

# Multiple Perspectives of the Discharge Process: Transitioning from a Long-Term Care Facility to Home

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## Abstract

**Objective:** The purpose of this qualitative study was to explore the experiences and discharge process of residents, family members, and staff when older adults transitioned from a skilled nursing facility back to their homes.

**Methods:** Participants were recruited using purposeful sampling in person and via flyers. The residents were three older adults between the ages of 65 and 95, two family members, and four staff involved in the discharge process: the Social Services Designee, the Director of Rehabilitation, the Director of Nursing, and the facility Administrator. Staff and family members were interviewed one time while the older adults completed three interviews.

**Results:** The interviews were transcribed verbatim and analyzed revealing three themes to describe the complexity and importance of communication among all the health professionals and family members involved in the process: The Discharge Experience, Communication, and Challenges.

**Keywords:** Discharge process; Older adult; Skilled nursing facility; Aging in place

## Introduction

The public health initiative Healthy People 2020 [1] aims to promote health and increase quality of life. Health and quality of life is something that should be addressed and examined regardless of the age, group, or setting. Health and quality of life in older adults is determined by several factors, which include not only physical wellness but also other social and cognitive functions [2]. Morley [3] shared those older adults' desires to live in the community or in a long-term care facility vary with the most important factor being the satisfaction that comes with the choice and ability to live out their desires in their home or in a supported setting. In the United States the majority of the elderly population prefer to stay in their own homes and communities for as long as possible, or in other words, age in place [4]. The Aging in Place movement aims to increase the quality of life of the aging population by promoting participation in meaningful occupations at home and within their community [5].

While residing at a skilled nursing facility, whether it is for a short term or long term stay, the residents' lives become centered on the routines and activities of the facility and at times they may lose touch with the community around them. The context of the skilled nursing facility influences occupational engagement, quality of life, and identity [6]. The person's sense of belonging to their greater community or feeling like an active member of that community can be lost while inside the walls of the skilled nursing facility. The transition from a skilled nursing facility to home where the individual can continue to "age in place" is vital but often challenging for the older adult and all other parties involved with the process [7,8].

Reicherter and Billek-Sawhney [8] developed a method of analyzing and assessing community reintegration for older adults. Factors influencing older adults' ability to reintegrate into the community included finances, social support, and health care needs. Older adults receiving medical care in a nursing home are in a process of change and adaptation. The change in environment, twenty-four hour care, and social engagement can positively impact the residents at a long-term care facility by providing for physical and social needs. However, for the older adults with advancing medical needs, these unfamiliar surroundings and frequent displacements can be unsettling and

detrimental to their health [8]. To remedy this potential health risk, the familiarity within the skilled nursing facility needs to be addressed as well as to the process and supports necessary for the older adult to transition back home if appropriate.

Discharge planning is the cornerstone in the transition home from a long-term care facility to home. The discharge process and resources provided to the client should be individualized, supportive, and reflect the setting and community where they will be returning. In a systematic review of discharge practices, Shepperd et al. [9] revealed the significance of having an individualized discharge plan for those transitioning from the hospital to home. Discharge processes that were structured and allowed for adequate time and notification led to a reduction in hospital length of stay and readmission. Home evaluations are an essential part of the structured discharge process, helping the team understand the resident's needs in regards to equipment and community support to ensure a safe discharge process. Crennan and MacRae [10] however, found that home evaluations were not identified as a standard practice within the United States due to productivity standards and corporate health care models as compared with other countries.

While standardized practices are pivotal in providing the best care, it is also important to take into account the perspectives of health care professionals involved in the discharge process, which include physicians, nurses, therapists, and case managers [11]. MacRae [4] emphasized the importance of the role of therapists and social workers indicating that they play "a critical role in reconnecting an isolated individual with her or his community by making appropriate referrals

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and by facilitating the ability to access social support systems and benefit the caregiver by providing support and respite". A team approach is necessary to facilitate a safe and supportive discharge process.

Previous literature on community reintegration focuses on the transition from an acute hospital setting to home [7,9,10,12,13]. Inadequate practices in discharge planning impact older adults adversely and can lead to increased risks of hospital readmission [7]. The discharge process should be examined in relation to long-term care settings for this same population as many older adults may spend time in a long-term care facility [3]. Due to the inconsistencies in the discharge process it is important to gain the perspectives of both the elderly patient as well as the interdisciplinary team members. In a search of the literature there was a lack of research addressing the discharge experience from a long-term care facility back home for the geriatric population. The purpose of this study was to explore the experiences and discharge process of clients, family members, and staff when persons transition from a skilled nursing facility into their communities.

## Methods

### Study design

We used a phenomenological study design to explore key stakeholder's perceptions of the discharge process and acclimation to the home environment. This research design proposes that the most reliable source of information is from the personal experiences of the individual. Phenomenology "is simultaneously holistic and also relativistic to the particular experiences and situations of each person" [14]. By using this design, the individual experience is captured by examining multiple perspectives of one shared phenomenon.

### Participants

The participants included 3 residents of a skilled nursing facility, one of their family members (2 total), and four key staff members. For resident participants, inclusion criteria included: English speaking, cognitively intact, older adults between the ages of 65 and 95 who were able to give their own consent and had received occupational therapy services at a long-term care facility within the final two weeks before discharge and who were not on the researcher's caseload. Participants needed to have a score of 24 or more on the Mini-Mental State Examination.

Family participants were English speaking and spent at least eight hours per day with the older adult for four days each week. Criteria for staff participants included: any employee involved in the discharge process.

### Interview

Forty-one guiding questions were developed from review of the literature and used to conduct a series of three semi-structured interviews with the older adults. The guiding questions were piloted with one older adult between the ages of 65-95 years and reviewed by a panel of experts with experience in qualitative research. Feedback from the pilot study and panel of experts resulted in changes to question content, sequencing, and wording. Twenty-two interview questions were used with the staff and family member interviews.

### Procedures

Following IRB approval I recruited older adults, their caregivers, and staff at the skilled nursing facility by handing out an informational flyer. After the older adult was discharged home, and screened with the

Mini Mental State Examination to see if they qualified for the study, informed consent was obtained. The older adult participants partook in three 60-minute audio-recorded interviews. The first interview was within one week of discharge from the facility, the second interview was two weeks after discharge, and the final interview was one month post discharge. The family members participated in one audio-recorded 60-minute interview within one month post resident discharge. Staff participated in one audio-recorded 30-minute interview. All of the interviews were transcribed verbatim and analyzed.

### Data analysis

Interview transcripts from the older adults, their caregivers, and skilled nursing facility staff, as well as field notes from the researcher were the data for this research study. The interviews were transcribed verbatim, individually coded by the researcher and the faculty advisor. In order to manage reactivity and bias in the study, the primary researcher used reflexivity to examine the influence of the insider perspective by keeping a reflection journal. Peer debriefing was also utilized to maintain rigor [15]. The codes were discussed and the researcher developed a master codebook. The researcher and faculty advisor both utilized concept maps [16] to organize data and further develop the categories. The researcher and faculty advisor analyzed the categories and then identified emergent themes [15].

### The discharge experience

Discharge is indeed a process. The participants felt it began at various points in the rehabilitation experience. Overseeing the facility, Thomas, the administrator shared that discharge planning begins upon admission, "From day one the goal is what the plan to go home is, what is our discharge plan, really we are talking about that from when they walk in the door so it's not a surprise." From a staff perspective, the discussion of transitioning home began with the first care plan meeting and involved constant communication between the interdisciplinary team and residents. For the older adults it was a process as the plans often changed depending on insurance and how well they were doing. Fred, one of the older adults, reported that initially he thought he was going to be staying at the facility for seven to 10 days but because his insurance approved more days, he stayed another week. At his second care plan meeting Fred shared that they had set a date but then there was a change a couple days later. He explained, "Then they said I wasn't going home until Saturday and all of a sudden Margaret said, 'Did you want to go home today?' It was on a Thursday and I go, 'I'll start packing'". Margaret, the social services director approached him and asked him if he would like to leave the same day. Though he had not planned on leaving that day, Fred, anxious to go home, took the opportunity. Grant, another older adult stated that he initiated the discussion of discharge after a doctor's appointment. His wife, Debbie shared that she was not at any care plan meetings and was not even aware of when the discussion of discharge began because there was no communication:

No calling me at home to make me aware of what was going on because even with the discharge, I wasn't told and I believe that if you're discharging someone you should – I mean yes, he's a grown person but he's still under medication. So call the spouse to let them know what's going on.

The older adults and their family members shared different experiences of the initiation of the discharge process from the timeline described by the staff participants.

The discharge experience varied for the three participant groups in terms of perspectives of roles and the process itself. For the staff members they described the discharge experience in terms of key player roles in the discharge process. Gloria, the Director of Nursing, explained, "Everybody is involved, the whole team is involved: Rehab, nursing, social services." The participants also noted that dietary, the primary care physician, the family, and the resident should be involved in the process from the beginning. Although there was recognition of the interdisciplinary team in the discharge process, it seemed to be more of a concept rather than a reality as schedules were difficult to accommodate. Margaret shared, "But mainly its rehab and nursing" who determined whether the older adult was ready for discharge. For example, Gloria described the process of discharge from the nursing perspective:

"We discharge patients based on either per request or patient is already ready for discharge. So then we receive order from the doctor and we inform the family, we do the discharge paperwork and then social services do follow up if they were discharged".

In contrast Fern, the Director of Rehabilitation, described the process as one that involved a close collaboration with the patient and family member continuously focused on the level of function and safety:

"The first thing we'll have to see is what was the patient's prior level of function...have meeting with patient and family to make more realistic goals then see and with the team, IDT team then you will know at least we will have an idea where the patient is going that's when we set and we start doing discharge planning".

Although Fern highlights the rehabilitation role in the process as far as equipment and home recommendations, she acknowledges that not only staff of the skilled nursing facility needs to be involved but the family members as well:

"Then, if there is equipment, we'll have to... order the equipment - if we have to do some evaluation the patient is going home per se, we go do home evaluation and after day of evaluation, we do recommendations, what the patient need at home and they - we usually try to involve family, doctors and all the discipline - IDT team to do the discharge planning".

The discharge experience seemed centered on the desire to return home and resuming previous roles as well as the environment. All three older adult participants shared an eagerness to return home. Grant commented, "I was excited about going home". Paul shared his excitement in finally returning home after he had been in and out of hospitals for months before he arrived at the skilled nursing facility. "If you don't go home, you're just out of some place for nine months; won't you be excited to go home?" He could not identify one specific reason why it felt so good to be home, "I don't know what the best thing is; I'm happy that I'm home".

This excitement was in returning to familiar environment and familiar routines including "a real shower". In Fred's experience at the facility he found the new surroundings required some adjustment. He now had to share a room with another person and get used to people coming in and determining his schedule. His routines had also changed due to his physical abilities and facility practices. He explained the experience of having a shower at the skilled nursing facility:

"Well sitting on a little rolling cart and getting a shower is a, it was okay. Ha, ha, ha. I never had anybody wash my body before, especially a guy, wheeling you down the hall. Well that was a first because I'd

never been in a hospital, spent the night in a hospital or rehab, it was different".

It took time for the older adults to adjust to the new environment of the skilled nursing facility and the older adults expressed the importance of a supportive staff to assist this adjustment.

Although excited to be home, all the participants recognized the value in the care provided by the facility. Paul shared his progress of going from four therapists helping him to walk with one moving his legs for him, to walking with the assistance of only one person standing by. Grant, while he preferred being at home acknowledged the achievements he made while at the facility, stating, "The time at (the skilled nursing facility) was very important it created a great foundation for me. So I don't think I would be where I am at this point if it wasn't for my experience (there)". The older adults preferred to be home, however, they appreciated the help and progress they made at the skilled nursing facility that made it possible to return home.

The two family member participants experienced different roles in the discharge process. Debbie's husband needed minimal assistance while Chloe's husband required more care which made it more difficult with her own health challenges. The functional level of their spouses influenced their perception of the discharge process. Debbie explained:

"Well, what I thought my participation in that the exit for him, the discharge process was that I was going to just take his belongings that he had in the room and put it in the van and take him home".

Debbie shared her role should have been more active as far as being informed about all decisions because she felt like the effects of the pain medication may have influenced the information her husband communicated with her. On the day of discharge she was supposed to provide transportation, however, her husband had told her an ambulance would be taking him home. Debbie explained:

"We had lunch together and I think we were good two hours sitting in this room waiting for... I think the walker as the incorrect size was there, but still during that time we were still waiting for the ambulance".

While Debbie shared a role that was more active in the discharge process while Grant was at the skilled nursing facility, Chloe had a role that seemed to become more involved once Paul left the facility. Once her husband left the facility Chloe was now responsible to follow up with the home health services and found herself in constant communication with the skilled nursing facility trying to get the proper equipment recommendations. She had transitioned from being responsible for decisions regarding her husband's care while at the facility to physically taking care of him by her at home. Chloe felt frustrated and inadequate with her new role as the primary caregiver now for her husband. Chloe stated,

"If I was stronger, he would be in a better position. And then again, I also feel that for while I think he would need somebody, let's say, if a caregiver had to come in here for couple of hours in the morning, to get him up and ready and started, it would be that much easier on me. It's so much time consuming and I feel like sometimes, I am not doing it right because I am not trained for that".

While her husband was at the skilled nursing facility Chloe was responsible for signing the discharge paperwork and was basically being informed of the decisions and equipment her spouse would be receiving. Chloe's new role as caregiver included transferring, bathing, and feeding her husband for which she did not feel she was adequately prepared.

## Communication

The participants expressed communication needs between the interdisciplinary team and the older adult and their family members during the discharge process as well as once the older adult had transitioned home.

The staff shared two different perspectives of communication, between the interdisciplinary team and with the family. Margaret, the social services designee, felt that the staff communication was a strength stating, "I think communication and teamwork really make it, run smoothly from our end". Disagreements between the interdisciplinary team and the family however impacted communication and discharge outcomes. Fern testified,

"I work here 12 years and I always face problems when it comes to discharge disagreement of family, at the same time sometimes it does happen disagreement between the IDT where the patient can go some of them would say, oh yeah, he needs to go assisted living, the others will say no he needs to go to board and care, others will say he can't go home".

At times the interdisciplinary team would not agree about the discharge destination and this only compounded difficulty in dealing with family conflicts. Margaret discussed the need for more frequent meetings regarding discharge planning due to unrealistic family expectations.

"So sometimes we have to have three or four meetings regarding the discharge home, normally we'll have maybe one or two, but sometimes we have to have more than one, more often because the family is not being realistic about maybe the hours of care that's going to be needed to help take care of that relative or the safety of just leaving them home all day by themselves while you go off to work or you are running your errands some of the people are not realistic about those things".

Discrepancies in family and staff expectations regarding the level of care required to ensure a safe discharge home led to increased communication and care plan meetings to come up with a solution. She also explained communication issues can occur in helping residents and family members to understand safety concerns regarding discharge.

"Mainly the thing is somebody who wants to go home, and the family thinks they can go home, but they're not safe to go home. That's one of the biggest challenges is trying to make the family and the resident understand and a lot of times it's because the resident is forgetful, and they forget safety issues".

As the facility administrator, Thomas tries to facilitate communication between the staff and family:

"It is challenging, but my approach is to make sure the patient and their family knows what the therapist, nurses and doctors are recommending. So, I want to make sure they understand fully whatever it is that the medical professionals are recommending and then let them know it is their choice and then I respect that, I respect that choice".

From a patient perspective, the participants overall felt that there should have been more communication from the beginning about how the discharge process worked and what their responsibility was in the process. Grant explained how the discharge process was confusing as a resident, "I don't think there was enough communication between the staff that was in charge as a discharge and myself and relating to me what was happening and where they were in the process of my discharge". This lack of communication left the residents feeling there

was no true uniform process and they were unsure of what they were supposed to do or what was supposed to happen.

As family member, Debbie also shared a perceived lack of communication from the skilled nursing facility regarding her husband's discharge. She felt there was little communication about adaptive equipment and how he was going to be transported home. Frustrated she shared,

"Just confirming would mean letting me know these are the things you have to – what Grant needs, we'll need. These are the things we are going to be ordering for him and make sure you have room to take them home. Nothing was ever communicated to me".

The impact of timely communication was also very important for the family members. Chloe was more passive up to the day of discharge and once her husband returned home, she realized she wished there had been more training and communication before he discharged. As family members there was a shared desire for increased communication in general.

## Challenges

All of the participants experienced different challenges in relation to the discharge process or the transition home from the skilled nursing facility. Staff members shared the major challenge to the discharge process was the constraints of insurance coverage. Length of stay is determined by the insurance as Fern explained, "Depending the payer source it could be Medicare or it could be patients have to pay that is very important, that's the key how long they are going to stay in the facility". Thomas stated, "Sometimes insurance dictates when the family and the patient feel they are ready to go. If their insurance isn't covering them anymore they feel it's time to go because they don't want to pay". At times premature discharge may occur for a variety of reasons including family or resident request but it "depends on their insurance too" as Gloria also stated. Insurance coverage was a challenge because it caused residents and family members to request to leave before the older adult was physically prepared to go. This at times led to more hospital readmissions as Margaret explained, "We have you know, said to some people okay, you insist on going home, but don't like you go home, and then a few months later they're back to the hospital because they couldn't make it at home, but we couldn't convince them in meeting after meeting". Fern expressed her concern about premature discharge due to financial issues influencing the safety of the older adult by stating,

"There are some people that they go home, they are forced to go home, not the facility force them but they are forced to go home because they cannot pay or co-pay. Is that safe discharge? No, just to save money or they cannot afford it, they go home and save and they go home and they come back to hospital again the same different – with different kind problems".

This challenge was not a rare occurrence as she also shared, "It does happen a lot of patients go home because they cannot pay".

The older adults faced their own separate challenges. Fred was met with the challenge of establishing new routines as he shared his previous roles and routines. His daily experience involved exercise and dealing with pain, "Well yeah, I still got to do my exercises and when I do the trying to bend the knee back more, that's the worst". Grant expressed the mental and emotional challenges he faced before he left the skilled nursing facility, "I saw no energy from the other patients at all, and it was kind of disheartening and eventually it became depressing". He found it difficult being one of the youngest patients at the facility, also

sharing that “it felt me like most of the patients there, this was their last stop”. The perceived lack of energy from other residents took a toll on his mental and emotional wellbeing while at the facility.

Paul expressed scheduling challenges with the home health services after discharge:

“Because they keep on changing it tomorrow; then she called that she couldn’t come. This is what I can’t understand. She told me I’m going to have meeting tomorrow – emergency meeting. How the hell you would call the emergency meeting tomorrow. I never heard of that”.

He also was worried about his wife being his caregiver, “I am concerned like she is not strong enough to what I need, but I think I help her more than – if I depend on her I’ll be killed already”. Now that he required extensive assistance, he was unsure of his wife’s physical ability to take care of him. Although she did get a few sessions of transfer training, Paul was not very confident in transferring with Chloe and realized he would have to depend mostly on himself. This created tension between them as they tried to adapt.

The family members experienced challenges with the discharge process and also once the older adult returned home. Debbie shared challenges on the day of discharge regarding receiving the proper adaptive equipment and miscommunication about the transportation arranged to bring Grant home. Despite the challenges, Debbie felt confident about being home with Grant. She shared, “I figured whatever problems that you know – or difficulties he may have been getting about, we would be able to conquer them and deal with them.”

In Contrast, Chloe explained:

“After a week I’ve thought some days when he was a little more difficult, I thought to myself maybe he should have stayed in a little bit more. So, he is more stable and stronger then it would be easier for me to help him. Things have been working out with the therapy now. He is much stronger but he still gets frustrated with me and that makes me anxious”.

Challenged with facing the reality of a premature discharge, she expressed the realization that it would be easier to assist him if he had remained longer at the skilled nursing facility. The dynamics between their new relationship of caregiver and client led to conflict in the level of care she was able to provide for him.

“And then he gets sometimes frustrated if I go to do something and I don’t do it right that how come I don’t know how to do it or why can’t you do it or you are strong enough. He sees I am not strong enough. He says that. And then that’s upsetting to me”.

## Results

This study explored multiple perspectives of the discharge process from a long-term care facility to home. Four staff members from a skilled nursing facility, three older adults, and two family members participated in this study. The staff who participated included Thomas, the facility administrator, Margaret, the social services designee, Fern, the director of rehabilitation, and Gloria, the director of nursing. Fred, Grant, and Paul were older adult residents of the skilled nursing facility whose length of stay varied from three weeks to four months. Their ages ranged between 65 and 73 years old. The family member participants were Debbie who was the spouse of Grant, and Chloe the spouse of Paul. Three themes reflect the participants’ discharge process and transition home: The Discharge Experience, Communication, and Challenges.

## Discussion

Differences in previous experiences shaped different perspectives for the older adults and their family members. Two were residents at the skilled nursing facility for less than two months and were able to gain back their mobility relatively quickly. One older adult participant had been away from home for nine months and had a severe decline in function and independence, which changed the very dynamic of his relationship with his wife. While the roles of the family members in the discharge process carried some similarities when their spouses were in the skilled nursing facility, the wives’ experiences were transformed once the older adults had transitioned back home.

Although the staff agreed to the general steps in the discharge process as well as the key players, the family members reported a discrepancy in the follow-through with this process as shared by the older adults and their family members. As seen by Bauer et al. [7] there appeared to be inconsistencies in the discharge process. Lack of uniformity in the process as well as communication resulted in confusion for the older adults and their family members. One couple shared how because of miscommunication they really had no idea what the process was and were lost on the day of discharge. Shepperd et al. [9] found that adequate time to notify the family and individual of discharge was an effective method of maintaining a structured process. This was an issue as far as informing the family members of the process itself, and also reflective of the fact that the older adults’ discharges and discussion of returning home were self-initiated by the older adult or their family.

The staff of the skilled nursing facility differed in their perspectives on communication. They generally agreed that communication with the family was necessary for a successful discharge and that they often faced challenges in communicating with the family. There was, however a difference of opinion about the communication between the interdisciplinary team. Some participants felt that the team communicated well while others were able to identify problems in working as a team.

The challenges of the financial context as influenced by insurance coverage was recognized by the staff of the skilled nursing facility to be a significant factor in decisions made by older adults and their family members regarding discharge. It was a subject brought up by all of the staff participants as an area of concern for the safety of the older adults and their family members. It also was a factor influencing a premature discharge for one of the older adults, which impacted his wife. External policies were something the staff wanted addressed because they felt insurance companies was determining how long a resident could stay that was not necessarily always based on need. The reality is that the health care system does not always work in favor for those who cannot afford co-payment or to pay privately beyond what is covered by their insurance.

Limitations of this study included the various diagnoses of the older adult participants that lead to vastly different experiences. This study only explored the perspectives of older adults who were returning home from a skilled nursing facility, while many older adults transition to and from other level of care facilities.

In the future it would be beneficial to do a longitudinal study on the experience of the older adults and their family members after being home for six months to a year. Aligning with the current drive in healthcare to reduce readmissions, we recommend evaluating the discharge process in relation to number of readmissions to skilled nursing facility.

## Conclusion

This study explored the multiple perspectives of the discharge process from skilled nursing facility to home. From the exploration of the complex discharge process emerged three themes: the discharge process, communication, and challenges. The discharge experience varied for the three groups as far as roles and expectations. Discharge planning required the communication of all three groups: staff, older adults, and their family members. Effective communication is crucial in ensuring a safe and successful transition from long-term care to home for older adults. Finally, there are many different challenges that each of the groups had to face during the discharge process. The multiple perspectives shared in this study would help health care professionals understand the discharge experience and better serve older adults and their family members when transitioning from long-term care facility to home.

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