THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

Summary of Regional Discharge Planning Focus Group Meetings

conducted by

The Hospital & Healthsystem Association of Pennsylvania
The Pennsylvania Health Law Project
The Disability Rights Network
The Pennsylvania Association for Area Agencies on Aging
The Pennsylvania Office of Long-Term Living

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Summary of Regional Discharge Planning Focus Group Meetings

During early 2009, The Hospital & Healthsystem Association of Pennsylvania (HAP) was approached by disability advocates, representatives from the Office of Long-Term Living, the Disability Rights Network of Pennsylvania, the Pennsylvania Association for the Area Agencies on Aging, and the Pennsylvania Health Law Project to discuss what opportunities existed to provide hospitals with information and resources to help hospitals return the elderly and disabled back to their homes in the community following acute care hospitalization. As a result of these conversations, there was a decision to host a focus group comprised of hospital discharge planners, case managers, and social workers to learn what would be most beneficial to them in terms of resources and assistance. Although the idea was to host one focus group, there was strong interest across the state to participate in this type of discussion. In the end, there were three focus groups that were held during September and October in Philadelphia, Harrisburg, and Pittsburgh.

These sessions were designed to understand what could be done to help hospital staff in developing discharge plans that would successfully return the elderly and disabled to the community. However, it became abundantly clear that hospital discharge planners, case managers, and social workers faced many challenges and impediments that not only hindered their ability to return patients to the community immediately following discharge, but also may have contributed to re-hospitalization. During the focus group sessions, facilitated by HAP staff, the discussions focused on the following:

- Understanding the barriers that hospital case management and discharge staff encounter when trying to help individuals return to home following hospitalization.
- Identifying what assistance, information, and other supports would be needed by hospital case management and discharge staff to help facilitate patient discharge to home rather than a nursing home.
- Sharing ideas about how to make resources and information accessible and understandable to other hospital case management and discharge staff across the state.
- Next steps in this process.

The following summary reflects some of the key themes and recommendations that emerged during the discussion with the participants at the focus group meetings in each of the areas—barriers to helping people return home; assistance, information, and supports needed; how to make transitioning home available to more disabled adults; and how best to spread the word.

Barriers to Returning Patients Home After Acute Hospitalization

Family Issues

A major issue that impacts effective discharge planning that emerged repeatedly across all three focus groups related to family involvement, family expectations, and family issues of all sorts. The following represent some of the issues identified by those that participated in the focus groups with respect to family issues that they deal with on a daily basis:

- One of the main barriers to effective discharge planning is the short amount of time that hospital discharge planners, case managers, and social workers have to work with a patient and family to effectuate discharge from the hospital. Most participants indicated that average hospital length of stay was between four to five days; and depending on the circumstances, it was often difficult to either locate or identify a family member to discuss discharge options or who would be willing and able to assist in the care of the patient following hospital discharge.

- Family members are often not prepared and overwhelmed with the amount of information they need to process and decisions that they need to make in a compressed period of time. Many of these decisions require some understanding of the patient's finances, and very often, the patient doesn't even understand his/her insurance coverage or financial situation, let alone a family member.

- In all three focus groups, participants noted that sometimes decisions are made by the patient and the family that might not be in the best health care interests of the patient but are viewed as necessary to maintain family stability. One example that was provided involved a family that relied on the patient's social security check. Although placement in a nursing home might have been a better discharge placement for this patient, the patient and family feared that this money would not be available to the family to help with their living expenses. As a result, this patient was discharged back to home. Others echoed that these situations were not uncommon and often after the patient returned home, the patient was re-hospitalized because of lack of sufficient support and care provided by the family.

- Participants described situations where they were dealing with individuals who were the designated power of attorney (POA), but clearly did not understand or were prepared for this responsibility. Across all three focus groups, there was considerable discussion about how POAs need to be better selected and need to represent the interests of the patient.

- Several hospitals indicated that they needed to petition the court for guardianship in extreme circumstances when the patient could not make a decision and they could not identify a person who was able and willing to serve in this role. Across all focus group discussions, hospitals indicated that it was extremely difficult to obtain a court date, often leaving the patient stranded in the hospital for several weeks. Participants acknowledged disparities between counties in their response to a request for guardianship.

- Patients and families don't understand the Medicare home health benefit, particularly that the patient needs to have skilled needs to qualify for the benefit and that the nurses or therapists only will be visiting the patient for short intervals of time to monitor or provide care/therapy. Patients and families don't realize that they often need to find and pay persons who would come to the home to provide assistance with shopping, meals, and other activities such as bathing and dressing.

- Patients and families don't understand that nursing home placement might be temporary before the patient is stronger and healthy enough to return home. There continue to be many negative connotations around nursing home placement by patients and families. This can result in a patient going back home without the necessary supports, which then lands the patient back in the hospital for second or more repeated hospitalizations before a decision is made to place the patient in a setting that can offer more intensive nursing care or therapy.

- Several participants also indicated that family members often expect hospital discharge planners, case managers, and social workers to craft a customized plan for their family member, meaning that they expect the hospital to mix and match what is available into a discharge package that meets the patient's needs.

- There also was considerable discussion about estate recovery and how that affects family decision-making not only for nursing home care, but also as it relates to home- and community-based services.

Ideas to Assist with Family Issues:

- There needs to be more public and community education about the various levels of care, including what types of patients are best suited for those settings and what services are provided in those settings. Everyone acknowledged that this is education that needs to happen proactively, but because of the nature of the education, most people don't seek out this information until they really need it.

- In concert with the above, there also needs to be more education about eligibility, meaning that individuals need to understand what services they are eligible for based on their insurance coverage, specific medical condition, and intensity of service required.

- Clarifying responsibility among family members should be established upon admission. Prompt identification and family member contact needs to be established immediately. A family member plan should be developed and agreed upon on the first day. This plan should include a family contract with the ultimate goal of returning the patient to his/her home in the community if there is agreement among the patient and family that this is a desired and viable goal.

- Provide more information to hospitals about Pennsylvania's nursing home transition program. This is a program that helps eligible nursing facility residents return home to live independently in the community. The program was implemented during 2006 and has

resulted in transitioning approximately 5,500 individuals back into the community. Some of the services that might be available to individuals include: (1) attendant care; (2) affordable housing; (3) medical equipment and supplies; (4) home modifications; (5) assistance with security deposits; and (6) personal emergency response systems. Increasingly, the types and number of persons participating in the transition team meetings has increased, and nursing homes have gradually started to identify candidates to refer to this program. The most challenging aspect of this program has been around what strategy to use to best target patients who would benefit from this program and its associated interventions.

- Increase use of senior centers to provide education about the care delivery system, medical insurance, and how to be prepared to make decisions regarding health care preferences.

Care Transitions

Another issue that received considerable discussion was about the need to ensure that services needed by the patient could be rapidly deployed or implemented following hospital discharge. The participants stressed that the first 24–48 hours following hospital discharge are often critical to avert re-hospitalization. The following represents some of the challenges mentioned by those that participated in the focus groups:

- As a result of the short time that patients spend in the hospital and the length of time associated with determining whether a patient might be eligible for a home- and community-based waiver program, hospitals often have to seek alternative placement for the patient until a determination can be made and those services can be put in place. There was agreement that placement in the nursing home should not be considered the endpoint, but rather should reflect a stop along a journey to home. Hospital representatives talked about the need for talking more about bridging care from one setting to another.

- Across all the sessions, the participants indicated that the sense of urgency is different ("clock ticks differently") between the hospital and the respective Area Agency on Aging. There was agreement among all the focus groups that a barrier to home placement is the length of time that it takes to complete forms through the Area Agencies on Aging for waiver programs. A typical time frame to complete the various tasks, such as the application, Medical Assistance approval, completion of the MA 51 form by the physician, and completion of the assessment can take up to eight weeks; and then after that, it could take a few months to get all those services in place.

- **Focus group participants felt that Area Agencies on Aging needed to be accessible every day of the week during normal business hours**. Area Agencies on Aging need to consider transitioning to the same business model hospitals utilize, not just Monday through Friday. Further, consideration should be given to having a live person answer calls and explain services that are available. Hospital participants talked about having access to an expert who could help them with understanding what programs were available and what programs for which individual patients might meet the qualifications and eligibility requirements.

- There seemed to be a general desire among those who participated in the focus groups to test ways to rethink how the Area Agency on Aging staff interact with hospital staff on a more permanent and ongoing basis. For instance, in the Pittsburgh focus group, hospitals involved in the Care Transitions project in Westmoreland County through Quality Insights of Pennsylvania shared that staff in the Area Agency on Aging were deployed as coaches using Dr. Eric Coleman's model. The hospital identifies those patients whom it believes are at high-risk for hospital readmission. Staff from the Area Agency on Aging visit the patient while the patient is in the hospital; make one home visit; follow up with two phone calls; and assist the patient with managing his/her health care using a personal health care record that has been developed. According to hospital representatives at the focus group, this program has helped tremendously in building a closer working relationship between the Area Agency on Aging and the hospital, and helps to ensure continuity of care for the patient. The focus needs to be on identifying those patients at risk for re-hospitalization. There need to be ways to expand the program using other community resources, including reaching out to faith-based organizations to potentially tap into a group of individuals interested in volunteering to assist with this program.

- At the Harrisburg focus group, representatives from Reading Hospital shared information regarding a care management pilot program they are working on (with an insurer) and are in the process of creating/planning for those individuals who are known as "frequent fliers" to their emergency department. These individuals are those that continually visit their emergency departments for conditions that are not true emergencies, such as the common cold. The conditions they present with could be treated in a physician's office. They come to the emergency department for various reasons: inability to obtain an appointment with their physician, they don't know how to navigate the system, little or no money for drugs they might get prescribed by their physician, or transportation issues, etc. They also have found there are some culture-related issues associated with some of their "frequent fliers." For example, many of their patients that are Puerto Rican in descent are not familiar with going to a physician for their care. In Puerto Rico, they go to the hospital for all of their treatment and care. As a result, they visit their emergency department as this is all that they have ever known to do to receive medical care. As part of the pilot project, Reading's plan is to hire an outpatient social worker—someone, for example, who knows the systems, has knowledge of the services that are out there, and also has familiarity with homeless shelters. This individual would carry an outpatient caseload only. Funding for this position would be through the hospital, in which the costs would far exceed the reimbursement; however, it is felt this will be much more cost-effective in the end than the continual care provided to the "frequent fliers," the majority of which are uninsured. The hospital may pursue grant money to assist with the pilot program as well. They are modeling the pilot program from a Camden, NJ, program that has been very successful. This program formed a coalition to manage these individuals and is funded by the Robert Wood Johnson Foundation. They have an entire team that focuses on these individuals. The pilot project at Reading is ready to move forward, pending final approval from their CEO. Consideration should be given to identifying or developing programs to assist persons who use emergency departments frequently to make better choices/decisions when seeking care.

- There was general consensus that there needed to be implementation of community case management so that gradual declines in functional and health status can be identified sooner and result in earlier intervention. No one is absolutely certain what this looks like, but believes that there needs to be funded demonstration projects that allow for the development of community-based case management. Right now, staff at the Area Agency on Aging only may see elderly individuals once or twice a year and miss an opportunity to intervene earlier.

- Discharge focus group participants also stressed that it would be important to have representatives from the Area Agency on Aging follow patients that have to be placed temporarily in nursing homes to ensure that every effort is made to have that patient return to the community with the appropriate care and supports (see references previously to the Nursing Home Transitions program).

- There also was a discussion about problems encountered with home care in that the patient might not be seen by home care nurses until 48 hours after discharge or that therapists may take as long as a week to evaluate the patient and begin home therapy. Patients who don't receive this attention in the home immediately following discharge are potentially at-risk for re-hospitalization.

- At the Harrisburg focus group, several participants mentioned that when therapists document that "24-hour supervision needed," it often limits what post-acute arrangements can be made for the patient. Several participants noted that this is often documented by the therapists because of medical liability concerns and a bias that institutional placement represents the safest environment for that patient's care. There was agreement that therapists should be documenting what is required to achieve goals so that other options could be pursued in terms of how to deliver those services to assist patients in meeting those goals.

- Discharge planners discussed the issue of hospitals often being the victims of the "dumping syndrome" as they are the safety net of the community and will not turn anyone away. They reported an increase in the number of for-profit nursing homes that will discharge patients, with no real medical need, to the hospital and then not accept the patient back.

Ideas to Assist with Care Transitions:

- Consider conducting periodic regional meetings that include providers across the continuum of care, payors, Area Agencies on Aging, and Centers for Independent Living to assist with the development of programs that promote better continuity of care, help to promote return to home with community services, and prevent re-hospitalization.

- Promote opportunities for hospitals to have more ongoing interaction and dialogue with the Area Agencies on Aging and Centers for Independent Living.

- Fund demonstration projects that promote the development of a community-based case management program and peer assistance models for the elderly and disabled.

- Create "circles of support" groups (family members, community volunteers, faith-based groups, community social services, etc.) that provide primary focus on individuals that have expected re-hospitalizations and individuals with chronic diseases.

- Utilization of disease-based management programs for chronic diseases.

- Develop a "community provider" program in which others in the community are involved in the discharge placement of patients. Consideration should be given to using churches and mid-level practitioners in these programs. Also, consideration should be given to include an individual from the local Area Agency on Aging office.

- A "Community Case Management" program is needed with the incorporation of outpatient social workers being involved. Participants referenced a pilot program (with 30–40 patients) initiated by Joanne Lucas in Camden, NJ, that used outpatient social workers for patients that were "frequent fliers." This ten-year program was funded by the Robert Wood Johnson Foundation. While researching this pilot program, the following program that is similar in nature, "New Jersey Program Finds Alternatives for ER Super Users," is located at: http://www.kaiserhealthnews.org/Stories/2009/March/09/ER-Super-Users.aspx. Community case management would assist with many language barrier issues that often occur, especially with completing disability applications, which they often have difficulty navigating.

- Improve communication across settings of care. Efforts should include development of cross-setting team meetings and use of standardized communication tools, such as use of a written transfer form.

- There should definitely be some quality monitoring efforts to determine the effectiveness and timeliness of Area Agencies on Aging in matching and ensuring delivery of services to elderly persons.

- **Redesign the waiver application process to make it more efficient.** For instance, is there the possibility of assuming presumptive eligibility; expediting physician documentation; ensuring patient assessment within 48 hours; and making sure that services are in place within 24 hours of the person's arrival home?

- Community Choice has been an attempt by the state to help older adults and persons with disabilities receive home- and community-based services. This program is available in selected Pennsylvania counties (Allegheny, Chester, Delaware, Cumberland, Dauphin, Fayette, Greene, Lancaster, Montgomery, Perry, Philadelphia, and Washington). In these counties, a phone number has been established that can be called 24 hours-a-day, seven days-a-week. A case manager can meet with a person who needs at-home services to find out what services the person needs and can complete all the paperwork needed to ensure services can be in place within 24 hours if necessary. A person who applies for home- and community-based services through the Community Choice process will be asked questions about how much income and savings he or she has. Then, within 60 days, the county assistance office will verify the information, but during these 60 days, the person will be receiving services. From a financial standpoint, there is concern about putting in services

for which the person might not meet financial eligibility requirements. Anyone who applies for home- and community-based services through the Community Choice process must be careful in stating income and savings. If it is found that a person has more money than is stated on the application, the person may have to pay for the home- and community-based services that were provided.

- A universal application needs to be developed for Medical Assistance and waivers. In addition, once the application is completed and additional forms are required to be completed, data fields (such as address, telephone number, etc.) should self-fill with the information to prevent duplication of efforts. The applications should be "real time" and provide the capability to track them through the process.

Health Insurance Issues

During all three of the focus groups, a wide variety of insurance-related issues were discussed that affected hospital discharge and patient placement:

- There were some insurance practices that were particularly unique to certain regions and certain payors. For example, in Philadelphia, some of the Medicare Advantage plans have implemented patient co-pays for each home visit by a nurse or therapist, which could add up quickly as an out-of-pocket expense for an elderly person. This out-of-pocket expense discourages utilization of services that might be needed to promote healing and/or functional status. Lack of such services might contribute to re-hospitalization. Further, many agencies have difficulty collecting these co-pays, which end up as bad debt for the health care provider.

- Consumers believe that they have access to certain medical benefits because they are listed on their insurance plan. They don't realize that they often must meet criteria in order to receive those benefits. Only persons who pursue appeals can overturn original coverage decisions made by insurers.

- Focus group participants described situations in certain markets where certain insurers promise extensive coverage to persons for modest monthly fees; however, when the hospital attempts to access those services for the individual, they quickly discover that there are no providers in the network that accept that insurance. One plan, in particular, promises low monthly premiums and free transportation to physician appointments. However, when the patient goes to use the insurance, they are finding that there are limited or no providers that accept the insurance.

- There also have been experiences with commercial insurers imposing specific limitations on the amount of therapy that can be provided, as well as limitations within contracts on accessing durable medical equipment. During the Harrisburg session, several hospitals described having to pay for patients' durable medical equipment and home modifications in order to discharge the patient from the hospital. One hospital indicated that they spent up to $100,000 a year for certain kinds of durable medical equipment and other services that were not covered by insurance.

- Many hospitals also disclosed that they ended up paying for other services, including dialysis services for the illegal alien that has no insurance; assisted living for the patient with no home; and administration of home intravenous antibiotics for patients without insurance or those where insurance would not cover those expenses.

- There was widespread agreement that many patients could benefit from placement and care in a long-term acute care hospital. However, the Pennsylvania Medical Assistance program does not recognize or pay for this level of care. This makes it particularly difficult to place Medical Assistance patients who require this level of care. And those in the Pittsburgh session described the problems that they are increasingly encountering with commercial insurers in attempting to get approval to move a patient to a long-term acute care hospital. Specifically, participants noted that since insurers already paid the hospital a case rate for care, it was not in their best interest financially to pay any additional fees for long-term acute care.

- In Pittsburgh, there also was a conversation about insurers only approving outpatient observational status for patients while hospitalized or retrospectively denying the inpatient admission, and then approving the stay as an outpatient observation patient. Several described situations with commercial insurers where they felt that a second level review by a physician to determine appropriate level of care was not occurring.

- During all three sessions, there was strong sentiment that the Medicare three-day inpatient requirement as the criteria for nursing home coverage was obsolete and needed to be changed. This rule has become a bigger problem as many patients arrive at the hospital but don't require a hospital level of care. Many are brought to the emergency department essentially for long-term placement. The policy needs to be re-evaluated, particularly in light of the fact that most of the hospitals are working hard to improve patient flow. This rule many times serves as a roadblock to effective capacity management.

- In Philadelphia, the issue of how to coordinate care for veterans following hospitalization was mentioned. There was a lengthy discussion about the various intricacies and issues surrounding veterans' health care benefits. Many indicated that they don't understand how best to assist veterans with their hospital discharge needs. More assistance and information is needed for veterans. Philadelphia focus group participants indicated that it is especially difficult to get a "live" person on the telephone to assist with questions related to veterans and their benefits.

- Increasingly, many insurers are denying admission to inpatient medical rehabilitation. Instead, insurers have approved admission to a "high-end skilled nursing facility." Yet, there are few such nursing homes that will accept medically complex patients; and certainly, patients with no insurance or Medical Assistance are less desirable for admission to these organizations.

- During all the focus groups, there also was concern that there was not reimbursement for some level of care below that of nursing homes. Specifically, payment for assisted living and personal care homes were mentioned. Those at the Harrisburg session feared that with the implementation of more stringent assisted living and personal care home regulations

that there may be the unintended consequence of discouraging the creation of more assisted living options in Pennsylvania.

- In general, there was concern about health care providers' (including physicians), family's, and patients' understanding of "home" care services and what is covered and not covered by insurance.

- Medicare does not pay for home IV antibiotics. There are more and more patients requiring six to eight weeks of IV antibiotics for blood and bone infections, many of which have become resistant to some antibiotics and require longer dosage periods. If a patient is on Medicare, they are not allowed to go home to receive IV antibiotics. They only can go to a facility even if they have no other medical need. This could be addressed by getting Medicare to pay for home infusion services to cut back on nursing home stays. If a patient is uninsured, often they will stay in the hospital for those six to eight full weeks just to receive a daily or twice daily IV antibiotic—putting the patient at risk for a number of hospital-based complications, other infection, and costing the hospitals thousands for the cost of the hospital bed.

- There was some discussion about the Department of Public Welfare, Office of Long-Term Living's new program called the Integrated Care Initiative. The Integrated Care Initiative will be a voluntary program that would allow persons already enrolled in federally funded Medicare Special Needs Plans (SNP) to combine their state Medicaid benefits and services into the same Medicare plan. About 100,000 older Pennsylvanians who have both Medicare and Medicaid (also referred to as dual eligible consumers) are already getting their Medicare benefits through Medicare SNPs. This initiative would add the state Medicaid services to the SNPs. Currently, the dual eligible consumer's Medicare and Medicaid benefits are accessed through separate systems with different provider networks and different billing and payment systems. Consumers would have the choice of getting combined/integrated care through a single system or they may continue to receive their services separately through their federal Medicare and state Medicaid programs. This program will be offered only in certain regions of the state.

Ideas to Assist with Health Insurance Issues:

- Despite repeated attempts, the Medical Assistance program has not recognized or considered payment to long-term acute care hospitals. Most persons in the focus groups believed that it would be beneficial if the Department of Public Welfare (DPW) would consider paying for long-term acute care hospital stays.

- Focus group participants asked that there be efforts to eliminate the three-day hospital stay Medicare rule. They suggested replacing this rule with the need to meet medical necessity criteria and allow referrals by primary care providers for nursing home coverage by Medicare instead, regardless of whether or not the person had an acute care stay or not.

- Hospitals need access to grants or other funds to help offset the costs of durable medical equipment, services, and other supplies needed by patients to help them return to their homes. As previously mentioned, many hospitals pay expenses for equipment and supplies,

such as patient lifts, bariatric equipment, stair lifts, and temporary ramps. Additionally, hospitals pay for dialysis services, assisted living, transportation, and home antibiotic services in order to move the patient out of the hospital. By providing these services, it has prevented the need to keep the patient hospitalized or place them in nursing homes. After analyzing the total cost, hospitals have found it is actually cheaper to fund it this way than to keep the patient in the hospital for an extended period of time for which they would not get reimbursed. Two resources mentioned during the Harrisburg session that could help hospitals with these issues were the Pennsylvania Assistive Technology Foundation (PATF) which provides loans or grants for assistive care and the Pennsylvania Initiative on Assistive Technology (PIAT) which promotes the lending of certain types of equipment.

- There needs to be more consumer education about how insurance plans make decisions to provide coverage for benefits provided for on one insurance plan and in simple language.

Housing or Home Arrangements

Another area that emerged as a barrier to discharge planning back to the home were issues related to housing or home situations:

- As many shared during the sessions, nursing facilities have become the primary choice for post-acute care hospital placement due to their immediate accessibility, the fact that this level of care may be reimbursed depending on the circumstance, and because they are considered a safe environment. Unfortunately, once the patient is placed in the nursing home, there is little incentive for families to consider moving the patient back to their home or apartment.

- There are an increasing number of elderly parents that have disabled or special needs children living in their home. This is a big challenge when the elderly parent is hospitalized and needs post-acute care services but refuses those services because they need to care for the adult child living with them. This also might be the case if an elderly person is providing care at home for their spouse.

- The homeless represent considerable challenges for care following hospital discharge in that they don't have a home to return to. Many homeless individuals do not want to go to a shelter. Discharge planners are placed in a difficult situation in getting the patient discharged but not having a place for this individual to go.

- Individuals that could be placed in group homes following discharge presents a barrier in that group homes will not take individuals back on the weekends.

- An issue that came up during each session involved problems with obtaining assistance from protective services. During every session, hospitals indicated that protective services often does not act on referrals from hospitals because the person is receiving care in a safe environment. Hospitals often feel like they are placed in an untenable position of returning the person to an unsafe environment that could expose the hospital to some level of liability for an "unsafe discharge." Additionally, there were concerns that there is no legal standing

around protective services for those older than 18 and less than 60 years of age.

- There also was some discussion about the need for housing locators for those with disabilities to help with long-term placement.

- For individuals who do qualify for home-care services, oftentimes home care staff has a problem of accessing the patient's residence during the day if the door is locked and the patient is unable to get to the door if they are home alone. When this situation occurs, hospitals are more likely to refer a patient to a nursing home or the patient may even lack the service they need in their home.

- Personal care homes are not funded with public monies. Many believed that personal care homes would convert to assisted living. Participants pointed out that there are many readmissions coming from assisted living/personal care homes. There is concern that individuals in these living situations are only receiving minimal care, when they might really need more care than what is being provided.

Ideas to Assist with Housing or Home Arrangements:

- Promote enactment of Senate Bill 699, which expands protections for all adults regardless of age.

- A listing of housing resources needs to be established, including apartment locators that are wheelchair accessible.

- "Human Resource Centers" should be established and provided in each county to assist homeless individuals. In addition, some sort of short-term placement centers should be established.

- For individuals who may not be able to get to the door for home health, discharge planners could ask patients/families to identify a trusted neighbor or friend who could be given a key to enable nurses, therapists, and aides to access the patient's home and care for the patient.

- As assisted living becomes more available and more utilized, discharge planners, care managers, families, and patients need to understand what assistive services are actually provided in that setting.

Physician Involvement

Several of the issues that the focus groups noted with physicians included the following:

- Many hospitals employ hospitalists who may not be as familiar with the patient and the patient's family as the patient's family physician. This lack of familiarity and relationship with the hospitalist as compared to their family physician can impact discharge planning. However, others noted that hospitalists tend to be more supportive of coaching models and greater involvement of patients in their own care.

- Physicians often are unfamiliar with home- and community-based services, which person might qualify for these services, and how to qualify certain persons for these programs.

- Physicians may write orders indicating that the patient requires 24-hour care, which then affects discharge planning options.

- Often, the orders for discharge are written without adequate notification and preparation by the rest of the health care team and with the patient and family.

Ideas to Assist with Physician Involvement:

- There needs to be ways to make physicians more aware of what home- and community-based programs exist and what qualifies persons for those services.

- There were suggestions that efforts need to be made to reach out and engage hospitalists because of their strong interest in care coordination.

- Identify and share ways to enhance communication between primary care physicians/practitioners and hospitalists.

- Primary care physicians/practitioners need to make discharged hospital patients a priority for post-discharge follow-up. Every effort should be made to see discharged patients within seven days of discharge, if not sooner.

Other Patient Population Concerns

Throughout the three days, there were multiple concerns raised with respect to challenges in finding placement for specific types of patients:

- Understanding and appropriate discharge/care planning for disabled patients.

- Elderly patients with addictions to street drugs. The volume of these patients continues to rise.

- Patients with behavioral health conditions are generally difficult to place following an acute-care hospitalization. Many end up in boarding homes initially, but often they cannot be managed in this environment because of the behavioral health issues. Nursing homes do not want to admit these patients because they are disruptive, interfere with care provided to other residents, and don't really get the services they need in the nursing home environment. Many times, patients with behavioral health problems end up back in the hospital and often have longer lengths of stay precisely because of these long-term placement problems. Some indicated that they have had to place these patients in nursing homes that offer better behavioral health management programs in other states.

- Illegal aliens needing dialysis. This was mentioned during each focus group with all pointing out that the only way to move these patients out of the hospital was for the hospital to pay for dialysis services offered by a for-profit dialysis center.

- Many hospitals are finding it increasingly difficult to find placement following hospital discharge for bariatric patients. There are many problems associated with discharging these patients. Nursing facilities will not accept them citing fire codes will not be met if they have a bariatric patient in their facility. Many hospitals do not have the equipment to handle the weight of these patients or the means to transfer them from the hospital. Some have had to use Mack trucks with a mattress in the back to transport these patients, often to facilities in other states that are equipped to provide care to this population of patients. During the Harrisburg session, participants indicated that they have discharged patients to facilities in Ohio and Arkansas that had the equipment to provide care to morbidly obese patients.

- Individuals with no medical problems; only social issues.

- Hospitals are seeing an increase in the number of patients that have waivers—many times two to three patients per week. Patients that have waivers are finding it increasingly difficult to find providers to care for them, as fewer and fewer are accepting waiver patients. There needs to be an increase in the number of physicians that will accept waiver patients.

- There is no single point of entry for services for individuals who are elderly and disabled.

- In western Pennsylvania, concerns about the transportation funding were expressed. Participants indicated that transportation was problematic in some of the more rural areas in terms of discharging a patient to the home, and making sure that the individual was then able to travel to appointments or services that were needed following hospital discharge.

- There also were several concerns raised with respect to the aftercare required for prisoners who no longer met the criteria for inpatient hospitalization. In Pittsburgh, one participant described a situation where a prisoner had a percutaneous intravenous central catheter (PICC) placed and needed three weeks of antibiotic therapy. The corrections facility would not accept this patient with the PICC line, and the hospital has no other options for interim placement of this patient.

Overarching Recommendations

The focus group meeting participants provided several recommendations that were consistent but represent overarching recommendations. Some have already been mentioned in the above named sections. There also were specific recommendations for HAP:

- Create a centralized repository or clearinghouse of information that is accessible to hospital discharge planners, case managers, and social workers. The clearinghouse should contain a central website of national and state resources, a directory of information, and a direct way to get the information to case managers.

- A central repository (such as kiosks) containing all of this information/resources should be developed and available for families and patients.

- Hospitals should have one point of contact who is available seven days-a-week and who is knowledgeable about programs and can direct or help a hospital with questions. It is not enough to have the information posted on a website. The participants envisioned some sort of call center that could direct their call to experts for immediate assistance.

- There should be funding for demonstration projects that promote different models of care coordination between health care providers and community resources, such as the Area Agencies on Aging and/or the Centers for Independent Living. These demonstration programs should include different health professionals across various settings of care.

- Consideration needs to be given to funding other levels of care aside from nursing home care to help bridge placement from the hospital back to the home and community setting.

- Redesign the waiver application process to make it more efficient and timely, including integrating the application for Medical Assistance and the waiver programs.

- The Medicare three-day hospital stay rule should be eliminated. Patients should be evaluated for long-term care based on medical necessity criteria regardless of whether inpatient care is provided or not.

- Promote enactment of Senate Bill 699, which would expand protections for all adults regardless of age.

- Consideration needs to be given about how best to address access to services for the elderly who are also disabled—Area Agencies on Aging versus Centers for Independent Living.

- The state should promote the formation of more LIFE programs in the state. The LIFE programs offer incredible resources for community-based care. Additional programs would allow individuals to remain in their home with ample services and medical care.

- Education about medical coverage and how to deal with denials should be paramount.

Finally, those that participated in the discharge focus groups suggested that it would be helpful to meet on a regular basis either by conference call or in-person. Some of the areas that were identified as possible future meeting items included:

- There needs to be further conversation about some of the special population issues.

- Ways that hospitals are reducing preventable readmissions.

- Development of standardized communication tools to assist with the transmission of important patient information verbally, in writing, or through electronic records across provider health care settings.

- Education about resources offered through the Pennsylvania Health Law Project.

- Consideration about how HAP can promote more networking and communication among hospital discharge planners, case managers, and social workers.

Resources

The list below provides a list of a variety of resources that participants shared during the focus group meetings:

Area Agencies on Aging—listing by county: (http://www.p4a.org/agencies.htm)

Assistive Technology:

- Pennsylvania Initiative on Assistive Technology (PIAT)—provides for demonstrations on assistive devices, short-term assistive technology loans, and purchase of refurbished assistive technology (http://www.disabilities.temple.edu/programs/assistive/piat/)

- Pennsylvania Assistive Technology Foundation (PATF)—provides low-interest loans to persons with disabilities and older adults to allow them to purchase needed assistive technology (http://www.patf.us/)

Consumer-Directed Training Series: A training manual and video designed for consumers who direct their own care in their own homes. The training helps the consumer make informed choices and take control of their service delivery. (http://www.jevshumanservices.org/cdt/default.asp)

Disability Rights Network: 800-692-7443 (http://www.drnpa.org)

- Living at Home with Major Disabilities
- Assistive Technology Brochures

Estate Recovery Program: The estate recovery program enables the commonwealth to recover from the estate of individuals who were 55 years of age or older at the time nursing facility services or home- and community-based services were received. (http://www.dpw.state.pa.us/servicesprograms/other/003670689.htm)

Estate Recovery Program Brochure:
(http://www.dpw.state.pa.us/Resources/Documents/Pdf/Publications/Pub0332-07_English.pdf)

Home- and Community-Based Services: Home- and community-based services are sometimes called waiver funded services or waiver programs because they are provided under special conditions through federal approval whereby certain rules for Medical Assistance eligibility are waived. These programs will be referred to as home- and community-based services (HCBS). HCBS provide services beyond those covered by the Medical Assistance (also referred to as Medicaid) program that enables individuals to remain in a community setting rather than being admitted to a long-term care facility. If an individual is determined eligible for more than one HCBS program, the individual cannot receive services under two or more such programs at the same time. The person must choose one HCBS program and receive the services provided by it. (http://www.dpw.state.pa.us/ServicesPrograms/MedicalAssistance/003670306.htm)

Home- and Community-Based Services Booklet:
(http://www.portal.state.pa.us/portal/server.pt?open=18&objID=352458&parentname=Dir&parentid=6&mode=2)

Housing:

- Home Modifications (http://homemods.jevs.org)
- Pennsylvania Housing Finance Agency (http://www.phfa.org)
- Case Management Society of America offers resources on senior housing options (http://www.cmsa.org/Consumer/Resources/SeniorHousingLocator/tabid/333/Default.aspx)

"Living at Home With Major Disabilities" Booklet: This booklet describes the amazing personal stories of Pennsylvanians who are enjoying life and independence in their own homes rather than nursing homes. Like most people, they wanted the greater independence that comes from having the services they need provided in their homes.
(http://www.pasilc.org/documents/Brochure.OLTL.final.pdf)

Long-Term Living Training Institute: (http://www.ltltrainingpa.org/)

Long-Term Living Helpline—(866) 286-3636: Helpline can answer your questions and give you additional information on long-term living services in Pennsylvania. Trained professionals will send you materials, help you determine your needs, and refer you to resources or programs that will help you meet those needs.

Nursing Home Transition Video: "Being Home" (five-part series): Video about consumers' experiences with transitioning from a nursing home back to the community.
(http://www.ltltrainingpa.org/resources/video.cfm)

Pennsylvania Association for Area Agencies on Aging: (http://www.p4a.org/)

- Informational booklet on Pennsylvania waiver programs
- Nursing Home Transition program video
- Consumer-Directed Care Training Services

Pennsylvania Council on Independent Living: (http://www.pcil.net/)

Pennsylvania Department of Health's Head Injury Program (HIP):
(http://www.portal.state.pa.us/portal/server.pt/community/head_injury_program/14185)

Pennsylvania Department of Health's Head Injury Program Tip Card:
(http://www.portal.state.pa.us/portal/server.pt/gateway/PTARGS_0_75878_805984_0_0_18/head%20Injury%20Rack%20Card.pdf)

Pennsylvania Health Law Project: (800) 274-3258 (http://www.phlp.org)

- Health Services and Veterans' Issues—Kyle Fisher—(215) 625-3897

Pennsylvania Office of Long-Term Living:

- Long-Term Living Helpline—(866) 286-3636)
- Frequently Asked Questions about Estate Recovery
- List of Centers for Independent Living
- List of Area Agencies on Aging
- List of other Community Service Providers

Discharge Planning and Community Services for Seniors and People with Disabilities
Crozer-Chester Medical Center
Upland, PA (Philadelphia)
September 29, 2009
10:00 a.m. – 2:00 p.m.

DISCUSSION TOPICS

Generally, we try to outline a few of the topics that will be discussed and see if there are other suggestions for additional topics.

A tentative list of topics for discussion include:

Barriers to Helping People Return Home

- What do you do about families who do not wish to take responsibility for the patient, but are the POA?
- Working with doctors who keep finding reasons to keep the patient.
- Who are the key members of the discharge planning team and who assumes responsibility for the plan?
- How can counties better serve patients who need to transition from nursing home to home in a more timely manner?
- Family/patient barriers to discharge—lack of understanding criteria.
- Increasing co-pays for skilled care and prescriptions have impacted discharge planning as the costs are too high for patients/families.
- What to do with patients who refuse SNF and home is not a safe discharge.

Assistance, Information, and Supports Needed

- Lack of resources for discharge planning for an increasing number of uninsured patients.
- What processes do we have in place to get family members involved at an earlier stage?

How to Make Transitioning Home Available to More Disabled Adults

- Issue of competent, physically disabled patient insisting on going home alone with limited PCA in-home supports and no family supports. Patient keeps coming back to the hospital because of medical issues he/she can't manage.
- Emergency preparedness for persons with disability at home or in the community.

How Best to Spread the Word

- Is there a coordinated website that can provide resources within the state, other than going through the Office of Aging website?
    - Where can we discharge ventilator patients who need dialysis?

Discharge Planning and Community Services for Seniors and People with Disabilities
The Hospital & Healthsystem Association of Pennsylvania
Harrisburg, PA
September 30, 2009
10:00 a.m. – 2:00 p.m.

DISCUSSION TOPICS

Generally, we try to outline a few of the topics that will be discussed and see if there are other suggestions for additional topics.

A tentative list of topics for discussion include:

Barriers to Helping People Return Home

- How to persuade PA HMOs to acquire more participating DME/PT/OT/PCP providers to ensure adequate aftercare.
- What do we do when an elderly person needs 24-hour supervision, no family to stay with them, no resources to privately pay, and has done the nursing home route in past and refuses to return?
- Lack of resources for behavioral health patients in the community—effect on hospital and emergency department throughput.
- Education of Medicare beneficiaries and physicians about nursing home placement without the three qualifying hospital days. How to finance?
- Homeless—returning to the street without an address? Providing HHC on the street?
- Patients that require long-term acute care and have no other payor source than Medical Assistance.
- How to handle frequent hospital readmissions related to poor home compliance with treatment?
- How can we as case managers get buy in from the physicians to write discharge orders for home health?
- Prospective payment seems to have limited home health agencies' ability to case manage CHF patients greater than 60 days. Can someone address what avenues home health can utilize when patient is having ongoing issues after 60 days?
- In working with patients with cognitive impairments, not safe to be alone, holes in community services when family is working, high cost of day care or private duty, and assisted living not affordable—what to do with these patients?
- Difficult placement issues (bariatric, behavioral, high-cost).
- Office on Aging sends patients to ED for us to "deal" with them when the issues are clearly social ones, not medical.
- Increased community needs with decreased county services funding.
- Looking to the near future: the effect the declining economy and changes in health care policy have on hospital systems.
- Increase in uninsured—how to assist with medications, home care, DME.
- Lack of assisted living beds for those on fixed, low incomes.
- Polypharmacy and readmissions.

- Out-of-state Medicaid patients.

Assistance, Information, and Supports Needed

- Obtaining more nursing agencies/home health services for pediatric patients, especially with special needs.
- What is being considered as a long-term plan to foster communication between government, private insurance, and providers?
- What services are available for adults under 65 who live alone and don't have resources to pay for help to come to their home with custodial care?
- Community resources to assist in discharge planning.
- Tell us the options available to see if we discharge planners are aware of availability. Often we know the resources but they are scarce or not readily available.
- What resources do exist for in-home services for those who need more than a few hours of assistance and lack funding?
- PDA waiver services funding needs to be increased.
- Additional funding sources needed for older residents to use assisted living facilities.
- Role of state government in assisting patients to access community services.
- Post discharge financial options (assisted living, home health services, etc).
- I am interested in what programs other facilities are developing to address readmission rates to hospitals.

How to Make Transitioning Home Available to More Disabled Adults

How Best to Spread the Word

- Will there be opportunity for demonstration projects to test out new models?

Other

- Changes to Medicare three-day rule for SNF placement related to RAC implementation and targets.

Discharge Planning and Community Services for Seniors and People with Disabilities
Hospital Council of Western Pennsylvania
Warrendale, PA
October 21, 2009
10:00 a.m. – 2:00 p.m.

DISCUSSION TOPICS

Generally, we try to outline a few of the topics that will be discussed and see if there are other suggestions for additional topics.

A tentative list of topics for discussion include:

Barriers to Helping People Return Home

- Lack of transportation services in rural communities and the effect of discharge planning.
- Increase in the uninsured population and the subsequent difficulty in arranging needed post discharge services.
- Turnaround time for enrollment into waiver programs needs to be shortened.
- Decreasing re-admissions.
- Availability of transportation to CHF clinics and follow-up care that is user-friendly to ensure keeping post-acute care services to deter readmits.
- Lack of high-level skilled facility beds in community—ventilators, dialysis, bariatrics.
- Lack of community resources for disabled, homeless, etc.
- How might a formalized continuum of care pathway be developed using a "population-based" approach vs. disease condition approach in order to enhance patient outcomes? Example: triggers based on risk factors; incorporate external agency contacts; measure outcomes.
- Issue of Medicare patients who need skilled care but do not qualify for three "acute" days.
- Difficulty for nursing to provide enough education prior to discharge with rapid turnover of patients.
- Greater number of uninsured and many medical needs that often can't be met.
- Availability of medication/compliance with administration to prevent unnecessary readmissions.

Assistance, Information, and Supports Needed

- Services for partnering with post-acute entities are vital in care transition.
- Discussion of proactive measures that will enhance communication between community referral sources.
- Is there grant money available for helping to complete forms?
- How can we identify on admission who needs assistance and contact appropriate help?
- How can we make sure everyone involved is on the same page with patient care?
- Managing communications between the patient, families, and caregivers (i.e., for those in group homes).
- What are the expectations of group home personnel from hospital staff and physicians?
- Strategies to manage readmissions related to patient non-compliance with home treatments.

- How to manage patients that are homebound, requiring IV medications and have only Medicare.
- How to assure compliance with treatment plan and follow-up in elderly patients without good support systems and low finances.
- Services available to reconfigure the home environment to facilitate a safe return.
- Broadening of "home care services" to support staying in the community beyond skilled services.
- Securing expensive medication for the elderly who are not necessarily indigent.
- What kind of data exists currently for the two subsets (elderly and disabled) if one were to examine: a) re-admission rates at 7-days, 30-days, and 90-days, b) statistics for disposition plan—discharge to home, SNF, shelter…?
- Prescription assistance for people who cannot afford co-pay or are in "donut hole."
- No services, or very limited, for people age 19 to 59. Must be over 60 to access many services.
- Support structures for caregivers who provide care for loved ones in their homes.
- Decision makers for elderly MR patients.
- Post-acute care services for behavioral health patients.

How to Make Transitioning Home Available to More Disabled Adults

- Need more community resources.

How Best to Spread the Word

Other

- Three-day requirement for SNF placement.

Attendees: Discharge Planning and Community Services for Seniors & Disabled Individuals Crozer-Keystone Location on September 29, 2009

Donna Antenucci, Albert Einstein Medical Center
Teresa Pajak, Abington Health Lansdale Hospital
Kathy Gillan, Brandywine Hospital
Ellen Hoye, Bryn Mawr Rehab Hospital
Jeanne McDonnell, Byrn Mawr Hospital
Mary Beth Porter, Byrn Mawr Hospital
Maryann Butler, Crozer-Keystone Health System
Barbara Looby, Crozer-Keystone Health System
Jane Rutledge, Crozer-Keystone Health System
Audrey McCash, Lower Bucks Hospital
Bonnie Koresko, Montgomery Hospital
Kathryn Duffy, Paoli Hospital
Shawna G. Kates, Riddle Memorial Hospital
Marianne Collins, Riddle Memorial Hosptial/MLHS
Linda Anthony, Disability Rights Networks of PA
Terry Barley, AAA-Cumberland County
David Gates, PA Health Law Project
Melissa Dehoff, HAP
Lynn Leighton, HAP

Attendees: Discharge Planning and Community Services for Seniors & Disabled Individuals
HAP Harrisburg Location on September 30, 2009

Mary Ann Jackson, Community Medical Center
Patricia Donley, Good Samaritan Hospital
Kristin Rovers, Good Samaritan Hospital
Susan Bogush, Holy Spirit Hospital
Vicki Quaid, Holy Spirit Hospital
Catherine Engledow, Lancaster General Health
Julianne Reid, Lancaster General Health
Laura Dobrosielski, Lehigh Valley Health-Muhlenberg
Maureen Sawyer, Lehigh Valley Health-Mulenberg
Barb Smithson, Lehigh Valley Hospital
Marilyn Hake, Memorial Hospital
Bob Cooney, Mid-Valley Hospital
Pat Boerger, Penn State Hershey Medical Center
Velma Carter-Dryer, Penn State Hershey Medical Center
Cindy Johnson, Penn State Hershey Medical Center
Pam Miles, St. Luke's Hospital
Joanna Lucas, The Reading Hospital & Medical Center
Bonnie Werley, The Reading Hospital & Medical Center
Lynn Clinton, Waynesboro Hospital
Crystal Lowe, P4A
Pam Auer, Disability Rights Network
Musen Nealis
Sharon Wilkes, OLTL
David Gates, PA Health Law Project
Melissa Dehoff, HAP
Sharon Muscatell, HAP

Attendees: Discharge Planning and Community Services for Seniors & Disabled Individuals Hospital Council of Western Pennsylvania on October 21, 2009

Jennifer Mechling, ACMH
Kimberly Hopey, Allegheny General Hospital
Mary Lou Keriger, Allegheny General Hospital
Jayne McCauley, Clarion Hospital
Kathy Keir, Excela Health, Frick Hospital
Beverly Legath, Excela Health Westmoreland
Georgeann Doutt, Healthsouth Harmarville Rehab Hospital
Stephanie Meola, Indiana Regional Medical Center
Denise Stefan, Indiana Regional Medical Center
Donna Scanlon, Indiana Regional Medical Center
Gary Godla, Jefferson Regional Medical Center
Louise Reese, Jefferson Regional Medical Center
Heidi Garland, Memorial Medical Center
Christine Baloh, Monongahela Valley Hospital
Sherry Rowsick, St. Clair Hospital
Annette Lynn, Tyrone Hospital
Mary Beth Coughlin, West Penn Hospital
Vicki Lohr, UPMC Bedford Memorial Hospital
Erin Guay, PA Health Law Project
Sharon Wilkes, PA Office of Long-Term Living
Lynn Leighton, HAP
Sharon Muscatell, HAP