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

Real Choice Project:
Referral System Assessment

Final Report
2007

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Statewide Independent Living Council of Kansas (SILCK)

We would like to express our tremendous appreciation to the very busy hospital discharge planners and staff members from Area Agencies on Aging and Independent Living Centers across the state who took the time to participate in lengthy interviews and focus groups. Without their involvement, and the support of their respective agencies, this project would not have been possible.
# Table of Contents

Acknowledgements ........................................................................................................................................ ii

Table of Contents ........................................................................................................................................ iii

Executive Summary ........................................................................................................................................ iv

Introduction ................................................................................................................................................ 1  
  Project Purpose ....................................................................................................................................... 1  
  Background and Rationale ..................................................................................................................... 1

Real Choice Project Design ...................................................................................................................... 5

Findings .................................................................................................................................................... 7  
  Description of Discharge Planning in Kansas Hospitals ........................................................................ 7  
  Key Players in Hospital Discharge Planning Processes ........................................................................ 15  
  Referral Processes in Hospital Discharge Planning .............................................................................. 19  
  Identification of Barriers and Best Practices in Discharge Planning Processes .................................... 24  
  Training and Continuing Education ...................................................................................................... 35

Recommendations ..................................................................................................................................... 38  
  Recommendations that Focus on Structural and Systemic Issues ...................................................... 38  
  Recommendations that Focus on the Hospital Intake Process .............................................................. 40  
  Recommendations that Focus on Screening and Assessment Processes ........................................... 40  
  Recommendations that Focus on the Role of Physicians ..................................................................... 41  
  Recommendations that Focus on the Role of Hospital Discharge Planners ......................................... 42  
  Recommendations that Focus on the Role of AAAs and ILCs ............................................................. 42  
  Recommendations that Focus on the Role of Consumers and Their Family Members ........................ 43  
  Recommendations that Focus on Trainers at Hospitals, AAAs, and ILCs ............................................ 44  
  Recommendations from the Panel of Expert Consultants ..................................................................... 44

Conclusions .............................................................................................................................................. 45

References ................................................................................................................................................. 48

Appendix A:  Study Design & Methodology ............................................................................................. 50  
Appendix B:  Focus Groups ..................................................................................................................... 59  
Appendix C:  Real Choice Panel of Expert Consultants .......................................................................... 61  
Appendix D:  Project Recommendations ................................................................................................. 63
Executive Summary

Maximizing choice is an avenue for supporting independence and honoring our citizen’s health care preferences. Strengthening the linkages between hospital discharge planning and home and community based services is one method of increasing choices that lead to independence. When consumers have increased choice in post-hospital care settings, they prefer to return home following a hospital stay with support services rather than enter an institutionalized setting, ultimately saving money for themselves, taxpayers, and insurance companies.

Kansas Department of Social and Rehabilitation Services (SRS) contracted with the University of Kansas School of Social Welfare’s Office of Aging & Long Term Care (OALTC) to conduct the “Real Choice Project: Referral System Assessment.” The purpose of this 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 through:

- Increased understanding of the hospital discharge planning process;
- Identification of barriers to choice in care settings after discharge;
- Identification of strategies to overcome barriers and enhance best practices to increase choice;
- Identification of methods for effective dissemination of successful practices and barriers to choice in care settings after hospital discharge.

The Real Choice Project conducted telephone surveys with a representative sample of Kansas hospitals and achieved a 93% response rate (Phase I). Phase II interviews were conducted with representatives from 100% of AAAs, 100% of targeted hospitals, and 92% of ILCs. Our research team also conducted four focus groups across the state (Phase III), which confirmed and provided additional detail to project findings and recommendations. A panel of expert consultants provided guidance throughout all stages of the project (see Appendix C in the report for panel membership). Findings related to selected research questions are highlighted below. Please see the full document for a complete report of project results.

What is the organizational structure of hospital discharge planning within Kansas hospitals?

The description of the organizational structure within which hospital discharge planning occurs encompasses hospital and community characteristics as well as credentials and job responsibilities of hospital discharge planners. Hospital discharge planning is structured differently across a diverse range of Kansas hospitals that varies by hospital size, geographic location, population density, ownership, credentials of the discharge planners, and caseload. Hospital employees who work in hospital discharge planning tend to be social workers or nurses with bachelor’s or master’s degrees. Of the 43 hospitals that participated in our telephone survey, 35% currently employ social workers, 35% nurses, and 30% either both nurses and social workers or a team approach to hospital discharge planning. Specific job responsibilities among Kansas discharge planners reflect commonalities across hospitals in the many tasks and activities performed. Discharge planners noted that making referrals, patient teaching, helping with
financial issues, assessment, counseling, and coordination activities were prominent discharge planning functions.

**How do hospitals, AAAs, and ILCs describe hospital discharge planning processes?**

Hospital discharge planners identified common processes across many Kansas hospitals. 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. Generally, workers from AAAs and ILCs each described hospital discharge planning from their perspectives in a similar manner. Typically, AAAs and ILCs were brought into the process “too late” through a referral from a hospital discharge planner, the consumer or family member, or a third party such as food programs or home health services.

**Who are key players in the hospital discharge planning process?**

A wide variety of key players were reported by discharge planners and workers from AAAs and ILCs as participating in hospital discharge planning processes. This included the older adult or younger adult with a disability, hospital social workers, nurse case managers, physicians, home health services, health department, family and friends, insurance companies, therapies such as occupational or physical therapy, admission nurses, and staff members at rehabilitation facilities. Hospital workers tended to identify key players who work within the hospital setting, while community-based agencies seemed to more often identify key players from other community-based settings.

**How are AAAs and ILCs involved in discharge referral processes?**

Hospital discharge planners might not be brought into the planning process for every patient. Many hospitals conduct a screening at intake to identify the need for a “social services” referral, which referred to the within-hospital assignment of the consumer to the hospital discharge planner. Hospital discharge planners, AAA providers, and ILC staff overwhelmingly concurred that hospital discharge planning should begin upon admission. Of the hospital discharge planners, 91% reported making referrals to AAAs and 86% reported making referrals to ILCs. Some comments from a few hospital discharge planners implied a lack of awareness of the full role that AAAs and ILCs play in providing services that allow consumers to return home with supports following a hospital stay. Some discharge planners specifically requested additional training regarding community resources.
What are barriers to effective hospital discharge planning?

Barriers to effective discharge planning were related to structural or policy issues, or day to day aspects of discharge planning. From the perspective of study participants, addressing these issues would increase the number of people able to return home following an acute care hospital stay and would allow staff members to do their jobs in a more efficient manner. A brief listing of selected barriers follows:

- **Structural issues**: These barriers included finances (i.e., program funding, insurance coverage), access to services (i.e., housing, human resources, rural issues), transportation (i.e., to needed services), and administrative processes (i.e., time to determine eligibility, waiting lists, time needed to set up services, hours of operation).

- **Timing of referrals**: These emerged as a barrier in two ways: 1) hospital discharge planners experienced delays in getting referrals from physicians, and 2) community-based workers experienced delays in getting referrals from hospital discharge planners.

- **Communication**: One set of concerns was that consumers or family members did not always share information about pre-existing conditions or current services. Communication with physicians was problematic at times, and inconsistent interpretation of HIPAA guidelines was also cited as a barrier to communication.

- **Medical complexity**: Study respondents perceived that the medical conditions of hospitalized older adults and younger adults with disabilities were becoming increasingly complex. This led to barriers related to the level of severity of the medical condition and time needed to educate others in the use of medical equipment or assistive technology.

- **Conceptual approach**: Two themes emerged that centered on the service provider’s philosophical or conceptual approach to hospital discharge planning. The first theme related to the “medical model” and stemmed from the differing training programs that physicians, hospital discharge planners, and community-based workers attended. The second theme related to safety versus independence and referred to workers being placed in situations where they were balancing potentially conflicting roles—to maintain the consumer’s health/ prevent rehospitalization, and to follow through with the consumers’ first choice for post-hospital care settings.

What are recommendations for systems change?

This study 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. See Appendix D of the report for a full listing of project recommendations; a few abbreviated examples are presented below:
• Streamline program eligibility processes to enable services to be in place upon dismissal from the hospital.

• Work with hospital intake procedures to identify consumers who are receiving home and community based services or may be eligible for SRS services; notify AAAs and ILCs as soon as possible.

• To help ensure that services are in place as soon as possible, complete the UAI and other screenings while the consumer is still in the hospital.

• Develop a model program for people not eligible for Medicaid but who are in danger of spending down to eligibility status if they do not receive support to return home following an acute care hospital stay.

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

• Provide dedicated time and structured opportunities for employees to network and learn about community resources.

• Conduct concerted outreach so that the local hospital discharge planners and workers from the AAA and ILC are able to determine effective referral strategies.

• Encourage hospital discharge planners to routinely make rounds with physicians to improve communication.

A consistent thread throughout the barriers identified by this study was time. Time constraints were attributed to shorter hospital stays, referrals and discharge notices made too late in the process, and large caseloads. Dedicated time is needed for assessments to allow a good rapport between the discharge planner and consumer. This includes time to fully (and repeatedly) explain service options and include family members in the process as appropriate. Time is needed to make referrals, which entail inevitable rounds of phone calls. And time is needed for networking and keeping abreast of local resources and changing program requirements. In addition to barriers, numerous best practices and suggested strategies for overcoming barriers were identified. Again, dedicated time is one of the barriers to implementing these strategies. For example, as seen in the description of administrative processes as a structural barrier the advent of shorter and shorter hospital stays poses additional time barriers. With a three to four day hospital stay and a discharge planning process that typically takes multiple days to complete-- even with the best case scenario of referrals made to community agencies on the day of hospital admission, there will still be situations when someone will be discharged before home and community based services are in place.

Some of the recommendations made by discharge planners, AAA case managers and ILC counselors focused on interactions with key players in the discharge planning process. For example, one recommendation was to train physicians in discharge planning in order to increase their understanding of the various roles that discharge planners and community-based service
providers play. Physician training programs should also increase physician awareness about community-based options for post-hospital care. The importance of including consumers and family members in the process is recognized, but there were multiple barriers to their full participation, including short hospital stays, the consumer not feeling well, consumer’s resistance to utilizing support services, medication side effects, and the complexity and rapidly changing status of the consumer’s condition. Effective follow up on these issues will require input from the perspectives of consumers and their family members—something that was outside the scope of the current study.

Respondents in this study indicated that increasing consumer choice by targeting specific aspects of hospital discharge planning systems is feasible and likely to be effective. These specific recommendations are briefly described in the bullets previously listed and detailed in the full report. Therefore, it is anticipated that following through with the provided recommendations will result in desired change. Continued attention to efforts to increase choice for older adults and younger adults with disabilities will make it possible to have their long-term care needs met in the setting they prefer.
The University of Kansas School of Social Welfare  
Office of Aging and Long Term Care  
Real Choice Project: Referral System Assessment  
Final Report, August 2007

Introduction

Project Purpose

This research was conducted as part of the federal Real Choice Initiative. The Kansas Department of Social and Rehabilitation Services (SRS) is the administrator of funds for this initiative in Kansas. SRS contracted with the University of Kansas School of Social Welfare’s Office of Aging & Long Term Care (OALTC) to conduct the “Real Choice Project: Referral System Assessment.” The purpose of this 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 through:

- Increased understanding of the hospital discharge planning process  
- Identification of barriers to choice in care settings after discharge  
- Identification of strategies to overcome barriers and enhance best practices to increase choice  
- Identification of methods for effective dissemination of successful practices and barriers to choice in care settings after hospital discharge.

Background and Rationale

Home and community based services are one option to allow older adults and younger adults with disabilities to live in their residential setting of choice—at home. Real Choice funds are available to states through the federal New Freedom Initiative. Kansas has implemented multiple programs with these funds. The current project builds on the CARE Enhancement Project, a pilot project which was funded by Real Choice funds. The North Central-Flint Hills Area Agency on Aging conducted this pilot project that provided enhanced case management in two hospital-based sites. Hospitals in Emporia and Council Grove represented urban and rural settings, respectively. The project’s final report identified the need to: 1) inform medical professionals about home and community based services, and 2) include case managers from AAAs home and community based services earlier in the hospital discharge planning process. Other Real Choice initiatives include a Links for Living public relations campaign, community capacity building activities in targeted areas of the state, and a major systems transformation project which is being managed through the Self-Help Network in Wichita.

Based on the information and experience from previous Real Choice initiatives, the state recognized the need to better understand the diverse models for hospital discharge planning across Kansas hospitals; the referral processes between hospitals, Area Agencies on Aging (AAAs), and Independent Living Centers (ILCs); barriers to effective hospital discharge planning for older adults and younger adults with disabilities; and effective practices to overcome these barriers. To this end, the Department of Social and Rehabilitative Services
subcontracted with the OALTC to collect data from hospitals, AAAs, and ILCs to fill this information gap and to make recommendations to increase choice in care settings for older adults and younger adults with disabilities who are discharging from hospitals.

Choice is closely linked to, and may be considered a surrogate for, independence. The loss of independence is a primary concern for older adults and younger adults with disabilities, and the preservation or enhancement of independence has been cited as the desired outcome of home and community-based services (Gibson, 2003; Harlton, N., & Fast, 1998). Studies have documented the perspective of consumers on aspects of independence that are related to their living arrangements (e.g., Hammer, 1999; Mack, Salmoni, Viverais-Dressler, Porter, & Garg, 1997; Petry, 2003) with one sample of older adults noting that a move to a nursing home meant loss of control, independence, and sense of self (Forbes & Hoffart, 1998). As a primary value of the Independent Living Movement, independence is a complex conception that stresses living in the community. Community participation encompasses full participation as a citizen in those activities that are available to others (Frieden & Cole, 1985; Kennedy, 2002). Consistent with life course theory, the advent of a health crisis that results in an acute care hospital stay presents a threat to consumers’ ability to remain living in their community home (Sergeant, 2006).

Maximizing choice is an avenue for instigating independence, especially as pertaining to societal-level civil rights and community-based services. From the perspective of the Independent Living Movement, the function of services is to facilitate independence, with specific goals of consumer control through choice and participation in community-based living (Cohen, 1992; Frieden & Cole, 1985). Innovative service options increase the available choices in one’s environment (Frieden & Cole, 1985) and strengthening the linkages between hospital discharge planning and home and community based services is one method of increasing choice. When consumers have increased choice in post-hospital care settings, they prefer to return home with support services rather than enter an institutionalized setting. Chapin and colleagues (2002) compared similar groups of older adults who had applied for admission to a nursing facility. One group entered institutionalized care, and the other was diverted to the community with home and community based services (Chapin et al., 2002). Overall, they found that the diverted cohort was successfully able to maintain community tenure. Through the 15th month of the study, the majority (53%) of diverted older adults was residing in the community, and approximately 18% were still residing in the community after 60 months. Each diversion from an institutional placement, in turn, potentially saves taxpayer money in the form of state Medicaid expenditures. For example, the Kansas Department on Aging reported that 17% of older adults who applied for admission to a nursing facility were diverted from a nursing facility placement in 2006, resulting in an estimated savings of 21 million dollars. Therefore, as this study identifies strategies to enhance the hospital discharge planning process and referral system to home and community based services, it is anticipated that increased consumer choice will result in additional diversions back to the community.

As one of the first steps in this project, we explored existing literature to identify previous work which would inform our research design. Information from the literature review informed the development of the survey and interview questions, identified potential barriers to choice in hospital care settings, and suggested strategies to overcome those barriers and increase choice in care settings. We learned that our study is unique in that we explore hospital discharge planning
practices across an entire state. In addition, our study examines the referral process from the hospital to community-based agencies and includes the perspective of home and community-based service providers; this focus is not prevalent among the existing literature. This state-wide focus and documentation of multiple perspectives resulted in the identification of a broader range of issues than is possible in many studies. For example, Backer, Howard, and Moran (2007) examine innovative methods utilized by different states in preventing homelessness among populations who are discharged from hospitals. In our study, homelessness is only one of the issues explored and housing issues comprise only one subset of resulting recommendations.

Per the literature, the aim of effective discharge planning from the hospitals perspective is to reduce the number of days that are spent in the hospital while simultaneously reducing the readmission and acute care admission rates (Minichello, Auerbach, & Wachter, 2001). Achieving this aim may either be advantageous for consumers in hospitals or cause further difficulty for them. It is particularly interesting to note how discharge planning policies may affect older adults and the people with disabilities as part of at-risk populations. LeClerc, Well, Craig, and Wilson (2002) found that older adults are discharged from hospitals even though they may still be sick as a part of the cost containment effort within hospitals. There appears to be an ignorance of the struggles that consumers may face in their lives post-discharge because of acute health circumstances or disability. Participants in the study faced intense physical and emotional needs and a difficult social and physical recovery process (LeClerc, Wells, Craig, & Wilson, 2002). According to Feather (1993), existing payment and insurance plans may put pressure on hospitals to discharge patients before a proper discharge plan is prepared for a patient. It is possible that changing insurance policies play a role as well. One aim of discharge planning is purported to be making the transition to the home more safe and effective. However, this goal may be becoming more and more difficult to achieve in light of changes in hospital and insurance policies.

**Barriers to Effective Discharge Planning**

Not many studies have been conducted on discharge planning within hospitals and their effectiveness (Watts, Pierson & Gardner, 2006). According to Walker, Hogstel, and Curry (2007), there are several factors that can influence discharge planning within a hospital. Some of these are age at hospital admission, patient readmission rates, and insurance provision. In a study with nurses who carried out discharge planning within hospitals key barriers to effective discharge planning were identified (Watts, Pierson, & Gardner, 2006). Some of these were workload issues, inadequate communication, and a failure to adequately plan discharge. Around two-thirds of the nurses in the study said that they had difficulty in formulating a discharge plan due to inadequate information. Another study with caregivers of patients in hospitals identified inadequate communication to be a primary reason for untimely discharge (Minichello et al., 2001).

Timing has been identified as a barrier within the discharge planning process. One-third of nurses within one study believed that discharge planning should start pre-admission or upon admission (Watts et al., 2006). An equal number believed that the planning should start once the patient was in a stable condition. However, a study conducted by Dill (1995), found that often, the doctors give discharge planners short notice to actually plan the discharge. There appears to
be a lack of understanding about the time required to actually coordinate and plan post-discharge services for the consumer. It is very likely, in the case of community-based services, that the consumer may be discharged into the community before the services have actually been set up (Dill, 1995). Different hospital workers such as doctors, social workers, and nurses may have varying perceptions about the barriers in the discharge planning process, especially with regards to timing (Minichello et al., 2001). Physicians in this study identified the unavailability of sub acute care beds and lack of appropriate testing as the reasons for the untimely discharge of the patient.

Lack of active involvement by the consumer’s caregivers (i.e., family members) has been cited as another reason for ineffective discharge planning (LeClerc et al., 2002). However, in some cases over-involvement of family members in decision making processes may also cause a problem. Dill (1995) discusses issues of patient autonomy in the discharge planning process. Even if discharge planners do make arrangements for their transition to the community, older adults might not be sure of the exact nature of services that they are receiving. The discharge plans may not involve the older adult adequately and may not be effective due to this lack of involvement. Very often, family members may control discharge planning decisions and consumer choice may not necessarily figure in this decision making process, because discharge plans may be based on the psychosocial assessment of the patient’s medical and living condition and may not necessarily prioritize patient choice (Dill, 1995).

To summarize, barriers to effective discharge planning that have been reported in the literature include high workloads among discharge planners (Watts et al., 2006); ineffective communication between discharge planners and community based providers (Minichello et al., 2001); inadequate communication between physicians and discharge planners (Dill, 1995); lack of or excessive involvement of family members in the discharge planning process (LeClerc et al., 2002); issues surrounding patient autonomy and the discharge planners’ decisions with regard to patient safety (Dill, 1995); insurance issues (Feather, 1993) and timeliness of discharge (Minichello et al., 2001; Watts et al., 2006).

**Effective Discharge Planning and Increased Choice in Care Settings**

The literature also identified best practices for effective discharge planning. Communication between physicians, nurses, family, and community service providers is important to allow consumers to maintain their health and to ensure that their readmission rates to the hospital are low (Walker, Hogstel, & Curry, 2007). According to Backett, Howard, and Moran (2007), effective discharge planning which helps to link consumers to community resources can help the consumer get stable housing and have a higher quality of recovery and health. It is critical for hospital and social service organizations to coordinate services and plan consumer discharges together (Henry, 2006). Other suggestions for effective discharge planning are the use of an interdisciplinary team approach, effective communication within the hospital setting, promoting the role of the family in patient care, and maintaining the continuity of care by making adequate community referrals (Walker et al., 2007). Effective discharge planning may reduce readmission to the hospital and increase consumers’ length of time at home. In addition to the factors noted above, trained discharge planners with higher qualifications have been found to contribute to more effective discharge planning.
Steeman et al. (2006), rates of readmission and institutionalization were lower for older adults for whom discharge planning was carried out by social workers and trained case managers. Cooperation from the physician and staff within the hospital was also found to be an extremely important factor in effective discharge planning. The physician’s role is particularly important as the physician is responsible for signing the actual discharge order (Feather, 1993).

Overall, the literature identified barriers to discharge planning and factors that could contribute to more effective practices. The majority of these studies have not examined the perspectives of community based service providers. Also, studies tended to examine discharge planning for older adults while we also looked at younger adults with disabilities. In that sense, ours is truly a holistic study. One of the strategies to improve hospital discharge planning practices that emerges from the literature is an increase in effective communication in two areas: 1) between physician and discharge planners, and 2) between discharge planners and community based service providers (Walker et al., 2007). Other strategies include using an interdisciplinary team approach (Walker et al., 2007), increased training and qualification requirements for discharge planners (Steeman et al., 2006), and building adequate linkages within the community (Backer et al., 2007). This study will add to the literature base by providing a description of hospital discharge planning practices across a state that includes both urban and rural areas, identifying barriers and best practices related to choice in post-hospital care settings, and comparing perspectives of hospital discharge planners and community-based service providers on the process and referral practices.

Real Choice Project Design

This study provides an increased understanding of hospital discharge planning processes used across the state, identifies barriers to choice in care settings following discharge, identifies strategies and best practices to overcome barriers and increase choice, and identifies methods for effective dissemination to the target audiences. This was accomplished by answering the following research questions:

- What is the organizational structure of hospital discharge planning within Kansas hospitals?
- Who are hospital discharge planners in Kansas?
- Who are key players in the hospital discharge planning process?
- How are AAAs and ILCs involved in discharge referral processes?
- What are barriers to effective hospital discharge planning?
- What are best practices to overcome barriers?
- How do key players in hospital discharge planning processes prefer to receive training or additional information on best practices?
- What are recommendations for systems change?

Data for this project were gathered through a combination of qualitative and quantitative methods in three phases: 1) brief telephone surveys, 2) semi-structured telephone interviews, and 3) focus groups involving representatives from hospitals, AAAs, and ILCs. A complete description of the research design and methods for achieving project goals and objectives is...
included in Appendix A. A panel of expert consultants provided guidance throughout all stages of the project (see Appendix C for panel membership).

Real Choice project objectives delineate the major steps for gathering, analyzing, and interpreting data to answer the research questions. These objectives are listed in Table 1, along with information on the dates each were accomplished.

**Table 1: Progress towards program objectives**

<table>
<thead>
<tr>
<th>Obj. #</th>
<th>Objective</th>
<th>Progress</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Form a panel of expert consultants to provide project guidance.</td>
<td>Completed</td>
<td>See Appendix C for panel membership.</td>
</tr>
<tr>
<td>2</td>
<td>Conduct a telephone survey with a sample of hospital discharge planners from a variety of hospital types and geographic areas. (Phase I)</td>
<td>Completed</td>
<td>96% response rate. See Appendix A for full sample description.</td>
</tr>
<tr>
<td>3</td>
<td>Conduct telephone interviews with 6-12 Hospital Discharge Planners who represent a variety of hospital discharge processes. (Phase II)</td>
<td>Completed</td>
<td>100% of 13 targeted hospitals.</td>
</tr>
<tr>
<td>4</td>
<td>Conduct telephone interviews with case managers from AAAs. (Phase II)</td>
<td>Completed</td>
<td>100% of 11 targeted AAAs.</td>
</tr>
<tr>
<td>5</td>
<td>Conduct telephone interviews with independent living specialists/ counselors from ILCs. (Phase II)</td>
<td>Completed</td>
<td>92% of 13 targeted ILCs.</td>
</tr>
<tr>
<td>6</td>
<td>Convene 4 focus groups to reach consensus on best practices for hospital discharge planning in Kansas. (Phase III)</td>
<td>Completed</td>
<td>Kansas City (5/10/07) Hays (5/31/07) Wichita (7/12/07) SSWLHC¹ (7/20/07) See Appendix B for focus group descriptions.</td>
</tr>
<tr>
<td>7</td>
<td>Provide a written synthesis of relevant information to state policy-makers for purposes of decision-making for systems change.</td>
<td>Completed</td>
<td>Preliminary report submitted 6/6/07. Final report completed 9/14/07.</td>
</tr>
</tbody>
</table>

¹ Society for Social Work Leadership in Health Care, Sunflower Chapter
Findings

This report provides results in a question and answer format because we have found that state policy makers find this approach most helpful for drawing policy implications from our research.

Description of Discharge Planning in Kansas Hospitals

The description of discharge planning that emerged from this study is taken from the perspectives of hospital discharge planners and workers in community-based agencies (AAAs and ILCs). The information gathered provides a description of various titles of the hospital discharge planners and their supervisors, discharge planners’ credentials, their roles and job responsibilities, and annual caseloads. Additional information is provided on the similarities and differences in hospital discharge planning processes as reported by workers from hospitals, AAAs, and ILCs. This includes descriptions of the process itself and two themes that emerged from the analysis: 1) screening and assessment, and 2) differences in hospital discharge planning for older adults and younger adults with disabilities.

What is the Organizational Structure of Hospital Discharge Planning within Kansas Hospitals?

Representatives we interviewed from Kansas hospitals referred to hospital discharge planners by a myriad of position titles. These included: Discharge Planner Educator, Director of Case Management, Interim Social Services Discharge Planning Manager, Social Service Designee, Case Manager, and Social Worker. The amount of time spent in hospital discharge planning positions ranged from two to 18 years.

Those who perform discharge planning reported to individuals within the hospital organizational system who held a variety of titles including: Director of Nursing, RNC Director, Department Head, Senior Vice President, QA and Risk Management Manager, Chief Nursing Executive, Hospital Administrator, Director of Continuing Care, Director of Case Management, and CEO. In some hospitals, discharge planners were supervised by someone who did not work directly with older adults or younger adults with disabilities; in other hospitals, there was only one person who did hospital discharge planning and that person had multiple roles. The contrasts were striking. For example, some supervisors in large, urban hospitals reported that they supervised over 30 staff members who worked with the discharge planning process in some capacity; another nurse who worked in a small, rural hospital told us that in addition to nursing duties, she was the discharge planner plus the school nurse for the local school district. A discharge planner commented on the autonomy inherent in her position:

If I need to report to anyone, it would be the Director of Nursing. I am pretty well out there on my own. I just kind of do all the different things and don’t have to interact too often. But, occasionally if there’s a big concern, it would be the Director of Nursing.
Who are Hospital Discharge Planners in Kansas?

**Credentials.** Hospital employees who worked in hospital discharge planning tended to be social workers or nurses with bachelor’s or master’s degrees. Credentials of discharge planners varied widely and included: MSW, Licensed MSW, BSW and licensed BSW. Some social workers held MBA and Master’s in Gerontology degrees. Nursing credentials included RN and BSN. Some hospitals were structured so that nurses and social workers shared or divided discharge planning duties in various ways. For example, in one hospital the nurse oversaw issues related to medication and durable medical equipment while the social worker set up referrals to needed services; in another hospital the social workers worked specifically with patients with terminal or severe and chronic diagnoses while the nurses worked with patients that were more likely to be referred into community-based services. In the Phase I stratified random sample of the 43 hospitals we surveyed, 35% currently employed social workers, 35% nurses, and 30% both nurses and social workers or used a team approach for hospital discharge planning. (See Figure 1)

A comparison of hospital discharge planners’ credentials (e.g., social workers, nurses, or teams) with the size of the hospital (e.g., small, mid-sized, large)\(^2\) indicated statistically significant patterns ($\chi^2 = 22.385; p < .001$). As seen in Figure 2, 69% of smaller hospitals (i.e., 1-49 acute care beds) reported that nurses did their discharge planning. The majority (63%) of mid-sized hospitals (i.e., 50-99 beds) hired teams of discharge planners containing social workers, nurses, and occasionally others. Large hospitals (i.e., 100+ beds) reported using both social worker (55%) and team models (40%). While size of hospital was related to the credentials of hospital discharge planners on staff, the population density\(^3\) of the county in which the hospital was located was not statistically significant ($\chi^2 = 7.851; p > .05$). However, there was a trend ($p = .97$) towards greater numbers of rural and mixed density counties hiring

\(^2\) Based on data downloaded from the Kansas Hospital Association website.

\(^3\) Based on county population: Rural = <30,000; Mixed = 30,000 – 49,000; Urban = 50,000+; U.S. Census Bureau, Census 2000 Summary File 1.
nurses (50% and 44% respectively) to do discharge planning, while more urban areas reported hiring social workers (47%) or teams (47%). The credentials of hospital discharge planners were not related to type of hospital ownership ($\chi^2 = 7.568; p > .10$).

**Roles and job responsibilities.** Hospital discharge planners commented on the nature of their role in discharge planning, “My job is to see that our patients have everything they need or are able to have all their needs met when they return home.”

Another told us:

> A patient who has been living in a home by themselves and has a stroke and comes in, and maybe the neighbor is the one who found the person, and we have to do some research and digging trying to find people [next of kin].

Specific job responsibilities among Kansas hospital discharge planners reflected commonalities across hospitals in the many tasks and activities performed. Discharge planners noted that making referrals, patient teaching, helping with financial issues, assessment, counseling, and coordination activities were prominent discharge planning functions. Several discharge planners expressed that coordination and referrals were the most time consuming functions they performed. One hospital discharge planner referred to the time (she/he) devoted to discharge planning tasks, “I would say the organization of making things happen definitely is the largest.” Paperwork, documentation, and using computers are common tasks reported by discharge planners with one discharge planner noting, “I do a lot of paper work. Paper work, probably 95 percent of my time.”

While discharge planning was the primary role performed, hospital discharge planners with either nursing or social worker credentials also reported serving in multiple other capacities including utilization review, committee work (e.g., ethics, quality improvement), and involvement in risk management activities. Involvement with interdisciplinary teams was also identified as a discharge planning role. One discharge planner described this as, “We wear a bunch of different hats . . . ” and another told us, “We’re the magical, mystical miracle workers.”

**Caseload.** Estimates of the number of individuals on the discharge planner’s caseload who were being discharged from hospitals varied widely across interviewees. Questions about monthly caseloads were difficult for the discharge planners to answer. They were not used to tracking their workload in this manner. In general, reports of an average monthly caseload size ranged from five to seven for one discharge planner to 110 cases for another. One smaller hospital reported an average of 4 cases per month. Most discharge planners reported that their primary responsibility was to older adults, and that they spent the majority of their time with older people who comprised the largest proportion of their caseloads over the course of a year (ranging from 70% to 95%). Lower annual caseload proportions were reported for individuals with disabilities with estimates ranging from 10% to 30%. Given the problems that hospital discharge planners had with responding to the caseload questions, it is difficult to ascertain whether this summary is typical across Kansas hospitals. However, it is clear that caseloads vary widely from hospital to hospital, with implications for potential interventions.
These data on organizational structure of hospital discharge planning in Kansas indicate that staffing patterns for discharge planners vary from hospital to hospital. This has implications for the development of training plans, as discussed further in the section on training needs. The multi-faceted nature of the work done by hospital discharge planners has implications for barriers related to timing within the discharge planning process. Some of the tasks described, such as trying to locate family members, may take more time than anticipated. Timing issues are described in more detail in the section on barriers.

**How do Hospitals, AAAs, and ILCs Describe Hospital Discharge Planning Processes?**

Phase II interviews with hospital discharge planners identified some common processes across many discharge planning procedures. In general, the processes described to us 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. Concern for patient safety was a prominent theme throughout, especially for older adults. Respect for patient’s right to self-determination was commonly weighed against patient needs for safety, and sometimes posed an ethical dilemma for the discharge planner.

Some hospital discharge planners emphasized patient and family involvement in the discharge planning process and some described meeting the patient’s goals as a successful outcome, “Every patient has to be involved and informed.” Another discharge planner noted, “All the patients are included in their own discharge planning.” An emphasis on returning the patient to their home upon discharge was prominent across hospitals and was reported as happening frequently among patients who were discharged. Ongoing collaboration with community service providers was also cited by hospital discharge planners as serving to enhance the discharge process. While discharge planners described these common activities, their descriptions of the way the process unfolded and played out varied across hospitals. This seemed to depend on available community resources, the understanding of the discharge planner regarding these resources, and on the practices of the attending physician (additional information on the physician’s role is provided below). Strategies for improving choice in post-hospital care settings for older adults and younger adults with disabilities will need to be flexible in order to be tailored to the circumstances within each community.

Generally, workers from AAAs and ILCs described hospital discharge planning processes from their perspectives in a similar manner. Typically, AAAs and ILCs were brought into the process through a referral from a hospital discharge planner, the consumer or family member, or a third party service such as Meals on Wheels or home health services. Usually, referrals from hospitals were for consumers already receiving services but a few interviewees said they occasionally receive a referral for someone who needs an assessment to determine eligibility to enter the program. The next step in the process is to meet with the consumer and conduct an assessment. Ideally, this could take place in the hospital before the consumer returns
home, and is discussed in more detail in the section below on Screening and Assessment. Many of the community-based workers interviewed talked about the importance of including family members, and using the assessment to determine consumer preferences as well as needs. A few ILC workers mentioned conducting the assessment with the consumer in a rehabilitation center or in a nursing facility. At this point, case managers from AAAs talked about setting up a plan of care, setting up services, and doing required paperwork. Workers from ILCs described the process of setting up services and expressed additional concerns about the process being driven by the physician rather than the consumer.

Overall, the three entities represented by interviewees tended to describe a similar process. The hospital discharge planners placed more emphasis on the dynamics that occur within the hospital setting, and the role they play coordinating those efforts. Community-based workers began their descriptions of the process from the referral point—which they felt occurred too late in the process. The rest of this section provides information on certain aspects of the hospital discharge planning process: screening and assessment, differences between older adults and younger people with disabilities, and perceptions of the most important tasks. This is followed by sections on key players and the referral process.

Screening and assessment. Hospital discharge planners as a whole viewed screening and assessment as a vital part of the hospital discharge planning process and used a variety of means to accomplish these tasks. The assessment function was identified as providing an opportunity to build rapport with the consumer, to identify post-hospital discharge needs, and to develop a plan to connect consumers with community resources. Overall, respondents from hospitals, AAAs, and ILCs made positive or neutral comments about the required assessment tools, and the few negative comments received primarily came from the perspective of AAA case managers. By far, the majority of respondents perceived that the assessment was most effective if conducted in the hospital before the consumer was discharged.

Discharge planners emphasized the importance of a comprehensive bio-psycho-social assessment which commonly included assessment of patient cognitive and emotional status, physical functioning, living situation, formal and informal supports, needs for assisted technology and home modifications, advanced directives, and spiritual concerns. Some hospital discharge planners relied on other team members such as physical therapists to provide a more in-depth assessment of patient needs in the discharge planning process. A few hospital discharge planners undertook the role of CARE Assessor and performed CARE Assessments to screen for potential post-hospital nursing home discharge.

A variety of means were employed by hospital discharge planners in screening and assessment for hospital discharge. A number of hospitals used computers and computerized screening and assessment software (two used “Canopy” software). The use of computers with consumers was noted by one hospital discharge planner to pose a barrier between the patient and the discharge planner, “You can’t look at their face while you’re working with a computer and get their reaction when you ask them questions.” Others relied on chart review and admission criteria to guide the discharge process, as well as nursing database assessments which provided information derived from specific screening questions. Other discharge planners noted the use of various assessment tools and forms they have developed.
Like hospital discharge planners, workers from AAAs and ILCs reflected on the importance of a comprehensive assessment for home and community based services upon hospital discharge in meeting the client’s post-hospital discharge needs. Both agencies mentioned using the Uniform Assessment Instrument (UAI) which was sometimes done in conjunction with a CARE Assessment (CARE) to screen for potential placement in a nursing facility. During both interviews and focus groups, community-based workers expressed the desire to be brought into the hospital discharge planning process sooner, in part so the required assessments could be conducted at the hospital before the consumer returns home or to an alternative placement.

The community-based workers from both AAAs and ILCs discussed the roles that the assessment plays in gathering vital information necessary to have appropriate services in place once the consumer returns home. An AAA case manager explained the process:

_I see the person at the hospital most usually before they go home when possible. And I do my total assessment there and the hospital gives me basic information, their resource sheet, and also their discharge medication so that I know what medication, etc., that the person is going home on. And I do the complete assessment with them._

One role the assessment played was to document need for services. Workers from ILCs tended to describe the importance of ongoing assessments that were highly individualized. They distinguished between formal assessments needed to determine service eligibility and more informal assessments for other types of support:

_To get them qualified for in-home supports, we do a set-in-stone assessment. If we’re not looking at getting them involved in services at home and we’re looking at other things, it’s more of an informal data collection._

The assessment process also provided an opportunity to educate the consumer regarding post hospital service options. In some cases this involved counseling to assist the consumer in understanding potential outcomes of the event that led to the hospital stay, and acceptance of the need for post hospital services. An AAA case manager explained:

_It’s a huge amount of information we’re trying to impart . . . And then trying to do the ten-page assessment, and that kind of thing. And they’re not feeling well, to boot, plus just dealing with the aging issues. You know, accepting the reality that some services are going to need to be done, and all of that. Discharge occurs so rapidly that there isn’t a lot of time for the party to process what’s going on._

A worker at an ILC expressed a similar sentiment and described how the assessment process may be used to introduce the idea of different services that are available:

_Even if they say I don’t need that kind of service, or I don’t need somebody to come in and help me with bathing or whatever, and as you start talking, ‘Well, you know, if you_
maybe use this or maybe if this were available to you, then maybe those things would happen less and maybe you wouldn’t forget to pay the rent or maybe you wouldn’t have falls.’

Some AAA case managers volunteered information on the length of time it takes to complete the assessment, noting that the entire assessment may take from 30 minutes up to two hours to complete, and adding that paperwork requirements to the process can bring the total time up to 4 hours for a consumer who was not previously receiving services. According to the 2006 CARE Annual Report, the average time to fully complete a Level I CARE assessment, which is conducted with consumers who are considering placement in a nursing facility, was about three working days. This poses challenges when, as respondents reported, the average hospital stay is 3-4 days.

Community-based workers from AAAs and ILCs gave several reasons why an assessment conducted with someone who is in the hospital may take longer than a typical assessment in the community. Some of these reasons were related to the state of the hospitalized consumer himself or herself (e.g., not feeling well, processing everything that is happening, taking medication, psychological acceptance of the need for services). Other things that contributed to a longer assessment time included an assessment with someone who did not previously receive services, meeting with family members who may be arriving from out of town, following up the UAI with additional assessments, cognitive decline due to dementia or memory problems, and the need for counseling mentioned above. In spite of these issues with the additional time it may take to conduct an assessment with the consumer while he or she is still in the hospital, the need to increase the opportunity to conduct the assessment at the hospital emerged as a strongly supported recommendation. Some workers from AAAs and ILCs had developed strategies to work around these time issues. They told us they conducted an initial assessment at the hospital, with a follow-up once the consumer returned home; this strategy helped when faced with short hospital stays and rapidly changing health conditions. One AAA case manager described an assessment with a hospitalized consumer who had experienced a significant change in condition:

Where it gets tricky is if they’ve had a substantial change. . . . Unfortunately, with as fast as it[the hospital stay] goes, a lot of times I have to make those changes just based on a phone assessment instead of an actual in-person assessment. Then I usually follow up at home pretty soon after they leave.

Many hospital discharge planners and community-based workers expressed interest in working together to conduct needed assessments before the consumer leaves the hospital. However, care should be taken to address issues such as short hospital stays, medication side effects, rapidly changing consumer condition, and ability to function in the home versus the hospital setting. Suggestions included beginning the assessment in the hospital and finishing it at home, or completing the assessment while the consumer was in the hospital, and updating it later in the home setting. As some locations have already implemented these strategies with success, structured opportunities where these service providers share their strategies with others may be an effective way to instigate change. It should be noted that these strategies, while considered by
most to be potentially effective, will require additional time commitments on the part of the consumer and the assessor.

**Differences between older adults and younger adults with disabilities.** Many hospital discharge planners reported differences among older adults and younger individuals with disabilities with respect to hospital discharge planning. While common discharge planning tasks such as assessment and care planning remained consistent for the two groups, several discharge planners perceived differences in resource needs, agencies, and services between the two populations, largely based on differences in patient needs:

Yes, they have similar needs but the situation and dynamics are different. Assessments cover the same general categories, but we individualize. For example, the effects of polypharmacy on older adults is different than with a younger person.

There are consistent similarities in the elderly and you just have a real pattern of services that are available for them. It’s the very unusual cases of disabilities that maybe you don’t have the qualified people to help. That’s the difference. Sometimes you need more qualified people to do the service.

Some discharge planners expressed that younger patients were more engaged in planning, took more responsibility for their care, or were more motivated to return to work and to be independent. A few comments from hospital discharge planners noted what they perceived as differences in the service systems that target older adults and younger adults with disabilities. It is possible that consumers’ differing expectations helped shape these perceptions.

Independent Living Center staff members involved with younger and older individuals who were being discharged from the hospital provided responses which were similar to those of hospital discharge planners regarding differences in the discharge planning process. Largely, ILC workers viewed a successful outcome for hospital discharge similarly for younger and older adults, “To return to a safe home with needed services in place.”

Like hospital discharge planners, many ILC workers saw service needs and resources as different for older adults. They also differentiated between the use of reimbursement sources such as the specific Medicaid waivers for older and younger adults, and the use of Medicare. While themes of consumer advocacy and choice were dominant themes in discussions across these groups, some ILC workers tended to individualize assessment questions relative to the older or younger adult:

For some people, the word incontinence – they’re like – what do you mean incontinence? Some of our older folks don’t understand what you mean by incontinence. The younger folks understand what incontinence is. So, sometimes you have to put it so that they can understand. Do you have accidents; do you make it to the bathroom in time?

Workers from ILCs perceived that while older adults primarily wished to return home after a hospital discharge, that they were less likely to do so than younger adults with disabilities.
One ILC worker reflected that due to the consumers’ cognitive impairments or for other reasons—the consumer may be less involved in the discharge planning. This ILC worker stated:

*A lot of it has to do more with a family and the social worker doing the discharging—kind of making those decisions for the consumer versus the consumer being able to make those choices.*

The hospital discharge process was viewed as more difficult when working with older adults according to one ILC worker who notes:

*“The other thing is pride because a lot of the older population are very independent and self-reliant and have never asked for help and don’t like asking for assistance.”*

**Most important tasks.** When asked about the most important tasks they performed as part of hospital discharge planning, representatives from hospitals, AAAs, and ILCs gave priority to meeting the needs and wants of consumers. Hospital discharge planners’ sentiments sometimes reflected safety issues, as well as patient-focused care, concern for patient choice, and patient rights. One hospital discharge planner expressed: *“Put the patients first. Their feelings, their wants, their needs.”*

Hospital discharge planners also noted that assessment and evaluation of the patient was an important task in the discharge planning process. Getting a *“complete look at the person,”* meeting the consumer’s goals, and educating the consumer about community services and their health condition were essential tasks. Collaboration and communication with other disciplines and the physician was noted as significant, as well as attention to patient rights and safety. The following quotes from hospital discharge planners exemplify these sentiments: *“Making sure they’re safe. That their dignity and rights are intact and that they are safe.”* *“Going in and talking to the patient to verify that we’re heading in the right direction.”* *“Ensure each person has a place to go home to and somebody to take care of them.”* These most important tasks were closely linked to successful outcomes, as an AAA case manager described:

*I was involved in the discharge planning after I made the request and it involved the doctor, the social worker, the physical therapist, the occupational therapist, the nurse. It’s the first time in my five years that it’s ever happened— that was successful. It was successful because... my client went home knowing what to expect when she got home and knew exactly what was going to be in place when she got there. We had everything in mind for her. We had her physical therapy ready to go, we had the visiting nurse there. We had all of that set up along with her caregivers. All of that was in place by the time she walked out the door.*

**Key Players in Hospital Discharge Planning Processes**

**Who are Key Players in the Hospital Discharge Planning Process?**

Representatives from hospitals, AAAs, and ILCs identified a wide variety of key players as participating in hospital discharge planning processes. This included the older adults or younger adult with a disability (sometimes qualified as *“when possible”*), hospital social
workers, nurse case managers, physicians, home health services, health department, family and
friends, insurance companies, therapies such as occupational or physical therapy, admission
nurses, and staff members at rehabilitation facilities. Hospital workers tended to identify key
players who work within the hospital setting, while community-based agencies seemed to more
often identify key players from other community-based settings. Community-based players
included workers from AAAs, ILCs, the local health department, and other community services.
Table 2 lists responses to an interview question regarding the degree of involvement of selected
key players in discharge planning processes. Numbers and percentages in this table reflect
responses across agencies.

<table>
<thead>
<tr>
<th>Key Player</th>
<th>Frequently or Always Involved (N = 39)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older adults &amp; younger adults with disabilities</td>
<td>34 (87%)</td>
</tr>
<tr>
<td>Hospital discharge planners¹</td>
<td>21 (84%)</td>
</tr>
<tr>
<td>Family &amp; friends living in same household</td>
<td>32 (82%)</td>
</tr>
<tr>
<td>Physicians &amp; nurses</td>
<td>26 (67%)</td>
</tr>
<tr>
<td>Home health agencies</td>
<td>23 (59%)</td>
</tr>
<tr>
<td>Meals programs</td>
<td>17 (44%)</td>
</tr>
<tr>
<td>Nursing &amp; long term care facilities</td>
<td>15 (38%)</td>
</tr>
<tr>
<td>Family &amp; friends living in different households</td>
<td>14 (36%)</td>
</tr>
<tr>
<td>AAAs²</td>
<td>8 (32%)</td>
</tr>
<tr>
<td>Hospice care</td>
<td>12 (31%)</td>
</tr>
<tr>
<td>ILCs³</td>
<td>6 (25%)</td>
</tr>
<tr>
<td>Adult protective services</td>
<td>8 (21%)</td>
</tr>
<tr>
<td>Health department</td>
<td>7 (17%)</td>
</tr>
<tr>
<td>Respite care</td>
<td>6 (15%)</td>
</tr>
<tr>
<td>Church</td>
<td>5 (13%)</td>
</tr>
</tbody>
</table>

Note: Key players listed in order of involvement from highest to lowest.
¹Responses from AAAs and ILCs. (N = 25)
²Responses from hospitals and ILCs. (N = 25)
³Responses from hospitals and AAAs. (N = 24)

Hospital discharge planners. Hospital discharge planners might not work directly with
all hospital patients. AAA and ILC representatives were aware of this, and only 84% of AAAs
and ILCs perceived that hospital discharge planners were frequently or always included in the
discharge planning process for older adults and younger adults with disabilities; 16% reported
rarely or sometimes. A few workers at AAAs and ILCs reported working with a consumer who
was leaving the hospital but had not been flagged by that hospital as needing a social services
referral to the hospital discharge planner.

AAAs and ILCs. AAA and ILC staff members who worked with hospital discharge
planning held a wide variety of positions. These positions were structured in different ways:
some were employees of the agency who are based out of the central office, while others were
based in “satellite offices” which might have been over 100 miles from the agency’s primary location. Some of these employees were subcontractors. Staff members who worked with those being discharged from hospitals occupied multiple positions within the structure of the AAAs and the ILCs. At the AAAs, these included Senior Care Act Case Manager, CARE Coordinator, Program Specialist, Administrative Assistant, Nutrition Coordinator, Director Case Managers, Director Senior Care Act, Fiscal Coordinator, and Case Manager. At the ILCs, these included Independent Living (IL) Advocate, IL Specialist, IL Counselor, IL Skills Trainer, Housing Specialist, and Program Services Director. A few interviewees from AAAs and ILCs volunteered the information that they had worked as hospital discharge planners in the past.

Regarding the involvement of AAAs, 68% of workers from hospitals and ILCs felt that AAAs were included as key players in the hospital discharge planning process only rarely or sometimes. The remaining 32% who perceived that AAAs were included frequently or always had an interesting distribution; almost twice as many hospital discharge planners (63%) perceived the AAAs were frequently or always involved in hospital discharge planning processes than did ILCs (37%). Most representatives from hospitals and AAAs (75%) perceived ILCs as being involved in hospital discharge planning processes only rarely or sometimes. This perception was evenly distributed across hospital and AAA respondents. Discharge planners from some smaller hospitals noted that younger adults with disabilities would likely be sent immediately to a larger, urban hospital and that the majority of their caseloads consisted of older adults.

Consumers and family members. Older adults and younger adults with disabilities were perceived as being frequently or always involved in their planning processes by 87% of all respondents. These frequently or always responses were split evenly across agency type. Some respondents who said consumers were sometimes or rarely involved qualified that rating by noting that cognitive limitations or severe health issues kept all consumers from participating. More than one supervisor of hospital discharge planners expressed concern that the additional amount of time it takes an older adult to understand the information and make decisions might be a barrier to including older adults in the process in some situations, and that this was an area where additional training is needed.

According to 82% of all those interviewed, family and friends living in the same household as the consumer were frequently or always included in hospital discharge planning processes. Responses were pretty evenly split across interviewees from hospitals, AAAs, and ILCs. On the other hand, only 36% of family and friends who do not live in the same household as the consumer were perceived to be frequently or always involved in hospital discharge planning processes. Hospital discharge planners reported that younger adults with disabilities were more likely than older adults to be self-advocates. This could account for the lower percentage of ILC workers reporting that family and friends, whether living in the same household or not, are frequently or always involved in hospital discharge planning processes.

Physicians and nurses. Regarding the involvement of physicians and nurses in the discharge planning process, 100% of hospital discharge planners reported that physicians were frequently or always involved. However, only 54% of AAAs and 46% of ILCs perceived that physicians and nurses were frequently or always involved. These differences were statistically
significant ($\chi^2 = 9.923; p < .01$). Qualitative data suggested that multiple issues related to physicians sometimes served as a barrier to choice in post-hospital services. These issues are described in greater detail in the section on barriers.

During Phase II interviews, hospital discharge planners described the physician as primarily responsible for the medical management of the patient. Physicians also constituted a primary source of referrals for discharge planning and social work consultation within the hospital setting. Discharge planners noted they commonly worked with physicians, “To coordinate the specifics of the discharge.” Hospitalists were also recognized as an important part of the hospital discharge planning process. The hospitalist model is one where consumers are assigned to an “inpatient physician” for the duration of time they are in the hospital. This is in contrast to the traditional model where the consumers’ primary care providers manage the consumers’ care throughout the hospital stay. This transfer of care may be voluntary or mandatory (Wachter, 1999). One hospital discharge planner who worked for a hospital that recently began working with a hospitalist model told us:

“*The hospitalist system has potential for enhancing the discharge planning process because it is easier to contact and get information from hospitalists that are at the hospital, rather than the physician who comes by the hospital infrequently.*”

Quantitative data indicated that workers from AAAs and ILCs did not recognize physicians and nurses as key players as often as hospital discharge planners. However, a number of these community-based agencies talked about the role of physicians. For example, ILC staff members recognized the physician responsibility to the “*overall health and care of the patient*,” and saw the physician role as one of diagnosis, identifying medical needs, medications, follow-up and meeting equipment needs. An AAA case manager described physicians and nurses as key players in this manner:

*The key player, the major player, of course, is the hospital staff, whether that be the physician, the nurse, the social worker, the case manager. They’re the key players because they’re the ones that are dealing with the current crisis. I would say a key player would be possibly home health agencies that the doctor would order through Medicare. Our agency would be a key player for a lot of patients. We have follow-up, whatever the physician would be saying the patient needed to follow-up would be another key part of discharge.*

*Home health or visiting nurses programs.* Fifty-nine percent of respondents reported that home health or visiting nurses services participated in hospital discharge planning processes frequently or always. These responses were fairly evenly split across agency type. Home health services played a unique role as a referral source for AAAs and ILCs in some areas. Respondents told us that it is possible to set up these services immediately, and therefore some hospital discharge planners and/or physicians tended to make a referral to home health over AAAs and ILCs. In at least one area of the state, it was the home health service who would call in a referral to the AAA or ILC once they saw the consumer post-discharge and felt that additional services might be warranted:
So sometimes it’s kind of not a direct referral. Actually, typically we probably get more referrals, and I’m just guessing, from the home health people that the hospital social workers have arranged.

Meals programs. Meals programs were frequently or always involved in planning processes just under half the time (44%), according to respondents. It is interesting to note that 47% of these frequent or always responses came from AAA case managers, compared to lower percentages from hospitals (24%; n=4) and ILC workers (30%). While these differences were not statistically significant ($\chi^2 = 2.711; p > .10$), one factor in the differing perceptions could be the role that AAAs play in managing Meals on Wheels programs. To someone outside the agency, a referral to Meals on Wheels might be regarded as a referral to an AAA—whether specifically to a meals program or to a Medicaid waiver service. As with home health services, meals programs sometimes served as an avenue to identify new people who need services. For example, a hospital discharge planner may make a referral to a meals program. A worker from the meals program is sent out to do a brief assessment and may realize that the consumer is interested in and would qualify for Medicaid Waiver services. A case manager for a Medicaid Waiver program at an AAA told us:

[Hospital calls] at least initially to start Meals on Wheels and then we end up kind of getting them through the back door-- where you’re going out and doing your two-page assessment for Meals on Wheels and all of a sudden it’s like oh boy, this is way more than a Meals on Wheels.

Adult protective services (APS). APS elicited numerous comments from respondents. While 79% of those interviewed perceived that APS was involved in the planning process only rarely or sometimes, the role attributed to APS involvement varied widely. In some instances APS could play a proactive role to help secure emergency housing, while in other instances some respondents felt APS was brought in by family members who did not like the choices the consumer was making regarding post hospital care. Some who were interviewed had been involved in cases where decision-making capacity may have been prematurely assessed while the consumer was still recovering from an illness and under the influence of strong medication.

Others. Other key players included staff members from nursing and long-term care facilities, rehabilitation facilities, health department services, churches, respite care, and hospice. See Table 2 for the distribution of responses for degree of involvement as perceived by all those interviewed. Note that there was a trend towards a larger percentage of interviewees from hospitals and AAAs reporting hospice care frequently or always (42%, 50% respectively) compared to ILCs (8%). This trend approached statistical significance ($\chi^2 = 5.056; p < .10$) and was likely related to the younger age of the population served by ILCs.

Referral Processes in Hospital Discharge Planning

How are AAAs and ILCs Involved in Discharge Referral Processes?

There were two levels of referrals that emerged as inherent within the hospital discharge planning process: 1) within the hospital, and 2) from the hospital to community-based agencies.
This report describes within hospital referrals to hospital discharge planners and referrals from the hospital specifically to AAAs and ILCs as the lead agencies for Medicaid home and community based and other services.

As noted above, hospital discharge planners might not be brought into the planning process for every patient. Many hospitals screened at intake for the need for a “social services” referral, which was the within hospital referral to the hospital discharge planner. Hospital discharge planners, AAA providers, and ILC staff overwhelmingly concurred that hospital discharge planning should begin upon admission. In fact, a few hospital discharge planners expressed that discharge planning should begin prior to admission, and noted that sometimes this was the case with surgical patients. As a whole, hospital discharge planners noted that discharge planning most frequently began (meaning the social services referral was made to the hospital discharge planner) when the patient was admitted, or within 24 hours of admission, although in cases where patients were acutely ill, the process might be delayed.

Hospital interviewees were asked if their discharge planners had ever made at least one referral outside the hospital setting to AAAs and ILCs (the second type of referrals). Information was also gathered on the circumstances in which referrals were made. Of the hospital discharge planners, 91% reported ever making at least one referral to an AAA. This indicates that hospital discharge planners seemed to be aware of the existence of AAAs. However, as we reported earlier, quantitative data indicated that 68% of workers from hospitals and ILCs felt that AAAs were included in the process only rarely or sometimes. While the hospital discharge planners that we interviewed tended to be aware of AAA services, they might not be making use of the AAA as a referral source as often as possible. These hospital discharge planners stated that they made referrals to AAAs for a variety of reasons, including the following:

• in-home evaluations
• the older adult tells the hospital they use home and community based services
• the hospital would like a screening for possible nursing home placement
• “There are needs I [hospital discharge planner] don’t know how else to meet.”

At least one hospital respondent said she referred to AAAs for the nursing home placement screening and did not seem to be aware of other AAA services. This could indicate that some discharge planners might not be aware of the role that AAAs play in providing supports that allow consumers to return to home with support following a hospital stay.

Hospital respondents (86%) also reported that they made referrals to ILCs. However, respondents in two hospital interviews did not seem to understand the function of an Independent Living Center. One respondent reported that she referred to ILCs when she felt the younger person with a disability needed a “non-home setting like a group home or independent living setting.” This suggested that some respondents might have been thinking of other services (such as assisted living) when they reported making referrals to ILCs. It is unknown how much of this confusion might have been due to the language used in the interview questionnaires. Interviewers used the generic “Area Agency on Aging” and “Independent Living Center” while the respondents might have been more familiar with the local agency name (e.g., Three Rivers, Inc., The Whole Person, Inc.).
We also gathered information on referrals from the perspectives of the AAA and ILC workers. While AAA staff members noted that hospital discharge planning should ideally begin at admission and that they should be notified of the consumer’s hospitalization as soon as possible, they reported they were often contacted on the day of discharge, or after discharge. One AAA case manager, however, reported that they were notified of hospitalization upon admission by the discharge planners, and attributed this to efforts to enhance their visibility in the community:

We’ve made ourselves visible in the area . . . we’ve tried to make ourselves visible, tried to let them know what we can and cannot do. . . We try to work together to coordinate services. Many times we run up against a person who doesn’t want help or they don’t want to pay for help. There’s a lot of brick walls that we face. But, I think we have good rapport with our discharge planners in the small areas.

Independent Living Centers contended that discharge planning should ideally begin when the patient is admitted to the hospital, but that this was not a typical experience for some of them:

Usually it becomes a last-minute rush. Like, for example, you get a phone call and you need – they want to put somebody on services and they’re being discharged the next day. That typically happens a lot.

They further noted:

Sometimes I notice they call me right away. Other times I get a call the day they are released. It’s great for me if I get a referral right away.

It usually happens the day they are leaving or even after they have already left.

Another ILC staff member noted the effects of positive relationships with hospital discharge planners:

We have a much better working relationship now with most of those hospitals than we’ve ever had in years gone by. I think we’ve been able to effect some change ourselves in helping those folks to understand that the sooner they can begin planning for a discharge, and the more advance notice we get, we can actually go out to hospitals. We can visit there. We can get assessments done. We can begin to explore funding for home modifications and do a lot of things if we are given ample time. That’s a very important aspect to this whole line of inquiry.

During interviews with community-based services, we also asked workers from AAAs and ILCs if they made referrals to each other. All ILC workers interviewed (100%) reported making referrals to AAAs. These referrals were made when the consumer was age 65 or older; they qualified for the Frail Elderly Waiver, or if there was a need to set up congregate or other meals. All but one AAA case manager (92%) reported that they made referrals to ILCs when the
consumer was below 60 or 65, or when it was the person’s choice. Some AAAs had an intake system where the case manager we interviewed was not the first point of contact with consumers. In these instances, the AAA intake worker would be the one to make any referrals to ILCs. The one AAA respondent who did not report making referrals to ILCs worked as a case manager in an agency that used this intake model, and would not be expected to make these referrals.

There is general agreement that the hospital discharge planner should be brought into the process as soon as possible, and that the discharge planner should ideally make referrals to AAAs and ILCs on the day of admission. When discussing community-based referrals with hospital discharge planners, the timing of the notice of discharge became an issue. It seems that some discharge planners waited until they knew when the consumer would leave the hospital before making the community-based referral. Helping the discharge planners understand how they can work with the AAAs and ILCs earlier in the process could be an effective strategy to pursue. Hospital discharge planners who have networked with the AAAs and ILCs recognized how these agencies could help them complete tasks in the hospital discharge planning process. One hospital discharge planner who attended a focus group with representatives from AAAs and ILCs said:

I just had a horrible thought. I was just wondering how many of our staff have been setting up, spending hours and hours setting up services when there’s already stuff in place.

In areas of the state where AAAs and ILCs have made a concentrated effort to conduct outreach to local hospitals, the parties involved described the discharge planning process as flowing fairly smoothly. This outreach strategy may be more feasible in rural areas of the state where the AAAs and ILCs work with fewer hospitals that have a small number of discharge planners on staff.

**How do Key Players Communicate in the Discharge Planning Process?**

Communication within the hospital discharge planning process serves multiple purposes and takes many forms. Communication is necessary to understand consumers’ preferences for post-hospital care settings, gather information for assessments, make referrals, provide training and education to consumers and family members regarding post-hospital care, and to share information across agencies in order to set up needed services. Several modes of communication used to share information within hospital systems, from hospital personnel to the consumer or family members or community-based agencies, and with physicians were described along with comments on successes and frustrations.

Within hospitals, information is shared through notes on consumers’ charts, electronic medical records, social service notes on “chart-link,” and multi-disciplinary discharge planning meetings. By far, the most frequent mode of communication used is the telephone. Other information is passed on informally through email or in person. AAA case managers reported communication with hospital discharge planners through discharge planning meetings or more informally, in-person or on the telephone. One AAA worker told us that they communicate with hospital discharge planners through the consumer. ILC workers also communicated via the
telephone and directly with the consumer. In addition, they wrote letters, advocated for the consumer with hospital staff and communicated with landlords regarding the consumers’ housing needs. All entities (hospitals, AAAs, ILCs) reported frustration with telephone communication, and each had a few representatives that reported the others did not return phone calls.

Hospital discharge planners had quite a bit to say about communication with physicians. One hospital discharge planner cited collaboration with the physician as one of the most important tasks in the discharge planning process, and another described, in general, how information is shared in the discharge planning process:

It’s usually done individually. You know, me talking with the doctor, talking with the patient, talking with the family.

Physician orders for discharge planning orders were commonly received via face-to-face contact with the physician, through written orders in the patient’s chart, or through telephone communication with the physician. Discharge planners also communicated with physicians by writing notes or placing brightly colored stickers on the front of the patient’s chart to get the physician’s attention.

Many AAA case managers reported that their contact with physicians was limited. Some reported calling physicians with, “specific questions or problems,” or to obtain orders for a consumer’s equipment needs. The case managers further noted that, “They [physicians] never make referrals” and “We rarely get a call from a doctor.” Similar to AAAs, the ILCs did not often communicate with physicians directly, but worked through hospital discharge planners to accomplish discharge planning tasks. One AAA case manager, however, expressed an alternative perspective:

A lot of things that I would like to set up, it’s so much easier to set up while they’re [consumer] in the hospital because you have access to the physician right there and you can kind of corner them and they can find stuff and do what you need them to do, rather than trying to chase them down post-discharge.

A Phase III focus group of social workers who worked in healthcare settings gave an explanation for the lack of referrals and communication from the physicians themselves. They made the point that many physicians focused on the consumer’s medical care needs and relied on the discharge planners to be the point person for communication and to handle the details of the “social services consult.” One discharge planner explained it this way, “with some physicians they tell us, give us some guidance in how to start.” Participants in this focus group stressed that different physicians had different preferences for communication, which made consistency across discharge processes a challenge. Additional information on barriers to communication and potential solutions is discussed in the following section.
Identification of Barriers and Best Practices in Discharge Planning Processes

Themes related to barriers emerged from Phase II interviews with staff from hospitals, AAAs, and ILCs—the majority of whom worked directly with older adults or younger adults with disabilities. Therefore, many of the barriers they described were related to the day-to-day aspects of hospital discharge planning such as timing of referrals, communication, medical complexity, and differing philosophical or conceptual approaches to discharge planning. Some interviewees described structural or policy issues, however most of these macro-level barriers emerged from Phase III focus group discussions and the project’s panel of expert consultants who were aware of the policy connections to some of the day-to-day barriers. The following barriers are described in more detail below: structural and policy, timing of referrals, communication, medical complexity, and workers’ conceptual approaches to discharge planning.

What Barriers to Effective Hospital Discharge Planning are Related to Structural and Policy Issues?

The vast majority of interviewees from hospitals, AAAs, and ILCs worked long hours, had large caseloads, and juggled a diverse range of job responsibilities while working to meet the post-hospital care needs of older adults and younger adults with disabilities. The following structural issues were identified as barriers to providing choice in care settings for a greater number of older adults and younger adults with disabilities. From the perspective of study participants, many of these structural issues, if addressed, would increase the number of people able to return home following an acute care hospital stay, and would facilitate the hospital discharge process in a manner that would allow the staff members involved to do their jobs in a more efficient manner. These structural issues are related to finances (i.e., program funding, insurance coverage), access to services (i.e., housing, human resources, rural issues), transportation (i.e., to needed services), and administrative processes (i.e., time to determine eligibility, waiting lists, time needed to set up services, hours of operation).

Financial. Program funding has an impact on caseloads, which in turn impacts the amount of time workers in hospitals, AAAs, and ILCs may spend with each older adult or younger adult with disabilities and with their family members. Time is needed to conduct assessments and explain service options—a necessary step when the goal is to provide choice in care settings. Dedicated time is also needed to make referrals, set up services, and keep abreast of new community service options. Some funding issues specifically addressed Medicaid Waiver Programs. For example, reimbursement for the Physical Disabilities Waiver Program (PD Waiver) is lower than for the Frail Elder Waiver Program. ILC workers, especially in rural areas, reported that this made it difficult to hire staff members that were willing to work as personal care assistants for the PD Waiver. In rural areas of the state, administrative policies that disallow travel reimbursement for home visits (i.e., to conduct an assessment) are another barrier to hiring and keeping staff members. According to some of the people we interviewed, changes in insurance coverage for hospital stays are factors that affect choice in post-hospital care settings. As a case manager from an AAA explained:
There is a limited number of days that insurance covers hospital stays—and the quick fix is send people to a nursing facility.

Access to services. Some structural barriers limited access to services. People who worked in rural areas of the state described challenges that included non-availability of some services, travel distances, and scarcity of staff to hire in personal care assistant and other positions. According to KDOA, inavailability of services is the major reason that needed services are not provided to older adults who receive a CARE assessment. A case manager at an AAA told us:

Well, it’s the travel and it’s the lack of resources out here. ... That’s the problem out here, is people living in rural distant areas and not having all the caregivers we need.

Lack of both affordable and accessible housing was an issue in both rural and urban areas, with homelessness emerging as one of the more challenging barriers in urban centers. Housing barriers were reported to be time consuming and often there was no solution available. Reported challenges to housing included unsafe homes, rats and insect infestations, and freezing pipes. When a home was not accessible, we were told that often structural modifications took time and money. Sometimes a home could not be modified or a landlord did not approve of needed modifications. If the consumer needed to move, waiting lists for affordable and accessible housing precluded going directly home following an acute care hospital stay.

Transportation. Transportation posed another barrier. This included transportation from the hospital to home, and once home to needed medical and therapy appointments. A hospital discharge planner summed it up, “Transportation. It really tends to bog things down.” Transportation was mentioned in both urban and rural areas, but it seemed to be described more often in terms of an insurmountable issue in the lesser-populated areas of the state as another discharge planner noted:

Some of the rural areas are particularly bad. That even though the assessment, you know, your assessment can be the best thing in the world, but if there’s no services available, like transportation, is huge.

Administrative processes. Some barriers or delays in the discharge planning process were attributed to administrative policy and processes. Many interviewees and the focus groups expressed concern over the length of time it takes for SRS to determine eligibility for Medicaid. Waiting periods for medical cards, food stamps, Section 8 housing, or Senior Care Act services were viewed as a barrier to sending someone directly home from the hospital. All of the little delays add up to create a potential barrier for a discharge to home. A worker from an ILC described the potential delays:

Housing has a waiting list, our home and community based services has a little bit of a waiting list. If they’re applying for Medicaid there’s a wait. If they’re applying for social security there’s a wait. If they’re applying for benefits, usually there’s a wait.
One of the challenges is the immediacy of the need for services in relation to the amount of time it takes to set up the needed services. A case manager from an AAA explained:

*Services take anywhere from five to seven days to actually get started because of the paperwork process and contacting the providers and making sure they have an adequate staff to meet the individuals needs.*

Pressures from more efficient surgical procedures and technologies and from insurance companies for shorter and shorter hospital stays add to the necessity of being able to set up services rapidly. Complicating the situation is the fact that hospitals are open 24 hours a day, seven days a week, while community based service agencies are typically open Monday through Friday during standard business hours. People we interviewed told us that a typical hospital stay is three to four days. The quote above indicates that it usually takes from five to seven days to put post-hospital services in place. The three to four day hospital stay is out of a seven day week, while the five to seven day wait for services comes from the framework of a Monday through Friday business work week.

**What Barriers to Effective Hospital Discharge Planning are Related to Timing of Referrals?**

Each party we interviewed—from hospitals, AAAs, and ILCs—described delays in referrals as a challenge. Hospital discharge planners experienced delays in getting referrals from physicians, and community-based workers experienced delays in getting referrals from hospital discharge planners. Additional themes related to the timing of referrals emerged such as the fact that not all hospital discharge planners see every consumer, past negative experiences with long waits for community-based service eligibility, and conflicts due to demanding caseloads.

From the perspective of hospital discharge planners, they often received physician orders for community placement “two hours” before the consumer is discharged. A hospital discharge planner commented on the timing of a referral she received from a physician:

*I got a call last night [Wednesday] at 8:00. I was working late. I got a call from a surgeon who said, I just want you to know that the patient that we were going to discharge on Saturday is being discharged tomorrow.*

If a physician automatically writes an order for nursing facility placement, the discharge planners may find themselves in the role of advocate for the consumer who would prefer to go home with support services. When the discharge planner makes a referral, making actual contact with community services may be difficult within the short time a consumer is hospitalized due to time spent leaving messages and playing phone tag. As noted above, improving the timing of referrals from hospitals to community based agencies will not solve all the barriers to choice in post-hospital placement services. At least one hospital discharge planner told us that past experience with the length of time it took to set up community based services led her to believe that this was a useless referral for a discharge planner to make—she doesn’t bother any more since services will not be in place when the consumer goes home. Other discharge planners
made comments that indicated they were not aware of the full extent of home and community-based services that were available.

It is important to note that not all consumers exiting the hospital received direct services from a hospital discharge planner. The system varies across hospitals, and one discharge planner described the process where she worked:

_Hospitals are required to do discharge planning on everybody, but how you do that is different. It may be that nursing assessment does it on everybody. We do a discharge planning screening where we use the high risk screening criteria that we’ve developed to pick up those patients. But if they are 34 or 48 and married, have insurance, and it’s not a diagnosis... that’s likely to need services, we won’t pick them up. The nurse will do... a little discharge screening._

Some hospitals have established screening systems upon intake and if the consumer was not flagged as needing social services consult, they would be discharged without a comprehensive discharge planning process. If a discharge planner did not see the consumer, he or she would not be in a position to make a referral.

From the perspective of AAAs and ILCs, referrals are often received too late in the process. A study participant from an AAA told us:

_Sometimes we are getting contacted too late from the hospital and that’s a major barrier. The hospitals are just waiting too long to get us involved._

Some community based workers reported being invited to a hospital discharge or planning meeting at the last minute. They are unable to attend if they have another assessment, home visit, or other meeting scheduled at that time.

Study participants from hospitals, AAAs, and ILCs tended to agree that issues related to the timing of referrals could negatively impact consumer choice in post-hospital care placement. A worker from an AAA summed up her perspective:

_I think that—because services are not necessarily in place to assist them, that other alternatives [to going home] are having to be chosen such as temporary nursing facility stay or out-of home stay. Simply because... there’s not always a coordinated effort prior to discharge. Or we are contacted when time is of the essence and we cannot get them the staff and services set up to allow them to come home safely._

**What Barriers to Effective Hospital Discharge Planning are Related to Communication?**

Communication barriers were described in relation to communication with consumers and family members, physicians, situations which require transfer of care, and interpretation of HIPAA regulations.
Consumers and family members. This study gathered information from the perspectives of workers from hospitals, AAAs, and ILCs, therefore the information reported here on consumers and family members is from the professionals’ perspectives. To fully understand these issues and before taking action on strategies for interventions it is important to also understand the consumers’ perspectives.

Many study respondents during interviews and focus group discussions expressed concern that consumers or family members did not always share information about pre-existing conditions or current services. This could be for a variety of reasons. For example, respondents speculated that the consumer may not think of HCBS services or case manager in terms of receiving “services.” The consumer or family members may not understand relevance of sharing information about pre-existing conditions or current services, or they may be overwhelmed with the situation at hand. The lack of communication may occur because there are problems with services they already have in place, or because they are concerned about going home. Respondents expressed empathy for the consumers and their family members, describing them as sometimes overwhelmed, under stress, confused due to medication or cognitive decline, or just not feeling well. In some cases, dynamics among family members were said to contribute to communication issues. These dynamics have also been identified in the literature examining barriers to discharge planning. Both the lack of involvement of family members (Dill, 1999) or their excessive involvement in patient affairs (LeClerc et al., 2002) can reduce the effectiveness of the discharge planning process. Some AAAs and ILCs told us they worked with a “very large percentage” of non-English speaking consumers. Other AAAs and ILCs reported that some consumers have difficulty communicating preferences due to frustration and anger over their current health crisis, functional limitations that may be exacerbated by medications and current health status, and reluctance to be a self-advocate. This latter barrier to communication about preferences was perceived by hospitals and ILCs as occurring more often among older adults than among younger adults with disabilities. A worker at an ILC told us:

...educating your consumers, too, because I think that sometimes they are so scared or nervous about going against their doctor. I mean, it depends so heavily on their physicians and... on their age and just the generation of the consumer-- which one they are in.

Physicians. Communication with physicians was described as problematic by many hospital discharge planners, and is closely related to timing of discharge issues described above. Studies have found that adequate communication between physicians and discharge planners and a clear perception of their roles were important factors in determining effective discharge planning in a hospital (Dill, 1995; Feather, 1993; Minichello et al., 2001). In our study, circumstances varied widely across physicians. We heard reports of doctors who did not like to use computer-based communication systems installed in the hospital, and/or had very busy schedules, meaning that valuable time was used to track down the doctors to communicate about discharge issues. A discharge planner explained:

And so we’ve tried to... use this one sheet as a communication tool. Some of the physicians use it great. I can leave a note one afternoon saying I think this patient is
going to need a wheeled walker and the next morning I’ve got my order for the wheeled walker. Some of them, I have it on there day after day after day and I highlight it and underline it and the patient is dismissed without an order for the wheeled walker. And so then you’re spending twice as much time.

In urban areas, a couple of case managers described managed care systems where the discharge planning was not done by the hospital staff members, but by the managed care companies:

They have their own group of doctors and their own discharge planners . . . and that does play into it because we do have a lot of people with the Medicare Advantage Plans.

The managed care environment was described by these few community-based workers as confusing and difficult to navigate, in spite of efforts they made to understand the system.

Transfer of care. Transfer of care within or between hospitals may pose additional communication challenges, however, this does not cause as many problems in smaller hospitals. A larger hospital gave its perspective on the potential implications of transfer of care, “It can create problems, challenges in communication and information may be lost.”

HIPAA. HIPAA issues may arise when transfer of care occurs across hospital settings, and when making referrals or setting up services. It became clear from the interviews that service agencies interpret HIPAA guidelines inconsistently, and areas where agencies follow a stricter interpretation report delays in the ability to set up services. Within the context of the tight timeframe to have services in place before the consumer returns home, delays become critical. In one area of the state where the local AAA requires that the HIPAA form be signed anew by the consumer at the hospital, and on the AAA’s form, the AAA case managers have provided the hospital with their forms to have on hand. This was reported by a local discharge planner and case manager to have facilitated the process—somewhat. Some interviewees reported that a few service agencies (other than AAAs or ILCs) may use HIPAA guidelines “as an excuse.” This does seem to be happening less and less, as several respondents reported that the situation is not as bad as it was a few years ago.

What Barriers to Effective Hospital Discharge Planning are Related to Medical Complexity?

Study respondents perceived that the medical conditions of hospitalized older adults and younger adults with disabilities were becoming increasingly complex. This led to examples of barriers related to the level of severity of the medical condition and use of medical equipment or assistive technology.

Level of severity. Medical complications and increasing level of severity of functional limitations or frailty among consumers were discussed by Phase III focus groups as a barrier to returning to home in the community after a hospital stay, “And we have the issue that we’re dealing with a higher acuity of people. In every area that we work with, they are sicker.” Because people returning home now have more complex medical needs, longer time is required to set up an array of services. Barriers stemming from increased medical complexity include
those related to medical equipment and assistive technology, the “medical model,” and balancing independence with safety.

*Medical equipment and assistive technology.* Interviewees from hospitals, AAAs, and ILCs all cited acquiring medical equipment and setting up assistive technology as an important part of discharge planning. Technical advances and increased availability of equipment have enabled people to return home when it previously was not possible. However, with increasing medical complexity, the type of equipment may become increasingly complex. It may be difficult to adequately educate the consumer and family members about the equipment during the short hospital stay. It is also important for personal care assistants to understand their role with a consumer who uses a ventilator or Foley catheter. For example, the consumer may not understand why some people coming to the home are able to work with this equipment while others are not.

**What Barriers to Effective Hospital Discharge Planning are Related to the Service Provider’s Conceptual Approach?**

Two themes emerged that centered around the service provider’s philosophical or conceptual approach to hospital discharge planning. The theme related to the medical model stems from differing training programs that physicians, hospital discharge planners, and community-based workers attended. The theme related to safety versus independence is one which places the worker in a situation where he/she is balancing potential conflicting roles—the first to maintain the consumer’s health and prevent rehospitalization, and the second to follow through with the consumer’s first choice for post-hospital care settings.

*Medical model.* Some people interviewed expressed frustration at the “medical model” under which hospitals operated. This included lack of familiarity with newer social service programs such as home and community based services and attitudes stemming from medical training. We heard from several research participants that physicians readily make referrals to nursing facilities. One hospital discharge planner postulated that doctors might jump to a recommendation to a nursing home because they are most familiar with options for nursing home care. A person who worked at an ILC explained their strategy to address this issue:

...because the doctor said I want you to go into a nursing home, they [consumers] believe that they have to do that. And so we try to give them options and choices and let them know that we can provide the services that they need in their home. And doctors, after they see it happening, are always satisfied. I think they just kind of jump to a nursing home admission quickly.

While many of these comments were attributed to physician training in the “medical model” rather than taking a holistic approach to meeting consumer’s needs, this perspective was associated with hospital discharge planners as well. At least one discharge planner who was trained as a social worker and who supervised discharge planners with both social worker and nursing credentials perceived:
There is a barrier if the discharge planner was trained in the medical model.... [The consumer] needs someone who will consider the environment. There is danger of underestimating family dynamics, culture, religious beliefs. You can’t just treat the diagnosis and expect it to happen.

Another hospital discharge planner made the connection to physicians:

*We need an explanation for why doctors order certain things such as 24 hour care... They look at things through the medical model. There needs to be a paradigm shift.*

Some felt the type of training that physicians received instilled an attitude that is counter-productive to a consumer choice approach. Someone from an ILC described this further:

*Well, the attitude that a person with a disability is broken. The attitude that a person with a disability is an idiot. The attitude that nobody but the doctor knows what’s best for anybody. The attitude that you couldn’t possibly have a clue as to how to take care of yourself.*

Another ILC worker expressed concern:

*... the overall – I guess, philosophy or opinion or whatever - that I run up against, especially with doctors and stuff, is that oh, there’s no way they can go home and be at home without 24-hour care. How are you going to give them 24-hour care? I don’t know if they’re thinking in terms of, you know, their liability for discharging somebody home that’s not going to have 24-hour care when they get home, or if they truly think this person isn’t capable of doing much of anything for themselves, or what the case is. But that’s generally the attitude of some of the medical people I run into. Not so much from the social work side or the discharge planners’ side – which frequently discharge planners follow recommendations of the hospital or the doctor or whatever. . . I would say the barriers are the attitudes of the medical staff. That is probably the most significant barrier in getting them home versus putting them into [a nursing home].*

*Balancing independence with safety. Balancing the values conflict of safety versus independence was a struggle for respondents from hospitals, AAAs, and ILCs. The functional status of someone in the hospital might vary widely from day to day, as a hospital discharge planner described:*

*People in hospitals... may be extremely confused on Monday and Tuesday they are oriented again. I mean that’s how much they can change. Or we can plan for a dismissal on Wednesday. You come in Wednesday morning and suddenly they’re confused and their temperature has went [sic] up.*

The day-to-day variability in functional status poses challenges to hospital-based assessments. Closely tied to this issue is the discharge planning role of a consumer who is under guardianship or who has a medical power of attorney. Although someone may not currently be making legal decisions, their opinion should be heard and respected. During both Phase II interviews and
Phase III focus groups, a few research participants expressed concern over situations where decision-making rights were taken away from the consumer while they were still in the midst of a health crisis:

...or a lot of times I’ve had cases where the patient will have gone into the hospital and because of, you know, the medication that they’re on or the types of pain killer or other treatment that they’re receiving, sometimes makes them a little incoherent and not quite with the rest of the world-- for lack of better terminology-- and they kind of come across that way as not being able to make decisions or being psychologically, quote-unquote— “fit.” They rush in and they do a psychological assessment on the person while they are under all these influences of medications. And then as [the consumer gets] better and they are on less medications and they’re coming out of that... they’re able to make their own decisions and continue. By that point the whole guardianship wheel is in the process of turning and, you know-- declaring that person incompetent so that they can take that choice out of the person’s hands.

Some related comments were described as “safety issues” that could be a barrier to sending consumers home in the community. As one hospital worker described:

I don’t think there’s really an easy answer. You try to build a safety net in there but every time it comes up it’s very difficult. Often-times as a discharge planner you don’t have support with that. You know, several people on your team are going to feel very strongly that this person can’t go home, that there’s no way, they don’t even know where they are today. I mean, things like that and you end up having to discharge them and if this person goes home and something really bad happens, is this going to come back on me? So, I would like to have more [training] on that from the standpoint of where do we stand?

A worker at an Independent Living Center explained:

Sometimes people don’t make the choices we want, but the important thing is that it is their choice. For example, some don’t want a lot of support people in their home. However, we have to consider the danger as well.

**What are Best Practices to Overcome Barriers?**

Identification of best practices and suggestions for strategies to overcome barriers were taken directly from Phase II interviews with hospital discharge planners and workers from AAAs and ILCs, Phase III focus group discussions, feedback from the project’s panel of expert consultants, and researchers’ synthesis of qualitative data. Best practices and strategies are presented in relation to structural issues, timing of referrals, communication, and medical complexity.

**Strategies to address structural issues.** The primary suggested strategy for structural issues was to bring these issues to the attention of policy makers. This would include identified structural barriers related to finances (i.e., program funding, insurance coverage), access to
services (i.e., housing, human resources, rural issues), and administrative processes (i.e., time to determine eligibility, waiting lists, time needed to set up services, hours of operation).

Representatives from state agencies and professional organizations that address the issues of concern in this study participated on the study’s expert consult panel (see Appendix C). In addition to providing a valuable perspective on study results, panel members highlighted various issues they have been working on to provide new information with which to address selected structural issues as they emerged from the analysis. For example, representatives from KDOA shared that a recent policy change (i.e., Senior Care Act budget enhancement) will allow services to begin while consumer eligibility is being determined, and funds will become available to pay for up to 45 days of service if the older adult is later found to not be eligible. As another example, after preliminary recommendations were sent to panel members, representatives from Kansas Department on Aging (KDOA) met internally to discuss the recommendations, compile feedback, and determine which points to initially pursue. By the time the project’s expert panel met the following week, agency representatives were able to report steps already taken to implement some recommendations. One of KDOA’s actions was to partner with two AAAs to submit a Nursing Home Modernization Grant from the Administration on Aging, which would implement and evaluate a model program and “cash and counseling” initiative. Facets of the proposed program model were based on findings from this study and an earlier Real Choice pilot project. The proposal targets a group that one of the current study’s focus groups told us was falling through the cracks—people not eligible for Medicaid eligibility but who were in danger of spending down to eligibility status if they did not receive support to return home following an acute care hospital stay. Although this application was not funded, the process generated the plan for a model program that could be piloted as funds become available. Work to streamline eligibility processes and address additional structural and policy barriers should continue to be encouraged.

Best practices to improve timing of referrals. Some areas of the state reported they had made some progress towards improving timing of referrals to community-based services. Some hospitals provided structured opportunities for networking and learning about community resources, such as a once a month “lunch and learn” meeting. We did hear one caution—it can be a challenge to keep these opportunities from turning into a monthly sales pitch from area vendors. Another strategy that some community-based agencies have used with reported success is to conduct concerted outreach to the hospital discharge planners and the local AAA or ILC (depending on who is doing the outreach). As previously described in the section on referral processes, the few areas of the state which did this reported an effective working relationship across all three entities (hospital, AAA, ILC) that resulted in more efficient service delivery. An intervention that is in place in a few areas is one that originally targeted emergency preparedness in the wake of Hurricane Katrina—emergency packets containing relevant information are kept in a packet that hangs from a highly visible doorknob, ready to grab on the way to the hospital. Other people reported encouraging consumers to tape the case manager’s card to the refrigerator, and one focus group member explained:

If even EMS personnel could be trained to say look on the refrigerator for anything, cause I’ve gotten calls from the ambulance people before. I’ve gotten calls from the police before saying I saw your card on the refrigerator.
Best practices to improve communication. In addition to the outreach activities described above, we heard about initiatives designed to improve communication between the hospital and consumers, and within the hospital itself. To increase opportunities for consumers, some supervisors of hospital discharge planners targeted communication training that emphasized taking the time to fully explain to consumers and their family members the services for which they may qualify. We were told about efforts to facilitate consumer empowerment from all three entities, although we also heard concerns from community-based services that their local hospitals did not seem to set this as a priority.

Within hospitals, communication strategies focused on activities that increased choice in post-hospital care settings, and facilitated communication with physicians and others involved in the consumer’s care. Some hospital discharge planners told us they routinely made rounds with physicians, which was another strategy in practice to improve communication. Making rounds with physicians was discussed extensively in one focus group:

Discharge planner 1: ...we have one nurse and one social worker assigned to rounds at 7 a.m...

Moderator: How do you find that works?

Discharge planner 1: We get dodged some, but I think that’s the best thing we’ve come up with, which is pretty good.

Discharge planner 2: We’ve got physicians who come in even earlier than that and so our case managers, we’ve got them here at 6 o’clock in the morning to start rounding with those physicians. Otherwise they’d miss it completely.

Discharge planner 1: How long do your rounds then take?

Discharge planner 2: Probably about an hour, hour and a half.

Discharge planner 1: So that’s not too bad.

Discharge planner 2: No, it isn’t. It saves so much time in the long run.

In this same discussion, someone from a large, urban hospital brought up the fact that each of their physicians conducted rounds at different times of the day. One hospital addressed this challenge by collecting typical hours for rounds from each doctor, then assigning rounds across the hospital’s discharge planning staff members.

Best practices to address medical complexity. Some hospitals developed strategies to improve communication and ensure needs are met in situations where a consumer’s medical needs were particularly severe or complex. One hospital utilized a “Hard to Place Committee” that focused on post-hospital placement for consumers that were hard to place due to severe medical or nursing needs. The committee considered how they could best treat the consumer and where they could find the best placement options for continued care outside the hospital. This
model provided an opportunity to advocate for a return home with home and community based supports in lieu of an automatic referral to a nursing facility. Discharge planners from Veterans Administration hospitals described a “Bed Huddle” strategy, which does not take place around the consumer’s bedside but rather in an auditorium setting:

It involves our utilization review, physicians, social workers, the discharge planners, nursing staff, but also representatives from our hospital administration. So it is a combined clinical and administrative effort to look at what more we can do to provide discharge planning services to our veterans.

Interviewees who worked with this model described it as “very effective” and a good method for identifying barriers to discharge planning. Regular bed huddles ensured communication between doctors, hospital discharge planners, and other hospital personnel.

Suggestions for best practices related to different conceptual approaches used by service providers centered on the need for more training for physicians, discharge planners, and community-based workers. These suggestions are explored in more depth in the next section along with other suggestions for training.

Training and Continuing Education

Training enhances the skills that discharge planners and community based service providers use to facilitate successful discharge planning and post-discharge services. Hospital discharge planners reported having requirements for Continuing Education Units (CEUs), and this varied depending on their credentials (social worker or nurse). The majority of respondents from AAAs and ILCs reported that annual training was a requirement for their jobs. Some of the community-based respondents held credentials (e.g., social worker or nurse) that required CEUs.

What Continuing Education or Training Formats do Key Players in Hospital Discharge Planning Processes Prefer to Attend?

Many discharge planners reported that their hospitals have manuals that outline procedures for hospital discharge planning. We requested and received examples of manuals from eight hospitals that represented two medium, three large, and three small hospitals. A review of these manuals revealed no notable differences in policy in relation to hospital size or credentials of the discharge planners. A few of the manuals described the hospital discharge planning process narrowly and followed the approach described in the medical model theme described above, while the others had a broader, interdisciplinary view of the discharge planning process. For example, one manual briefly outlined the information needed to conduct discharge planning, and focused on assessments of prior health status, the current diagnosis, functional level, socio-economic status, and existing support systems. This contrasted with another hospital’s manual which included a broader description of the discharge planning process as “Continuity of Care.” This manual described discharge planning as an interdisciplinary process that recognized the changing needs of the consumer, and involved both consumers and their family members in the process. Most manuals stated specifically that hospital discharge
planning should begin at admission. Several hospitals also sent in forms that they use in the discharge planning process that could be used as a model for other hospitals with less developed or less comprehensive hospital discharge planning systems.

AAAs and ILCs preferred the following training formats:

- Interactive versus passive learning
- Group settings
- Use of visual aids
- Training outside the agency
- Conferences

Hospital discharge planners preferred to receive training through:

- Interactive versus passive learning
- Guest speakers
- Monthly meetings
- Training outside the agency
- Conferences

On-line training was only mentioned by hospital discharge planners and was only desired in specific situations. This included some types of mandatory training, or a refresher for needed information already learned but not recently used. More than one hospital described a training structure where guest speakers come in on a weekly or monthly basis. The speakers provide information on community based services and possible referrals. These sessions were described as effective and conducive to collaboration, communication, and networking. However, at least one hospital described how these informational meetings had turned into a forum that certain businesses used to promote products and that attendance had dropped dramatically since this happened. The hospital discharge planners seemed to be able to leave the hospital setting for training if the purpose was to acquire needed CEUs, however, some discharge planners preferred to receive all of their CEUs from within the hospital setting.

Workers at hospitals, AAAs, and ILCs all recognized the value of networking that occurs at conferences. However, not all employers provide funds to attend state conferences that may be a day’s drive from home. Hospital discharge planners attend conferences that relate to their credentials (nurse or social worker) or area of interest within their field. Area Agencies on Aging attend the Governor’s Conference on Aging, and some hospital workers reported attending this conference as well. ILCs attend the ILC Summit or the Kansas Disability Caucus.

Some respondents from hospitals, AAAs, and ILCs mentioned they are the ones within their agencies that provided in-house training. These interviewees expressed interest in train-the-trainers materials related to hospital discharge planning.
What Topics would Key Players in the Hospital Discharge Planning Processes Like to See Offered as Continuing Education Opportunities?

One of the types of training most frequently requested by hospital discharge planners or their supervisors was related to increased knowledge about available resources in the community. This category included information about local services, Medicaid and Medicare regulations, and program eligibility requirements. Hospitals, AAAs, and ILCs specified training topics that were related to services, such as:

- Assessing the home for safety
- Moral-legal-ethical obligations regarding safety versus independence
- Referrals to an AAA versus adult protective services
- Understand which facilities take consumers who are Medicaid-eligible
- Best ways to work with people who already have services in place
- Discharge planning for consumers who need both hospice and home health services
- Resources for people with a newly acquired disability
- Hospice services/End of Life care
- Updates to Medicaid and Medicare programs/SRS policy changes
- Discharge planning process in general

Two other training topics that were requested multiple times by discharge planners were homelessness and older adult disease processes. AAAs and ILCs also requested training on homeless issues.

Other requested training topics were related to skills or specific disease or risk factors:

- Crisis management
- Case management skills
- Collaboration with community agencies or hospitals
- Working with the whole person (versus working within the medical model)
- Conflict resolution
- Abuse and neglect
- Mental health and suicide

Information on hospital staffing patterns for discharge planners indicated different patterns exist across hospitals (see section on organizational structure). However, there were no statistically significant relationships between the credentials of hospital discharge planners and the type of training they requested ($\chi^2 = 11.853; p > .10$). While this makes choice of training topics easier, discharge planners with nursing or social worker backgrounds receive their training through different venues. We were unable to identify, and research participants confirmed, that there are currently no professional organizations or conferences that specifically target hospital discharge planners with either nursing or social worker credentials.
Recommendations

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. The focus group discussions resulted in additional recommendations with rankings of their importance and feasibility. The full set of recommendations was presented to the panel of expert consultants in early August 2007 (see Appendix C for membership). Panel members discussed the recommendations and generated their own recommendations which are included at the end of this list. A listing of the following recommendations without the accompanying narrative is provided in Appendix D.

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 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.

These recommendations focus on three key areas: 1) retroactive reimbursement, 2) reducing time on waiting lists, and 3) increasing attendant care. Most of these structural and systemic recommendations came from a focus group discussion and center on easing the consumer’s transition from the hospital to the home. They also address the lack of retroactive reimbursement for provided services which might delay or stop a consumer from accessing home based services. Consumers who do not qualify for Medicaid are also in a particularly vulnerable position as organizations are unable to access funds that may be used to help these people with their immediate needs even on a temporary basis:

*There are just a tremendous number of those folks who don’t fit tidily into the Medicaid pigeonholes...*
This same focus group recommended the development of a model program which would address the needs of those consumers who did not qualify for Medicaid as well as those who were waiting for eligibility determination. Program characteristics of the model program were designed to meet the needs of low-income populations who do not qualify for Medicaid. These study respondents expressed concern that some consumers may be experiencing a service gap between hospital discharge and the beginning of services for this group while program eligibility was being determined. The focus group suggested that services for these consumers should be charged on a sliding scale basis or should be dependent on the income level of the consumer. A full range of services should be provided to these consumers, and time lost in provision of services because of waiting lists and eligibility determination would be eliminated. Later participants who reflected on the recommendation for this model program added an additional recommendation for a similar program model for Medicaid-eligible populations.

- 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).

Additional structural and policy recommendations were related to housing issues:

- 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.

A focus group in an urban area made a number of recommendations for housing. Members from the AAAs and the ILCs suggested that the process of conducting background checks often strained the consumer’s finances:

*The other issue is that a lot of times when they [consumers] are looking for apartments there’s the deposit to do the background check so depending on how many they are looking at, every time they want one that they want to be in, they could put out four deposits. It’s*
$100 a time. And then they get turned down for all four of them and it’s a non-refundable deposit. They don’t have that to give up.

The focus group suggested that the background check process be simplified or removed. A hospital discharge planner suggested that a model program where medical students provided services at homeless shelters as “part of their rotations” had potential to help with some of the access to post-hospital care issues facing homeless populations.

**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.

In this set of recommendations, AAAs and ILCs made suggestions on how hospital discharge planners may improve their intake process. Discharge planners would identify a consumer that currently receives services through an agency card showing that they receive services from a AAA or ILC, a Medical card which may show that they receive home and community based services, or by asking a simple series of questions during hospital intake. Once discharge planners identify a consumer who receives services, they could immediately inform the service providers about the consumers’ condition and collaborate on discharge planning:

> The medical card will say when they come in if-- it is coded-- if they have HCBS. Where they would know that, they do have some type of in-home service. And possibly do we need to contact this person [AAA or ILC] because sometimes we don’t hear. If the attendant doesn’t call us and the individual is in the hospital and facing surgery or whatever, we may not hear until it’s time for them to go home.

**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., CARE) while the consumer is still in the hospital; review current assessment tools to determine if conducting these 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.

The above recommendations focus on conducting accurate and timely assessments of the consumers’ medical condition and services. Most study participants recommended that assessments be conducted within the hospital before the consumer returns home. However, there were two exceptions who felt that portions of the assessment were best conducted in the home setting for the most accurate information. Some supervisors of hospital discharge planners felt that discharge planners would benefit from increased knowledge on effective ways of conducting assessments with this population. Comments across the board indicated some need to explore the interface between the provision of services based on need as determined by an assessment tool and following core principles of empowerment and consumer choice.

**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 rehospitalization.

• 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.

Physicians play a very important role in the discharge planning process. The role of many physicians in impeding a rapid and effective discharge to home based services was emphasized by discharge planners. Many times physicians were unaware of the multiple roles and responsibilities of the hospital discharge planner and the available community supports. Hospital discharge planners and staff from the AAAs and the ILCs all felt that physicians needed to be made more aware of their roles and services:

*Yeah, one of my things is mainly with the doctors that are participating because I don’t think that they are very educated about in-home services...*
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.

Hospital discharge planners are the key point people between the hospitals and community based service providers. The above recommendations focus on improving the lines of communication between hospitals and the community based organizations and between discharge planners and physicians. AAAs and ILCs in the focus groups and the panel of expert consultants felt that there was a need for greater educational resources that discharge planners could access to gain knowledge about issues of consumer choice, advocacy, and about the philosophy and roles of ILCs and AAAs. Discharge planners themselves requested additional educational opportunities to learn more about community resources and new program models. This would help them communicate better with these organizations and coordinate discharge planning with respective service organizations. Internal communication in the hospital could be improved if the discharge planner joined the physician at rounds to discuss discharge planning issues on a case-by-case basis.

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 the 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.

The above recommendations focus on the leadership role that AAAs and ILCs play during a consumer’s transition from the hospital back to the community. It has been suggested that these organizations form the point of referral for all other services in their community. Resources on issues specific to service provision by the AAAs and the ILCs such as complex medical needs and HIPAA should also be made available to community-based workers:

...And I think they are struggling with the acuity in that patient because now they are going home with Foley catheters in or they are going home with a G tube in and they are going to have, maybe need tube feeders. ...they still need to take care of the patients, so they probably have nurses and attendant care people who are not familiar with that, so we need to be able to bring them up to that level.

It is also recommended that AAAs and ILCs further improve their communication with discharge planners by keeping them informed of the status of discharged consumers who are accessing home and community services. This would establish a continuous line of communication between service providers and discharge planners, and give discharge planners success stories to help educate other medical personnel on the benefits of home and community-based services.

**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.

These recommendations focus on consumer choice and self-determination. Consumers should be aware of their rights and should be educated on making the best possible decisions with regards to their health care. Some recommendations made by AAAs and ILCs suggest that consumers increase their awareness of their medical history and inform medical staff in hospitals about pre-existing conditions when possible. Consumers and their families should also be offered education on the power of attorneys and advance directives to help them ensure their wishes are followed in case of hospitalization.

**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.

Some people interviewed planned or conducted training in their respective agencies. Trainers expressed interest in various topics related to discharge planning and community based services. Internal training programs should also focus on inservice options that enhance workers’ ability to access skills and resources that are currently available in the community, as this was an identified need.

**Recommendations from the Panel of Expert Consultants**

• Streamline the housing background check.

• Provide hospital discharge planners with resources and information 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.

Recommendations from the project’s panel of expert consultants provide suggestions for an overall improvement in the interaction between hospitals and community based service providers. The panel considered the recommendations that had been suggested by other focus groups. Recommendations for removing background checks for housing and expediting approval for assistance services, and educating physicians on existing programs and resources were also made in focus groups that were conducted throughout the state. The expert consultants expanded on previous recommendations on improving communication between key players in this process (creating a formal networking structure between hospitals, ILCs and AAAs) and removing structural barriers to accessing services (removing lifetime cap for home modifications). In addition to these recommendations, the expert consultants endorsed recommendations generated from earlier phases of the project.

Conclusions

The Real Choice Project conducted telephone surveys with a representative sample of Kansas hospitals with a 93% response rate (Phase I). Phase II interviews were conducted with representatives from 100% of AAAs, 100% of targeted hospitals, and 92% of ILCs. The project conducted four focus groups across the state (Phase III), which confirmed and provided additional detail to project findings and recommendations.

Data analysis from the Phase I hospital surveys, Phase II interviews, and Phase III focus groups revealed a diverse range of discharge planning processes across Kansas. Consideration was given to hospital size, geographic location, population density, ownership, credentials of the discharge planners, and caseload. Findings identified a very general process that included the identification of individuals to refer for comprehensive discharge planning or a “social services consult,” meetings with the consumer and sometimes family members to conduct an assessment, coordination amongst all players within the hospital setting, determination of needed services, referrals, and set-up of services. However, the process plays out in multiple ways. Discharge planning differs according to community characteristics, the organizational structure of the hospital, and individual circumstances of each consumer. A wide variety of key players both within and outside the hospital setting may or may not be included depending on consumer needs. The physician’s role in the process is often a critical one, but again these interactions vary widely and depend greatly on the individual physician. The importance of including consumers and family members in the process is recognized, but there are barriers to their full participation, including short hospital stays, the consumer not feeling well, consumer’s resistance to utilizing support services, medication side effects, and the complexity and rapidly changing status of the consumer’s condition. Effective follow up on these issues will require input from the perspectives of consumers and their family members—something that was outside the scope of the current study. 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 study identified several barriers to choice in post-hospital care settings. The barriers centered on structural issues, referral practices, communication, and medical complexity of the consumer’s condition, and some of the barriers identified in this study have also been described in the literature. For example, structural barriers such as insurance coverage (Feather, 1993), issues surrounding housing (Backer et al., 2007), and the timeliness of discharge (Minichello et al., 2001; Walker et al., 2007) have also been identified as barriers to effective hospital discharge planning. Previous studies that examined discharge planning practices have also recommended improved communication between physicians and other key players in the discharge planning process as an important area that requires improvement (LeClerc et al., 2002; Walker et al., 2007).

A consistent thread throughout the barriers was time. Time constraints were attributed to shorter hospital stays, referrals and discharge notices made too late in the process, and large caseloads. Time is needed to enhance many aspects of hospital discharge planning, including dedicated time for assessments that allow a good rapport between the discharge planner and a consumer who is feeling unwell and experiencing medication side effects. This includes time to meet with the consumer in the hospital to conduct assessments, explain service options and include family members in the process as appropriate. Time is needed to make referrals, which entail inevitable rounds of phone tag. And time is needed for networking and keeping abreast on local resources and changing program requirements. In addition to barriers, numerous best practices and suggested strategies for overcoming barriers were identified. Again, dedicated time is one of the barriers to implementing these strategies. For example, as seen in the description of administrative processes as a structural barrier the advent of shorter and shorter hospital stays poses additional time barriers. With a three to four day hospital stay and a discharge planning process that typically takes multiple days to complete-- even with the best case scenario of referrals made to community agencies on the day of hospital admission, there will still be situations when someone will be discharged before home and community based services are in place.

Another issue that arose was that hospital discharge planners do not have a centralized training structure that provides opportunities to meet with and hear about successful strategies used by peer organizations. Discharge planners, AAA case managers, and workers from ILCs all attend their respective conferences, trainings, and workshops. In the case of discharge planners, the educational opportunities are dependent on the credentials of the workers. The literature notes that trained case managers and social workers have been found to plan more effective discharges, and rates of readmission and reinstitutionalization for patients who are discharged by trained staff have been found to be lower than those who were discharged by less trained staff (Steeman et al., 2006). Therefore, training strategies that overcome the lack of a cohesive training structure for hospital discharge planners, provide CEUs for both nurses and social workers, and address the time constraints of these workers are critical.

One of the key recommendations made by discharge planners, AAA case managers and independent living advocates and counselors was to educate physicians in discharge planning in order to increase their understanding of the various roles that discharge planners and community-based service providers play. Most medical training programs concentrate on building clinical skills and may not focus on collaborative practice-- in one study, resident physicians identified
discharge planning as an area that they feel unprepared to deal with and regarded the process as time consuming and cumbersome (Chodosh et al., 1999). The literature emphasizes the importance of the physician’s role in determining the effectiveness of discharge planning and increasing choice in care settings. Therefore, training programs should also increase physician awareness about community-based options other than a nursing facility for post-hospital care. The respondents in the current study reported communication barriers with physicians. The literature also identifies a lack of communication between discharge planners and clinical staff who may view discharge planning activities through different lenses. It has been found that communication skills training programs can greatly alter the physician’s attitude towards patient care (Jenkins & Fallowfield, 2002), and what may be required is an integration of clinical skills with effective post-discharge service delivery (Mizrahi & Abramson, 1985). Greater involvement in patient care and respect for patient views may allow the physician to gain greater knowledge of the services that a patient is currently accessing and what services may be planned for them in accordance with their needs and wishes. Social workers can bring their skills into physician training exercises. Some studies have recommended collaborative practice between the social worker/discharge planner and the physician, and have found that collaboration between the two lead to more effective service delivery for patients and families (Kitchen & Brook, 2005; Mizrahi & Abramson, 2000).

Respondents in this study indicated that increasing consumer choice by targeting specific aspects of hospital discharge planning systems is feasible and likely to be effective. Therefore, it is anticipated that following through with the provided recommendations will result in desired change. Study participants and members of the panel of expert consultants expressed interest in additional information related to these findings. They were specifically interested in further research regarding the roles of specialty hospitals and managed care; the perspectives of physicians, older adults/younger adults with disabilities, and allied health personnel; the roles of other services such as hospice and adult protective services, and the implications of consumer access to informal support. Further research in these areas would likely generate additional strategies to increase choice in post-hospital care settings for older adults and younger adults with disabilities.

The data collected in this study provide a detailed and comprehensive base for use in planning initiatives to increase choice, and in applying for federal grants and other types of funding to implement these initiatives. Both the quantitative and qualitative components point to key strategies to improve communication among ILCs, AAAs, and hospital discharge planners; address structural, timing, communication, and other barriers, and disseminate information on best practices to overcome identified barriers. Continued attention to efforts to increase choice for older adults and younger adults with disabilities will make it possible to have their long-term care needs met in the setting they prefer.
References


Appendix A: Study Design & Methodology
Real Choice Project: Referral System Assessment
Research Design and Methodology

Data for this project were gathered through a combination of qualitative and quantitative methods in three phases:

- Phase I, telephone surveys with hospitals
- Phase II, semi-structured qualitative interviews with hospitals, Area Agencies on Aging (AAAs), and Independent Living Centers (ILCs)
- Phase III, focus groups with representatives from hospitals, AAAs, ILCs, and other community-based services.

A panel of expert consultants provided guidance throughout all stages of the project (see Appendix C for panel membership). The University of Kansas IRB approved procedures for human subjects’ protection and measures to ensure confidentiality. All surveys and interviews were conducted by phone; the four focus groups were held across the state in meeting rooms provided by Senior Centers, ILCs, and hospitals.

Research Questions

The purpose of this study is to identify ways to increase choice in care settings for older adults and younger adults with disabilities following a hospital stay. The study provided an increased understanding of hospital discharge planning processes used across the state, identified barriers to choice in care settings following discharge, identified strategies and best practices to overcome barriers and increase choice, and identified methods for effective dissemination to the target audiences. This was accomplished by answering the following questions:

- What is the organizational structure of hospital discharge planning within Kansas hospitals?
- Who are hospital discharge planners in Kansas?
- Who are key players in the hospital discharge planning process?
- How are AAAs and ILCs involved in discharge referral processes?
- What are barriers to effective hospital discharge planning?
- What are best practices to overcome barriers?
- How do key players in hospital discharge planning processes prefer to receive training or additional information on best practices?
- What are recommendations for systems change?

Definitions

With guidance from the project’s panel of expert consultants, the following definitions were used:

Hospital discharge planning—the focus of this study is on referral systems and the patterns of interactions across those involved in planning post-hospital care for those who experienced an overnight stay in a hospital.
Targeted beneficiaries of hospital discharge services—older adults (ages 60+) and younger adults with disabilities (ages 18+).

Targeted hospitals—community-based and Veterans Administration hospitals in Kansas (the discharge process from nursing homes, mental health facilities, day clinics, hospitals on military bases, and other non-hospital institutionalized settings are not included).

Sampling Plan and Sample Description

To target hospitals for Phase I, the telephone survey, the study used a stratified, random sample based on the following hospital characteristics: geographic location, ownership, population density, and size (based on the number of acute care beds). Telephone surveys were conducted with discharge planners or their supervisors in each hospital. For Phase II, we conducted semi-structured, qualitative interviews with AAAs, ILC, and hospitals, targeting a minimum of one respondent familiar with the discharge planning process at every AAA and ILC in the state. Due to the large number of hospitals, a purposive sample based on size, hospital ownership, and population density was used for the Phase I hospital survey. Interviewees from Phase II recommended potential focus group participants from hospitals, AAAs, ILCs, and other community-based services for Phase III of the study. In some cases, they offered themselves or recommended a colleague. Others declined, with a few volunteering time constraints as a reason. In all study phases, researchers took steps to encourage participation, such as:

- Providing the agency’s executive director or discharge planning supervisor with information about the study and letting the director/supervisor decide who among those familiar with the hospital discharge planning process would be the research participant. This allowed agencies to identify the staff member most knowledgeable about discharge planning and ensured a comprehensive interview due to his/her availability.

- Using a sampling plan that targeted multiple hospitals per category in the stratification table. “Back-up hospitals” to be used in case of refusals to participate were identified for categories with more than five hospitals.

- Beginning qualitative analysis of interviews and field notes immediately after the initiation of data collection. This allowed researchers to identify emerging themes, adapt sampling strategies based on interview data, and continue interviews until saturation had been reached. For example, initial interviews with research participants indicated that multiple staff positions within each agency worked with consumers who were discharging from hospitals. The sample was expanded to include a second person within an agency when strongly recommended by the first interviewee.

- Enlisting the panel of expert consultants and organizations such as Kansas Area Agencies on Aging Association, Statewide Independent Living Centers of Kansas, Kansas Association for Centers of Independent Living, Society of Social Work Leadership in Health Care (KC/MO and Sunflower chapters), and the Kansas Hospital Association to encourage members of their constituency groups to participate.
- Offering a financial incentive ($20 per hour) for participation in Phase II and III, due to the amount of time involved with the semi-structured interviews and focus groups.

Sample Description

Phase I. For the telephone surveys, 45 hospitals were identified through a stratified random sample that was based on geographic location, ownership, county population density, and number of acute care beds. Our sample for the hospital surveys represented the range of categories within each of these strata. The survey sample targeted a minimum of five hospitals in each category for hospital location, ownership, population density, and size (number of acute care beds); where there were fewer than five hospitals per category (e.g., investor-owned and Veterans Administration hospitals) all those hospitals were targeted. This resulted in a sample that did not exactly mirror the proportions of different hospital types in the state, but ensured that each hospital type was adequately represented. Figures 1 and 2 illustrate the proportions of hospital location and hospital ownership among those included in the Phase I sample and in the state of Kansas. Figure 3 shows that the survey sample is fairly evenly split among hospitals from rural (53%) and urban areas (47%). The geographic distribution of hospitals across the state is actually quite skewed, with 80% of hospitals from rural areas and 20% from urban areas. Likewise, Figure 4 illustrates the split of small (33%), mid-sized (26%), and large (41%) hospitals in the survey sample. Again, the actual state distribution is skewed: small (73%), mid-sized (13%), and large (14%).

Six target hospitals declined to participate in the survey (did not respond to repeated attempts to contact); 3 backup hospitals from the same strata as these hospitals were substituted. This resulted in a 93% return rate. Hospitals that declined to participate were mid-sized or large, non-profit or government owned, both urban and rural, and mainly from the northeast portion of the state (1 from SW). Most hospitals in Kansas fall into these categories; there were no characteristics that stood out among hospitals that declined to participate.

Phase II. For the semi-structured, qualitative interviews, we interviewed a purposive sample of 13 hospital discharge planners who were targeted based on size of hospital, hospital ownership, and population density. The hospital sample included representatives from four small, three mid-sized, and seven large hospitals that were located in areas with both urban (eight) and rural (five) population densities. Hospitals were distributed across the state, using regions delineated by the Kansas Hospital Association as a guide. This included two hospitals from the northeast, five from the southeast, four from the south central, and two from the most rural areas (north central, northwest, and southwest regions). Finally, all types of hospital ownership were represented, with interviews from one investor-owned, two Veterans Administration, two government-run, five religious-affiliated, three non-profit hospitals. Because we conducted the 13 interviews across the four types of hospitals containing two to five subcategories each, we were able to provide diverse perspectives of the primary issues raised in Phases I and II. These perspectives were confirmed through focus groups with representatives from hospitals, AAAs, and ILCs in Phase III.
Hospital Telephone Surveys: Sample Demographics

Phase I hospital telephone surveys: 93% return rate (42 out of 45 targeted hospitals).

Figure 1

Hospital Location of Real Choice Survey Sample and State of Kansas

Figure 2

Hospital Ownership for Real Choice Project Surveys and for the State of Kansas

Figure 3

Population Density for Real Choice Project Surveys

Figure 4

Hospital Size for Real Choice Project Surveys
For AAA interviews, we interviewed one staff person from each of 11 AAAs plus one additional person from one AAA for 100% coverage. Since more than one staff position within AAAs work with older adults who are discharging from hospitals, the additional interview in one AAA provided information from the perspective of multiple job roles.

For ILC interviews, the project interviewed one staff person at 12 of 13 ILCs plus one additional person from one ILC for 92% coverage. Again, the additional interview allowed us to assess the range of perspectives on the hospital discharge planning process across multiple job roles within a community-based agency.

**Measures**

Questions from the survey and semi-structured interview guides were developed based on a literature review of hospital discharge planning, from input of a panel of expert consultants, and based on background interviews with representatives from hospitals, AAAs, and ILCs. In Phases I and II, telephone surveys and semi-structured interviews were pilot-tested with one hospital, one AAA, and one ILC. Since subsequent changes to interview guides were minor, researchers received IRB approval to include this data in the actual study. Minor changes included shortening the length of the Phase II interviews so they could be completed within one hour as recommended by the project’s panel of expert consultants.

**Phase I.** Telephone surveys with hospitals collected quantitative data that was designed to answer research questions related to the organizational structure of hospital discharge planning within Kansas acute care hospitals and characteristics of the hospital discharge planners themselves. Seventeen questions focused on organizational structure, training and continuing education, screening and assessment, types of referrals, frequency of various post-hospital care settings, and a general rating of the hospital discharge planning system in their area. Questions were close-ended (e.g., Does your hospital have a manual or written policies regarding hospital discharge planning, yes/no), short answer (e.g., How many hospital discharge planners do you supervise? What type of training or continuing education do you feel your hospital discharge planners need?), or a rating (e.g., Overall, on a scale of 1 to 10, how would you rate the hospital discharge planning system in your area?). All questions were analyzed as quantitative data.

**Phase II.** Semi-structured interviews with hospitals, AAAs, and ILCs gathered information from the perspective of key players in the hospital discharge planning process. Interview questions were primarily qualitative in nature, and inquired about organizational structure, training and continuing education, and the hospital discharge planning process. The number of questions varied by agency; the hospital interview contained 47 questions, the ILC interview contained 42, and the AAA interview contained 36 questions. The difference in the number of interview questions was related to the varying missions of each agency. For example, only hospital discharge planners were asked, “How does transfer of care within the hospital affect discharge planning?” Hospital discharge planners and ILC workers may interact with both older adults and younger adults with disabilities so additional questions in these interview guides inquired about both populations.
The question format included both short answer (e.g., What are your credentials/professional training?), rating (e.g., Overall, on a scale of 1 to 10, how satisfied are you with communication in the discharge planning process for older adults and adults (18+) with disabilities?), closed and open ended questions (e.g., Are there aspects of hospital discharge planning for which you would like to receive additional training, yes/no; If yes, what are they?). Questions regarding the hospital discharge planning process were divided into sections which focused on the following: (1) general processes (e.g., Walk me through a typical discharge planning process with an older adult?); (2) timing, (e.g., When do you believe discharge planning for older adults and adults with disabilities should begin?); (3) screening and assessment (e.g., Do your screening or assessment practices differ depending on whether the person is an adult with a disability (18+) or an older adult? If yes, how?); (4) key players and referral processes (e.g., Would you say the following parties are rarely, sometimes, or frequently included in the hospital discharge planning process? Choices included key players such as older adult or adult with a disability, home health or visiting nurses, etc.); (5) communication and service delivery (e.g., How is information shared with others involved in the discharge planning process?), choice (e.g., In your experience, where would most adults with disabilities leaving a hospital choose to live?), evaluation and successful outcomes (e.g., Please describe a successful outcome for an older adult?).

Probes and additional questions were asked for clarification or to follow up on information that emerged from preliminary analysis. For example, one hospital discharge planner mentioned the hospital-based physician as a key player in the discharge planning process and the interviewer followed up with additional questions to better understand the potential impact of the hospitalist model on hospital discharge planning processes.

**Phase III.** Focus groups served multiple purposes: 1) confirmed the trustworthiness of themes that emerged during analysis of Phase II surveys and Phase III interviews, 2) generated recommendations to increase choice in post-hospital care settings for older adults and younger adults with disabilities, and 3) provided feedback on the importance and feasibility of project recommendations. To confirm the trustworthiness of emerging themes, the research team met with the expert consultants during the transition between Phase II and Phase III. The expert panel noted that there was not much detail about the structural barriers that emerged during Phase II. As policymakers were interested in these particular issues, a specific focus on structural issues became one of the topics for discussion in a focus group (see Appendix B for a listing of targeted themes for each focus group). During focus groups, the facilitator introduced the project and presented 2-3 themes which were emerging from the data to date. Participants were asked open-ended questions such as, “How does this fit with your experience?” “What strategies have you used that are successful?” “Do you agree or disagree? Why or why not?”). Recommendations generated from the discussion (e.g., complete the UAI and other assessments while the consumer is still in the hospital) were posted and participants were asked to vote for the five most important and the five most feasible recommendations. The voting process spurred additional discussion between participants and provided information on the most important strategies (e.g., develop a model program that targets those who are not eligible for Medicaid) and the strategies most likely to increase choice in post-hospital care settings (e.g., at hospital intake, determine which consumers are currently receiving home and community-based services and notify case managers).
Data Management and Analysis

In Phases I, II, and III, telephone surveys, interviews and focus group discussions were tape-recorded (with permission from participants). Researchers also took notes of the main points from participants’ responses and the discussion during the surveys, interviews, and focus groups. In each phase of data collection, interviewers verbally discussed the surveys, interviews, and focus groups individually with the project coordinator or lead research assistant, or during weekly team meetings. The discussion topics included any confusion with survey or interview questions, key points raised during interviews, and logistical issues such as length of interview or technical issues with tape recorders. This information allowed us to further enhance assessment instruments, note topics that surfaced in multiple interviews, and add probe questions related to emerging themes. In Phases I and II, interviewers entered quantitative data into a SPSS database and recorded their notes and observations of responses to the survey and interview guides in designated files to use for quality control and as a back-up in case of tape recorder failure. In Phase III, a summary of recommendations from the focus group was compiled within a few days of each focus group meeting. Tapes from Phases II and III were transcribed for additional analysis.

In all phases of the study, initial analysis began after each survey, interview, and focus group was completed. Immediately after data collection, interviewers documented their observations of the interviews. Within 48 hours, interviewers generated memos, and discussed emerging themes, key issues, and quotes that represented concepts heard over multiple interviews (inductive process). In Phase I, quantitative analysis of telephone surveys with hospitals provided frequency counts, percentages, and cross tabulations on data related to the organizational structure of hospital discharge planning across the state. In Phase II, semi-structured interviews were transcribed and analyzed using the constant comparative method of data analysis and with the assistance of Atlas software for data management.

For the qualitative analysis of interview transcripts and interviewer notes in Phase II, the project manager was the primary interview coder (74%), and had assistance from two doctoral students who each coded some interviews (18%, 8%). It is important to note that the research team encountered problems with the recording equipment. Tape recorders did not pick up sound on eight interviews (21%). This occurred at random across all three interviewers. In these cases, interviewer notes, which were generally completed within 48 hours of the interview, were transcribed and coded. To ensure trustworthiness, the following process was used for consistency in the use of codes:

1. Initial codes were inductively generated from memos, interviewer notes, and team meetings (e.g., safety vs. independence, empathy), and deductively generated from the interview guide and a literature review (e.g., ideal beginning, ideal reality, timing of discharge, empowerment & self-advocacy). A preliminary coding guide was developed that each coder used for reference throughout the coding process. This is very clear.

2. Four interviews were chosen based on diversity of perspectives (two hospitals, one AAA, one ILC) for the purpose of generating the greatest possible themes. Interviews were separately coded and discussed by the research team. Coders used open coding to
generate new codes when appropriate, and also identified exceptions to emerging themes. For example, several interviewees suggested that workers from AAAs and ILCs assess consumers before hospital discharge and this had been noted as an emerging recommendation. Yet two interviewees specifically noted that they preferred to conduct these assessments after the consumer returned home.

3. The project manager revised the coding guide, added mutually agreed-upon definitions to be used throughout the coding process, assigned interviews to be coded, and maintained frequent contact with each coder throughout the coding process. The coding team met weekly throughout the analysis period, and used the coding guide to anchor consistency in the use of codes. Very few new codes were added at this point, however the definitions of some existing codes were expanded. For example, the code “structural & systemic issues” was originally defined as policy and organizational structure, but was expanded to include barriers due to assigned job duties, program design, waiting lists, and funding.

Following the coding process, searches on individual code words or families of codes that represented concepts were used to pull out related content across and within interviews. Members of the research team reviewed this content, identified relevant issues, and wrote brief summaries of concepts. Concurrently, quotes and summaries were grouped into broader themes and answers to project research questions.

For the Phase III analysis, discussions and recommendations from the focus groups were summarized and transcribed. Transcripts and/or tapes were reviewed one person to ensure that the notes accurately represented the group discussion. Recommendations from focus groups were identified and synthesized into the recommendations generated through Phase II analysis of semi-structured interviews.

The recommendations and descriptive data regarding hospital discharge planning processes and referral systems in Kansas will provide state policymakers with an understanding of how the hospital discharge planning process and referrals differ across the state so that future system enhancements can be tailored to the needs of each site. The mixed methods approach used in this project ensures that diverse perspectives from a variety of key players are considered, and that resulting recommendations describe feasible strategies to increase choice in post-hospital care settings for older adults and younger adults with disabilities.
Appendix B: Focus Groups
### Real Choice Hospital Discharge Planning Focus Groups

<table>
<thead>
<tr>
<th>Location(^1) (date)</th>
<th>Representation(^2)</th>
<th>Themes Presented for Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kansas City (5/10/07)</td>
<td>AAA(2) ILC (2)</td>
<td>Timing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Keeping current on local resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Safety vs. independence</td>
</tr>
<tr>
<td>Western Kansas - Hays</td>
<td>Hospital AAA ILC</td>
<td>Timing</td>
</tr>
<tr>
<td>(5/31/07)</td>
<td></td>
<td>Structural barriers</td>
</tr>
<tr>
<td>Wichita (7/12/07)</td>
<td>Hospital AAA ILC</td>
<td>Decision-making process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Housing issues</td>
</tr>
<tr>
<td>El Dorado (7/20/07)</td>
<td>Hospital(^3)</td>
<td>Physician’s role</td>
</tr>
<tr>
<td></td>
<td>Community-based services (not AAA or ILC)(^3)</td>
<td>Hospital intake process</td>
</tr>
</tbody>
</table>

\(^1\) Focus groups took place in meeting rooms at one senior center, two ILCs, and one hospital.  
\(^2\) Representation included three AAAs, three ILCs; eight hospitals, and two community-based service agencies (nonAAA/ILC).  
\(^3\) Meeting for the Society of Social Work Leadership in Healthcare, Sunflower chapter.
Appendix C: Real Choice Panel of Expert Consultants
### Real Choice Panel of Expert Consultants
**Office of Aging and Long Term Care**  
**University of Kansas**

<table>
<thead>
<tr>
<th>Name</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Devyani Chandran</td>
<td>OALTC</td>
</tr>
<tr>
<td>Rosemary Chapin</td>
<td>OALTC</td>
</tr>
<tr>
<td>Janis DeBoer</td>
<td>KDOA</td>
</tr>
<tr>
<td>Monica Flask</td>
<td>Via Christi, Wichita</td>
</tr>
<tr>
<td>Carmal George</td>
<td>North Central-Flint Hills AAA</td>
</tr>
<tr>
<td>Julie Govert Walter</td>
<td>K4A/ North Central-Flint Hills AAA</td>
</tr>
<tr>
<td>Doreen Higgins</td>
<td>OALTC</td>
</tr>
<tr>
<td>Cornelia Jeffery</td>
<td>KDOA</td>
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<tr>
<td>Shannon Jones</td>
<td>SILCK</td>
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<tr>
<td>Terry Koenig</td>
<td>OALTC</td>
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<tr>
<td>Julia Lloyd</td>
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<td>Bill McDaniel</td>
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<td>Valerie Merrow</td>
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<tr>
<td>Kelly Nightengale</td>
<td>Independence Inc.</td>
</tr>
<tr>
<td>Marla Pearson</td>
<td>Newman Memorial Hosp, Emporia</td>
</tr>
<tr>
<td>Michelle Ponce</td>
<td>SRS</td>
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<tr>
<td>Roxanne Rachlin</td>
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<td>Patsy Samson</td>
<td>KDOA</td>
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<tr>
<td>Jennifer Schwartz</td>
<td>KACIL</td>
</tr>
<tr>
<td>Julie Sergeant</td>
<td>OALTC</td>
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</table>
Appendix D: Project Recommendations
Real Choice Referral System Assessment Project
Outline of Recommendations

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 (see Appendix C for membership). 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 rehospitalization.

• 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.