The University of Kansas
School of Social Welfare
Office of Aging and Long Term Care

Hospital Discharge Planning Project

Final Report
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Butler County Department on Aging
Central Plains Area Agency on Aging
Coalition for Independence
Independent Living Resource Center
Morris County Hospital
Nemaha County Home Health and Hospice
Nemaha Valley Community Hospital
North Central-Flint Hills Area Agency on Aging
Northeast Kansas Area Agency on Aging
Sabetha Community Hospital
Southview Home Care
Susan B. Allen Memorial Hospital
Three Rivers, Inc.
Via Christi Hospital
Wyandotte/Leavenworth Area Agency on Aging
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Introduction

Project purpose

The FY08 Hospital Discharge Planning Project builds on research conducted by the University of Kansas School of Social Welfare’s Office on Aging and Long Term Care (OALTC) as part of the federal Real Choice Initiative in FY07. The purpose of the current project is to contribute to the state’s capacity to increase the number of older adults who return home following a hospital stay through:

- Dissemination of recommendations from the FY07 Hospital Discharge Planning Study to key players across the state in order to encourage implementation;
- Development of community workgroups that include hospital discharge planners, AAA case managers, and community-based workers from related agencies to implement hospital discharge study recommendations;
- Identification of successful strategies and barriers to a smooth transition from the hospital to post-hospital services from the perspectives of older adults and primary caregivers;
- Creation of rapid notification methods to alert community-based services (e.g., AAAs) when a consumer receiving those services is hospitalized;
- Identification and dissemination of best practices for hospital-based assessment of consumers to determine any need for changes in in-home services; and
- Assessment of existing data that would allow KDOA to evaluate outcomes of hospital discharge planning initiatives, implementation of hospital discharge planning recommendations, and other long-term care policy reforms.

Background and rationale

The FY08 Hospital Discharge Planning Project directly builds on two earlier initiatives, the CARE Enhancement Project, and the Real Choice Project: Referral System Assessment. The CARE Enhancement Project, a pilot project managed by the North Central-Flint Hills Area Agency on Aging, provided enhanced case management for discharge planning in two sites. Hospitals in Emporia and Council Grove represented urban and rural settings, respectively. The CARE Enhancement Project’s final report identified the need for ongoing communication between key players in the hospital and
the community and recommended including case managers from AAAs home and community based services earlier in the hospital discharge planning process.

In FY07 the Kansas Department of Social and Rehabilitation Services (SRS) contracted with the OALTC to conduct the Real Choice Project: Referral System Assessment. The purpose of this nine month study was to contribute to the state’s capacity to increase choice in care settings for older adults (ages 60+) and adults with disabilities (ages 18+) who are discharging from hospitals. The FY07 Real Choice Project conducted telephone surveys with a representative sample of discharge planners from Kansas hospitals, and interviews with representatives from Area Agencies on Aging (AAA), Independent Living Centers (ILC), and hospitals. The research team also facilitated four focus groups that confirmed and provided additional detail to findings and recommendations from the surveys and interviews.

The FY07 study documented wide variation in the structural organization for hospital discharge planning. Across the state, discharge planning is structured differently across a diverse range of Kansas hospitals that vary by hospital size, geographic location, population density, ownership, credentials of the discharge planners, and caseload. Hospital discharge planners did identify common processes across diverse hospital settings. In general, common elements in discharge planning included: 1) identification of individuals with hospital discharge planning needs; 2) initial chart and medical record review; 3) a face-to-face meeting; 4) a bio-psycho-social assessment with the consumer and sometimes family members; 5) coordination of communication across all players within the hospital setting; 6) planning and goal setting with the patient; 7) review of community resources; and 8) referral(s) to community service providers. Discharge planners reported that much of the discharge planning process was driven by physician orders. However, the planning process plays out in multiple ways. Discharge planning differs according to the community characteristics, organizational structure of the hospital, available community resources, understanding of the discharge planner regarding these resources, practices of the attending physician, and individual circumstances of each consumer.

Barriers to effective planning processes were related to structural issues (e.g., insurance coverage, access to housing, waiting lists), timing of referrals, communication, medical complexity, and differing conceptual approaches. The FY07 project identified several best practices, strategies, and recommendations for increasing the effectiveness of hospital discharge planning processes. The variation across planning processes implies that strategies targeting these processes to increase choice in post-hospital care settings must be adaptable to systems within the local structural environment, and to the individual circumstances of each consumer. This was instrumental in decisions regarding approaches used in the current project.

The FY07 project resulted in numerous recommendations related to structural and systemic issues; the hospital intake process; roles of physicians, hospital discharge planners, community-based services, consumers, and family members. See Appendix A for a complete listing of recommendations from the FY07 project. Two of these
recommendations were targeted for the focus of FY08 activities. They were chosen because of perceived importance and feasibility of constructive outcomes. These recommendations are also in alignment with other KDOA initiatives.

- Creation of a rapid notification method to alert community-based services (e.g., AAAs) when a consumer receiving those services is hospitalized.

- Complete or begin assessment to determine any need for, or changes in, in-home services while the consumer is in the hospital.

Thus, the FY08 Hospital Discharge Planning Project worked on systems change, with a focus on the two recommendations bulleted above. In addition, based on our analysis of varied hospital discharge planning systems across the state, we have developed a process to more effectively implement future policy reforms. We also completed case study interviews with recently hospitalized older adults and their caregivers to understand barriers and best practices in discharge planning from their perspectives. Finally, the OALTC reviewed secondary datasets to assess their potential for tracking outcomes related to hospital discharge planning and other KDOA initiatives.
**Final Report**

**FY08 project objectives**

Objectives for the Hospital Discharge Planning Project, which were created in consultation with representatives from the Kansas Department on Aging, are listed in Table 1, along with information on progress towards accomplishing these objectives.

<table>
<thead>
<tr>
<th>Obj. #</th>
<th>Objective</th>
<th>Progress</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Develop action steps that will serve as a catalyst for community workgroups that are working on initiatives that target hospital discharge planning processes.</td>
<td>Completed</td>
<td>(Appendix B)</td>
</tr>
<tr>
<td>2</td>
<td>Maintain communication with key contacts related to hospital discharge planning to provide guidance in implementation of action steps.</td>
<td>Completed</td>
<td>Communication by e-mail and telephone has been ongoing.</td>
</tr>
<tr>
<td>3</td>
<td>Conduct interviews and develop case studies of 4 older adults and their primary caregivers to understand their perspectives on transitions from the hospital to post-hospital services.</td>
<td>Completed</td>
<td>(Appendix C &amp; Appendix D)</td>
</tr>
<tr>
<td>4</td>
<td>Target a minimum of three communities (mix of urban, mid-sized, rural) to ultimately increase the number of consumers who return home following a hospital stay through at least one of the recommended strategies.</td>
<td>Completed</td>
<td>Sabetha 4/9/08 El Dorado 4/23/08 Wichita 6/3/08</td>
</tr>
<tr>
<td>5</td>
<td>Identify needed data elements and evaluate existing data sets that could be used to determine consumer outcomes following hospital discharge.</td>
<td>Completed</td>
<td>(Appendix E)</td>
</tr>
<tr>
<td>6</td>
<td>Provide a written synthesis of relevant information to state policy-makers for purposes of decision-making for systems change.</td>
<td>Final report completed</td>
<td></td>
</tr>
</tbody>
</table>
Project Objective Accomplishments

Objective 1: Develop action steps that will serve as a catalyst for development of community workgroups whose partners include hospital discharge planners, AAA staff, and community-based workers from related agencies through dissemination of recommendations from the FY07 hospital discharge planning project.

A ten step process to guide community workgroup planning has been established. The impetus for holding workgroup meetings stemmed from FY08 recommendations to find dedicated time to form working relationships between hospital discharge planners, AAA case managers, staff from ILCs, and other community services. This would include determination of the best communication methods and coordination of services across agencies. The ten step process for the workgroups were based on recommendations and experience gained from focus groups in FY08. Following each workgroup the process was revised and tested for subsequent workgroups.

This information is provided in a general format that may be shared with key players at any locality when facilitating training or technical assistance. However, the process is structured so that the discussion will quickly hone in on priority issues of individual communities. Local staff members vary widely in their meeting facilitation skills and experience in planning and conducting community-level meetings. Some communities appreciated the time saved by simply having a ready-made agenda available while others benefitted from a greater level of technical assistance and meeting facilitation. See Appendix B for detailed action steps.

Objective 2: Maintain communication with key contacts related to hospital discharge planning to provide guidance in implementation of action steps.

We maintained communication by telephone, e-mail, and in person. Examples of our support included assisting one community in making a local resource sheet and another in initiating communication with their lawyer and the county government representative to discuss HIPAA interpretation.

Objective 3: Complete case study interviews with older adults and primary caregivers in order to better understand their perspectives on the transition from the hospital to post-hospital services.

Introduction: Although researchers are beginning to more closely examine transitions for older adult and caregivers across multiple settings such as from hospital to nursing home, from nursing home to home, many of these transitions have not been fully explored, especially from the perspective of the older adult and caregiver. These case studies examined the transition from the hospital to home and sought to obtain the older adult and caregivers' viewpoint about the discharge planning process. The literature on discharge planning is largely focused on the professional's (social work and nursing) perspective in contrast to the older adult and caregiver's perspective. Other writers
address the older adult and caregiver's involvement in the discharge planning process, but not on their view after the process has occurred. Also, there is literature on the importance of involving the older adults in discharge planning, such as to the nursing home, but again, virtually no studies address the older adult's and caregiving perspective of the hospital discharge planning process after it has transpired. The case study’s overarching research topic was to examine older adult and caregiver’s perspectives of the hospital discharge planning process in order to better inform decisions made by policymakers and direct service professionals.

Methods: IRB approval was received for all procedures, interview guides (see Appendix C), and consent forms necessary for interviewing older adult and caregiver participants. Recruitment of interview participants was challenging, particularly in small towns. Our initial recruitment strategy involved contacting home health agencies in three communities of varying population size (small, mid-size, and large). We contacted hospitals in these communities to obtain contact information for home health agencies that these hospitals make referrals to. We contacted approximately 16 home health agencies stating the purpose of study and eliciting referrals. However, these home health agencies described various reasons for being unable to provide referrals, e.g., the older adults were not on Medicaid, had not been discharged within 90 days, and were smaller agencies with considerable direct service responsibilities. Consequently, we solicited referrals from nearly all the Area Agency on Aging offices in Kansas to obtain referrals for study participation. This strategy proved effective and we were able to obtain four pairs (one older and one caregiver) for a total of eight participants.

Findings: All older adults indicated that the admission to the hospital occurred on an emergency basis (e.g., due to a stroke or blood clot). Two older adults were very satisfied with the discharge planning process; two expressed concerns about obtaining or understanding the use of medication. All family members were satisfied with the discharge process. Furthermore, one family member stated, “I think they [hospital staff] did their best. The doctor was…pretty attentive.” This caregiver further stated, “It is very important that these people [older adults being discharged from the hospital] get home care. It does keep them out of the nursing home and I think they’re more satisfied – physically and mentally. I mean I see it.”

Three out of four pairs of participants indicated that their discharge goals were met. One pair thought the discharge date was appropriate, although the older adult was not as healthy as they would have liked her to be. According to older adult participants, hospital staff (i.e., physician, nurse, social worker, rehabilitation staff, pharmacist and dietician) was involved in varying degrees in the older adult's discharge. All older adults indicated the physician was involved in placing the discharge order, but were unclear as to the specific role of the physician. All older adult participants were unclear as to the nurse’s role in the discharge; two discussed the role of the social worker in the discharge planning process. Two indicated rehabilitation staff was involved in the discharge; two reported no involvement. Three pharmacists were not involved in the discharge process and one was minimally involved. Only one older adult participant indicated any interaction with the dietician. Family members described an awareness of the hospital
staff involved, but they were typically unclear of their contributions to the discharge planning process.

Two older adults were familiar with the services and resources available through the Area Agency on Aging. One even commented that “He, (her AAA case manager) lives right out there (older adult pointed) and he just stops in to see how I’m doing.” Their case managers were responsive to their new medical needs post-discharge and adapted their services as necessary. Only one older adult mentioned the ILC, but not in relationship to the discharge. Three older adults were involved in discharge planning. All were motivated to be discharged. In particular, one older adult participant stated, “The hospital was very nice. The room was very nice. The people were very nice to me. But getting home is gorgeous.”

From all older participants’ perspectives, no caregiver was actively involved in helping to create a discharge plan with the older adult. However, from one caregivers’ viewpoint, she described being adequately involved in discharge planning. In contrast, one uninvolved caregiver indicated, “I would have liked a little bit more information so I would know what was going on with her [the older adult]...She sometimes doesn’t understand or hear things right, so I would appreciate it if they would have gave me a little bit of insight of what’s going on with her…I’ve got to go by what she says.” Two older adults were given options for resources and given an appropriate amount or more than enough options and this is consistent with family caregivers’ responses.

In general, interview participants were satisfied with their hospital discharge planning experience. Several indicated awareness of a variety of players in the process, but they were unclear about the roles that each professional played. This is also true for the roles of the AAA and ILC staff, in spite of the fact that three out of four interview referrals originated from AAA case managers. From the interviews it was obvious that respondents were receiving and were satisfied with the AAA case management services for Medicaid recipients, however the lack of understanding that these services stemmed from the AAA is of concern.

Objective 4: Target a minimum of three communities (mix of small, mid-sized, large) to ultimately increase the number of consumers who return home following a hospital stay through implementation of at least one change strategy.

Meetings were held in Sabetha (small), El Dorado (mid-sized), and Wichita (large).

Some similarities and differences existed in the three workgroups. Common themes included the need for ongoing communication between the AAAs, the ILCs, and hospital discharge planners, the need to create a system for rapid notification of community-based case managers when a patient receiving community-based services is hospitalized, and the need to update the workgroup when policy and program changes take place.

The workgroups did, however, differ in their approaches to address these needs. The smaller community focused on increasing networking opportunities since their locations
were dispersed over a wide geographic area. We helped to facilitate initial meetings and they plan on meeting twice a year to improve networking. The mid-sized community plans to invite the AAA to conduct trainings on new programs and policies on an ongoing basis. They also plan to hold “meet and greets” twice a year to keep in touch with other service providers. Members of the larger community workgroup felt that periodic meetings would not work as well for their large staff sizes and chose to designate community-based and hospital liaisons who would maintain contact and share information with their colleagues. The AAA Executive Director in Wichita noted that the workgroup held in her community was timely because the local partners were given an opportunity to prioritize and identify potential strategies before beginning a related project with state partners.

Strategies to address timing issues were also implemented in all three communities. Hospital discharge planners at the smaller hospital chose to directly walk up to the admissions office and look in the patient’s file for a Medicaid card to determine if he or she was receiving waiver services. This was a workable solution in the smaller hospital, because the number of newly admitted older adults in this rural area tends to be low. Follow-up with this location indicated that attempts to implement this strategy were only successful if the files were up to date and reflect recent Medicaid service changes. The mid-sized hospital is updating their computer system to show the patient’s Medicaid information electronically. This will allow the discharge planners to easily know if the patient is receiving community-based services. The larger community has been struggling with rigid interpretations of HIPAA policies resulting in delayed notification of hospitalization to community-based service providers, particularly AAA case managers. Local government policy will not allow AAA staff members to confirm or deny if a person is a client without a formal release of information. Members of this workgroup suggested that KDOA add hospitals to the UAI release of information form to resolve this problem. Several questions about the new annual Medicaid cards were mentioned by all groups.

Although there were clear variations in hospital discharge planning systems across the state, there was wide agreement that bringing together AAAs, ILCs, and hospital discharge planners was central to improvement of hospital discharge planning processes. These meetings generated different strategies for ongoing communication that can be tailored to individual community needs. The end result was systems change that provides a structure for dissemination of program and policy changes to key players in the discharge planning process. This can increase choice for older adults discharging from the hospital. However, these structures will need to be reinforced to stay in place.

**Objective 5:** Assessment of existing data that would allow KDOA to evaluate outcomes of hospital discharge planning initiatives, implementation of hospital discharge planning recommendations, and other long-term care policy reforms.

We developed a tool that can be used to identify data fields necessary to evaluate outcomes related to hospital discharge planning, community tenure, and mental health for older adults using Medicaid services. The following assessment forms were obtained and
examined: Kansas Hospital Association Dataset, Client Assessment & Referral Evaluation (CARE) Assessment, Uniform Assessment Instrument (UAI), and Minimum Data Set (MDS). OALTC staff members reviewed the assessment forms for information related to hospital discharge planning and other KDOA initiatives such as and community tenure and geriatric mental health for Medicaid-eligible older adults. The hospital association dataset includes discharge dates, length of stay, and DRGs. In order to effectively track hospital discharge planning data from this source, access to the Kansas Hospital Association data would need to be negotiated and purchased. The CARE, UAI, and MDS contain data from consumer assessments in settings including the community and nursing facilities. The Kansas Health Policy Authority has access to the Medicaid dataset for the state of Kansas and is able to provide reports on queries involving aggregate data. Datafields in the Medicaid dataset are related to billable services and are too numerous to list in this summary.

These datasets provide information that could be used to answer research questions and evaluate initiatives related to hospital discharge planning including community tenure, and mental health for Medicaid eligible older adults. An evaluation of hospital discharge planning initiatives could be accomplished with data from the Kansas Hospital Association because this dataset contains information on date of hospital admission, date of discharge, and discharge disposition (e.g. discharge to nursing facility). Additional information can be derived from Medicaid long-term billing information or 30 day follow up to CARE assessments.

To fully understand the potential of these datasets to answer research and policy questions related to hospital discharge planning it would be necessary to conduct univariate analysis on targeted datafields to assess frequency, distribution, and missing data. The decisions could then be made regarding potential linkages across datasets to answer more complex questions that would inform current policy issues.

To answer approved research questions that justify access to confidential data, social security numbers and dates of birth could be used to link the CARE Assessment, UAI, and MDS. This would create a large database including information on preferences for long-term care, home environment, NF anticipated length of stay, and informal supports. Medicaid numbers could be used to link UAI and MDS data. Variables that can be used to link the Medicaid dataset to other datasets are Medicaid ID number, social security number, and date of birth. Medicaid variables related to hospital discharge planning include date admitted or discharged to a hospital or nursing facility, admission type via DRG codes, and use of home health or waiver services that could be queried in association with a hospital discharge date. Detailed information on data elements found in each of the data sets reviewed is provided in Appendix E.

Objective 6: Provide a written synthesis of relevant information to state policy-makers for purposes of decision-making for systems change.

This final Hospital Discharge Planning Project Report was completed by September 30, 2008.
Implications and Conclusion

The focal point of the current project was the development and implementation of systems change that provides a structure for dissemination of program and policy changes to key players in the discharge planning process. An important factor was the pre-existing relationship between the AAA, community-based service providers, and hospital discharge planners.

The following policy issues emerged from these community workgroups. Local interpretation of HIPAA regulations are more rigid in some areas of the state making it difficult for hospital discharge planners to communicate with AAAs about consumers receiving services. A state-level change to add hospitals to the list of agencies included on the UAI release of information form would help solve this problem.

We also heard several comments regarding the benefits of the newly passed legislation allowing additional attendant care hours. It was generally thought that this policy change would facilitate hospital discharge to home. Short-term availability of 24 hour care/supervision following hospital discharge could also increase transitions to home instead of a nursing facility. Finally, a participant from at least one community felt that expedited services was helping increase discharge from the hospital to the home. It is recommended that SRS and KDOA continue to monitor criteria levels to find the best balance between the establishment of criteria that meets the needs of older adults, yet does not result in too many false positives. This policy has the potential for increasing hospital discharges to home if service providers are confident that likely applicants meet all eligibility criteria. Public education to help people understand eligibility criteria and documentation needed should help instill this confidence.

While we identified commonalities across community workgroups, such as the need for improved communication, we found that tailoring the intervention to the specific community was essential. For example, each community addressed the issue of improving communication, but they each selected a different method to achieve the desired outcome. These community meetings did result in verbal commitments to change behavior and implement strategies to improve communication and reduce the time to notify community-based workers that a consumer is hospitalized.

The interview participants, Medicaid-eligible older adults and their primary caregivers, were generally satisfied with their hospital discharge planning experience. Respondents were aware of a variety of players in the process, but they were less clear about the professional’s roles. From the interviews it was obvious that respondents were receiving and were satisfied with the AAA case management services for Medicaid recipients, however they were unable to associate the services received with specific agencies. This lack of understanding of the range of services available through the AAAs is a public relations issue that needs to be addressed in order for consumers to realize the options that are available to them and their family members.
Future work could build on FY08 and FY09 initiatives and document discharge planning from rehabilitation hospitals and from short-term nursing facility stays. Experience gained to date would facilitate evaluation of hospital discharge planning initiatives in the state. It is important to remember that we only interviewed a small sample of Medicaid-eligible older adults who had experienced an emergency admission to a hospital. Additional interviews or surveys of Medicaid-eligible older adults who recently experienced a hospital stay would provide more comprehensive information on their hospital discharge planning experiences and awareness of community-based services.

The FY08 project focused on selected recommendations from the hospital discharge study, and facilitated local community efforts to implement these recommendations. In order to implement additional recommendations, continued involvement by key players including KDOA policymakers, hospital staff members, and community-based agencies will be necessary. In FY09 we discovered that one of the greatest challenges is getting key hospital staff members involved due to their lack of support for coordinating with services outside the hospital setting. Interested community partners who understood the benefit of coordinated services included hospital discharge planners, AAA case managers, independent living specialists, hospice staff, and home health representatives. This project documented the willingness of these diverse partners to work together if they had the resources to facilitate and support to attend regularly scheduled meetings. The outcome of this service coordination is expected to be increased choice for older adults to return to the community and fewer referrals to nursing facilities as a permanent placement. This information will provide KDOA with a research-based foundation for planning model programs and other state initiatives to increase choice for Medicaid-eligible older adults who are being discharged from an acute care hospital setting.
Appendix A

Recommendations from the
Real Choice Referral System Assessment Project

2007
Real Choice Referral System Assessment Project  
(Recommendations from FY07 study)

The following recommendations were initially identified through analysis of Phase I telephone surveys and Phase II interviews with hospital discharge planners and direct service workers from AAAs, and ILCs. Selected recommendations and related issues were discussed in focus groups with representatives from hospitals, AAAs, and ILCs, and these discussions resulted in additional recommendations. In addition, the full set of recommendations was presented to the projects panel of expert consultants in early August 2007. Panel members discussed the recommendations and generated their own recommendations which are included at the end of this list.

Recommendations that Focus on Structural and Systemic Issues

- Allow retroactive reimbursement for home and community based services once Medicaid eligibility is determined (to parallel the reimbursement allowed for nursing facility services).

- Equalize reimbursement amounts for services across Physical Disability and Frail Elderly Waiver programs.

- Eliminate waiting lists for services (e.g., low income housing, Senior Care Act).

- Reduce the 45 day wait for eligibility and access to Medicaid-funded community-based services to a 3-5 day window.

- Increase number of allowable attendant care hours (specific to the Frail Elder Waiver).

- Provide non-medical companion services to adults with functional and/or cognitive impairments, including both Medicaid and non-Medicaid eligible populations.

- Provide bridge funding for attendant care services on a temporary and/or emergency basis for people who do not meet Medicaid eligibility guidelines or who are waiting for eligibility determination.

- Develop a model program to meet the needs of people who do not qualify for Medicaid. The model program can be fashioned after aspects of the Senior Care Act and the Working Healthy Program and should incorporate the following characteristics:
  - Sliding fee scale
  - No waiting lists
• Rapid determination of eligibility
• Provide the full range of attendant services
• No homebound criteria

• Develop a parallel model program for people who are Medicaid-eligible (omitting the sliding fee scale).

• Support policy change aimed at increasing the number of accessible apartments and homes.

• Eliminate the need for multiple background checks for housing; provide financial support for background checks and deposits.

• Explore model programs where medical students provide services to people living in homeless shelters.

**Recommendations that Focus on the Hospital Intake Process**

• Work with hospital intake procedures to develop a system where the hospital discharge planner is notified immediately when a consumer with a Medical card enters the hospital; note if there is already an “HC code” on the card that signifies that the consumer is already receiving home and community based services. Once a consumer has been identified as one receiving HCBS services, the hospital can notify the AAA or ILC as soon as possible.

• Add appropriate screening questions to intake assessments.

• Share information regarding pre-existing conditions and services with hospital discharge planners as soon as possible.

• Encourage hospital intake workers and emergency medical personnel to look for and ask about emergency information packets, wallet cards, or other information on pre-existing conditions, services currently received, and contact information.

**Recommendations that Focus on Screening and Assessment Processes**

• To help ensure that services are in place as soon as possible, complete the UAI and other screenings (e.g., Client Assessment Referral and Evaluation, CARE Assessment) while the consumer is still in the hospital; review current assessment tools to determine if conducting assessments outside the home setting would omit valuable information.

• Network statewide between AAAs and ILCs to determine best practices for completing assessments before the consumer returns home.
• Work with assessors to facilitate the most effective ways to gather information from older adults and younger adults with disabilities whose functional limitations may pose barriers to traditional assessment methods.

• Work with assessors to balance potentially conflicting service recommendations stemming from empowerment/consumer choice, and results from the formal assessment process.

**Recommendations that Focus on the Role of Physicians**

• Gather information from physicians to understand their role in the hospital discharge planning process.

• Educate physicians regarding home and community based services and the role of these services as alternatives to nursing facility placement, and to prevent re-hospitalization.

• Educate physicians regarding the role of the hospital discharge planner in coordinating access to these services and the importance of advance notice of discharge so services will be available when needed.

**Recommendations that Focus on the Role of Hospital Discharge Planners**

• Seek out information on consumers’ pre-existing conditions and services as soon as possible following hospital admittance (if possible, during pre-op prior to admittance).

• Consider ways to make timely communication with AAAs and ILCs more possible (e.g., reduced caseloads, cell phones for discharge planners).

• Contact community based services workers (AAA, ILC, other) immediately after learning that the consumer receives these services.

• Contact appropriate stakeholders to form a working relationship with local AAAs and ILCs to determine the best communication methods, given the organizational structure within your respective agencies.

• Provide dedicated time for hospital discharge planners to network with community-based service providers.

• Provide resources for hospital discharge planners regarding consumer choice, advocacy, and self-determination.
• Improve timely communication with physicians by going on rounds with physicians.

Recommendations that Focus on the Role of AAAs and ILCs

• Provide dedicated time to conduct outreach to form a working relationship with local hospitals to determine the best communication methods, given the organizational structure within your respective agencies.

• Consider whether AAAs and ILCs can serve as a referral point for all community-based services in their catchment area.

• Consider ways to make timely communication with discharge planners more possible (e.g., reduced caseloads, cell phones for case managers).

• Start and/or complete assessments for home and community based services while the consumer is still in the hospital.

• Provide resources for case managers regarding consumers’ complex medical needs (e.g., ventilators, Foley catheters) and related issues.

• Provide resources for home and community based service providers on appropriate interpretations of HIPAA regulations that facilitates timely communication across agencies; work to streamline procedures.

• Provide hospital discharge planners with feedback regarding follow up with consumers.

Recommendations that Focus on the Role of Consumers and Their Family Members

• Educate consumers and their family members regarding empowerment and self-advocacy.

• Gather information from consumers and their family members to understand preferred options for post-hospital care settings and hospital discharge planning processes from their perspectives.

• Educate consumers and their family members on the importance of sharing information on pre-existing conditions and services with hospitals upon admission.

• Educate consumers and their family members on the importance of designating a financial and medical power of attorney, and the advantages of advance directives.
• Provide multiple means to consumers (e.g., magnets, wallet cards, and emergency information packets) to facilitate communication regarding pre-existing conditions and services.

**Recommendations that Focus on Trainers at Hospitals, AAAs, and ILCs**

• Create train-the-trainers materials for continuing education departments at hospitals and personnel at AAAs, and ILCs who conduct internal trainings.

• Provide hospitals, AAAs, and ILCs with proven strategies to learn about and keep current on local resources and contacts.

**Recommendations from the Panel of Expert Consultants**

• Streamline the housing background check.

• Provide hospital discharge planners with resources regarding the Kansas Medical Assistance Program.

• Have occupational and physical therapists assess the home while the patient is in the hospital.

• Educate physicians before they graduate or during residency about home and community based services.

• Remove the lifetime cap for home modifications in the PD and FE Waiver programs.

• Expedite approval for home and community based services.

• Create a formal structure for networking between hospital discharge planners, ILCs, and AAAs.
Appendix B

Community Workgroup Action Steps
Community Workgroup Action Steps

Pre-Planning
1. Clarify meeting goals
2. Select people to invite
3. Arrange meeting time/location
4. Prepare agenda/handouts

Meeting Facilitation
5. Introductions
6. Review project background and future plans
7. Facilitate discussion
8. Select change strategies to pursue
9. Assign tasks and set deadlines

Follow-Up
10. Follow up with group members

Clarify Meeting Goals:
In order to plan a productive community workgroup meeting, think through desired end results during the pre-planning phase. This will assist in the selection of participants, creation of an agenda, and overall facilitation of the workgroup discussion. Goals for a first meeting might involve creating a social networking opportunity or selecting a change strategy and assigning tasks that would facilitate hospital discharge planning.

Select people to invite:
It is important to invite a diverse group of participants that represent various agencies, roles, and professional backgrounds relevant to the hospital discharge planning process. Essential input will be provided by the hospital discharge planners and AAA staff members. Other valuable participants include staff members from home health agencies, hospice centers, ILCs, and nursing facilities.

Arrange meeting time/location:
Due to hectic schedules and the “on-call” nature of their jobs, hospital discharge planners tend to have a difficult time leaving the worksite for meetings. The OALTC staff found it easiest to meet in hospital conference rooms allowing this important participant to remain close to his or her workplace. The meeting time was typically dependant on the availability of the meeting space.

Prepare agenda/handouts:
Important meeting topics can be summarized on handouts to minimize note taking during the meeting. It is also a good idea to create a sign-in sheet in order to follow up with meeting participants. A meeting agenda should be prepared and distributed to participants 4-7 days in advance of the meeting date. If you feel a group may need help
staying on task, a timeframe can be assigned to each agenda item. The following is a sample agenda:

I. Arrival & orientation
   a. Greet
   b. Introductions
   c. Meeting purpose
   d. Goals for the meeting

II. Review recommendations from the KU Hospital Discharge Planning Study

III. Review the discharge planning process in your community.
   a. How does the process work and what is your role?
   b. What are barriers?
   c. What works well?
   d. What recommendations would facilitate the discharge planning process and help overcome barriers?
   e. What are strategies or the first activities necessary to implement the recommendations?
   f. How can the OALTC or KDOA assist your efforts?

IV. Wrap up
   a. Follow up tasks, responsible party, and timeframe for completion
   b. Next meeting date

Introductions:
Ask all group members to introduce themselves stating their name, agency, and role related to hospital discharge planning. This helps create a better understanding of the key player’s responsibilities from the time of hospital admission to the coordination of home and community based services.

Meeting purpose and goals:
Take a few minutes to review your motivation for calling a meeting. It is likely that everyone in the room would like to find ways to streamline discharge planning processes and increase consumer choice. Share 2-3 potential recommendations to consider as change strategies. For example, based on input from stakeholders, the OALTC selected 1) Creation of a rapid notification method to alert community-based services when a consumer receiving those services is hospitalized and 2) Complete or begin assessment to determine any need for changes in in-home services as suggested strategies.

Facilitate discussion:
Have one person lead the discussion and another person take notes on flipcharts. Some questions for an initial meeting could include the following:
   - How does the hospital discharge planning process work in your community and what are the roles of key players?
   - What are barriers?
   - What works well?
- What recommendations would facilitate the discharge planning process and help overcome barriers?
- What are strategies or the first activities necessary to implement the recommendations?
- Do you need assistance from outside sources?

*Select change strategies to pursue:*
Many possible change strategies will be discussed during the course of the meeting. It is important to take time to review the list and select one or more strategies that group members would like to pursue. Select strategies that are manageable given the available resources and will be sustainable over time. Some communities find it helpful to begin with a small, concrete task. This helps build common experience and trust among workgroup members. Some strategies that were selected by Kansas communities included making a local resource sheet, having meeting participants assist in training of staff members from other agencies, designating AAA and ILC staff members to act as liaison with hospitals, and reviewing HIPAA guidelines.

*Assign tasks and set deadlines:*
Once change strategies are selected, allow group members to volunteer to follow up on necessary tasks. Make sure all tasks are covered. Help the group select a deadline for their work.

*Follow up with group members:*
Follow up with workgroup participants to determine if further assistance is needed. Set next meeting date if appropriate.
Appendix C

Interview Guides for Medicaid Eligible Older Adults and Primary Caregivers
Older Adult Interview Guide on the Hospital Discharge Planning Process

1. I wanted to ask you about your recent hospital stay and your discharge or return to home. Please tell me why you were in the hospital.
2. In general, can you tell me what it was like for you to go from the hospital to home/NF?
3. Who was involved in your discharge planning process or move from the hospital to home/NF (physician, social worker, physical, speech or occupational therapist, nurse, pharmacist, dietician, ILC, AAA, or other)?
4. What did each person do?
5. How did each person view your health?
6. How did each person work with you on getting better?
7. At the time of discharge, how did you view your health?
8. What had you hoped you would be able to do by the time you were ready to leave the hospital?
9. What plans were made for your discharge to home/NF?
10. How involved were you in the plan to leave the hospital?
11. Were there any major mix-ups or any confusion as you moved from the hospital to home/NF? Please describe.
12. What went well about the process?
13. What services were set up for your return home/NF (e.g., home health, rehabilitation services, independent living services, homemaking, nursing care)?
14. Were you given service options to choose from?
15. Were you given too many service options?
16. Were you given too few service options?
17. Are you happy with the decision to return to home/enter NF?
18. Were the services set up by the hospital discharge planner helpful?
19. How did these services work out for you?
20. Did you receive a list or brochure of resources in the community?
21. Did you use any of those resources? Please explain.
22. What resources would have helped your discharge plans to run smoothly?

I wanted to end our interview by asking you a few demographic questions.

1. What is your date of birth? (month/day/year) ___________________
3. How do you describe yourself?
   a. Caucasian/not Latino
   b. Asian
   c. African-American/not Latino
   d. Latino
   e. Native American
f. Other (please specify) _____________________

4. What is your current marital status?
   a. Never married
   b. Currently married
   c. Divorced, not remarried
   d. Widowed, not remarried
   e. Domestic partnership

5. What is your living situation?
   a. Alone
   b. With family
   c. With someone else
   d. Nursing facility

6. How did you pay for your hospital stay? (Check all that apply)
   __ Social Security
   __ Medicare
   __ Medicaid
   __ SSI/SSDI
   __ Veterans Pension
   __ Retirement benefits
   __ Other health insurance (i.e., Supplemental health or long term care)
   __ Other income
   ___ Unknown

7. Did finances affect your move from the hospital to home/NF?
   a. Yes
   b. No

8. Please explain
Primary Caregiver Interview Guide on Hospital Discharge Planning Process

23. I wanted to ask you about your family member’s (Use older adult’s name) recent hospital stay and the discharge from the hospital. Please tell me why the older adult was in the hospital.
24. In general, can you tell me what it was like for the older adult to go from the hospital to home/nursing facility (NF)?
25. Who was involved in the discharge planning process or move from the hospital to home/NF (physician, social worker, physical, speech or occupational therapist, nurse, pharmacist, dietician, ILC, AAA, or other)?
26. What did each person do?
27. How did each person view NAME’s health?
28. How did each person work with NAME on getting better?
29. At the time of discharge, how you view NAME’s health?
30. What had you hoped NAME would be able to do by the time NAME was ready to leave the hospital?
31. What plans were made for NAME’s discharge to home/NF?
32. How involved were you in NAME’s plan to leave the hospital?
33. Were there any major mix-ups or any confusion as NAME moved from the hospital to home/NF? Please describe.
34. What went well about the process?
35. What services were set up for NAME’s return to home or nursing home (e.g., home health, rehabilitation services, independent living services, homemaking, nursing care)?
36. Was NAME given service options to choose from?
37. Was NAME given too many service options?
38. Was NAME given too few service options?
39. Are you happy with the decision to return to home/enter NF?
40. Were the services set up by the hospital discharge planner helpful?
41. Did you receive a list or brochure of resources in the community?
42. Did you use any of those resources? Please explain.
43. What resources would have helped the discharge plans to run smoothly?

I wanted to end our interview by asking you a few demographic questions.

2. What is your relationship to NAME?

3. What is your date of birth? (month/day/year) ___________________


5. How do you describe yourself?
   g. Caucasian/not Latino
   h. Asian
   i. African-American/not Latino
   j. Latino
k. Native American
l. Other (please specify) ____________________

6. What is your current marital status?
   a. Never married
   b. Currently married
   c. Divorced, not remarried
   d. Widowed, not remarried
   e. Domestic partnership

7. What is your living situation?
   a. Alone
   b. With family
   c. With someone else
   d. Nursing facility

8. How did you pay for your hospital stay? (Check all that apply)
   __ Social Security
   __ Medicare
   __ Medicaid
   __ SSI/SSDI
   __ Veterans Pension
   __ Retirement benefits
   __ Other health insurance (i.e., Supplemental health or long term care)
   __ Other income
   __ Unknown

9. Did finances affect your move from the hospital to home/NF?
   e. Yes
   f. No

Please explain
Appendix D

Findings from Interviews with Medicaid-Eligible Older Adults who had Recently Discharged from a Hospital and their Primary Caregivers
Older Adult Interview Findings

**Reason for admission: Emergency or non-emergency**
#1 Emergency  
#2 Emergency  
#3 Emergency  
#4 Emergency  

**Hospital discharge process**  
#1 Went to routine outpatient physician appointment. Blood clot found and sent directly by physician to the hospital.  
#2 Began to have major difficulties walking and experienced sciatic nerve pain.  
#3 Had a stroke and went in because his right leg and arm didn’t have much control and his speech was slurred.  
#4 They thought she was having a heart attack, but it was a build up of mucus in her chest causing discomfort.  

**Satisfaction with discharge planning process (strengths or difficulties or confusion)**  
#1 No complaints, very satisfied and anxious to return home.  
#2 No complaints, discharge process ran smoothly.  
#3 No major complaints, although he mentioned not always understanding new medications and their purposes. Overall, he thought that it went well.  
#4 Her discharge was delayed about an hour so another doctor could look at her first. Nurse did not get her prescriptions to her on time so they had to be faxed to pharmacy. No major complaints though.  

**Goals met at time of discharge**  
#1 Goals were met and patient was able to walk.  
#2 Older adult was ready to be discharged from the hospital, but also stated that “No, I don’t feel healthy.”  
#3 Yes, goal met of being able to walk.  
#4 Yes, goal met of returning to normal activities. She already had a caregiver and homemaking services at her home.  

**Roles of all participants in discharge planning: Hospital staff**  
**Physicians**  
#1 Very involved, completed an assessment and discussed her treatment and discharge with older adult. Physician involved elder in the discharge process. #1 stated, “We just talk openly, but he [physician] does kind of sneak around and say, think you could rest good at home? Do you think this? Do you think that you could shower as good at home as you can up here?”  
#2 Physician gave order for discharge.  
#3 Installed a pacemaker, decided they “did what they could” and determined that he was ready to go home.
#4 “It was difficult to know who everyone was.” There were 2 doctors that she remembered, one came in daily and told her she was generally healthy and could leave.

**Nurses**

#1 Not directly discussed, but elder indicated that hospital staff (nursing) made sure that I was actually going home before they removed my IVs because I’m a hard “stick.”
#2 Older adult unsure of nursing role in discharge process.
#3 Present, although he did not comment on his/her actual role.
#4 Nurses were involved in hospital care, but not clear about role in discharge.

**Social Workers**

#1 Assessed elder’s home situation and equipment needs.
#2 Yes
#3 Doesn’t remember a social worker.
#4 Doesn’t remember this person, it all happened very fast.

**Rehabilitation Services (OT, PT, Speech)**

#1 although not directly related to pt’s discharge, the rehab staff helped pt gain back use of arms and strengthen legs.
#2 Physical therapists helped her strengthen walking.
#3 Therapists came in at least three times and said they had nothing to offer him because he was doing so well.
#4 Doesn’t remember this person, it all happened very fast.

**Pharmacist**

#1 Not involved.
#2 Not involved.
#3 Present, but he can’t remember her recommendations.
#4 Doesn’t remember this person, it all happened very fast.

**Dietician**

#1 Not involved.
#2 Not involved.
#3 Gave patient a paper to recommend a specific “heart healthy” diet.
#4 Doesn’t remember this person, it all happened very fast.

**AAA**

#1 Not involved and don’t know what it is
#2 Yes, has case manager who set her up with homemaking and home health services before admission and upon discharge from the hospital. However, the case manager increased the number of homemaking and home health service hours (so that elder would have someone coming into her home everyday) upon discharge from the hospital.
#3 No mention.
#4 Uses the “council on aging” all the time.
ILC
#1 Not involved and don’t know what it is.
#2 Not involved and don’t know what it is.
#3 Mentioned ILC, but not in relationship to this discharge.
#4 No mention.

Older adult participation in discharge planning
#1 Not directly discussed.
#2 Yes, she did think she was involved in the discharge.
#3 Involved, felt free to discuss his discharge.
#4 She helped select her discharge date by arranging her ride home.

Elder motivation to be discharged
#1 “I was happy to come home… and besides I have places to go.” “I have a big wedding to go to.” “I just have a happy environment to come home to and I think that helps a lot, because some people want to stay in the hospital.”
#2 “I was in there I think 12 days and I was anxious to get home.”
#3 “It was very thrilling, I think.” - the return home.
#4 “The hospital was very nice. The room was very nice. The people were very nice to me. But getting home is gorgeous.”

Caregiver participation in discharge planning
#1 She stated that she “did not want strangers in the house, because you are not as comfortable and we do have animals and we can just live normal.” Because of this desire to not have strangers in the home, the older adult and grandson came to an agreement that the grandson would provide caregiving. Her grandson, who is disabled, provides caregiving for the older adult, but was only minimally involved in discharge planning. He gets financially reimbursed to provide for all of her caregiving, e.g., physical therapy, transportation, and medication management.
#2 Caregiver is a paid professional and family participation in discharge planning is unknown.
#3 Mentioned that his wife is and can care for him, no other mention of her involvement.
#4 Not directly mentioned. He provided her transportation.

Services and resources
#1 Elder given options for resources and given more than enough resources. She was not given a brochure of resources, but was verbally provided this information.
#2 Elder given option for resources and given an appropriate amount. Older adult said the amount of resources was “just right.” Elder was not given a brochure of resources.
#3 Doesn’t know if he received a list, but he has used resource lists in the past.
#4 No list provided.

Demographics
Age: Range 67 to 85 years of age
Gender: Three women and one man
Marital status: Two widowed, one divorced and never married, one married
Living situation: Two lived with family, two lived alone
How did you pay for your hospital stay? All were on Medicaid and Medicare
Did finances affect your discharge? It did not affect any participant’s discharge

Caregiver Interview Findings

Hospital discharge process
#1 “It was more of a spur of the [moment]. She went in for something else, and the
doctor…found a blood clot, so it was unexpected.” While the older adult was in the
hospital they gave her medicine to dissolve the clot.
#2 “She couldn’t walk one morning when we came over….We called the ambulance and
they just took her to the hospital and she was in a lot of pain, too, in her back.”
#3 Patient at home and had a stroke. Admitted to the hospital and was assessed to need a
pacemaker which was also put in during the hospitalization and patient was started on
Coumadin.
#4 Family was concerned that mom had had a heart attack and they had her admitted into
the hospital where cardiac tests found out she did not have a heart attack. Son
indicated that mom has had several long stays in the hospital – and at one point was in
a nursing home after a long hospital stay – and so this hospitalization was “easy” in
comparison.

Satisfaction with discharge planning process
#1 No complaints and grandson was satisfied with the discharge planning process.
#2 No complaints and family caregiver said, “I think they [hospital staff] did their best.
The doctor was…pretty attentive.” The caregiver further stated, “It is very important
that these people [older adults being discharged from the hospital] get home care. It
does keep them out of the nursing home and I think they’re more satisfied – physically
and mentally. I mean I see it.”
#3 No complaints, very satisfied with discharge planning process.
#4 Son was basically satisfied, but there were issues with the fact that they couldn’t get
patient’s medications until the day after discharge – and hospital lost patient’s clothes.
Hospital helped set up the older adult with two gowns so that son didn’t have to make
an extra trip to bring the elder clothes.

Goals met at time of discharge
#1 At the time of discharge, grandson stated that although the older adult’s blood clot had
completely gone away, the elder “looked a lot better. She did. She…looked like she
was ready to get out of the hospital.”
#2 Goals were somewhat met. Family caregiver stated that the older adult is “fair. Not
real good, but we were going to try it [to be discharged from the hospital] anyways and
it worked out okay.” Furthermore, the caregiver wanted the older adult to be able to
“walk, get out of bed and go to the bathroom” before being discharged from the
hospital.
#3 Goals were not discussed by the family member.
Yes, the goals were met and patient was finally able to have the heart catheterization – after waiting four days due to difficulties with ongoing infections.

**Roles of all participants in discharge planning: Hospital staff**

**Physicians**

#1 “I have no idea whom any of the people were.” The staff did not formally introduce themselves to this grandson who is a formal, paid caregiver through the state for his grandmother. “Nobody really told me much at all when she was in there [the hospital].”

#2 Elder interrupted the family interview to say, “The total time that I was in the hospital, I had so many doctors in and out that I didn’t know who to believe.”

Family member not directly involved in discharge. She knows physicians were involved, but not the specific details.

#3 He placed the discharge order.

#4 Physician gave the order for the discharge.

**Nurses**

#1 “I have no idea whom any of the people were.” The staff did not formally introduce themselves to this grandson who is a formal, paid caregiver through the state for his grandmother.

#2 Probably, but does not know specific details.

#3 Pt and spouse health education. “They made sure that we understood what we needed to do at home [in regard to the pacemaker].”

#4 Nurses were the ones mostly involved in the discharge. For example, the hospital lost the patient’s clothes and nurses set up the older adult with two gowns so that she could go home without the son having to make an extra trip to the hospital to bring her clothes.

**Social Workers**

#1 “I have no idea whom any of the people were.” The staff did not formally introduce themselves to this grandson who is a formal, paid caregiver through the state for his grandmother.

#2 Family member not directly involved in discharge. She knows social workers were involved, but not the specific details.

#3 Assessed elder’s needs, but no intervention necessary.

#4 Not involved.

**Rehabilitation Services (OT, PT, Speech)**

#1 “I have no idea whom any of the people were.” The staff did not formally introduce themselves to this grandson who is a formal, paid caregiver through the state for his grandmother.

#2 Family member not directly involved in discharge. She knows physical therapists were involved, but not the specific details.

#3 Worked with the patient on walking, dressing, tying shoes after the stroke. #3 stated, “So physical therapy and occupational therapy was making sure he could walk and dress himself.”
#4 Not involved.

**Pharmacist**

#1 “I have no idea whom any of the people were.” The staff did not formally introduce themselves to this grandson who is a formal, paid caregiver through the state for his grandmother.

#2 To family member’s knowledge, not involved.

#3 Not involved.

#4 Pharmacist didn’t get prescriptions to the older adult before her discharge. Family had to obtain medications the next day after discharge from hospital.

**Dietician**

#1 “I have no idea whom any of the people were.” The staff did not formally introduce themselves to this grandson who is a formal, paid caregiver through the state for his grandmother.

#2 To family member’s knowledge, not involved.

#3 Not involved.

#4 Not involved.

**AAA**

#1 “I have no idea whom any of the people were.” The staff did not formally introduce themselves to this grandson who is a formal, paid caregiver through the state for his grandmother.

#2 Family caregiver made positive remarks about the AAA case manager’s role in the older adult’s discharge from the hospital. The caregiver stated, “he [the AAA case manager] is real good about coming by and he’ll visit with her on the phone. He’s real good.” The older adult chimed in and stated, “[He, the case manager] lives right out there [older adult points] and he just stops in to see how I’m doing.”

#3 Not involved and doesn’t know what it is.

#4 First indicated that AAA was not involved, but then later mentioned mom received Meals on Wheels and a homemaker and had these services before the hospital admission and they were set up immediately upon her discharge to home.

**ILC**

#1 “I have no idea whom any of the people were.” The staff did not formally introduce themselves to this grandson who is a formal, paid caregiver through the state for his grandmother.

#2 Not involved.

#3 Not involved and don’t know what it is.

#4 Not involved and don’t know what it is.

**Family participation in discharge planning**

#1 “Nobody really told me much at all when she was in there [the hospital]. And, grandson indicated, “I would have like a little bit more information so I would know what was going on with her…She sometimes doesn’t understand or hear things right,
so I would appreciate it if they would have gave me a little bit of insight of what’s going on with her… I’ve got to go by what she says.”

“There are no nurses or anything… She [occupational therapist] taught me how to do every[thing]… to do her massage to get the fluid moving [lymphatic drainage].”

#2 Family caregiver was not involved
#3 She was at the hospital every day and it appeared that she was satisfied with her involvement in the discharge.
#4 Son does not have a vehicle that his mom, the older adult, can get into (she is very overweight) and so he paid for a rental vehicle to bring her back home upon discharge from the hospital.

**Services and resources**

#1 Grandson was given options and the appropriate amount of resources. He was not given a brochure of resources. When asked if plans made for any home-based services upon the elder’s discharge, the grandson replied, “Yeah, that’s pretty much, I mean, that’s kind of my job right now.” The only thing the hospital did was discuss Life Alert with the grandson.

#2 Family caregiver given options for resources and given appropriate amount of resources. She was given a brochure of resources.

#3 Family given options for resources and given appropriate amount of resources. She was not given a brochure of resources.

#4 Son indicates he was given options for services and given appropriate amount of resources. He was not given a brochure of resources. Son indicated “someone is in mom’s home Monday through Friday”!

**Demographics**

Relationship to older adult: Two caregivers were family members (son, grandson); one caregiver provided professional care to the elder; one was a spousal caregiver.

Gender: Two men and two women
Appendix E

Dataset Review Tool for the Identification of Data Fields Relevant to Long Term Care Policy and Services
Data Fields Relevant to Long Term Care Policy and Services

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**COMMUNITY TENURE**

| Choice for LTC (Home w/ serv, home w/o serv, ALF, resid, board, NF) | x | | |
| LTC less than 90 days | x | | |
| NF Address & zip | x | | |
| Considering NF Placement | x | | |
| Additional needs-Assist Living | x | | |
| LTC Threshold | | x | |
| On HCBS-FE prior to 7/2000 | x | | |
| HCBS-PD transfer | x | | |
| Type of Res. | | x | |
| Accessibility-Home | x | | |
| Home amenities/features (elect, flush toilet, hot/cold H2O) | x | | |
| Does home have health safety issues? | x | | |
| Do you feel safe? Comments | x | | |
| Recc changes to living situations | x | | |
| Residential history 5 yrs prior | | x | |
| Discharge potential | | x | |
| > Pref to return to community | x | | |
| > Support person wants discharge | x | | |
| > Short stay anticipated | x | | |
| Level of self-sufficiency | | x | |
| Who participated in assessment | | x | |

**NF**

<p>| Date of entry | x | | |
| Admitted from | x | | |
| Date assessment completed | | x | |</p>
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