ARIZONA**HEALTH**FUTURES

The Coming of Age

A Technical Paper on
Aging, Health and
Arizona's Capacity to Care

MAY 2002

Meeting Community-based Care Needs in Arizona

Carol O. Long, Ph.D., R.N.

Meeting Community-based Care Needs in Arizona

Carol O. Long, Ph.D., R.N.
College of Nursing
Arizona State University
December 2001

The Coming of Age Project
School of Public Affairs
St. Luke's Health Initiatives
May 2002

Preface

Aging affects all dimensions of our society, but none so much as health. Because of this, St. Luke's Health Initiatives asked Arizona State University's School of Public Affairs and Morrison Institute for Public Policy to explore Arizona's capacity to meet the demands likely from an aging population.

This complex topic called for analysis from a variety of disciplines. Hence, as a key part of The Coming of Age research effort, we invited experts from different fields to explore and write about the topics essential to understanding public policy choices for an aging future. *The Coming of Age Technical Series* is the result. These papers provide in-depth, objective analyses of important trends and facts at the heart of the coming of age.

These technical papers provided the foundation for *The Coming of Age: Aging, Health and Arizona's Capacity to Care,* as well as *Four Scenarios of Arizona's Future.* All of the products from The Coming of Age project are available at www.slhi.org.

Roger Hughes, Ph.D.
Executive Director
St. Luke's Health Initiatives

John Stuart Hall, Ph.D.
Project Director and Professor
School of Public Affairs
Arizona State University

Meeting Community-based Care Needs in Arizona

Home health care refers to the broad spectrum of technical and professional health care and social services provided to individuals and families on a short or long-term basis. These services are delivered in the home to recovering, disabled, chronically or terminally ill persons in need of medical, nursing, social, or therapeutic treatment and/or assistance with the essential activities of daily living.[1] Services provided by home health care agencies are an integral part of the health care system in Arizona and may allow Arizonans to stay in their homes and prevent institutionalization even though they have specific needs.

In 1999, a comprehensive report on home health care services in Arizona revealed considerable instability in the home health care market.[2] In only six months, over fifty of the surveyed 146 home health care agencies, or 34 percent, had closed their doors. Twenty-one of those agencies were located in rural Arizona. Most of the closures were attributed to increasing governmental regulations, including the mandates in the *Balanced Budget Act of 1997,* surety-bond requirements, and the inability to survive competition and increasing business demands.[3] This survey also uncovered over twenty-seven underserved areas for home health care services in Arizona, many of them in rural areas and on Indian reservations. Although hospice agencies were surveyed in the 1999 study also, no disparities in service were evident nor was there the closure of many agencies, as experienced in the home health care businesses. This study follows up on the 1999 research to determine if access to community-based care—such as home health care services or other health care services—has been jeopardized and if individuals in need of community-based care in the state of Arizona are going without supportive health care services.

National Trends

The closure of home health care agencies has become a national trend. It is estimated that close to 25 percent of the certified agencies across the United States have closed their doors.[4] External factors have been driving this movement, most notably the Medicare Interim Payment System, which has now been replaced by the home health care Medicare Prospective Payment System (PPS) implemented in October 2000.

Many state home health care associations and health care professionals fear that those residing in their own homes will not have the requisite medical or nursing care to maintain their health. A study conducted at Georgetown University revealed that Medicare patients are being denied access to home health care and that the sickest patients are being hurt the most.[5] In a similar report, the federal General Accounting Office (GAO) and the Department of Health and Human Services Office of the Inspector General (OIG) cited that fewer home health users received fewer home health care visits and that high-use patients have shifted the benefit toward short-term use and fewer rural home health users.[6]

In another study, the OIG surveyed hospital discharge planners to determine the impact of the *Balanced Budget Act of 1997* on access to services. In *Medicare Beneficiary Access to Home*

Health Agencies: 2000, hospital discharge planners reported increasing difficulty in placing patients needing home health care, with many discharge-eligible patients either remaining in the hospital longer, being transferred to extended care nursing facilities, or being cared for at home by family or friends.[7] In their report, researchers with the OIG[8] found that access to Medicare home health care was not a problem, although choice of agency providers was limited. According to this report, 89 percent of the surveyed discharge planners stated they could place all of their Medicare patients who need home health care services with home health care agencies. Seven percent stated they were able to place all but one to five percent of eligible patients while four percent put the estimate above five percent. While most of the discharge planners stated that the availability of home health services seems to be sufficient, about a quarter of those surveyed stated that they experienced delays in discharge and transfer to home health care for those patients who need frequent or continuous intravenous transfusion, expensive drug therapies, or have extensive wound-care needs. In their conclusion, the OIG reported that Medicare beneficiaries discharged from hospitals continue to have sufficient access to home health care services and found little evidence that PPS limited a beneficiary's ability to access home care services.[9]

Arizona Trends

The home health care situation in Arizona is similar to other states. In 1998, 164 certified home health care agencies operated in Arizona.[10] Only seventy agencies remain today.[11] These agency closures are evident throughout the state, but are most notable in rural areas of Arizona. In addition, other communities in Arizona may already go without access to home health care, as noted in over twenty-seven underserved areas in Arizona.

Of those home health care agencies still operating, many are struggling with the effects of a nursing shortage and increasing paperwork required by the completion of federally mandated forms (such as the Outcome Assessment Information Set, known as OASIS).[12] Home health care agencies are also under pressure to survive a changing reimbursement system. The Health Care Financing Administration, now the Centers for Medicare and Medicaid Services, instituted this system over the last three years. Considering the continued pace of agency closures over the last two years, one might question the overall viability of an industry that has demonstrated cost-effectiveness and value in providing nursing and supportive care in the home setting.

The Arizona Association for Home Care (AAHC) recently conducted a telephone survey[13] of nine discharge planners located in rural Arizona hospitals. Half of the respondents found no difficulty in placing patients requiring home health care. Three discharge planners identified delays in placing Medicare patients who needed home health care. This was especially true if the patient needed "high-tech" care, oxygen therapy, or rehabilitation therapy. Reasons for the delays included reimbursement or payor restrictions, the lack of home health care staffing on weekends, the lack of special equipment needs, the nonexistence of home health care in the community, and home health care agencies screening referrals more closely. Staff from the AAHC noted, however, the limited and guarded responses that were solicited from this informal survey and identified the urgent need for further investigation.

The Problem

Although the *Arizona Home Health Care and Hospice Survey, 1999* provided a status report on these industries, it did not capture the gaps in community-based care that exist in the state related to home health care or other health care supportive services. Since data on home health care for Arizona is not collected by the state or any other agency, current status of the services is not well understood. Without this data, it is difficult to determine the status of home health care in the state, its impact in the community and any difficulties for the individuals need it. Furthermore, the survey did not capture the deficits in the capacity for community-based care, particularly with the vast amount of reported home health care agency closures.

The impact of home health care agency closures and increasing governmental regulations or other internal or external forces are not known. Also lacking is awareness about home health care services in rural Arizona. If agencies have closed in these communities, where are individuals going for care? If rural Arizonans seek care in the urban areas of the state and need continuing care at home, are their needs being met in their own communities? If so, how? What is the overall impact on individuals that need home health care services in urban settings in Arizona?

The Purpose

This study examines community-based care in Arizona from the perspective of hospital discharge planners and selected home health care leaders and administrators. Particular emphasis has been placed on the health care needs of the elderly population and how home health care agencies and other community facilities and resources are currently meeting their needs. Determining the extent of the problem, the current and future challenges in discharge-planning, and gaining a perspective as to what interventions have been successful can help identify solutions to problems at the community level.

The research addresses the following questions:

- What challenges are discharge planners in acute care institutions facing in meeting the needs for community-based care for our aging population?

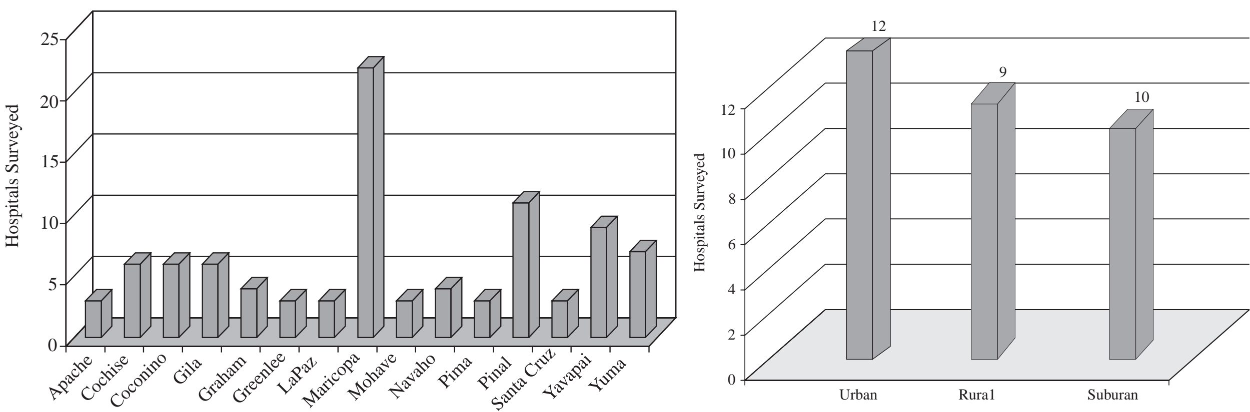

Figure 1. Available Hospital Service Areas by County

Figure 2. Available Hospital Service Areas by Geographic Setting

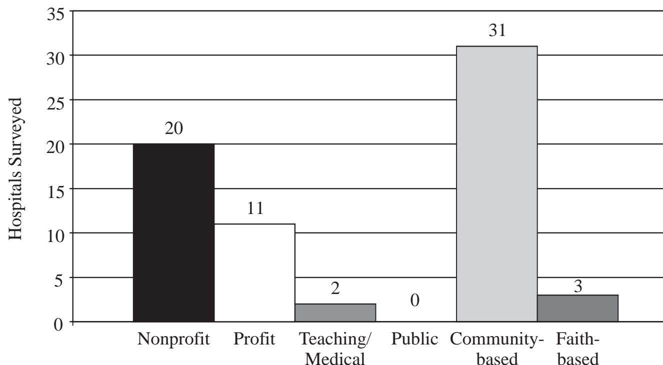

Figure 3. Respondents' Self-categorizations

- Are home health care beneficiaries getting access to needed home health care? If not, what other resources are available in the community?

Methodology

To investigate the suspected lack of access in Arizona in both urban and rural areas, a survey of discharge planners was conducted. The *Arizona Home Care Placement and Discharge-Planner Survey* consists of eleven questions on the perceptions of hospital discharge planners in facilitating the care needs of those being discharged from their hospital. The questions were derived from a previously conducted study[14] with additional queries constructed to target issues specific to Arizona.

Hospitals from the active members list of the Arizona Hospital and Healthcare Association (AzHHA) were contacted to secure the name and title for the individual(s) primarily responsible for making discharge plans for those who have had inpatient stays. An initial estimate of sixty available hospital discharge planners to interview was determined. AzHHA members representing clinic settings, children's hospitals, home health care agencies, laboratories, military facilities, health insurance plans, care centers, Indian Health Services, and behavioral health centers were excluded from the potential pool of participants. Approval for the protection of human subjects was secured from the Institutional Review Board at Arizona State University.

A separate survey of home health care agencies was conducted. This survey consisted of interviews with home health care leaders in the state. In addition, thirteen home health agency administrators completed reports related to one and five-year projections for the home health care industry, future issues, current challenges, and what an aging population will be facing in their communities over the years ahead.

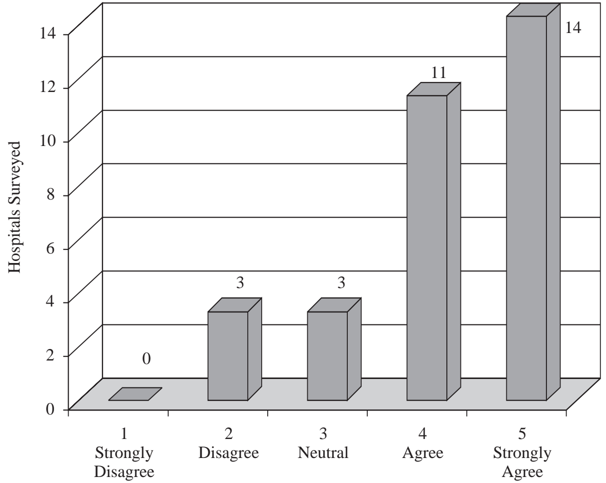

Figure 4. Increasing Home Health Care Placement Difficulties

Discharge-Planner Survey Results

Discharge planners typically are registered nurses, social workers, case managers, or utilization review staff. In many situations, patients do not need the assistance of these individuals in making plans for home health care or other settings. But for many others, particularly those who have encountered a life-changing medical or surgical event, a safe transition to alternative settings or for care at home depends on the expertise and skill of professionals trained in making these often complicated arrangements. For the

purpose of this study, discharge planners include all individuals, regardless of their professional affiliation or training, that are involved in the systematic review, referral, and planning for individuals being discharged from an acute care hospital setting. Although discharge planners encounter all populations and age groups in their daily work, the study participants were urged to consider the elderly population, in particular, when responding to the survey. Of the sixty available hospitals, twenty-nine individuals representing thirty-one hospitals participated in the telephone interview.

The hospitals. Although all of the surveyed hospitals were located throughout Arizona and admitted patients from their resident counties, some hospitals cared for individuals from neighboring counties or states (California and New Mexico) and from Mexico (Figure 1). Specialty or trauma hospitals were more likely to attract patients from every Arizona county and often from across the United States. Six hospitals provided care to individuals from Indian reservations. The hospitals ranged in size from twenty-two to 600 in-patient beds with twelve hospitals in urban, ten in suburban, and nine in rural locations (Figure 2). Most of the responding hospital personnel were from nonprofit facilities (twenty) and all of them (thirty-one) identified themselves as being community-based settings (Figure 3).

Discharge planners, social workers, and case managers. Department managers or the individuals who were solely responsible for the discharge-planning needs of patients leaving their facility comprised this group of respondents. At four hospitals, the manager was responsible for discharge-planning services at two different facilities that were part of their corporate structure. It was noted that often in larger hospitals a mix of social workers, registered nurse discharge planners, and utilization review people and technical staff comprised the discharge-planning team. Although collaborative efforts among team members were identified, each person had a distinct role in the discharge-planning process. The size of the discharge-planning department ranged from one to thirty with an average team of six staff members.

Most of the discharge planners were eager to provide information regarding the responsibilities and difficulties in fulfilling the multiple needs of patients who may need continuing care beyond the acute hospital setting. The respondents shared that there were many challenges in securing appropriate follow-up care for select populations and for individuals with multiple needs.

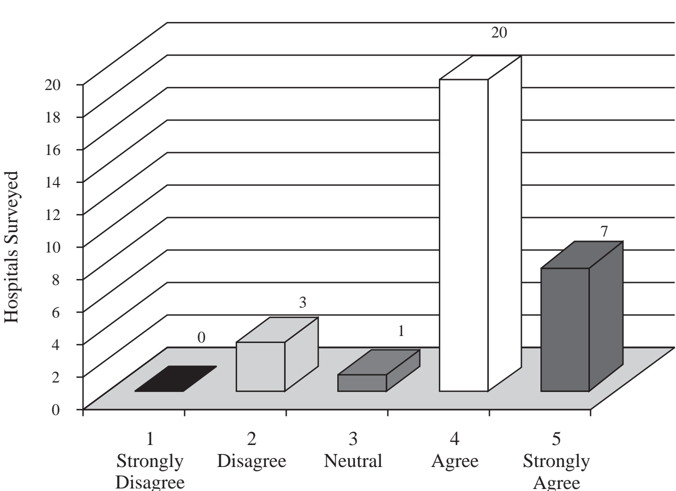

Figure 5. Delays Experienced Related to Types of Patients Needing Home Health Care

Discharge-planning difficulties. When asked if they were experiencing increased difficulty in the last eighteen months in placing patients in home health care upon discharge, eleven agreed and fourteen strongly agreed (Figure 4). The primary reasons were related to home health care agencies with selectivity of referrals, limited reimbursement, higher cost visits, the lack of previously available infusion

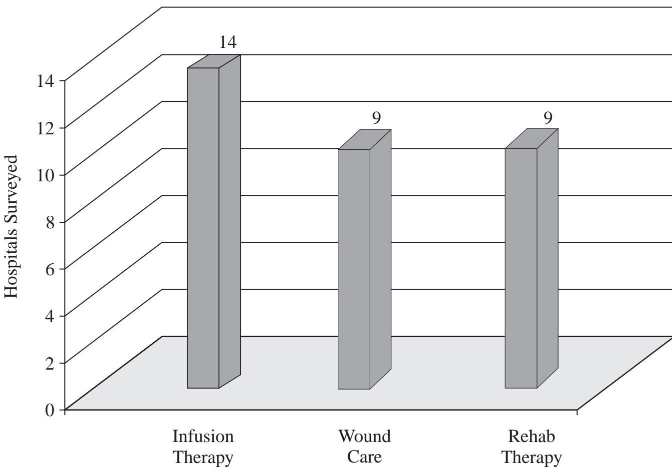

Figure 6. Post-discharge Treatments That Could Delay Patient Discharge

services, the inability to provide care in the evening or on weekends, and the absence of agencies in the rural areas. Two discharge planners indicated that there were but a few select Medicare-Health Maintenance Organization (HMO) providers in both the rural and urban areas, often limiting their choice of agencies. One southeastern hospital discharge planner said that the community had no home health care agencies at all. An urban hospital social worker noted that home health care agencies were much "more stringent" in determining what patients they would admit to service, often making it more difficult for the hospital to make a referral. Five discharge planners identified that the home health care PPS has led to increased difficulties in securing follow-up care for their patients. Several respondents indicated that the nursing shortage has also limited the capacity of home health care agencies to service referral requests. In all situations, the discharge planners identified this problem with the elderly population requiring home health care services.

Discharge-planning delays. When asked if they experienced longer delays in discharging patients to home health care, the responses were similar. Twelve discharge planners thought that increasing difficulties resulted in unnecessary delays for discharge from the hospital, while ten were neutral and eight did not feel that this was the case. The answers to this question were similar to the difficulties that the discharge planners faced in referring patients to home health care. The respondents elaborated on several key issues. One was the lack of resources in their communities, which included both home health care agencies and skilled nursing facilities (SNFs). Five discharge planners identified the nursing shortage as the main reason that home health care agencies were unable to take referrals. One discharge planner even questioned how long a patient would remain on service with an agency once they were admitted, highlighting the suspicion that care was very short-term. One discharge planner feared that a home health care agency's refusal to accept a case was financially motivated, due to increasing cost-constraints from the home health PPS. In all cases, the respondents indicated that the delay issue was a problem for the older population and two people felt that the problem included individuals of all age groups upon discharge from their hospital.

Types of patients. The hospital discharge planners were then asked if the difficulties and delays were related to issues in the home health care agencies or if there were certain circumstances or types of patients that were more problematic than others. Twenty-seven of the respondents either agreed or strongly agreed that they were experiencing delays related to the types of patients needing home health care services (Figure 5). In many instances, the planners qualified their statements by saying that the driving force behind the problem was the lack of resources in the community or within the agencies themselves, such as the lack of adequate staff to care for patients requiring extended care at home. Three respondents spoke of "unsafe"

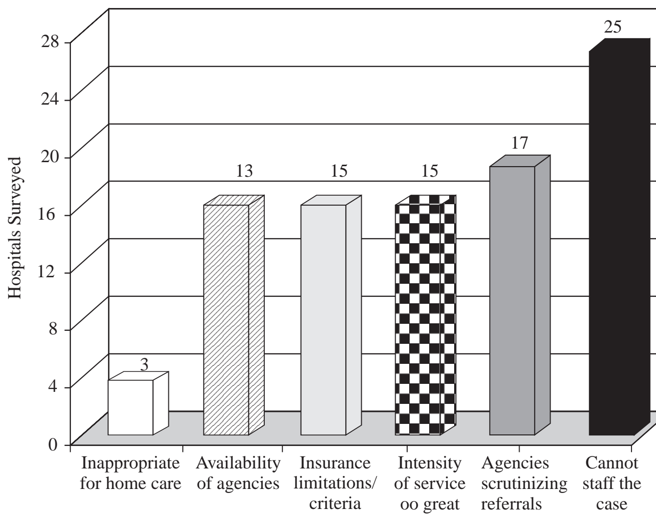

Figure 7. Reasons for Delays or Denial of Home Health Care after Discharge

discharges, where elderly individuals refuse to go to a long-term care setting yet no services are available in the community for the needed follow-up care. One discharge planner was very concerned about the homeless elderly in the community and the effort required to provide a safe and uncompromised journey from hospital to home.

The respondents were then prompted to address the various types of patients that could result in discharge delays: those patients requiring wound care, rehabilitation or therapy services, and intravenous therapy (Figure 6). Discharge planners representing fourteen facilities stated that infusion therapy for antibiotics or specialty intravenous medications is not a viable option due to poor home health care agency staffing or the lack of agencies in their area. Discharge planners stated that the home health care agencies did not have the available nursing staff to safely admit the patient for care and that reimbursement was limited or simply not available under the Medicare provisions. Several were quick to point out that in some cases, patients could go home but since they could not afford the specialized medications, either a longer hospital stay or transfer to another facility was necessary. Other discharge planners stated that since Medicare does not reimburse for prescription medicine, many elderly simply cannot afford infusion therapy medications at home.

Overall, patients requiring higher intensity of home health care, such as every day or twice daily visits, may not be admitted by the home health care agency. This could be typical for patients requiring extensive nursing care or for those requiring an rigorous physical therapy regimen. Other respondents noted diminished access to home health care if an unsafe discharge was apparent or if mental health care needs could not be met. One respondent noted that many older people want to go home only to find out that they cannot care for themselves adequately. Two discharge planners emphasized the importance of a caregiver to assist the patient at home, particularly if the home health care agency could not provide the requisite care. Patient location and distance for the home visit, such as in a rural setting, were particularly problematic for three discharge planners who had difficulties in making discharge-planning arrangements.

The home health care agencies. Delays in discharging patients, related to home health care agency needs, centered on three distinct but overlapping observations: the type of patient, competing agency constraints, and adequate agency resources. In some situations, a patient's needs may be too great to be cared for adequately at home by an agency. In other situations, "questionable skills," that are necessary for home health care agency Medicare reimbursement, may jeopardize the agency's willingness to assume care for a patient. Although the overall health care need may be apparent, if the care is not "skilled," Medicare will not reimburse for home health care services. When agencies lack resources, as with a shortage of nursing personnel or

poor reimbursement, care which may be extensive or geographically distant from the agency may be threatened.

Adequate staffing in home health care agencies was a primary reason (among twenty-five) for delays or denial of care (Figure 7). In particular, inadequate staffing in home health care agencies posed problems for weekend care and high-intensity cases. Discharge planners repeatedly reported that the home health care agencies were struggling with staffing issues, which resulted in the need to secure different providers or resources upon discharge. More than half of the respondents (seventeen respondents) agreed that home health care agencies were more closely scrutinizing patients before admitting them for care, while the intensity of care (fifteen respondents) and insurance criteria (fifteen respondents) also created delays in securing care through home health care agencies.

Three discharge planners expressed concern over the unsafe discharge of patients who return to their homes with extensive unmet personal care or “unskilled” needs. Some of these patients are “noncompliant” with their medical care regimen and tend to be readmitted to the hospital on a more frequent basis. Others have refused to go to a long-term care facility—preferring their independence to institutionalization. The discharge planners and social workers indicated that resources in the community might not be adequate or available to meet unskilled care for those elderly choosing to live at home.

The availability of home health care agencies was problematic for thirteen hospital respondents. It was of greatest concern to the rural hospital discharge planners but was also true for several urban hospitals. Two discharge planners indicated that there were a few select providers in urban settings where, in some circumstances, the patient may have the insurance and the need yet the agency cannot assume the responsibility for care. The limited or lack of choice of a home health care agency becomes more problematic if the provider cannot admit the patient for care due to marginal nurse staffing, geographic distance, the intensity of care, or reimbursement realities. In some cases, this may result in a delay in care for patients who have been recently discharged from the hospital. One respondent thought that the proprietary home health care agencies were “cherry-picking” or assuming care for patients where their profit margin was guaranteed.

Ability to place patients. Discharge planners were asked if they were ever unable to place patients for home health care services and when this would happen. One discharge planner said that this problem would emerge with “difficult” or patients with complex needs. Another discharge planner said it was a “daily problem” which usually required “talking someone into taking the case.” Lack of knowledge or reluctance to refer to home health care among physicians was never identified as an issue. Home health care availability in the community (twenty-one respondents) was the primary reason sited for the inability to place patients, followed by home health agencies refusing the case (twelve respondents), and the lack of or restrictive insurance coverage (seven respondents).

Two-thirds of the discharge planners regularly had some difficulty placing patients for home health care. Six respondents had problems either most or all of the time—four from urban and two from rural settings. In most situations, discharge planners found other avenues for placement and needed follow-up care when home health care was not a viable option. When patients were

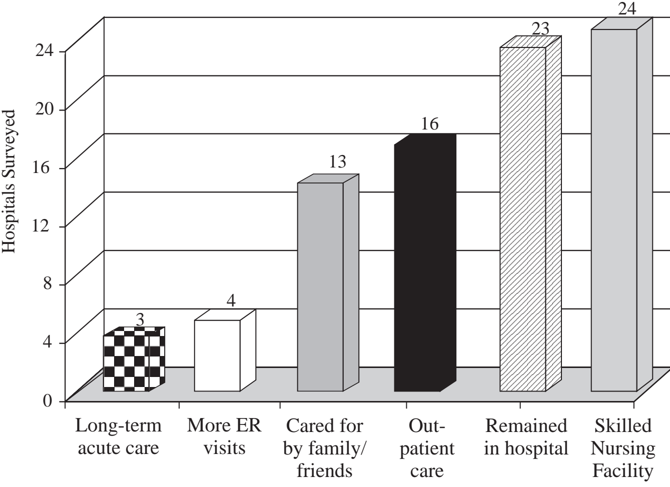

Figure 8. Comparison of Discharged Patients by Possible Alternative Arrangements

unable to return home with home health care, they would either transfer to a skilled nursing facility, remain in the hospital, obtain follow-up care in outpatient ambulatory settings, receive care from family members at home, secure needed care in emergency department settings, or enter a long-term acute care facility (Figure 8).

In addition, several creative measures were used to bypass home health care agency placements. In rural settings, the use of "swing beds" (a designation for transitional care) accommodates the continuing care needs of patients while they recuperate or await placement in an extended care setting. One discharge planner will contact the patient's attending physician to change the plan of care while another discharge planner asks families to "step up to the plate" and assume more care for their family member upon their return home. Two respondents work with assisted living or group homes to provide the needed follow-up care. In three communities, hospital discharge planners provide transportation to outpatient care settings or the physician's office for needed follow-up care. One hospital will provide free home care upon hospital discharge. In the rural areas, patients and their families may need to move into town for their continuing health care needs or the patient may need to receive care in another community setting far away from their home. With more options available in urban settings, the problem is not as insurmountable, however, several social workers were concerned over the closure of long-term care beds in the Phoenix metropolitan area.

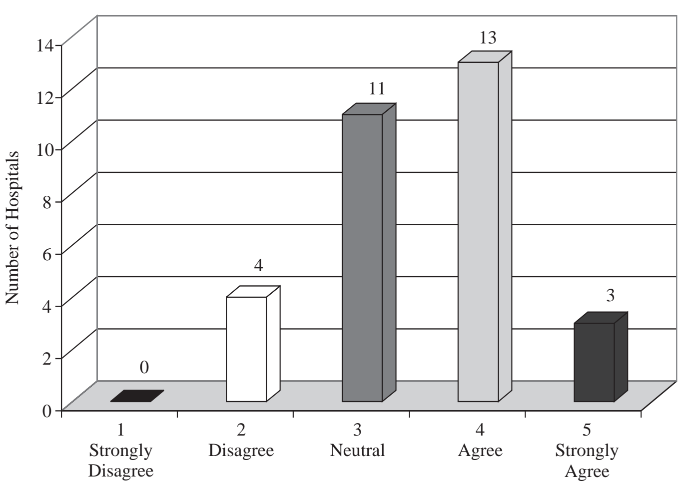

Figure 9. Increasing Rate of Hospital Readmissions within 90 Days of Discharge

Scope of the problem. The survey participants were asked if the number or percentage of patients requiring alternative arrangements had increased in the past eighteen months. Fifteen agreed and eleven strongly agreed that the number of patients requiring alternative arrangements in the past year and a half had increased. Respondents from nineteen of the hospitals provided an estimate that this situation was occurring anywhere from 5–60 percent of the time, with an average of 26 percent of their effort spent in managing alternative arrangements for home health care. When asked if this was a change in the type of patient presenting discharge problems to them in the hospital, most (twenty-three

respondents) either agreed or strongly agreed. One discharge planner felt the problem was that the resources had changed (e.g., less or not available) and not the type of patient. Others indicated that patients are "sicker and get out of the hospital quicker," requiring expediency in making discharge plans. Other explanations for the increased use of alternative arrangements included the lack of social support and a family network to care for individuals upon discharge. One utilization review person felt that the problem was worse in the winter, when people come to Arizona and do not have family to care for them if they become ill.

Knowing if the type of patient that presents discharge problems is predictable helps to determine what resources can be used in planning for their continuing care needs within the community. When the discharge planners were asked to rate if this was the case, sixteen agreed and nine strongly agreed. In addition, three respondents described mental health issues as a major concern for many elderly upon discharge from the hospital in that little care is provided in their communities for this significant need. When asked if the scope of the problem has increased, thirteen agreed and eleven strongly agreed that this was the case and that it had increased an average of 24 percent in their daily work.

Hospital quality management personnel and those who review the appropriateness of hospital discharges closely track readmissions of previously discharged patients. When the discharge planners were asked if the number or percentage of hospital readmissions within ninety days among patients who were originally discharged to a home health care agency had increased, eleven were neutral in their response while sixteen either agreed or strongly agreed (Figure 9). Many respondents did not have access to the readmission rates and some were reluctant to discuss their employer's experience with readmissions. One social worker had seen patients return to the hospital before the home health care agency had made the first home visit, often wondering why it takes so long for patients to be admitted to service. Another discharge planner said that the skilled nursing facility readmission rate is far worse at her facility than for home health care. One discharge planner referred to those regularly readmitted individuals as "frequent fliers," typically presenting a wide range of ongoing social and health care needs.

The hospital discharge planners indicated the types of patients, by diagnosis categories, that were more likely to be readmitted to the hospital after returning home, whether they had received home health care services or not. For discharge planners representing sixteen hospitals, patients with cardiac conditions, were more likely to be readmitted over the ninety-day course of time. Patients having respiratory conditions, such as chronic obstructive pulmonary disease, pneumonia, or other respiratory diseases, were also likely to be readmitted, as noted by discharge planners from eleven hospitals. Other respondents noted that those with surgical complications, end-stage renal disease, diabetes, and wounds were also more likely to return to the hospital. Other broad categories of patients included those who are noncompliant with their health care, elderly "snowbirds" or winter visitors, the undocumented elderly, those who are frail, and those with mental illness and borderline dementia.

Resources

Hospital respondents were asked if the shortage of registered nurses and home health aides had been an issue related to securing needed home health care for their patients. Nearly all (twenty-nine) of the discharge planners believed that the nursing shortage was problematic. One

felt that this was an issue in larger home health care agencies. Two others indicated that weekend and evening hour staffing was related to the shortage. One urban and one rural discharge planner believed that the shortage was not a problem, rather it was a matter of home health care agency financial resources.

All of those interviewed were asked if they were familiar with any agencies using telehealth [the use of communications technology to deliver health care services in a remote location] in the home. Only one person was aware of a home health care agency using telehealth. One discharge planner knew of telehealth being used in an insurance-related chronic-disease-management program and another was aware of telehealth psychiatric services in northeastern Arizona.

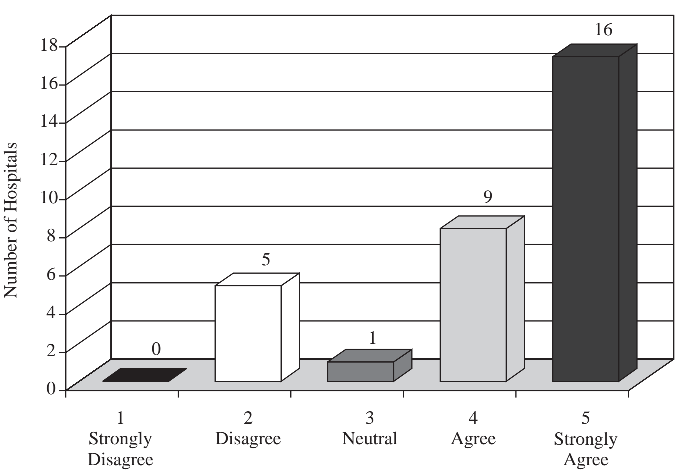

Figure 10. Decreasing Availability of Patients Home Health Care in Rural Areas

When asked how useful telehealth could be in the future, most of the respondents were hesitant or had specific reservations. Several thought that the elderly would have difficulty with this technology and another person thought that the technology would have to be "simple." Two discharge planners felt that telehealth is no substitute for the nurse. Five respondents thought that telehealth might be of some benefit for those with heart disease who need continued management over a long time. One discharge planner wanted to know who would pay for it and if Medicare would consider it as a covered benefit. Overall, most of the respondents were tentative and qualified their decision by identifying various clinical indications when telehealth interventions may be appropriate.

Insurance. Respondents answered specific questions about insurance. First, the discharge planners were asked if they felt that the availability of home health care for Medicare patients had decreased in the past three years. Overall, 81 percent of the respondents either agreed or strongly agreed that the Medicare home health care benefit has become more limiting in the past three years because of stricter admission criteria, limited reimbursement, and fewer agencies.

The respondents were also asked about the ability of the Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Long-term Care Services (ALTCS) to provide care at home after hospitalization. One-third of the respondents had problems with both of these programs. The reasons for difficulties with AHCCCS included problems with emergency care and select providers listed on the plan. Others indicated that AHCCCS was "good insurance" or was no worse than working with other insurance providers. The greatest barrier to ALTCS was securing an adequate number of providers to care for those at home. The other obstacles included the eligibility-waiting period that resulted in delays in starting care and difficulty in finding home health care resources.

Geographic distribution of agencies. The discharge planners were also asked if they were aware of any underserved areas for home health care in Arizona. Respondents from twenty-seven hospitals were aware of underserved areas in Arizona. The urban and immediate suburban areas of Phoenix, Flagstaff, and Tucson escaped any notable references to underserved areas for home health care. The underserved rural areas included many Indian communities, the Globe-Superior area, Wickenberg and its surrounding communities, the Prescott and Payson areas, and Yuma. Other underserved areas included northeastern Arizona north of Winslow, southeastern Arizona from Safford to Globe, Sierra Vista and Nogales, the surrounding Casa Grande area, rural Maricopa and Pinal counties, Ajo, Show Low, and the western communities of Parker, Lake Havasu, and Bullhead City.

Similarly, the discharge planners were asked if they had difficulty in making arrangements for their hospitalized patients who reside in rural areas and are returning back to their home or community. Nine agreed and sixteen strongly agreed that they were having difficulty in discharging patients to or within rural areas. The six remaining respondents, who were neutral or disagreed, were from either urban or suburban hospital settings.

Challenges that lie ahead…. The respondents had a lot to say about future challenges. Most of them reiterated that there "will be more of the same." Several indicated that the entire health care system is in turmoil and "the worse is yet to come." Most were pessimistic that the situation would improve in the near future, noting that increasing numbers of elderly with more years of life expectancy and the rapidly aging baby boomers will tax the health care system. A common theme was the lack of a "safety net" for those elderly without family in the vicinity. Without adequate familial networks and community resources, most felt that that the elderly will continue to "fall through the cracks." Another person cited increasing numbers of "fragile elderly who are living 'on the edge.'" One person indicated that technology has increased life expectancy only to produce individuals in greater need of care when there are less resources to meet those needs. The respondents also indicated that health care will become more fragmented and reimbursement issues will be forcing all health care providers to rethink their strategies to remain financially solvent.

The discharge planners were also concerned about reimbursement policies and how they may be compromising entry of the elderly population into community-based care settings. Compromised access includes the number of available agencies or facilities and the close scrutinization of potential admissions that, in some cases, has sent elderly patients to distant locations to secure care or for some others to go without. Overall, the discharge planners surmised that some Medicare beneficiaries would continue to face access problems in skilled nursing facilities and home health care agencies due to reimbursement realities and rigid insurance criteria. This holds true in particular for individuals with end stage renal disease, for those with complex care needs requiring technical nursing care that is expensive and, in some cases, is at a premium, and for others who have unskilled, custodial care needs. One discharge planner stated it was like being a "carpenter without a tool box," while another said it was "treading water" since she knew what to do for patients, but had few resources to execute the plan of care.

Several discharge planners indicated that increasing regulations for swing beds, acute care rehabilitation, and long-term acute care are likely. Several discharge planners were also

concerned about upcoming changes in reimbursement payments for select facilities and providers. These concerns include the implementation of PPS for acute rehabilitation settings and the threat of rural hospitals losing the "swing bed" option. These changes, coupled with the PPS rules for skilled nursing facilities and home health care agencies, will continue to tax discharge planners and, ultimately, the patients in making appropriate plans for those returning home from the hospital. Overall, discharge planners were very concerned about the lack of available skilled nursing facilities beds throughout the state in addition to the already diminished home health care resources.

Rural hospital discharge planners and social workers expressed concern over their hospitals' long-term survivability. When the hospital is the primary health care provider in the community, its continued sustenance is paramount for the health residents. Options such as "swing beds" assist some rural hospitals while others are unable to get through the governmental paperwork to secure these provisions for those needing continued nursing care where none exists. Becoming a "critical access" hospital is another option to secure stability for a struggling rural hospital. Overall, rural hospital discharge planners and social workers also reported less health care resources in the community.

Urban discharge planners are facing the same concerns if a patient from a rural hospital has been relocated to an urban facility for specialized care. Urban discharge planners recounted numerous situations where patient discharge back to the rural community is particularly burdensome due to the lack of resources in those areas. Others expressed continuing concern over the difficulties in making discharge plans for Indians returning to their communities or for the undocumented or homeless elderly. These difficulties may translate into increased length of stay for the hospital and the resultant unreimbursed costs. One social worker in an urban setting feared that continuing placement pressures would compromise the hospitals ability to remain fiscally solvent.

Current reimbursement and payment mechanisms continue to pose problems for hospital discharge planners and most envision it getting worse in the future. For those elderly in rural communities with Medicare HMO coverage, the problem has been more severe either with limited or no access to home health care services. Insurance contracts have resulted in fewer or a limited selection of providers. At times, these providers are unable to care for beneficiaries due to limited personnel resources and reimbursement constraints. AHCCCS also poses problems for some discharge planners, particularly if competing health care plans do not offer similar coverage.

The lack of qualified health care personnel, such as nurses and social workers, will continue to hamper efforts for efficient, effective discharge planning. This was echoed by an overwhelming majority of those interviewed. One social worker said, "We need to rethink how we deliver community-based care altogether."

What's working and what's not ... suggestions and solutions. The discharge planners were eager to share what was working in their facilities and communities to solve some of the dilemmas and challenges. Some solutions were of an internal nature—community hospitals recreating discharge-planning strategies. For example, one social worker in a rural hospital has instituted a care management "team" model that draws upon the expertise of the two professional

disciplines of nursing and social work to collaboratively meet the discharge-planning needs for those going home from the hospital. Then, hospital registered nurses become the "clinical watchdogs"—working with the patient's physician to better address discharge-planning needs right at the bedside. In another hospital, complimentary transportation home and to the physician's office and for home health care has decreased hospital readmissions while securing a timely discharge.

Several hospital discharge planners stated that they start early to make discharge arrangements for home. Even one social worker said that discharge planning now begins *before* an admission—dispelling a common perception held by most professionals that the time of admission is the gold standard for planning a discharge from the hospital. Two hospital representatives stressed the need for a quick assessment of the patient and an immediate discharge plan. This is particularly true if placement in a skilled nursing facilities placement is predictable. One rural hospital social worker relayed this concern especially if the patient could not be placed in a long-term care facility located in their community. He indicated that it is not uncommon for patients from his hospital to relocate to another community to accommodate their continuing health care needs due to the unavailability of long-term care beds in their town. Another social worker gives the ALTCS application immediately to the hospitalized patient who will undoubtedly require long-term care assistance in the home upon discharge. Another social worker contacts the Adult Protective Services unit of the Arizona Department of Economic Security for noncompliant patients or anticipated unsafe discharges.

Other suggested solutions centered on community connections. One suburban hospital had a chronic disease management program that lasted for two years. High-risk patients, who were cared for at the hospital, are followed in their homes with the goal of maintaining their health and preventing readmissions to the hospital. When funding for the program ceased, an increasing number of patients with chronic diseases were readmitted to the hospital. This case manager was disappointed that the program was no longer operational when it appeared to be particularly beneficial for the older, chronically ill population. She also believes that the hospital maintaining a community focus will assist those elderly in their service area for needed care. These community focus aspects include outreach, preventive care, networking with community agencies, and upholding the mission of the hospital.

Others believe that a case-management model for at-risk elderly in the community would be a viable option. Coordinated efforts among health care agencies, along the continuum of care for health promotion and the maximum independence of the elderly in our communities, is necessary in a fragmented system of health care. One hospital discharge-planning team prides itself in contacting all patients within twenty-four to forty-eight hours of discharge to evaluate if the transition plan of care has been successful and to intervene, if necessary.

Community education was a suggestion from several of the survey participants. These discharge planners and social workers felt that unrealistic expectations by some patients regarding their ability to care for themselves might spawn unsafe situations at home or create undue stress if their physical or mental health needs necessitate placement in a long-term care facility. Education could assist the elderly to become more knowledgeable about their care needs as they get older. One rural hospital presently holds classes targeted for those with diabetes, heart failure, and cardiac disease. These survey respondents recommended community education that

included such topics as advance directives, assistance for the elderly to develop realistic expectations from the health care system, and how to prepare for long-term care placement or assistance in the home.

In other settings across Arizona, discharge planners reported that hospital-based home health care agencies are working closer with their parent institutions to provide more extensive or comprehensive home health care services or to augment services in the hospital. These ideas range from inpatient palliative care units to improved communication between larger urban hospitals and those located in the rural areas. Other hospitals are creating tighter bonds with home health care agencies to collaboratively work toward improved transitions of care from hospital to home. One discharge planner preferred "one-stop shopping," where home health care agencies could provide all services (e.g., nursing care, home medical equipment) with one phone call or one fax transmission. Another discharge planner was in favor of a "streamlined" referral process. In other settings, the respondents favored managed care insurance contacts located on-site to assist in making discharge-planning arrangements.

Developing a consortium of health leaders in the community is on the drawing board for one rural hospital to brainstorm and problem solve for health care needs of their elderly population. Another social worker in a rural community in northeast Arizona used a similar approach to address mental health needs in their community. In another rural setting, community case managers meet monthly to network, make contacts, and construct intervention strategies to address community-based problems. Networking appears to be a predominant venue for rural discharge planners who rely heavily on local community resources, churches, and outpatient health care services.

Home Health Care Agency Results

Thirteen administrators and home care association leaders addressed questions related to the current challenges and future of home health care in the state. The qualitative findings centered on four themes: the agencies, agency personnel, the people and the community, and policy issues. Of those returning the questionnaires, twelve projected more difficulty and challenges in the years ahead and were less than optimistic about issues such as the nursing shortage, increasing governmental regulations, and community-based care for an aging population.

The agencies. One administrator said that home health care is just "limping along" and another said, "regulatory requirements are killing the home health care business." Four respondents were concerned about the decrease in the number of rural home care providers. One administrator felt that there is an increasing financial burden on agencies today to provide home health care. Another leader was optimistic, stating that the "future is bright" in that home health care will always be around but agencies will need to be more creative in the care delivery patterns. The use of point-of-care technology and telehealth may help agencies progress with increasing demands to provide cost-effective, efficient care.

Agency personnel. Eight leaders and administrators identified the nursing shortage as a major concern in staffing home health care agencies, with the shortage most acute in the rural areas of Arizona. One respondent was concerned that nursing moral was affected by the increasing paperwork burden. Another administrator felt that a caring environment was critical to nurse

retention while another voiced the ongoing problem of a lack of critical-thinking skills in nurses today.

The people and the community. The respondents identified several key concerns surrounding access to community-based care. Two administrators noted decreased availability of home health care and other community resources in rural areas, resulting in "increased pressure" for those remaining to provide adequate services. Four persons anticipate that Medicaid and ALTCS will need to respond to a growth in the demand for unskilled care in the home for our elders, but funding may be unavailable to support this initiative. Similarly, county health plans will need to address growing numbers of elderly with limited resources that require homebound-related supportive, custodial care.

Two other administrators were concerned about shortened hospital length of stays and the resulting increasing acuity of care when patients are sent home. For those ineligible for reimbursed home health care, access to supportive care services may be limited due to increasing out-of-pocket expenditures for those elderly who cannot afford to pay for it. One administrator projected that if home health care is unavailable, there will be more demand for nursing home and SNF care. Another administrator was concerned that competent, willing caregivers are difficult to find or nonexistent, making it harder for those elderly patients desiring to remain in their own homes.

Policy. Policy changes were recommended by many of the respondents. Reducing government regulations was the predominant issue. Six respondents requested a significant government-required paperwork reduction and three were specific in their answers, identifying OASIS forms as particularly time-intensive. One favored conducting an ongoing evaluation on the effect of PPS on access to home health care and one suggested that payment changes would occur once it was determined that home health agencies were profiting from PPS. One administrator favors removing the bundling for all medical supplies, since wound care supplies are extremely expensive. Determining the congruence for compliance between the Conditions of Participation and the state survey process was another recommendation by an administrator.

Other general policy concerns were identified. One administrator projected that "telehealth will become commonplace in an effort to reduce expenses," but another respondent does not believe that its impact will be that great, although the barriers to effective implementation of telehealth related to reimbursement should the explored. Two other respondents were in favor of prescription coverage for Medicare beneficiaries, as this would free up disposable income for the elderly while addressing the infusion therapy deficit, as noted by the hospital discharge planners.

Implications and Recommendations

The discharge planners and home health care agency administrators and leaders provided valuable insight into the dilemmas and challenges that they face on an ongoing basis in providing care and assistance to primarily an aging population. The discharge planners make detailed arrangements for large caseloads of patients who no longer require acute care. Discharge planners function in "revolving doors" with the opportunity to look inward to the hospital and outward to the community knowing that the hospital may serve several needs for that one patient. Discharge planners provide a holistic perspective to health care when caring for the patients in

their hospitals, while providing meaningful insight into the present and the future of health care in their communities.

The home health care administrators and leaders also provided insight into the current constraints and problems facing their industry and gave projections for the future. These agencies offer extensive medical and nursing care to individuals who are homebound and are in need of skilled care on a part-time, intermittent basis. Various recommendations are suggested that may assist local, regional, and the state health care system providers, regulators, and policymakers in tackling the emerging problems and concerns as noted in this study. The “6-C” approach of community connections, community-capacity building, communication, the continuum of care, care management, and creativity best encapsulates the recommendations as a result of this research study.

Community connections. A prevalent theme throughout the study was community connections. Community connections are linkages established among interested parties to find purposeful solutions to pressing problems. These connections can occur within and across organizational settings. An example of community connections within an organization was the efforts of discharge planners in one rural hospital to establish formal teams with the medical and nursing staff to address patient-specific issues and concerns as well as hospital-wide problems related to discharge-planning. Another example was the development of a hospital palliative care unit, designed to address the lack of hospice care availability in the community. Multidisciplinary and interdisciplinary team meetings or internal hospital task forces are also recommended to promote effective discharge planning.

Connections can also occur across organizational settings or agencies. One such example included several communities where home health care agencies formed alliances or partnerships with local hospitals to address patient care needs and to promote expedient discharge planning. Efforts included streamlining paperwork, on-site referral assistance, and “one-stop shopping,” thereby making the transition to home a smooth one.

Community-capacity building. Connections through community-capacity building are at work when multiple providers and agencies establish partnerships to identify and resolve health care and social needs of specific community populations. Community-capacity building, through coalitions, can also be generated when community liaisons and key health care providers work to solve problems specific for their living community by developing the mechanisms, skills, and structures to support effective problem solving while creating a platform for future success. For example, this occurred in one northeastern rural community when mental health needs of various populations were identified as a significant concern. Through regular meetings and networking, formalized plans to resolve a wide range of problems were identified. The development of coalitions can address specific community problems.

Another rural hospital holds monthly case management consortium meetings where health care providers across the community meet to discuss discharge planning and community-based care concerns. Attendees represent the full scope of disciplines and agencies ranging from governmental entities—such as the Arizona Long Term Care System—to health care providers—such as home health care agencies, the hospital, and long-term care establishments.

Networking and communication across disciplines, agencies, and providers becomes a common mode of operation to resolving community-wide problems.

Adequate capacity building for human resources was another prevalent theme in this study. The nurse shortage is a contributing factor to the inability to cover continuous care nursing requests, part-time intermittent skilled visits to the home, or specialty nursing care, as with infusion therapy. In other situations, geographic distance from the home health agency to the patient's home poses a barrier in some rural areas. Half of the surveyed home health care leaders believe that the paperwork burden is extreme and, in some cases, this may be turning nurses away from working in home health care settings. Further study regarding nursing resources in long-term care and home health care is needed. Short or long-term solutions for compromised geographic access may include telehealth interventions.

Communication. One expressed purpose of communication is education. Enabling health care consumers to make informed choices regarding their health care can be facilitated through education. Educational topics recommended by many of the discharge planners include advance directives, insurance coverage, information about the health care system, and anticipatory planning or how to prepare for future health care needs.

Since many informal caregivers have a significant role in providing care for their family members at home, supportive education is also recommended. This could include a wide spectrum of health care topics, such as fall prevention programs, home safety assessment, nutrition, and other care management practical advice. Community seminars or forums may be one strategy to promote education about these and other timely health care topics.

Evaluating the utility of technology through telehealth modalities, although not highly regarded by the discharge planners in this study, require further investigation. Several telehealth providers exist in Arizona and this is a rapidly growing venue for the provision of health care, most notably in rural or underserved areas across the country. Home health care services could be expanded through telecommunications technology if the regulatory, cost, and reimbursement issues can be addressed.

Continuum of care. Providing appropriate continuum of care services to individuals with varying health care needs as they progress through the health care system cannot be underestimated. Fragmentation of care may be a consequence of a disrupted care continuum. Yet, reimbursement restrictions by insurance companies, intermediaries, and carriers may jeopardize the timely transition and placement for individuals in the most appropriate care setting. Reimbursement policies need to determine how individuals can be treated in the least restrictive environment as possible. Thus, an assessment of home health care infusion therapy policies and reimbursement for costly prescription infusion medications is recommended.

Another aspect of the continuum of care is the capacity to meet long-term care needs within the community where one resides. Reimbursement policies may also be restrictive and limiting, since Medicare only pays for short-term, acute care, home care, or skilled nursing care needs and the state assists in meeting long-term care needs for income-eligible individuals. Promoting self-care and independence or providing for custodial care needs in the home or home-like settings should be examined further in light of potential cost-savings and the preservation of quality of life for an aging population. This is a frustrating issue for rural hospitals who may need to

transport patients to metropolitan areas for follow-up care and for urban hospitals attempting to make home care or long-term care placements in rural communities.

Care management. Care management can include a variety of strategies, ranging from case management services to at-risk individuals to disease management. Telehealth modalities may also be appropriate. Episodic treatment interventions need to be replaced by care management; community-based strategies that encompass the continuum of care. This is particularly true for an aging population with complex, chronic health care needs where educational interventions, professional health care support and management, and community resources can maintain one's independence in the home while preventing costly, and often preventable, hospitalization or institutionalization. Care management may assist in securing an individual's "safety net."

Creativity. Several hospital discharge planners used creative strategies to meet an array of issues ranging from readmissions to determining adequacy of the discharge-planning process. One hospital telephones all of their patients within twenty-four to forty-eight hours after discharge to discern if any remaining health cares needs require further attention and if the discharge plan was satisfactory. Other hospitals have implemented special transportation programs for homebound elderly patients, complimentary short-term home health care, follow-up care in the emergency department, discharge-planning problem task forces, and an entire array of remedies for intermittent or reoccurring problems. One home health care leader recommended a statewide discharge-planners-home health care agency meeting to collaborate on creative ways to address community resource issues. In most situations, community connections combined with creativity facilitates better discharge planning while strengthening the safety net for aging individuals in their community.

Unresolved issues. Some issues and problems appear to warrant further investigation. One such issue is to determine the adequacy and capacity of community-based care settings and services for an aging population. This requires an assessment and evaluation of the levels of care and services within community settings, specifically for long-term care and other community-based health care services.

Many discharge planners and home health care leaders were concerned that "safety nets" for an aging population have been compromised. Factors stressing the safety nets include geographic distance between families, growing life expectancy, increasing likelihood of living alone, more out-of-pocket expenditures for the elderly, increasing chronicity and complex care needs of patients, little or no resources in rural areas, diminishing access to home health care and long-term care due to limited reimbursement and other financial limitations, and shrinking nursing resources. These factors are taxing the health care system, eroding quality of life, and creating barriers for effective community-based health care. Determining what those safety nets are and how best they can be preserved requires further study.

The impact of health care policy crosses all community settings, hospitals, home health care, and long-term care, and may impact the integrity and preservation of community-based care. Policies that could be examined include the scope and breadth of insurance coverage, reimbursement formulas, the paperwork burdens of home health care nurses, and expanding health care coverage to include wellness and preventive interventions. How policy produces barriers to health care, induces fragmentation of care along the continuum, minimizes access to

long-term or home health care, affects health care personnel resources, and compromises the safety net for an aging population necessitates further exploration.

Summary

The health care system in Arizona, as elsewhere, is in an ongoing state of transition. As demographics point to increasing numbers of an aging population, the capacity within the state to meet health care needs for this group requires investigation and mobilization of resources to meet a multitude of needs. The data collected in this survey seem to indicate several alarming trends. Resolution of these complex issues requires facts, creative imagination, and the vision to prioritize and act. Some of these solutions have been recommended. Others are yet to be developed. A concerted effort by policymakers and planners can mitigate these pressing problems, while building a constructive model by "facing up to the future" for our aging population.

Notes

1. National Association for Home Care, *How to Choose a Home Care Provider* (Washington, D.C.: Author, 1996; accessed 19 July 2001), http://www.nahc.org/Consumer/htcahca.html.
2. Long, Carol O., *The Arizona Home Health Care and Hospice Survey, 1999* (Tempe: Arizona State University, 1999).
3. Long, Carol O., "???," *Arizona Nurse, 53* (2, 2000), 3–5.
4. "Medicare Home Health Agency Numbers Continue to Decrease," *Home Healthcare Nurse, 18* (7, 2000): 427.
5. Smith, Barbara M., Kathleen A. Maloy, and Daniel J. Hawkins, *An Examination of Medicare Home Health Services: A Descriptive Study of the Effects of the* Balanced Budget Act *Interim Payment System on Access and Quality of Care* (Washington, D.C.: George Washington Univeristy, 1998), http://www.gwu.edu/~chsrp/sps/hhs.html.
6. Office of the Inspector General, "Access to Home Health Care after Hospital Discharge 2001" (Washington, D.C.: Author, 2001, July a, OIG Report OEI-02-01-00180), http://oig.hhs.gov/oig/oei/oei.html.
7. National Association for Home Care, "General Accounting Office, Office of the Inspector General Issue Reports on PPS, Access and Quality in Home Health," in *NAHC Report, 879a,* Article 3, (Washington, D.C.: Author, 2000, September), 1.
8. Office of the Inspector General, "Medicare Beneficiary Experiences with Home Health Care" (Washington, D.C.: Author, 2001, July b, OIG Report OEI-02-00-00560), http://oig.hhs.gov/oig/oei/oei.html.
9. *Ibid.*
10. Long, 1999.
11. S. Brenton, personal communication, December 13, 2001.
12. Utterback, Karen B., "Prospective Payment Comes to Medicare Home Health." *American Journal of Nursing, 101* (7, 2001), 59–61.
13. Arizona Association for Home Care. Survey of Discharge Planners (Tempe, Arizona: Author, unpublished raw data, 2001.
14. Smith, Maloy, and Hawkins, 1998.