n = 1$) or were lost to follow-up ($n = 2$) after discharge resulting in 18 Veterans who fully completed the study and 14 caregiver interviews (Table 2). Veterans were 71 years of age on average and were typically male, white, and non-Hispanic. Most had served during the Vietnam era ($n = 16$, 88.9%). Three (16.7%) lived alone after discharge. The most commonly documented diagnostic categories at discharge included cardiac/circulatory (eg, heart disease, heart surgery, and stroke), pulmonary (eg, chronic obstructive pulmonary disease), and orthopedic conditions (eg, fractures and joint replacements). One or more mental health or cognitive disorders (eg, substance abuse disorders, dementia, post-

Table 2
Demographic and Background Characteristics ($n = 18$)

	N (or Mean)	% (or SD)
Veterans		
Age (y)	71.3	1.1
Male	17	94.4
White, non-Hispanic	15	83.3
Some college or greater	17	81.0
Married/partner	14	77.8
Vietnam service era	16	88.9
Combat Veteran (yes)	9	50.0
Length of military service (y)	7.4	1.7
Lives alone	3	16.7
Diagnoses documented at discharge (most common)		
Cardiac/circulatory (eg, heart disease, heart surgery, and stroke)	14	77.8
Pulmonary (eg, chronic obstructive pulmonary disease)	11	61.1
Orthopedic (eg, fractures and joint replacement)	10	55.6
Diabetes mellitus	8	44.4
Neuropathic conditions (eg, diabetic neuropathy)	8	44.4
Hyperlipidemia	8	44.4
Pain conditions (eg, arthritis)	7	38.9
Sensory conditions (eg, vision/hearing loss)	6	33.3
Falls history/unsteady gate	6	33.3
Urinary tract/renal diseases	6	33.3
Cancer/cancer detection or cancer history	6	33.3
Mental health disorders	6	33.3
BIMS score (postdischarge)	14.7	.4
PHQ-9 score (postdischarge)	4.9	6.1
Caregivers ($n = 14$)		
Age	66.4	6.4
Female	14	100
White, Non-Hispanic	11	78.6

traumatic distress, depression, and bipolar disorder) were documented at discharge for one-third of participants (n = 6). Caregivers were typically the wives (n = 12) of Veterans and lived with the Veteran at the time of the interview. Caregiver interviews could not be completed for all participants because of circumstances such as lack of availability, the participant declined to involve a caregiver, or the caregiver declined to participate.

Depressive Symptoms and Cognitive Status

There was little variation in BIMS scores, with all Veterans scoring in the range of 14–15 on this measure post discharge (M = 14.7, SD = .4). PHQ-9 scores ranged widely (M = 4.9, SD = 6.1, median/mode = 3, range = 0–23). Three Veterans scored in a range of mild depression (5–9). Two had scores indicative of moderate to moderately severe depression (10–19). One Veteran was identified as more severely depressed (20–27).

Qualitative Findings

Three inter-related themes emerged pertaining to Veterans' social connectedness pre- and postdischarge: (1) CLC stays may provide older Veterans with enhanced social connectedness and opportunities for social engagement, (2) levels of social engagement and connectedness varied after discharge and could be discordant with hopes and expectations for recovery described prior to discharge, and (3) Veterans may or may not describe themselves as "lonely" even when they are isolated. We describe these findings below and present representative quotes from Veteran/caregiver dyads in Table 3.

CLCs stays are often periods of social connection for older veterans

Veterans often spoke very positively of their social relationships in the CLCs, both with other residents and staff. Many expressed feelings

of social connection based on shared military history and other personal characteristics (eg, age and male sex). These sentiments were expressed both pre and postdischarge. For example, one Veteran, during his pre-discharge interview, stated "I go out, and I made friends here, and I talk to them about things that I would never talk to anybody else about." Another Veteran, at postdischarge, described relationships in the CLC with, "guys that I've only known for eight weeks, but it really seems longer than that because we share [...] common experiences." After returning home, a Veteran described how he valued the connections made with other men in the CLC and being able to express himself in a male-oriented setting: "You can talk man stuff, whatever, you know, hunting, fishing, racing."

Caregivers also observed the enhanced social connectedness Veterans reported. As the wife of one Veteran stated, "I think it was good for him because, at home, he always says he's an [introvert]. [...] When he got there and then he met a lot of guys that was in Vietnam where, they like, became like a little family." Another caregiver shared a wish that the Veteran would return to the CLC just for the social environment: "And, you know, if he goes back, he's – his social life over there was great. He loved having all those guys around [...] It was this whole little frat boy thing going on."

While in the CLC, some Veterans also formed connections with staff members in addition to their bonds with other Veterans. One Veteran described a phone conversation he had with another male resident from the CLC after both had discharged: "He said 'Yeah, you know, I was looking forward to coming home.' [...] 'But I miss the camaraderie that we had on that floor.' And he wasn't just talking about the patients." A caregiver described how her husband came to form bonds with nurses: "They were so good to him [...] He'd call me with a list of what he needed. And one of the things were the big bag of [chocolates.] He put them out and the nurses would come in and take some." At times Veterans would mention specific staff members with whom they had connected. For example, one Veteran described after

Table 3
Themes and Representative Quotes from Veteran/Caregiver Dyads

Participants	Representative Quotes	Themes
Veteran 1 (Disconnection)	"I was socializing quite a bit there, which would be with the physical therapist, the nurses, all the guys in there, you know...It sort of kept me occupied so I wouldn't get in these moods." (CLC) (V-Post)	CLCs stays are periods of social connection
	"He's a social person. That's why he's always so happy when he's in the hospital or rehab." (CG)	
	"I mean if I could—if I could physically do the things that I used to do, I wouldn't have that problem, but I can't anymore right now, so. That kind of gets to me every now and again you know. So I'll get a little depressed on that." (V-Post)	
Veteran 2 (Disconnection)	"...if he doesn't have fishing to go to or appointments where he can sit and talk to the people at the VA and stuff like that, then he's extremely isolated." (CG)	Experiences of social engagement/connectedness varied after discharge
	"I had gotten to the point where I was totally inactive. [...] But now as I told my wife, that I will start again to contribute to cooking meals, and go shopping with her, and get more exercise when we go shopping." (V-Pre)	
	"I've been on a constant downhill. I mean, it's not something that just started. It's something that's been working its way along for quite a while. I end up doing less and less and less and less." (V-Post)	Veterans may or may not describe themselves as "lonely" when isolated
	"I'm not a very big talker. I don't communicate well with people. And I'm at the stage where I more or less have them go their way and I'll go my way." (V-Post)	
Veteran 3 (Connection)	"Because see, at respite, he had people to talk to, you know, and socialization. Here he doesn't—that's what I was afraid was going to happen. He gets home, he's going to get in the same routine." (CG)	CLCs stays are periods of social connection; Experiences of social engagement/connectedness varied after discharge
	"These people love me the way I am, and I love them just the way they are. So, you know, there's nothing really wrong with being alone. From time to time you have to do it." (V-Post)	
	"We used to go to church all the time, and when his hip got really bad, we stopped going. Now, I think we're in the process of going back, but we keep in contact daily with the people we attended church with." (CG)	

CG, caregiver participant; V, Veteran participant (pre- or postinterview).

returning home, “There’s one [Chaplain] that I’ll probably give a call now that, you know, Christmas is through.”

Postdischarge experiences with social engagement, activity, and connectedness varied (and could be discordant with hopes and expectations for recovery)

Prior to discharge, each Veteran was asked to describe his or her hopes and expectations for the future, such as anticipated routines and social activities at home. A variety of responses were elicited with nearly every Veteran expressing some combination of a desire for improved health and physical function (eg, better mobility/less pain/avoid readmission) along with hopes for engaging in household, recreational, or meaningful social activities. In many cases, improved health and function were described in relation to social health and well-being. For example, one Veteran described how “I really want to walk again without no pain.” Like several other participants, he also expressed a motivation to exercise and spend time with his dog, “If I can walk easier and better, I’m going to be able to exercise with her.” Others expressed a general desire to increase or maintain physical activity, such as adhering to therapy regimens: “Well, I want to go back and spend time with my family and my dogs and relax for awhile and keep up with the postdischarge in-home exercise program that they have outlined for me.” For some, improved physical function was viewed as facilitating a return to normal activities and routines: “I just want to get back to where I was before I had surgery, because I was pretty comfortable with that life. I mean, I do chores around the house, you know and stuff like that.”

After returning home, disparate experiences with engagement, activity, and social connectedness were described. For several Veterans, these experiences were discordant with hopes and expectations described prior to discharge. For example, prior to returning home, one Veteran stated, “I’m gonna have to start more exercising, so that I can continue to gain [in mobility].” He also expressed enthusiasm to “get outside and...do some gardening work.” After discharge, he explained, “I don’t have high expectations right now [...] One step at a time” and described his daily routine as “watch TV, do a little reading [...] that’s pretty much it.” His wife was more direct in describing his struggle for recovery: “I think he’s very disappointed in it, because he went from cleaning the house to not being able to even feed himself within weeks. I think he’s just at the bottom. You know what I’m saying?”

Health and functional limitations prevented many from being as active as they had been in the past—either inside or outside the home. One Veteran, who lived alone, described a desire “to go back to working out, getting back in shape again [...] to make it a little easier around Walmart and some of the other stores,” during his pre-discharge interview. Postdischarge he discussed the continued challenges in maintaining his household: “No, a lot’s changed. I don’t get to do a lot of things. I have all kinds of little chores that I used to keep up with. And when you live alone and you have lots of time on your hands, you tend to do little things, and then come and sit down, and then go back and do a little bit more, and then come back and sit down.” It was also unclear whether Veterans were maintaining CLC peer connections post discharge, which may have offset increased isolation at home. One Veteran described his difficulties with staying in touch with friends from the CLC: “What disappoints me is, I made a couple of friends, or at least I thought I did in [the CLC]. They gave me their numbers, I gave them my numbers, badda bee, badda boop. One of them [...] has not returned my call [...]”

Caregivers also described desiring or making efforts to motivate the Veteran to become more engaged inside and outside the household after discharge. As one wife mentioned, “I have to remind him, call your friends there at the [CLC]. Just to do it on his own, he wouldn’t because that’s just the way he is. [...]” Some spoke about their desire to engage in more activities with their spouse, including one who

stated, “[...] but sometimes in the evening, I’ll say, ‘Well, let’s just take a ride and get an ice cream cone, you know?’ ‘No, I don’t want to do that,’ so. Now, he doesn’t seem to have the desire, I guess, you know, to get out and to socialize.” Another similarly described, “We used to go out to dinner. He doesn’t even want to do that anymore, which I find disappointing.”

Veterans described isolation after discharge, often without being “lonely.”

Even among Veterans who described engaging in mainly individual activities and/or those who lacked social connections beyond immediate family members, it was less common to endorse feelings of loneliness. Instead, some Veterans described introverted tendencies or lack of desire for social engagement. One Veteran, prior to his discharge, described the CLC as “like imprisonment” and post-discharge described himself as, “[...] a lone wolf pretty much all my life.” Another Veteran stated, “the nursing staff, everything has been very friendly” prior to discharge, but discussed a tendency to avoid communication once he returned home: “I don’t communicate well with people and I’m at the stage where I more or less have them go their way and I’ll go mine.” Certain caregivers also supported these statements (eg, “He’s just not a real gregarious person [...he’s] perfectly content to be by himself.”) For several Veterans, it appeared social withdrawal and isolation increased along with the progression of medical issues and functional losses. As one caregiver stated, “I’ve noticed, you know, with each hospitalization, he’s gotten like a turtle.”

Discussion

In response to changing policies (eg, “rebalancing”) and societal preferences regarding long-term services and supports in the US, more older adults are transitioning from SNF to home- and community-based care.^{6,7} Care transitions to the community from SNFs signify a clinically important change in social and environmental context (eg, from congregate healthcare environment to private home). The current study suggests that older adults may vary in the degree of social engagement, activity, and connectedness they experience during this transitional period, which may impact mental health and well-being after discharge. Moreover, chronic health conditions and impaired physical function were common contributors to increased social withdrawal and disconnection among Veterans taking part in this study. Experiences post discharge were discordant with hopes and expectations of several Veterans expressed prior to discharge (eg, greater physical activity vs spending time in front of the television) and was a source of marital stress.

One-third of the participants in our study also reported depression symptoms after discharge with one Veteran experiencing severe depression. Among those participants with depression scores in the moderate to severe range on the PHQ-9 (≥ 10 , $n = 3$), all were either homebound or relied on others for transportation at the time of our postdischarge interview. Two had existing histories of depression documented at discharge. Older adults and, in particular, those admitted to SNFs, typically have multiple comorbidities (health conditions, mental health symptoms, cognitive impairment, sensory loss, and impairments in physical functioning) and may face social and environmental barriers (eg, loss of driving status/transportation, communities that are not age friendly, among others) that contribute to social disconnection.^{4,27} Social isolation is itself among the greatest risk factors for mortality in this age group.⁴ Addressing these conditions and barriers are important steps toward improving social connectedness and overall quality of life for this vulnerable population after discharges from SNFs.

Our findings also highlight the unique nature of VA CLCs as residential health care settings in which older Veterans (usually men) form bonds with each other and with staff. Harrison et al similarly

found that CLC staff and residents described supportive relationships between residents and between residents and staff, which contributed to a reluctance to discharge Veterans once care goals were met.²⁸ Studies in non-VA, community nursing homes have also identified enhanced opportunities for social interaction and social connectedness in SNFs as having positive benefits for residents' mental health and quality of life.^{29,30} However, the COVID-19 pandemic has created substantial changes to the social context of nursing home care via restrictions on visitors and social distancing restrictions inside facilities.³¹ At the point of discharge, stringent social distancing measures for older adults with chronic health conditions have the potential to contribute to further social isolation for this already vulnerable group.³² Mitigating the risks of social isolation, both in the nursing home and in the community, is more than ever, an essential component of caring for this vulnerable population.

Recommendations for Clinical Assessment and Care in Nursing Homes

This study has important implications for clinical assessment, care planning, and transitional care in CLCs and other nursing homes. We recommend that SNFs integrate brief assessments of social functioning (eg, 3-item version of the UCLA Loneliness Scale,³³ Patient-Reported Outcomes Measurement Information System social health measures,³⁴ and the 6-item version of the Lubben Social Network Scale³⁵) as a supplement to required MDS assessments (eg, section D "Mood" and section F "Preferences for Customary Routine and Activities") to identify treatment/care planning needs in these areas. Goal setting for social functioning may, therefore, be viewed as an expansion of resident-centered care and rehabilitation goals, providing an equal emphasis on this area of functioning in relationship to more traditional treatment foci in SNFs (eg, physical health and functional abilities).

Particularly in the era of COVID-19, protocols are needed for addressing technology access and training needs for telehealth and virtual social contact (ie, use of commercial software and smart-phone apps to facilitate connections with community-based service providers, family, and friends after discharge). For example, socially isolated older adults with depressive symptoms may benefit from mental health services via telehealth (eg, problem solving³⁶ or behavioral activation treatment)³⁷ after a SNF discharge. Recreation and rehabilitation therapists may work with residents prior to discharge in planning for home-based activities that further support continued physical, mental, and social health recovery. Formal and informal organizations and programs with a component of social contact (eg, peer support/companionship programs, Veteran or religious organizations, Meals on Wheels, exercise programs, self-help groups, and senior centers/programs) are important and potentially under-utilized community resources at the point of discharge from SNFs. Van Orden et al³⁸ also propose the use of "Connections Plans," similar to Safety Plans for suicide risk and based on cognitive behavioral strategies, to address social isolation and loneliness in older adults. Engagement of family members and community service providers in creating and sustaining Connection Plans may be a unique, integrated approach to care planning and transitional care in SNFs that could address cognitive barriers to social participation, while furthering recovery goals.

Strengths and Limitations

This study recruited participants largely from rural areas. This is both a strength and limitation as knowledge of rural aging in the context of care transitions is needed; yet, the healthcare experiences of older adults in rural areas (eg, SNF care transitions) may be different from those of older adults in urban and suburban settings. Although a

considerable portion of US men ages 65 years and older are Veterans (43%),³⁹ findings may not generalize to non-Veterans, to older women, or to individuals with moderate to severe cognitive impairment. A final limitation of our study was the lack of pre-post comparisons of depression (PHQ-9) and cognition (BIMS). These screens were administered at postdischarge only and could not be feasibly captured from all participants' medical records prior to discharge, as was initially planned. However, the results provided relevant clinical information related to postdischarge well-being.

Conclusions and Implications

This study is the first to examine the experiences of older Veterans and their caregivers undergoing transitions in care from VA nursing homes. It contributes to research on nursing home transitional care where limited work has been conducted to engage the perspectives of older adults. Study results highlight the need to address social functioning during transitions from SNF to home, particularly given additional risks brought by social isolation (eg, suicide and all-cause mortality)^{18,40} that have the potential to be exacerbated by the COVID-19 pandemic. They also emphasize challenges in maintaining social function at the point of discharge, especially when faced with chronic health conditions, loss of physical function, and depressive symptoms. Research on interventions to improve social connectedness for older adults across transitions in care and in the community are equally needed. Practical suggestions for quality improvement include the need to integrate routine assessment of social functioning and to better integrate social functioning goals as part of care planning and transitional care.

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