

# Policy Brief

## Vermont Choices for Care Policy Brief: Hospital Discharge Planning

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### Summary of Policy Brief

In this policy brief, we explore how hospital discharge planning processes currently influence Vermont consumer choice and use of different long-term care settings. We also provide recommendations for changes to hospital discharge planning processes that would enhance consumer choice and the use of alternatives to nursing facilities. Through literature reviews and stakeholder interviews, we find hospitals, community providers, and nursing facilities engaged in many best practices related to discharge planning in general. Discharge planning can be effective, allowing for choice through communication and education, or ineffective, derailing choice on the part of consumers and families. We present several policy recommendations for the Department of Disabilities, Aging, and Independent Living (DAIL) to consider. These recommendations would enhance discharge planning processes through low-cost and no-cost strategies, designed

to foster communication at all levels and in multiple settings. We recommend that education should include information about Vermont Choices for Care (CFC) as well as other services. We also suggest exploring alternative reimbursement mechanisms as well as strengthening care transitions, as noted by Peter Lee:<sup>1</sup>

*“We have to stop thinking about patients as only hospital inpatients or outpatients or nursing home patients, but as whole people whose care we have to coordinate better.”*

**Peter Lee**

Former Executive Director  
National Health Policy  
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## Purpose of Policy Brief

This policy brief is part of a series of reviews of policies and procedures related to the implementation of Vermont's CFC initiative. The purpose of these policy briefs is to examine key policy questions and provide an external perspective to help DAIL ensure that policies and procedures are as effective as they can be in supporting CFC goals. Therefore, even though there is an understanding that hospital discharge planning can rely on the use of many services (i.e., hospice, rehabilitation settings, nursing facilities, and home- and community-based services), this brief focuses, to the extent possible, on the impact of CFC as an aid in the discharge planning process, which allows clients to regain and maintain the capacity to select a community setting. It is worth noting, however, that CFC is not the only aid in the process, and so, throughout this brief, other services and issues will be discussed in an effort to assist DAIL with a more complete description of hospital discharge planning in Vermont.

This policy brief describes how hospital discharge planning processes currently influence Vermont consumer choice and use of different long-term care settings. The policy brief concludes with a set of recommendations for changes to hospital discharge planning processes; these recommendations are intended to enhance consumer choice and the use of alternatives to nursing facilities.

## Overview/Background and Key Questions

In this policy brief, we aim to understand 1) the mechanisms used by providers and consumers to plan for hospital discharge and choose between various service options, and 2) the stakeholders' perceptions of the factors that facilitate and constrain effective and efficient discharge from hospitals to community settings.

We conducted literature and document reviews as well as telephone interviews with 28 key informants. These key informants included staff and leadership at Vermont hospitals, nursing facilities, home health agencies, area agencies on aging, CFC, the Vermont Department of Licensing and Protection, and trade associations with interest in hospital discharge planning. This policy brief reflects the summarized responses of the participating stakeholders and the document and literature reviews, in addition to our knowledge related to long-term care and discharge planning. Cases (i.e., real life stories) illustrating specific issues around discharge planning documents are included throughout the policy brief.

The following topic areas guided our reviews and interviews:

- "Usual" discharge planning processes and variations on these processes (including CFC's role)
- Facilitators that influence the discharge planning process/outcome (effective discharge planning)
- Constraints that influence the discharge planning process/outcome (ineffective discharge planning)
- Changes that would allow more consumers to be discharged to community settings

We conclude with policy recommendations for promoting discharge to community settings and making the discharge process and post-discharge experience better for all patients and clients, including CFC clients and individuals who applied for CFC while still in the hospital.

## Findings

### Overview

Current Vermont discharge planning processes reflect many of the best practices and challenges discussed in the literature on discharge planning.<sup>2</sup> All of the hospitals that participated in this project demonstrated the best practice of having an interdisciplinary team to review, identify, and develop discharge plans.<sup>3</sup> Even as the specific functioning of the teams was shaped by the policies and practices of each hospital, all teams had a designated individual — a care coordinator or a discharge planner — who was responsible for overseeing the creation of a client's discharge plans. Some hospitals extend the best practice of an interdisciplinary team to include participation from home health agencies (HHAs), area agencies on aging (AAAs), Visiting Nurse Associations (VNAs), and nursing facility representatives in the daily discharge planning meeting. All of the hospitals, community agencies, and nursing facilities also stated that the discharge planning process is client-centered and based on client choice.

Although many best practices were evident, the interviews also identified challenges involved in the discharge process, which may have an impact on a client's selection of an institutional

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<sup>1</sup> Taylor, Mark. (2010). Shutting the Door on Readmissions. Retrieved from the website: [http://www.hhnmag.com/hhnmag\\_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/01JAN2010/1001HHN\\_FEA\\_Readmissions&cdomain=HHNMAG](http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/01JAN2010/1001HHN_FEA_Readmissions&cdomain=HHNMAG)

<sup>2</sup> Merriman, Mary L. (2008). Pre-Hospital Discharge Planning: Empowering Elderly Planning Through Choice. *Critical Care Nursing Quarterly*. 31;(1) 15-17.

<sup>3</sup> Ibid. 15-17.

or a community setting. Based on the information gained from the interviews, we found that the Vermont discharge planning system depends on the following factors to function effectively and efficiently:

- Communications: the exchange of information between all of the entities involved in the discharge planning process
- Easy access to accurate information: the hospital, community providers, and nursing facilities can obtain and verify the information needed to provide services
- Knowledge of available institutional and community services: general understanding by all of the entities involved in the discharge planning process of all available services
- Understanding of all of the entities involved in discharge planning, including the roles of the hospital, the state, community agencies, and the nursing facility
- Public and private financial systems, which support community services
- Housing options for clients who are homeless or who need a community setting other than their own home/apartment

The interviews highlighted potential problems affecting each factor. For example, participants from community agencies noted the importance of knowing when one of their clients has been admitted to the hospital and the absence of any formal mechanism to notify them of this occurrence. Today, they depend on informal processes. Because access to this information is not reliably available, the case manager is unable to alert the hospital about services a client has already. This may cause the discharge planner to spend his or her limited time seeking similar services. By having complete, up-to-date information, a discharge planner can focus on any additional services a client may need rather than developing a plan that assumes the individual does not have any services at all.

## Discharge Planning

It has been suggested that “discharge planning is an integral but ill-defined process.”<sup>4</sup> The information gained from the interviews conducted for this policy brief only supports the first part of this statement. It is evident that all of the hospitals that participated in this review have discharge planning processes that are defined and integral to the hospital. All of the discharge planners stated that the process begins at admission; in fact, in cases of a planned admission, planning for discharge may begin even before a person enters the hospital.

The specifics of the discharge planning process varied at each hospital. Some hospitals hold daily multidisciplinary team

discharge planning meetings, which include community organizations and staff from nursing facilities, VNAs, AAAs, and HHAs. One hospital has a discharge planning process driven by the needs and practices of various units. Although this hospital has not traditionally included community providers, in November 2010 it began participating in an initiative through which an HHA coordinator is on-site every day. This coordinator represents HHAs across the state and is involved in discharge planning.

In hospitals that hold daily meetings, discharge planners and providers find these planning meetings useful and valuable. One nursing facility administrator

said, “We have attended discharge planning meetings at the hospital for years, and it’s always a beneficial thing to do.” One HHA coordinator stated, “I can keep track of HHA clients. I can answer patients’ questions about HHA services.” All community providers stated that attending the hospital discharge planning meetings informs their agency of new admissions and starts their own agency preparation for serving a client. They were often perplexed when interacting with hospitals that do not allow providers to attend discharge planning meetings.

### REAL LIFE STORY

#### Effective Discharge Planning

A man being discharged from a hospital during the holidays was going to need IV antibiotics at home for an extended period of time. Even though he had been informed of the home health services he would receive, he still had some concerns. To help reassure him, a vendor for the IV antibiotics talked with him while he was still in the hospital. The discharge planner also went to see him and explained what the home health nurse could do and what the patient would be expected to do. The discharge planner was able to reassure him that the nurse could find his house and gave him other necessary information: when the nurse was going to arrive, the paperwork she was going to review, and what she would do to help him with the IV antibiotics for the evening. So, he was able to know what to expect on the other end. With more understanding of the service, the man was more comfortable with receiving home health care and the discharge was viewed as a success.

<sup>4</sup> Maramba, Patricia J., Richards, Samantha, Myers, Amy L., and Larrabee, June H. (2004). Discharge Planning Process: Applying a Model for Evidence based Practice. 123.

Irrespective of whether meetings occur on a daily basis, many respondents had concerns about the general discharge planning process. Individuals who worked in nursing facilities were very concerned that hospitals do not always provide them with all of the information about clients. They were concerned about patients with behavioral health issues in the hospital. One nursing facility staff member said, “Recently we had a client who had a one-on-one [staffing] while in the hospital and no one told us, and we weren’t able to plan for that person.”

As noted above, HHAs, AAAs, and VNAs do not always know when one of their clients has been admitted to the hospital. Some VNAs, HHAs, and AAAs have hospital outreach staff or liaisons who can let them know. As many of the community provider respondents observed, if they are told about a hospital admission, then they can inform the discharge planner about the services the client is already receiving. Then the discharge planner can gain more information about the client and the client’s home situation to help determine appropriate discharge plans — an additional benefit.

Discharge planners also expressed their concern about the growing numbers of clients who have complex and multiple problems and do not meet the eligibility requirements for any specific state program. A group of respondents recounted an experience wherein a person remained in the hospital for over 200 days as the hospital waited for various state agencies to determine which one could serve the needs of the patient. One respondent shared that, during this period, the patient began to talk about the time in the hospital as an imprisonment.

Although CFC clients and patients/clients who apply for CFC appear to comprise a small segment of the overall discharge population, respondents were asked to describe their experiences working with these individuals and working with CFC. For the most part, there is little direct interaction between CFC and hospital discharge planning staff. Although all interviewed hospital staff receive the list of active CFC clients, no one talked about using it as a tool to determine whether a patient was a CFC client. Long-term care clinical coordinators (LTCCCs) reported that there are some CFC applications received for individuals who are already CFC clients, suggesting that the list may not be widely used. LTCCCs also remarked that many times hospitals submit CFC applications with missing information — such as the date of discharge, contact information for the hospital case manager, and location to which the patient was discharged. Only after contacting the hospital and then later reviewing the records

at the nursing facility do they get all of the information. Additionally, hospital participation at the monthly CFC meetings is either sporadic or not happening at all. However, both LTCCCs and discharge planners reported that LTCCCs are contacted by discharge planners if there is a complex case or any uncertainty about a patient’s qualification for CFC.

Community providers, nursing facilities, and hospital stakeholders raised concerns about the CFC application process and the functioning of the program. Respondents overwhelmingly felt that the CFC process is complicated and time consuming. The discharge planners assist patients with filling out the application. One hospital has a department that helps patients to complete the financial section of the form. Within this process, the discharge planners stated that they have a good relationship with the LTCCCs and can contact them to aid with the application and to do an assessment. All of the LTCCCs seemed willing to assist the discharge planners with completing the application, although there was not a

consensus among LTCCCs on the timing. One LTCCC thought that the assessment may not be valid if the patient was still acutely ill in the hospital.

Although some nursing facilities are willing to accept a client whose CFC financial eligibility is still in process, having to wait several months for this financial determination is economically burdensome. Many community agencies are unable to take the financial risk of providing services to clients before eligibility is

determined and assured. Further, respondents were also very concerned that there are waiting lists for CFC services.

## REAL LIFE STORY

### The Role of CFC

**There was a difficult placement situation with an active CFC client. The client went into the hospital because of behavioral issues. A Care Planning meeting was held and included the care planner, discharge planner, and LTCCC. The client ultimately was admitted to an Enhanced Residential Care home with similar residents. With this placement, there was a lot of brainstorming and community involvement to help make that transition. This collaboration resulted in an effective discharge.**

## Effective Discharge Planning

These factors lead to an effective discharge:

- Ongoing communication between everyone involved in the development of the discharge plan
- Agreement and acceptance of the discharge plan among everyone involved
- A discharge plan comprised of accurate and updated information
- Involvement of the patient and the family in discharge planning
- The entity serving the client after discharge being aware of the client’s upcoming discharge and creating a plan to serve the client

Respondents noted specific issues within the above themes. The nursing facilities noted the importance of identifying the doctor who follows the patient to the nursing facility and having all of the information about a client. VNAs, AAAs, and LTCCCs talked about the importance of being notified that a client was hospitalized, having the opportunity to talk with the client during hospitalization, and sharing information with the discharge planner in order to aid with the development of the discharge plan.

The interviewees agreed that the role of the patient and family members is important for an effective discharge. For example, an effective discharge occurred when the patient was educated about self-care while in the hospital, was made aware of resources in the community, could identify an emergency, and had the information to respond adequately to an emergency. The literature suggests that some of the above activities may be compromised due to the short time a patient is in the hospital, the acute nature of the patient's diagnosis, or the possibility that a patient may have marginal understanding of the discharge information yet report full comprehension; however, the respondents identified the above items as indicators of an effective discharge.

## Ineffective Discharge Planning

Some of the factors contributing to ineffective discharge planning are the exact opposite of those listed above:

- Lack of communication
- Agency and nursing facility not notified in a timely manner that a patient is going to be discharged from the hospital
- Agency and nursing facility receive incorrect and incomplete information about a client
- Patient advised not to go home and chooses to return home
- Client expectations exceed what the agency can provide

Nursing facility respondents more often mentioned the receipt of incorrect information — citing learning that a patient has behavioral problems after the patient is admitted to the facility. VNAs noted several factors constraining an effective

discharge, including the receipt of inaccurate medication lists, incorrect physicians' orders, and patients' not receiving any education on self-care while in the hospital. The discharge planners noted constraints that included having patients who don't qualify for any program and having patients who may potentially need services funded by multiple state agencies. No process currently exists to easily determine which state agency would best fund services for the client.

### Information needs: Staff and patient/family education

Most staff respondents reported receiving the information needed to provide appropriate discharge care to clients. However, nursing facility staff stated that they were not always confident that the hospital was providing all of the information

about a client, especially, as noted above, in cases where the client may have behavioral problems. VNA staff said that overall information is better than it used to be. However, VNA staff are still doing too many additional medication reconciliations (the process by which medications are reviewed before, during, and after hospitalization to make sure that clients have all necessary and appropriate prescribed medications). LTCCCs observed that with one

phone call, they can get doctors' and nurses' notes, which are very helpful. Overall, the staff respondents suggested that, with persistence, they can get the information they need, but that often this information-gathering involves a lot of time on their part.

Respondents felt that patients/clients and family members, unlike staff, did not get the information they needed to understand self-care and what was happening upon discharge in terms of services and expectations. Three general themes predominate:

- Patient and family members don't know what services are provided by the nursing facility, the VNA, HHA, the AAA, and CFC.
- Client and family expectations exceed the services that can be provided by the nursing facility, the VNA, HHA, the AAA, and CFC.
- Clients and their family members may be told about services in the hospital but they do not retain the information. VNA, HHA, and AAA participants also commented that often at their first meeting with a client they provided information about their agency's services.

### REAL LIFE STORY

#### Educational Needs

Sometimes people don't know what to expect from home health agencies. In fact, their expectations may be higher than what the agency can realistically do. For example, a patient was discharged home with a home health referral. She called the on-call service late at night to say she'd just been discharged and didn't have anything to eat in the house. She expected the agency to go shopping for her. The agency suspects that the person was told "when you get home, call the nurses and they will go shopping for you."

## Could patients be discharged to other settings?

When this question was asked, a setting was not specified. As a result, respondents identified the setting in which they thought a client could have been better served. Participants did not always report that clients referred to their organization were necessarily in the correct setting. Respondents from nursing facilities, VNAs, LTCCCs, and state agencies had different opinions about whether patients could have been better served in another setting.

While one respondent felt that discharges were always to an appropriate setting, VNA staff and LTCCCs stated that there are clients who could have returned home if they had appropriate services. Another respondent observed that nursing facilities today receive patients who are sicker and who may have benefited from a longer stay in the hospital. It was also observed that sometimes a discharge to a nursing facility occurs because a bed is available at a nursing facility and because a discharge planner may not be aware of community options. Additionally, one respondent noted that with more Enhanced Residential Care sites, more clients who are unable to return to their homes and who do not need nursing facility care would be able to return to a community setting.

## How can discharges to the community be increased?

Respondents were asked how discharges to the community could be increased. Across all of the responding groups, several themes were noted:

- More staffing in the community
- Affordable housing options for people who are homeless or are unable to return to their homes
- More home health services including more personal care service options
- Streamlined CFC application process and determination of service hours

The responses to this question tended to reiterate answers that were previously mentioned. Additionally, some of the responses were very specific to the current needs of an agency. VNA respondents who mentioned the idea of public awareness were more specific in citing the importance of having the public understand that VNA staff go through an extensive background check and therefore can be trusted to go into a client's home. A respondent cited instances in which people refused services because they didn't want to let a stranger into their home. There were also more global concerns. For example, respondents noted that policy changes and reimbursement changes can also contribute to a community setting being chosen.

## Changes recommended

This section summarizes the changes recommended by the interviewees. Respondents answering this question were not constrained by the practicality of a recommendation and instead shared ideas that they thought, based on their experiences, would improve the discharge planning process. In a few cases, the recommendations were very specific to a particular organization. For this policy brief, only system-wide recommendations are presented.

### Communications

- Improve communications continuously between all of the organizations.
- Develop a system for ensuring that a patient who is admitted to a nursing facility has a doctor who will continue to provide care to that patient.
- Establish a database on the state website to allow nursing facilities to indicate whether beds are available so discharge planners would only have to contact those facilities with space.
- Encourage hospitals to send referrals to organizations at least one day ahead of discharge. While the evaluators realized that this may not be realistic or desirable from certain points of view, improving communication through enhanced and strengthened processes is a laudable goal.
- Expand the e-discharge system; develop a wireless electronic record system that is accessible to hospital and community provider staff.

### Education

- Provide ongoing education to the hospitals about CFC.
- Begin educating the patient before discharge.

### CFC

- Increase available support for clients who present as moderate need at discharge.
- Explore a fixed payment system for services that would allow home health agencies some flexibility on how staff is assigned to provide services.
- Encourage attendance by hospital representatives and economic services representative at monthly waiver team meetings.

## Housing

- Use social workers/discharge planners to conduct home safety evaluation.
- Create housing/service alternatives, such as adult foster care, that allow private homes to accept one or two clients.

The above recommendations are presented as the respondents suggested them, with the aim of providing a picture of potential ideas for consideration by entities involved with hospital discharge planning. As noted above, some recommendations may not be feasible; however, we felt it was important to accurately represent the respondents' points of view.

## Policy Recommendations

In contrast to the changes recommended above, we conclude with more actionable and possibly immediate policy recommendations that take into account all of the data from the interviews and literature reviews as well as content knowledge and expertise.

The discharge planning process among the participating organizations is not static. This reality is exemplified in the following ongoing systems change activities:

- Vermont Assembly of Home Health Agencies' recent implementation of a Hospital Liaison Initiative to track HHA clients and to facilitate the use of HHA services
- Involvement of VNA and nursing facilities liaisons in hospital daily discharge planning meetings
- Use of electronic record systems to refer patients to nursing facilities and community service providers

Based on this reality, here are several policy recommendations and strategies to enhance discharge planning and its role in influencing the discharge setting for individuals through supporting appropriate communication and developing educational materials. Also, several recommendations address the role of technology as a facilitator as well as current ongoing efforts to develop service delivery models that bring together primary, acute, and long-term care.

**Recommendation:** Work with all interested parties to encourage hospitals to have discharge planning teams that are inclusive of the person being discharged and representative community and nursing facility providers. While many hospitals do encourage community participation, DAIL can encourage all hospitals to adopt an inclusive strategy for discharge planning.

**Strategy:** As Vermont implements the Blueprint for Health, which aims to improve the health status of all individuals in the state, this mechanism can be used to encompass the needs of Vermonters who use long-term support services:

- Bring together a group of interested parties to explore the steps needed.

**Recommendation:** Encourage active and meaningful attendance at Waiver Team meetings for key discharge planners involved with complicated or long-term patients.

**Strategies:** The Waiver Team meeting is an ongoing forum for the hospital discharge planners and providers to focus on the CFC process and clients. Steps to improve participation include the following:

- Support participation via conference call/speakerphone and, wherever possible, videoconferencing.
- Suggest that hospitals with more than one discharge planner have discharge planners rotate their attendance.
- Designate several meetings during the year as Economic Services meetings when a representative from Economic Services Division of the Department for Children and Families will attend to allow attendees to enhance their understanding of how best to help their clients to accurately complete the financial section of the CFC application. Make sure to publicize their attendance as an enticement for discharge planners (who voiced a desire to connect more with Economic Services).

**Recommendation:** Create online, web-based trainings about CFC that can be used by hospitals and community organizations to orient their staff to the CFC program and application process. Even though a small percentage of hospital patients may apply to CFC, the application and the process were identified as a significant concern by community providers, nursing facility, and hospital stakeholders. As a result, these trainings should include realistic explanations of the timeline of process and contact information needed to follow up on application status. In planning this training, other topics such as the roles of the AAA, the VNA, or the HHA may emerge as additional training needs.

**Strategies:** To ensure that all interested parties are informed of the CFC application process on a current and ongoing basis, online training can be developed. There are multiple options to evaluate in terms of cost-effectiveness and access:

- Webpage content
- Video presentations
- Interactive e-learning course

**Recommendation:** Encourage and support an online database that allows hospitals, nursing facilities, and community service providers to indicate either patients ready for discharge or capacity to accept patients. Then hospitals and providers can more easily communicate with each other. The database developed by Dartmouth-Hitchcock Medical Center has proven effective in helping with hospital discharge planning.

**Strategies:** Over time, the use of these types of databases should facilitate communication and information to improve the discharge planning system. The state can encourage other hospitals, the community providers, and the nursing facilities, to work together to determine the following:

- Content of the database
- Host site of the database (Should the database be supply-driven by the providers or demand-driven by the hospitals?)
- Mechanism for upkeep and maintenance
- Funding resources that don't rely on the state

**Recommendation:** Design public awareness campaigns and materials about home- and community-based services and the organizations that provide them. Initial materials could focus on potential or current users such as adults age 64 and older and their family members.

**Strategies:** The design of a public awareness campaign can be costly, but by working with the hospitals, community providers, nursing facilities, Vermont 211, and Aging and Disabilities Resource Centers, states can achieve the following:

- Determine whether there are promising practices taking place in the federal government, not-for-profits, or private-sector organizations and whether there are materials that can be inexpensively adapted to meet the needs of Vermont.

- For example, the Long-Term Care Awareness campaign, started in 2005 as a collaboration between the Centers for Medicare and Medicaid Services, the Office of the Assistant Secretary for Planning & Evaluation, and the Administration on Aging, has worked with 25 states to provide information and planning resources about long-term care services to specific households.

- Identify private- and nonprofit-sector partners with similar interests (providers of long-term care services and insurance companies) that can assist in the development of a public awareness campaign.

**Recommendation:** Develop and promote forums that bring together all agencies and providers involved in discharge planning to share information about their processes, to identify opportunities for improvement and collaboration, and to open lines of communication through networking.

**Strategies:** Mindful of the limited availability of time, the state can determine whether there are existing forums that can be used. For example, historically, hospital discharge planners have met on a regular basis. Additionally, DAIL can take the following steps:

- Use the data gained from this project to identify the possible content of the first forum.
- Encourage and work to ensure that the perspectives of interested parties such as clients/caregivers, Aging and Disability Resource Centers, and others are represented in the forum.

**Recommendation:** Develop online secure electronic health records to facilitate the exchange of information and the flow of the discharge planning process. Expand Vermont's electronic health record system to allow a hospital to determine whether a client is a CFC client and ensure that other relevant data related to hospitalizations and services are available to hospitals, community agencies, and nursing facilities.

**Strategy:** Vermont is well-positioned to make this recommendation a reality.

- Incorporate the needs of CFC, discharge planning, and home- and community-based services as Vermont works toward creating a secure online electronic record system as envisioned by the Blueprint for Health.

**Recommendation:** Explore, with community partners, reimbursement options to allow community organizations (VNA, HHA, and AAA) to increase services through innovative service delivery alternatives.

**Strategies:** There is an Advisory Council, which provides the opportunity for the state and community partners to explore reimbursement options. The state can use this council in two capacities:

- Examine possible reimbursement options that may result from the implementation of the Patient Protection and Affordable Care Act and other grant opportunities.
- Identify different aspects of reimbursement and invite experts to present on that specific topic.

**Recommendation:** Strengthen care transitions across the entire care spectrum, including acute, primary, and long-term care. As stated by Peter Lee in the opening of this policy brief, all patients, no matter the setting, are people — whole people — and should be treated as such. This “global” recommendation encompasses many of the other recommendations and strategies, especially those related to communication and building effective teams.

**Strategies:** In addition to the above recommendations and strategies, Vermont can build on the Blueprint for Health, the Administration on Aging Community-Based Care Transition Program demonstration (Sec. 3026 of the Affordable Care Act) and other team approaches to achieve the following:

- Enhance and support care transitions across all settings, including hospitals.
- Examine the potential utility of a medical home concept related to hospital discharge planning.

## Conclusion

The current planning process for discharge from hospitals to institutional and community settings accomplishes the goal of getting the majority of clients out of the hospital and into post-acute care, which will help clients to heal. However, there are aspects of the process that rely too much on informal connections and on all of the actors “doing the right thing.” Throughout the discussion of how the discharge process functions, respondents talked about having to make follow-up calls to gather the correct information needed. Respondents talked about the importance of being notified that a client was admitted to the hospital or that a client is discharged from a hospital; yet, in many instances there are no formal mechanisms to ensure that this information exchange occurs. In addition, because of the specific focus of this brief, the role and impact of the CFC application process emerged as a topic of discussion related to hospital discharge planning. Throughout, it was evident that, for the respondents, CFC is one of many tools that can be used to allow an individual to choose to live in the community.

As noted, the Vermont Assembly of Home Health Agencies launched an initiative in November 2010 that places an HHA coordinator in a hospital with the aims of tracking HHA clients, establishing formal information-sharing practices within the discharge planning process, and providing immediate input to hospital staff and to patients about HHA services. Based on the information obtained, it appears that more needs to be done to support hospitals’ inclusion of community and institutional providers’ participation in hospital discharge planning. All of the participants who are involved in this type of multidisciplinary interaction touted the benefits to the individual client and to the effective functioning of their organization.

The interviews also demonstrated that there are system processes that, if enhanced, will further facilitate the effective functioning of the discharge planning process. For example, one LTCCC observed that “options counseling is provided to a client after the person has selected CFC.” The question then arises: if the goal is to make clients aware of community alternatives, should/could options counseling occur sooner in the process? Even though large issues, such as continuing to realign the reimbursement system to enhance support for home- and community-based services, there are many segments of the process, such as those highlighted in the Policy Recommendation section of this brief, that can be no-cost or low-cost opportunities to improve the discharge planning process and enhance people’s ability to be discharged into settings of their own choice.

## Resources

UMass Medical School's Disability and Community Services conducted 28 interviews with key informants during preparation of this policy brief. These key informants included staff and leadership at Vermont hospitals, nursing facilities, home health agencies, area agencies on aging, CFC, the Vermont Department of Licensing and Protection, and trade associations with interest in hospital discharge planning. We also reviewed literature, policy documents, and operational documents provided by key informants. Below is a list of information reviewed.

## Literature

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